CHILD FATALITY PREVENTION SYSTEM: 2023 ANNUAL LEGISLATIVE REPORT

Child Fatality Prevention Act; §§ 25-20.5-401 — 25-20.5-409 C.R.S.

July 1, 2023

COLORADO
Department of Public Health & Environment

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Acknowledgements

It is with deepest sympathy and respect that we dedicate this report to the memory of those children and families represented within these pages.

Dedicated advocates across the state make this report possible. Thank you to all members and partners of the Child Fatality Prevention System who give their time and efforts to reviewing cases and entering data, developing and implementing prevention recommendations, and preventing child deaths in Colorado. For more information on the Child Fatality Prevention System, visit www.cochildfatalityprevention.com. This report can be found online at www.cochildfatalityprevention.com/p/reports.html.

CDPHE acknowledges that generations-long social, economic, and environmental inequities result in adverse health outcomes. They affect communities differently and have a greater influence on health outcomes than either individual choices or one’s ability to access health

care. Reducing health disparities through policies, practices, and organizational systems can help improve opportunities for all Coloradans.

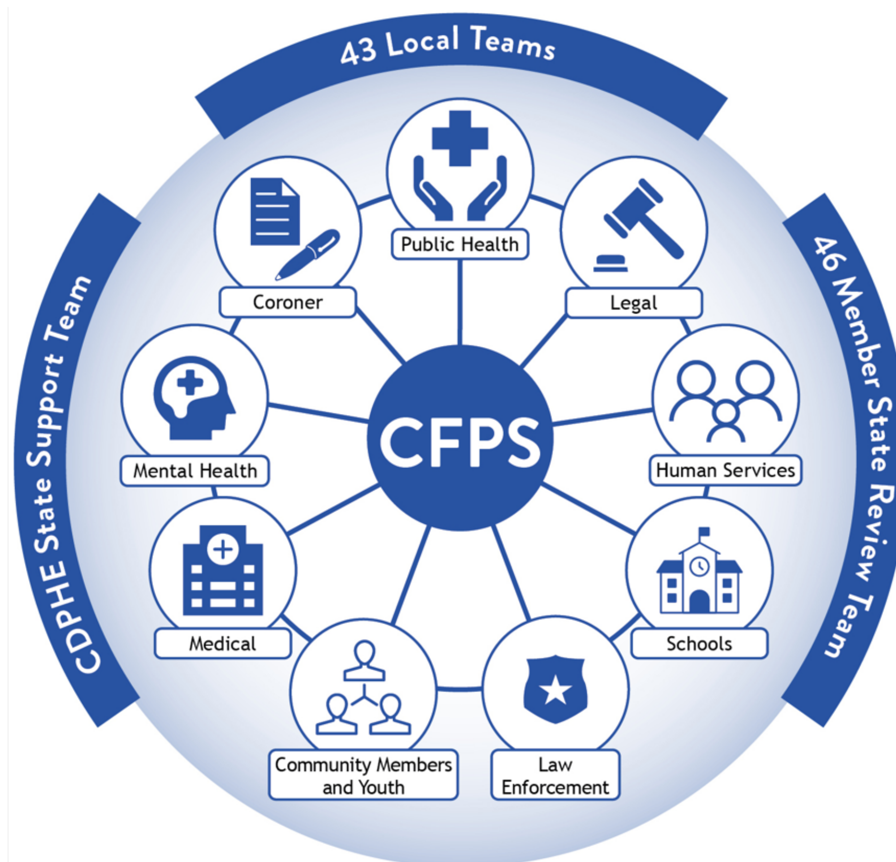
Definitions

- **Behavioral health** is defined as "the promotion of mental health, resilience and well-being; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities."[1]
- According to the Centers for Disease Control and Prevention (CDC), **adverse childhood experiences (ACEs)** are potentially traumatic events that occur in childhood (0-17 years), such as experiencing violence, abuse, or neglect, witnessing violence in the home or community, having a family member attempt or die by suicide. ACEs also affect aspects of the child's environment that can undermine their sense of safety, stability, and bonding, such as growing up in a household with substance use problems, mental health problems, and instability due to parental separation or household members being in jail or prison, among others.
- **SUID** stands for sudden unexpected infant death and is defined as deaths of infants under age 1 that occur suddenly and unexpectedly, whether explained or unexplained.
- **Sexual orientation** is a person's physical, emotional, and/or romantic attraction to people of the same sex or gender, opposite sex or gender, both sexes, more than one gender, or no gender. Examples include heterosexual, bisexual, gay, and lesbian.
- **Gender identity** is a person's innate, deeply felt sense of identifying as a man, as a woman, or non-binary, regardless of their sex assigned at birth. "Cisgender" means someone's gender identity is the same as their sex assigned at birth. "Transgender" refers to a gender identity that is different from the sex assigned at birth.
- **LGBTQ+** stands for lesbian, gay, bisexual, transgender, intersex, queer, and questioning. The '+' stands for other sexualities, sexes, and genders that are not included in these few letters (e.g., pansexual, agender, bigender, gender queer).

- **Inequities** are defined as systemic, avoidable, and unjust factors that prevent people from reaching their highest level of health.[2]
- **Disparities** are differences in health outcomes between people related to social or demographic factors such as race, ethnicity, gender, sexual orientation, or geographic region. Measuring disparities helps measure our progress toward achieving equity.[3]
- **Rural communities** are those that are not part of an urban area. Counties that have at least one city over 50,000 residents are classified as urban. Frontier communities are a subset of rural counties and are counties that have a population density of six or fewer people per square mile.
- **Doll reenactments** are an integral piece of a thorough and complete investigation when an infant dies suddenly and unexpectedly that helps with determining the cause and manner of death. Doll reenactments recreate the death scene using a weighted doll to allow investigators to visualize and document the position the infant was placed to sleep, where the infant was found, and other scene details that help investigators understand the circumstances that lead to an infant's death.
- **Children with special health care needs** are defined as young people who “...have, or are at increased risk for, a chronic physical, developmental, behavioral, or emotional condition, and who also require health and related services of a type or amount beyond that required by children generally.” Children who are in special circumstances like foster care, group homes, jails, detention centers, and other institutions are also considered to be children with special health care needs. While some children with disabilities also have special health care needs, this is not true for all children with disabilities.

Introduction

The Child Fatality Prevention Act (Article 20.5 of Title 25, Colorado Revised Statutes) established the Child Fatality Prevention System (CFPS), a statewide network that focuses on preventing child deaths. CFPS applies a public health approach to prevent child deaths by aggregating data from individual child deaths, describing trends and patterns of the deaths, and recommending prevention strategies. CFPS has been conducting retrospective reviews of child deaths since 1989. Housed at the Colorado Department of Public Health and Environment (CDPHE), CFPS consists of local child fatality prevention review teams (local teams), a 46-member State Review Team, and the CDPHE state support team. This graphic below shows the CFPS structure and the variety of partners who participate in the system.



CFPS teams review infant, child, and youth deaths that occur in Colorado due to undetermined causes, injury, violence, motor vehicle and other transportation, child maltreatment, sudden unexpected infant death, and suicide. Data from these case reviews show trends and patterns in these deaths and help CFPS identify strategies to prevent future deaths. The CFPS State Review Team develops recommendations for how to prevent child

deaths in an annual report. As required by statute, this report identifies recommendations to promote the safety and well-being of children in Colorado for state Fiscal Year (FY) 2022-23. This report also includes data from deaths that occurred from 2017-2021.

CFPS Data Overview

The impact of policies and systems on child deaths

Generations of social, economic, and environmental inequities contribute to the deaths of infants, children, and youth.[4] People exposed to these factors (outlined in Table 1 below) experience additional harm, resulting in higher rates of death. When interpreting the data, it is critical to not lose sight of these systemic, avoidable, and unjust factors. Researchers work towards understanding how geography, race, ethnicity, sexual orientation, and gender identity correlate with health. It is critical that data systems like CFPS identify and understand the lifelong inequities that persist across groups in order to eliminate them. When limitations in the data system exist due to how data are collected, or because data are not collected, CFPS strives to provide additional context and research about how inequities impact child deaths. By changing policies and systems that create and perpetuate inequities, CFPS can reduce the number of child deaths that occur in Colorado. Examples of these inequities include, but are not limited to:

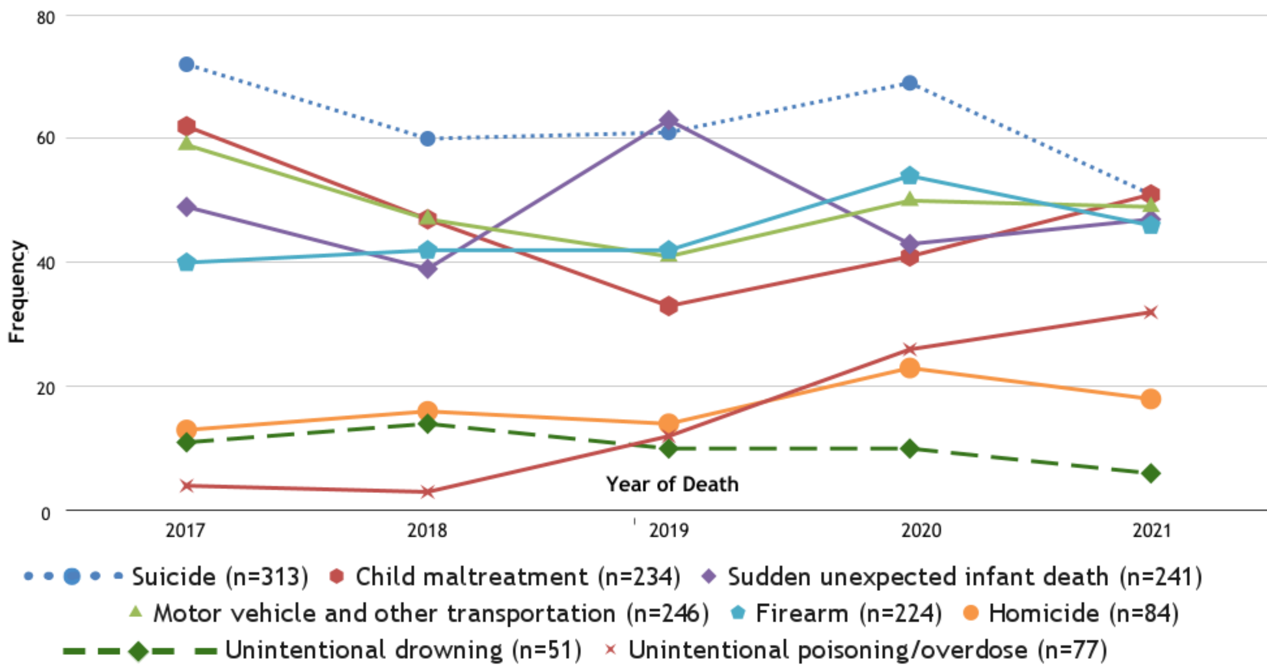
Table 1: Factors contributing to health inequities

Rural and Frontier Geography	Race and Ethnicity	Sexual Orientation and Gender Identity
Limited access to Level 1 trauma centers and mental and behavioral health services.[5] Increased stigma associated with mental illness and seeking help.[6] Longer response times by emergency medical services.[7]	Racism, discrimination, and historical trauma.[10,11] Limited access to high-quality education,[12] employment opportunities,[13] healthy foods,[14] culturally traditional foods,[15] and health care.[16] Chronic stress.[17]	Discrimination, stigma, and bias.[21] Rejection from family, friends, and community.[22] Non-inclusive school curricula and inadequate anti-harassment policies.[23] Insufficient access to LGBTQ+-informed health care.[24]

Rural and Frontier Geography	Race and Ethnicity	Sexual Orientation and Gender Identity
→ These and other factors contribute to higher death rates in rural areas, including suicide[8] and passenger vehicle deaths.[9]	→ These factors result in lasting health impacts for people of color that include infant mortality,[18] high rates of homicide and gun violence,[19] and increased motor vehicle deaths.[20]	→ This chronic social stress that LGBTQ+ children and youth experience influences health across the lifespan, including higher rates of suicide[25] and substance use.[26]

Data in this report come from reviews of deaths among those younger than 18 years of age occurring in Colorado between 2017 and 2021. CFPS uses death certificates to identify deaths among this population. The leading causes of death for CFPS among those younger than age 18 are suicide, motor vehicle and other transportation incidents, sudden unexpected infant death (SUID), child maltreatment, firearms, homicide, unintentional poisoning/overdose, and unintentional drowning. Figure 1 shows the leading causes of death among people under age 18 between 2017 and 2021. Child maltreatment deaths, overdose and poisoning deaths, and SUID increased between 2020 and 2021, while the other leading causes of death decreased. CFPS will monitor these trends in the coming years. More details about trends over time are available in a queryable CFPS data dashboard located at www.cochildfatalityprevention.com/p/reports.html.

Figure 1. Leading causes of death occurring among those under age 18 in Colorado and reviewed by CFPS by year, 2017-2021 (n=1220)



The overall rate of deaths reviewed by CFPS for the period was 18.2 per 100,000 Colorado residents. This rate combines all causes of death reviewed by CFPS and is interpreted as the overall rate of death among Colorado residents younger than age 18 due to injury, violence, and undetermined causes. The overall rate fluctuated year to year and ranged from a low of 17.1 per 100,000 population in 2018 to a high of 19.3 per 100,000 population in 2020.

Across several of the leading causes of death, CFPS observed significant disparities for non-Hispanic Black, non-Hispanic American Indian or Alaska Native, and Hispanic infants, children, and youth, as well as for young people residing in rural and frontier counties in Colorado. Disparities result from historical trauma and the social conditions facilitated by racism and discrimination and from limited resources and extreme social and geographic isolation. Changing policies and systems that create and perpetuate inequities can reduce the number of child deaths that occur in Colorado. More information about the impact of social factors on child deaths is outlined in the CFPS Statewide Data Overview and in the report: The Role of Policies and Systems in Child Deaths in Colorado. All are available here www.cochildfatalityprevention.com/p/reports.html.

In 2020 and 2021**, non-Hispanic Black infants, children, and youth were **7.4 times** more likely to die by poisoning/overdose*, **5.6 times** more likely to die by child maltreatment, **3.0 times** more likely to die by sudden unexpected infant death*, and **5.6 times** more likely to die by firearm* when compared with non-Hispanic white infants, children, and youth.

From 2017-2021, infants, children, and youth residing in frontier counties in Colorado were **4.1 times** more likely to die in motor vehicle crashes*, **1.6 times** more likely to die by firearm suicide, and **1.8 times** more likely to die by sudden unexpected infant death when compared with those living in an urban county. (*Difference is statistically significant; **Due to changes in the race and ethnicity categories that were made to align with the 2020 census, CFPS was only able to calculate race and ethnicity rates for 2020 and 2021.)

Understanding the impact of the COVID-19 pandemic on child deaths.

The COVID-19 pandemic has had a resounding impact on the lives of children and their families and communities, and CFPS is still working to fully comprehend the impact of the pandemic on child deaths in Colorado. For every child death, CFPS teams are asked to complete questions about the child's life including:

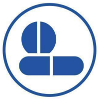
- Was the death an indirect result of the outbreak? Indirectly related deaths are less clearly connected to the incident, but ultimately result from it. An indirectly related death occurs when unsafe or unhealthy conditions are present during any phase of a crisis. Indirect deaths may occur immediately following the acute infection rates or may occur at a later time.
- Did COVID-19 related disruptions to supports and services like school, child care, employment, social services, health care, etc., impact the child or family?
- Was the child exposed to COVID-19 within 14 days of their death?

For deaths reviewed January 1, 2021 and December 31, 2021, teams determined that COVID-19 indirectly contributed to 6.1% (n=15) of deaths. When separated by cause of death, teams determined that COVID-19 indirectly contributed to 19.6% (n=10) of suicide deaths, 13.0% (n=6) of firearm deaths, and no homicide deaths. This is a decrease from 2020 where CFPS teams determined that COVID-19 indirectly contributed to 19.6% (n=41) of deaths

reviewed by CFPS that occurred between March 1, 2020 and December 31, 2020, including 60.7% (n=34) of suicide deaths, 38.3% (n=18) of firearm deaths, and 15.8% (n=3) of homicide deaths. CFPS and others continue to assess indirect impacts of COVID-19 on child deaths in the state.

Summary of CFPS Recommendations to Promote the Safety and Well-being of Children

Colorado policymakers and communities can play a critical role in ensuring the health and well-being of infants, children, and youth and their families by supporting policies that help families thrive. CFPS members recommend the following evidence-based strategies to prevent child death in Colorado. These recommendations are based on the collective expertise of CFPS and do not reflect the official position of CDPHE or of any individual CFPS member organization. For more information on the process used to develop and prioritize these recommendations, please read the CFPS Prevention Recommendation Process section below.



Overdose Prevention

Provide information to parents and communities in their preferred language about the risks associated with substance misuse and overdose and evidence-informed strategies to reduce these risks, including:

1. how to access and use naloxone and fentanyl test strips;
2. how to respond to a suspected drug overdose, including information on Colorado's Good Samaritan Law;
3. how to safely store and dispose of both prescription and illegal drugs;
4. how to avoid accidental ingestion of drugs by young children; and
5. how to have conversations with children about overdose and poisoning prevention in age-appropriate ways.

Suicide Prevention

Provide resources and education to parents and caregivers in their preferred language about how to prevent child and youth suicide, including:

1. family- and health-related factors that are protective against suicide risk;
2. resources around safe technology use and considerations around restricting technology access for young people; and

3. ways to support and affirm LGBTQ+ children and youth.

Behavioral Health

Increase access to culturally responsive behavioral health resources for children, youth, and families by:

1. increasing and diversifying the behavioral health workforce;
2. incentivizing care in rural areas;
3. improving affordability of care; and
4. decreasing stigma related to seeking help.

Gun Violence Prevention and Firearm Safety

Support evidence-based firearm safety practices by reducing access to firearms through safe storage and increasing access to affordable gun safety resources.

Child Maltreatment Prevention

Integrate primary care with wraparound services to support family resilience and promote positive childhood development, including connection to:

1. culturally responsive mental and behavioral health care for parents and caregivers;
2. community-based services through parent navigators, community health workers/promotoras and doulas; and
3. proven home visitation programs.

Infant Safe Sleep Environments

Offer evidence-informed and culturally and linguistically appropriate education on promoting safe sleep environments, to include harm reduction approaches, to parents and multigenerational caregivers.

Motor Vehicle Safety

Partner with new parents, youth, and families to promote safe driving practices through:

1. child passenger safety programs, including car seat distribution programs;
2. young driver safety programs; and
3. education on graduated drivers license laws.

Drowning Prevention

Improve knowledge and skills for parents and caregivers, children and youth, to follow water safety practices through expanded availability and affordability of safe swim programming.

CFPS Prevention Recommendation Process

Each year, CFPS partners participate in a community engagement process to develop and prioritize prevention recommendations based on information gathered from deaths that occur among children in Colorado. For the 2023 report, this process included: 1) reviewing the 2017-2021 CFPS data and local team prevention recommendations; 2) inviting a number of local and state review partners, and community organizations to discuss prevention recommendations, including review of the best available evidence for each recommendation; and 3) prioritizing prevention recommendations.

2017-2021 Data Presentation and Local Team Prevention Recommendations

To review the 2017-2021 data, partners participated in a two-hour online data presentation, including a state overview and data on leading causes of death for infants, children, and youth under age 18 in Colorado: child and youth suicide, child maltreatment, motor vehicle and other transportation, SUID, firearm, unintentional drowning, homicide, and unintentional poisoning. A recording is available at www.cochildfatalityprevention.com/p/reports.html.

For each child death case reviewed, teams develop recommendations to prevent future similar deaths. For the 246 child deaths that occurred in 2021 and were reviewed by teams in 2022, local teams made over 500 prevention recommendations. These recommendations ranged from providing additional services and support to families, to changing organizational policies and state laws, to improving the health of infants, children, youth, and their families. On an annual basis, the CFPS state support team aggregates these recommendations and shares them widely with system partners. Local team recommendations form the basis for the prevention recommendations in this report.

Prevention Recommendations Discussions and Prioritization

After reviewing the 2017-2021 data, and prevention recommendations from the local teams, community partners with lived and professional expertise related to the various leading causes of death discussed which prevention recommendations to include in the 2023 Legislative Report. Following these conversations, partners voted on which recommendations to include in the report, using the following considerations: evidence-base, impact on the identified leading causes of death, impact on equity (with attention to unintended consequences), the population health impact(s), and whether the recommendation originated from the local teams.

Overdose Prevention

Provide information to parents and communities in their preferred language about the risks associated with substance misuse and overdose and evidence-informed strategies to reduce these risks, including:

1. **how to access and use naloxone and fentanyl test strips;**
2. **how to respond to a suspected drug overdose, including information on Colorado's Good Samaritan Law;**
3. **how to safely store and dispose of both prescription and illegal drugs;**
4. **how to avoid accidental ingestion of drugs by young children; and**
5. **how to have conversations with children about overdose and poisoning prevention in age-appropriate ways.**

Overdose deaths among those under age 18 in Colorado increased significantly between 2017 and 2021. The rate of overdose in 2017 was 0.3 per 100,000 (n=4) and significantly increased to 2.5 per 100,000 (n=31) in 2021. In total, 77 children and youth died of overdose from 2017-2021. The overall rate of overdose deaths for this period was 1.2 per 100,000 population in Colorado, significantly higher than the national rate over the 2018-2021 period (0.6 per 100,000 population).[27] Youth ages 15-17 accounted for 76% (n=57) of overdose deaths reviewed by CFPS during this period. Youth in this age group had significantly higher overdose rates when compared to younger children and died from overdose at a rate 17 times higher than youth ages 10 to 14. In 2019, 33% (n=4) of overdose deaths among children and youth involved fentanyl. This increased to 77% (n=20) in 2020 and remained high at 66% (n=21) in 2021. This is consistent with national data showing rises in fentanyl-involved deaths. CFPS will monitor this trend closely.

Also concerning are the racial and ethnic disparities in overdose deaths. From 2020-2021, Black children and youth (less than 15 years old) in Colorado were nine times more likely to die by overdose than their white peers. Similarly, Hispanic children and youth were twice as likely to die by overdose in Colorado than their non-Hispanic peers. The causes for racial and ethnic disparities in overdose deaths are complex, but may be related to factors like inequitable access to mental health care and treatment due to racism.[28]

Overdose deaths include those of accidental and undetermined manners of death, as determined by the coroner. These can include deaths due to overdose by

prescription, illicit, or over-the-counter drugs or may also result from poisoning with other substances, such as household cleaners, carbon monoxide, plants, or pesticides. It does not include intentional deaths (i.e., deaths that are the result of homicide or suicide), although making those determinations in some deaths can be difficult.

Due to the increasing number of overdose deaths in Colorado among people under age 18, and particularly youth of color, as well as the concern about the increase in overdose deaths involving fentanyl, more resources are needed to support evidence-based educational campaigns to inform Coloradans about fentanyl and to expand availability of harm reduction resources. A synthetic opioid that is up to 50 times more potent than heroin and 100 times more potent than morphine, fentanyl causes overdose symptoms more quickly than heroin or other opioids, underlining the importance of education on how to respond in a timely manner.

In addition to education about the risks associated with fentanyl, xylazine, and other emerging overdose trends, education should encompass a full spectrum of substances including alcohol, marijuana, prescription drugs, and other legal and illegal substances that have the potential for misuse and overdose.

Partners critical in providing this information include agencies and organizations that serve children and families, including public health, child welfare, health care and behavioral health care providers, and youth programs. Information should be provided in culturally and linguistically appropriate ways and address the underlying causes of substance use, including adverse childhood experiences.[29] Education can take place anywhere including schools, churches, sports teams, harm reduction centers, libraries, community centers, and child care centers.

Access to naloxone and fentanyl test strips

Fentanyl is widespread in the drug supply in Colorado and comes in pills, pure powders, and powder mixed with other illicit drugs such as methamphetamine, cocaine, heroin, and benzodiazepines. It cannot be seen, tasted or smelled when mixed into other drugs. Naloxone and fentanyl test strips are both tools used in harm reduction efforts related to opioid use. Naloxone is a medication that can reverse an opioid overdose. Naloxone is widely available at no cost through organizations that distribute it through the Colorado Naloxone Bulk Purchase

Fund or it can be purchased without a prescription from pharmacies. Naloxone is for everyone who knows someone, or may come into contact with someone, who uses opioids, not just for people who use opioids. In fact, it is not possible to self-administer naloxone, if an overdose occurs. Someone else will need to administer it, which is why education for family and friends is key.

Fentanyl test strips are used to test drugs for the presence of fentanyl and should be made widely available from pharmacies and community organizations that provide harm reduction services. It is important to continue the expansion of free naloxone distribution and other state and local resources to make naloxone and fentanyl test strips widely available in communities.

Responding to a suspected overdose or poisoning

Responding to a suspected drug overdose or poisoning can be a critical and lifesaving situation. It is important for all members of the community to know the signs of an overdose and respond quickly. Increasing awareness of Colorado's Good Samaritan Law (§18-1-711 C.R.S.), which provides legal protection to individuals who seek medical assistance for someone experiencing a drug overdose, can help ensure people act quickly if there is a suspected overdose or poisoning. The law is designed to encourage people to seek medical help without fear of prosecution for drug-related offenses.

Safe storage and disposal

Safely storing and disposing of prescription and illegal drugs is important to prevent unintentional access and potential harm to others, as well as to prevent drugs from being misused or illegally diverted. Prescription and illegal drugs in the home should be stored in a secure location and out of reach of children, such as in a locked box or cabinet or in a locking pill bottle. It is also critical to promote and expand safe medication and drug disposal sites like those happening through the Colorado Medication Takeback Program. Additional information on safe use, safe storage, and safe disposal of prescription medications can be found on the Take Meds Seriously website.

Avoid accidental ingestion by young children

There is an alarming trend regarding fatal and near fatal incidents of child maltreatment due to fentanyl exposure/ingestion. Substance misuse has been a key risk factor associated with

incidents of child maltreatment for many years, but the lethality of fentanyl is changing the landscape of working with families experiencing substance misuse. In 2021, fentanyl exposure/ingestion accounted for 35.3% (6/17) of near fatal child maltreatment incidents. Tragically, the number of fatal incidents of child maltreatment that were related to fentanyl exposure/ingestion in 2021 was 15.6% (5/32). In 2022, there have been 7 reported incidents of fatal child maltreatment due to fentanyl exposure/ingestion, and 5 reported incidents of near fatal child maltreatment due to fentanyl (2022 numbers are provisional).

To avoid accidental ingestion by young children, it is critical to educate parents/caregivers on the importance of not leaving medication where children can access them. This means storing all medications or illegal drugs in a locked box or pill bottle, located in a high cabinet or drawer that is out of reach of children. Parents/caregivers also need to understand that if they suspect their child has accidentally ingested prescription medication or illegal drugs, they need to seek medical attention immediately. Additionally, because treatment options vary based on the size and age of the child, it is critical for parents/caregivers to share as much information as possible with first responders on the potential dosage and type of substance that was ingested.

(Pursuant to §25-20.5-407(1)(i) C.R.S., the Child Fatality Prevention System (CFPS) State Review Team collaborates with the Colorado Department of Human Services (CDHS) Child Fatality Review Team (CFRT) to **make joint recommendations to prevent child fatalities** based on the systematic review of cases reviewed by both systems. The CDHS CFRT reviews incidents of fatal, near-fatal, or egregious abuse or neglect determined to be a result of child maltreatment when the child or family had previous involvement with the child welfare system within the last three years. This recommendation was informed by an increase in the number of unintentional overdose deaths among very young children.)

Discuss overdose and poisoning prevention with children in age-appropriate ways

Early childhood is a period of transition where education is critically important. New mothers and caregivers of substance-exposed newborns should receive education as part of a plan of safe care established upon hospital discharge. Once home, the Smart Choices Safe Kids resource helps parents and caregivers understand ways to prevent exposure to multiple types of substances throughout the life of their child.

Having conversations with children about overdose and poisoning prevention should start early and be done in age-appropriate ways. Children as young as 3-4 years old can learn that taking too much medication or taking medication that is not given to them by an adult can be very dangerous. As children grow older, using more detailed explanations and real-life examples can illustrate the importance of avoiding medications not prescribed for them or that are provided to them by strangers.

Combining efforts to reduce the harms of opioid use, making sure families have the information and tools they need to keep young people safe, and safer disposal and storage practices creates a powerful multi-pronged approach that can save the lives of children and young people in Colorado.

Suicide Prevention

Provide resources and education to parents and caregivers in their preferred language about how to prevent child and youth suicide, including:

1. **family- and health-related factors that are protective against suicide risk,**
2. **resources around safe technology use and considerations around restricting technology access for young people, and**
3. **ways to support and affirm LGBTQ+ children and youth.**

Suicide is the leading cause of death among all children and youth ages 5 to 17 in Colorado. In total, 313 children and youth died by suicide in the state from 2017-2021. The most common stressors identified for child and youth suicide deaths were family discord, followed by arguments with parents or caregivers, parents' divorce or separation, and other serious school problems. Notably, just over a third (34.2%) of children and youth who died by suicide in Colorado had previously experienced child maltreatment as a victim. Acknowledging that many factors contribute to suicidal thoughts and dispair among young people in Colorado, CFPS recommends a multi-pronged approach to preventing suicide.

Suicide prevention and suicide intervention are both important to address suicide, but they differ in their focus and timing. Suicide prevention refers to the efforts and strategies designed to reduce the risk of suicide before an individual is in crisis. This includes supporting connectedness among youth, especially connections with trusted adults; education and awareness campaigns; mental health promotion; and early identification and treatment of mental health conditions. Suicide intervention, on the other hand, refers to the supports, treatment, and resources provided to those experiencing suicidal despair or thoughts of suicide. This includes crisis hotlines, emergency services, and mental health professionals providing immediate support and suicide-specific treatment. Colorado has increased access to suicide intervention services through various programs, including the state's Colorado Crisis Services. Additionally, youth have access to at least three free behavioral health sessions as part of the I Matter Program. However, focusing additional efforts to prevent suicide will help to decrease the need for these types of crisis intervention programs.

Partners critical in providing resources and education on suicide prevention include families, health care providers, schools, public health, community organizations, and health facilities. Family members and trusted adults can often recognize early signs of suicidality in a young person and are a critical bridge to help ensure youth receive comprehensive, suicide-specific care. Health care providers providing community mental health, primary care, and pediatric care can help to identify risk by ensuring that suicide and depression screenings are happening at every visit. Staff at schools can include resources and education for everyone from school counselors and teachers to administrators, lunchroom staff, and custodial staff. Mental health professionals are a critical part of the staffing structure for schools. Education can be provided in a variety of community locations including schools, libraries, support groups for parents, and through warm lines that can offer support to parents addressing the day-to-day stressors and not only in emergency situations. Education should be provided in ways that are culturally and linguistically appropriate, including awareness of cultural differences in addressing mental health when raising awareness about suicide risks.

Family- and health-related factors that are protective against suicide risk

Several factors are protective against suicide risk, including:

1. Strong social support. It is important for individuals to have strong social support networks, such as supportive family members, friends, or community members. Research shows creating connectedness can reduce the onset of suicidal behavior.[30,31] Prioritizing out-of-school programs for youth connectedness allow youth to get connected with peer supports and trusted adults, both of which have been shown to reduce negative behavioral health outcomes, including suicidal ideation.[32]
2. Positive family relationships: It is important for individuals to have positive family relationships including open communication, emotional support, and a sense of connectedness. Providing training to youth on healthy relationships can decrease generational trauma and reduce risk factors.
3. Good sleep habits: Making sleep a priority and changing a few behaviors can increase youth sleep duration to the recommended 8-10 hours of sleep and help protect against suicide.[33] Studies have found that individuals who report sleeping fewer hours per night are at higher risk for suicidal ideation, suicide attempts, and completed suicide.[34] Young people who report problems sleeping are more than seven times as

likely to report suicidal thoughts.[35] It is thought that sleep plays a role in regulating mood and emotions, and that disruptions in sleep patterns can lead to increased negative emotions and impaired decision-making. This, in turn, may increase an individual's vulnerability to suicidal thoughts and behaviors.

4. Access to mental health services: Access to mental health services and support, including therapy, counseling, and medication, can help individuals manage mental health conditions that increase suicide risk.

Safe technology use and considerations around restricting technology access for young people

Technology has become embedded into the everyday lives of young people. Extensive research exists on the potential harms associated with social media and excessive technology use on the mental health of children and youth. Less researched, however, are the potential benefits that cell phones, social media, and other technology may have for young people by providing them with connection and support outside of their in-person networks. In particular, more research is needed about the impact that restricting technology as a punishment has on child and youth suicidal ideation and attempts. In one example, the Utah Department of Health and CDC researched the deaths of youth who died by suicide in Utah from 2011 to 2015 and found that, prior to their deaths, 12.6% of youth experienced family conflicts as a result of a caregiver restricting technology use, such as a cell phone, laptop, or gaming system.[36] Several child death review teams in Colorado and partners in other states have noticed technology restriction as an emerging pattern among youth who die by suicide. While much of this is anecdotal evidence, there is a need for further research regarding possible links between punishment in general, and technology restriction in particular, as well as resources for parents and caregivers to inform them of safer technology use and considerations around punishment.

It is important for parents to be aware of the potential risks of technology use, including the use of the internet, social media, or mobile phones, to harass, intimidate, or bully someone - commonly known as cyberbullying. Cyberbullying can trigger feelings of hopelessness, worthlessness, and isolation, which can lead to suicidal thoughts and behaviors. According to a study in the Journal of the American Medical Association, “experiencing, but not perpetrating, cyberbullying is associated with adolescent suicidality above and beyond other forms of peer aggression experiences and established risk and protective factors. Assessment

of cyberbullying experiences among children and adolescents should be a component of the comprehensive suicide risk assessment."[37] Parents, educators, and mental health professionals should take steps to prevent cyberbullying and offer support to those affected by it.

It is critical to understand how technology may or may not be impacting an individual's emotional well-being when determining how best to approach prevention strategies. Technology use can pose risk or offer support and connection to all youth. Some young people experience harm through technology, social media, etc., which could include being cyberbullied, experiencing negative messaging about bodies and health, and could expose young people to harmful adults. Some young people, especially those who experience discrimination, can find protective and supportive communities online.[38]

These risk and protective factors that come with technology use can be heightened for youth experiencing thoughts of suicide. It is important that young people, especially those experiencing suicidal despair and thoughts of suicide, are receiving support and resources and protective communities while online. Adults can play a key role in considering how to ensure that a young person's online presence and experience is a positive, connected one.

Support and affirm LGBTQ+ children and youth

Experiences of discrimination, including transphobia, homophobia, and biphobia, can contribute to feelings of suicide among LGBTQ+ children and youth. As collecting information about sexual orientation and gender identity after a young person has died is incredibly difficult, CFPS supplements child death review data with other sources including the Healthy Kids Colorado Survey (HKCS). Data from the 2021 HKCS shows that lesbian or gay youth are 4.3 times more likely to have attempted suicide in the past year when compared to heterosexual youth. Transgender youth are four times more likely to have attempted suicide in the past year when compared to cisgender youth. Youth who are unsure of their gender identity, unsure of their sexual orientation, bisexual youth, and asexual youth also report attempting suicide at higher rates than their cisgender and heterosexual peers.[39]

Creating supportive, safe and inclusive communities where children and youth can feel comfortable expressing their gender identity and sexual orientation without fear of judgment or discrimination is critical to promoting mental health and well-being among this population. Parents and caregivers play a critical role through family acceptance and understanding of

LGBTQ+ youth. A supportive and accepting family environment can greatly improve mental health outcomes and decrease suicide risk for LGBTQ+ youth.[40] LGBTQ+ youth who are affirmed and accepted by their family, parents, and/or caregivers are more than eight times less likely to attempt suicide than their peers who are rejected by their family, parents, and/or caregivers.[41] Families should communicate to LGBTQ+ youth that they can have happy futures as LGBTQ+ adults; work to ensure that all members of their family and social circle respect their young person; and advocate for their youth if they are being mistreated or discriminated against at school, work, or in another setting. Families should avoid unsupportive behaviors such as pressuring their young person to be or act more or less masculine or feminine; pressuring their youth to keep their identity a secret from others; discouraging their young person to have access to LGBTQ+ friends, events, community, or other resources; and blaming their young person for any discrimination that they face as an LGBTQ+ person. Nonprofit organizations, medical professionals, school administrators and teachers, and other professionals serving and interacting with families should provide education on what family-related factors are protective against suicide risk (i.e., the Family Acceptance Project toolkit and resources). For a more comprehensive list of strategies to support and affirm LGBTQ+ children and youth, see the Suicide Prevention Commission Youth-Specific Initiatives Work Group Recommendation to Support LGBTQIA2S+ Youth and Young Adults (Ages 0-24).

Ensuring that families have access to this information, in a language they understand, is essential to preparing parents and caregivers to be the best supports to the young people in their lives that they can be and can help prevent suicide. For more information about suicide prevention efforts in Colorado, visit the Office of Suicide Prevention webpage.

Behavioral Health

Increase access to culturally responsive behavioral health resources for children, youth, and families by:

1. **increasing and diversifying the behavioral health workforce,**
2. **incentivizing care in rural areas,**
3. **improving affordability of care, and**
4. **decreasing stigma related to seeking help.**

Colorado policymakers and communities are and should be investing more resources to better meet the behavioral health needs of young people across the state. Unmet behavioral health needs can contribute to suicidal despair and ultimately suicide. Of the 313 young people who died by suicide in Colorado from 2017-2021, just over half (55%) had received prior behavioral health services, and even fewer (38%) were currently receiving behavioral health services when they died. According to a recently released report from the Colorado Health Institute, creating culturally responsive approaches within communities is an essential pillar of building a strong youth behavioral health system.[42]

For deaths reviewed by CFPS, suicide is the leading cause of death among young people in Colorado, often precipitated by behavioral health concerns. The burden of behavioral health support for young people is frequently falling to schools who do not have adequate behavioral health staffing to address behavioral health concerns. Educators cannot continue to carry this burden without additional support. Federal, state, and local policy influencers, including city council members and county commissioners; institutions of higher learning; health care systems; public and private insurers and youth-based programs can all play a role in increasing access to culturally responsive behavioral health care.

Culturally responsive resources take into account the unique cultural backgrounds, experiences, and values of individuals and communities. By recognizing and respecting these differences, behavioral health providers can better meet the needs of children, youth, and their families and provide more effective care. Additionally, behavioral health resources are very limited for populations with undocumented status, who are uninsured, or who are non-English speaking. Being culturally responsive includes providing services in the preferred language spoken by the individual.

Increasing and diversifying the behavioral health workforce

Colorado's behavioral health care workforce should represent the diversity of the communities and people who live, learn, work, and play here. Behavioral health providers tend to be primarily white; however, these white providers often serve a racially and ethnically diverse population.[43] It is important to recruit and train behavioral health providers from diverse backgrounds who are sensitive to cultural differences and can provide services that are tailored to meet the needs of diverse communities, especially services tailored for young people. This begins with higher education institutions ensuring people with diverse backgrounds are recruited into the behavioral health fields, creating clear career paths for entry into the workforce, and providing loan repayment and financial incentives. Additionally, employers must work to build inclusive workplaces by addressing and dismantling bias within the workforce, shifting workplace culture to one of psychological safety, and building accountability structures within workplaces. Health systems that welcome culturally responsive education and diverse hiring practices help reduce behavioral health disparities.[44]

Incentivizing care in rural areas

Access to behavioral health care in rural areas is challenging due to a shortage of behavioral health professionals, limited health care facilities, and insufficient insurance coverage. Improving access to behavioral health care in rural areas requires a multi-faceted approach that addresses the unique challenges of those in need of behavioral health care in the context of rural isolation and proximity to better resourced high population centers. Providing practice incentives, such as education loan repayment or similar grants, can overcome an important barrier to practice behavioral health professionals in rural underserved areas. It is also critical to set encounter rates to sufficient levels to incentivize their participation in various insurance programs, especially those serving populations with lower incomes.

Implementing telehealth services can improve access to behavioral health care in rural areas. Telehealth provides a way to address common barriers including lack of transportation, inability to leave the house or be in public, as well as privacy concerns due to the stigma associated with seeking and receiving behavioral health care services that may keep many young people from seeking care in-person, especially in rural areas of the state. Currently, not all communities in Colorado have access to stable and affordable broadband internet to be able to access telehealth services. As described in Colorado's Digital Equity Plan, internet

infrastructure must be supported in the communities that need it most to ensure access to telehealth.

Improving affordability of care

Funding for behavioral health services must be prioritized to ensure that all individuals and families have access to high-quality care, regardless of their cultural background or socioeconomic status. This can include increasing funding for community-based behavioral health services, supporting behavioral health programs in schools, and providing resources for behavioral health services in underserved communities. Public and private payors must also ensure that behavioral health services provided through health plans sufficiently provide for the needs of the populations they serve. Research also suggests that telehealth not only improves access to and quality of care, but also reduces costs.[45,46]

Decreasing stigma related to seeking help

Reducing stigma around seeking care for behavioral health requires a collective effort. Individuals, community partners, media organizations, and others with the potential to influence the narrative related to behavioral health can speak out against stigma and discrimination, which includes challenging negative stereotypes or stigmatizing language, and correcting misconceptions about behavioral health. Creating a safe space for open dialogue about behavioral health can also help reduce stigma. This can be done through community support groups, peer-led discussions, and educational programs that promote mental wellness and reduce stigma. Creating a more supportive and inclusive environment for those struggling with behavioral health concerns is necessary to increase the number of people willing to seek help when needed.

Young people in Colorado have behavioral health needs that can be better met by ensuring that they have resources that meet their unique needs. Young people deserve care that is affordable and provided in their own communities, no matter where they live. This care should also be delivered in culturally responsive ways by people who understand their cultural contexts. These efforts in conjunction with efforts to destigmatize seeking help for behavioral health needs can improve the lives of children and youth in our state and help prevent deaths.

Gun Violence Prevention and Firearm Safety

Support evidence-based firearm safety practices by reducing access to firearms through safe storage and increasing access to affordable gun safety resources.

CFPS reviews deaths of children involving firearms in Colorado, regardless of whether the death was determined to be an accident, a suicide death, or a homicide. From 2017-2021, 224 children and youth ages 0-17 died as a result of firearm injuries. The number of yearly firearm deaths for the time period ranged from a low of 40 deaths in 2017 to a high of 54 deaths in 2020, averaging 44.8 deaths per year. For deaths reviewed by CFPS, most firearm deaths were by suicide (52.7%, n=118); however, the proportion of homicides by firearm (43.3%, n=97) has increased in recent years. Unintentional firearm-related injuries accounted for 2.7% of firearm deaths (n=6). Notably, firearms were used in 90.5% (n=76) of child homicides in which the perpetrator was not a caregiver.

Regardless of the cause of death or specific circumstances, it is clear that too many young people in Colorado are dying by firearms. These deaths can be prevented by reducing access to firearms, both for young people themselves and also for adults who may use firearms to injure or kill young people, and by increasing education for young people and their families about firearm safety, including storage.

Reduce access to firearms through safe storage

In 2021, the Healthy Kids Colorado Survey asked students about perceived access to firearms; 16.8% of students said it was “sort of easy” or “very easy” to access a handgun, with higher prevalence among male and older-aged youth and with differences between racial and/or ethnicity groups. Schools in rural areas were more likely to report perceived easy access. Students who had felt sad or hopeless, attempted suicide, or been in a fight were more likely to say they had access to a handgun.[47] At the same time, CFPS data highlight that firearms used in fatal incidents were most frequently stored unlocked and known to belong to the child or youth’s caregiver. Given that children are likely to have easy access to firearms in their own homes, it is critical that families know how to take action to reduce access to firearms, especially if there are concerns about young people harming themselves or others.

Firearm-owning households should adopt best practices for safe and secure storage,[48] especially when children and youth live in or visit the home. State law requires firearms to be safely stored when they are not in use to prevent access by unsupervised youth and other unauthorized users. This may include changing the locks on guns or safes, making sure the keys or combinations are secure, and locking up ammunition separately from firearms, among others. Best evidence shows that keyed or combination-code trigger locks are the preferred mechanism to prevent the trigger from being pulled and the firearm discharging. Making trigger locks and locked storage, such as safes, more accessible and affordable can encourage responsible storage practices and prevent unauthorized access to firearms. In addition to securing firearms in homes where young people live, families can consider storing firearms outside of the home during a time of crisis. This safe storage interactive map includes a list of places in Colorado where someone can temporarily store their gun out of the home. These measures can prevent not only child fatality and injury, but suicidality, retaliatory firearm involvement, substance-involved firearm access and usage, or despair-driven firearm use.

In the case of imminent threat, extreme risk protection orders allow family members, law enforcement, or other concerned parties to petition a court to temporarily remove firearms from an adult who may pose a risk to their family or others during periods of crisis. Law enforcement and public health systems should provide education to families and communities on Colorado's gun safety laws, including understanding steps that can be taken prior to requesting a protection order, as well as the process to obtain an extreme risk protection order, when warranted.

Increase access to affordable gun safety resources

Gun owners can help prevent firearm-related deaths and keep loved ones and others safe. Promoting and providing affordable firearm safety training can help educate gun owners and their household members about safe handling, storage, and responsible use of firearms. This is especially important when there are children and youth in the home. Firearm safety training should be made broadly available to gun owners through hunter safety courses, firearms dealers, shooting ranges, groups that advocate for gun rights, and other organizations that support the sale and use of guns.

Several initiatives in Colorado currently address gun safety among gun owners. The Colorado Firearm Safety Coalition is a group of gun shop owners, firearm safety instructors, and public health professionals with a shared goal of educating firearm retailers, range employees, and the general public about suicide prevention and firearm safety. Engaging these organizations can help to promote responsible gun ownership and limit child and youth access to guns. Similarly, CDPHE's Office of Suicide Prevention funds the Gun Shop Project, a suicide prevention program that empowers local firearm ranges, retailers, and others, to share critical suicide pre[49] vention messaging with firearm owners.

Colorado has dedicated resources to understanding and preventing firearm deaths. The Office of Gun Violence Prevention is leading the state in these efforts and CPFS will continue to partner with the office to ensure the safety of Colorado's children and youth.

Child Maltreatment Prevention

Integrate primary care with wraparound services to support family resilience and promote positive childhood development, including connection to:

1. **culturally responsive behavioral health care for parents and caregivers;**
2. **community-based services through parent navigators, community health workers/promotoras and doulas; and**
3. **proven home visitation programs.**

Children get off to a better, healthier start when caregivers and parents have the support and skills needed to raise them. Health care, public health, behavioral health, social services, child welfare and community-based providers should take a positive, strengths-based approach to building family resilience to prevent child maltreatment in a variety of settings that reach families. Preventing child maltreatment will also prevent deaths caused by maltreatment. From 2017-2021, there were 234 deaths where child maltreatment caused and/or contributed to the circumstances of death. The rate of child maltreatment deaths for infants under age 1 was more than six times the rate for all ages and 14 times the rate for those ages 5 to 9. Of the child maltreatment deaths occurring during this time period, neglect caused or contributed to 62% of the deaths, abuse to 29.1%, and both to 9%.

Primary care providers play a critical role in identifying and addressing risk factors for child maltreatment, such as parental stress, behavioral health issues, substance abuse, and domestic violence. Primary care providers can screen for risk factors for child maltreatment during routine visits using validated screening tools to identify families who may need additional support. They can also provide parenting education and support to families, including guidance on child development, behavior management, and positive parenting techniques. However, primary care providers are only the first step in providing comprehensive and culturally responsive support to families; additional wrap-around care is also critical. Wrap-around care supports families by coordinating services and resources from multiple providers, including health care and behavioral health providers, social service agencies, and community organizations. Primary care providers serve as a critical link to refer families to additional community-based resources and programs to facilitate wrap-around care services.

Increase access to culturally responsive behavioral health care

Caregivers, including parents and other adults who support and care for infants, children, and youth, have some of the biggest impacts on young people's lives. Poor caregiver behavioral health can impact the health and well-being of the young people they take care of and can even contribute to child deaths. Research shows that high levels of caregiver stress and poor behavioral health contributes to child maltreatment.[49] When caregivers have behavioral health needs, they should have access to support and treatment, including both crisis care and ongoing care. Caregivers need behavioral health treatment that accommodates their needs as caregivers and addresses barriers to care. This care should also be provided by professionals that meet the diverse cultural and linguistic needs of caregivers and understand community-specific concerns about seeking care for behavioral health. Behavioral health care providers should also be affirming of caregivers' sexual orientations and gender identities, such as using the correct gender pronouns and not making assumptions about someone's identity or sexuality.

Increase access to community-based services through parent navigators, community health workers/promotoras and doulas

Community-based services help families to navigate complex systems in ways that increase family resilience and promote positive childhood development. Families are likely to have more trust and rapport with community-based organizations because of existing relationships. Community-based providers are often members of the same communities they serve, which means they have a deep understanding of the cultural and linguistic diversity within those communities. This understanding allows them to provide care that is sensitive to the unique needs and preferences of individuals from diverse backgrounds. They can help families access the resources they need to address the challenges they face, such as housing, health care, and child care. These various community-based providers play a critical role in improving health outcomes and reducing health disparities by providing culturally appropriate health education and helping to connect community members to health resources. However, funding for these services can be challenging to secure and maintain over time. Increasing access to community-based services requires establishing more sustainable financial resources.

Increase access to proven home visitation programs

Home visiting programs offer families support from non-judgmental, trained professionals, such as nurses or trained parent support providers in a location that is convenient and comfortable for the family, including the family home or a neutral location such as a park or library.[50] These programs improve child health and development, school readiness, parenting skills, caregiver health, and family income, employment and economic self-sufficiency. They also reduce family violence or crime and child maltreatment.[51] It is important for counties to have a variety of home visiting program options because families have different needs and each program has specific eligibility requirements. Home visitors should reflect the communities they serve so they can provide the most effective services. It is necessary for Colorado to scale up proven home visiting programs in Colorado so that all families with infants and young children can benefit.

Families and caregivers need holistic, flexible, culturally and linguistically appropriate support to build family resilience, promote positive child development, and prevent child maltreatment. Providers that can meet their unique needs while also matching families cultural and linguistic needs are essential to supporting caregiver behavioral health and broadly family wellbeing.

Infant Safe Sleep Environments

Offer evidence-informed and culturally and linguistically appropriate education on promoting safe sleep environments, to include harm reduction approaches, to parents and multigenerational caregivers.

When an infant dies suddenly and unexpectedly, often in their sleep, their death is classified as a sudden unexpected infant death (SUID). SUID is a leading cause of infant mortality in the United States, and these deaths are largely preventable. Between 2017 and 2021, 241 SUID cases occurred in Colorado, accounting for 15.2% of all infant deaths (under 1 year of age). According to the American Academy of Pediatrics (AAP), practicing safe sleep by creating safe sleep environments including having infants sleep on their backs in a separate sleeping space such as a crib by themselves on a flat, firm mattress without pillows, blankets, or other items can prevent SUID. In Colorado, only 60% of infants who died by SUID between 2017 and 2021 were placed on their back to sleep, 18% used a firm sleep surface, and only 13% had no soft objects or loose bedding. Consistent with national trends, the majority of SUID occurred among those under 5 months (72.6%). In addition, there is a significant disparity in the rate of SUID by race and ethnicity; the rate among non-Hispanic Black infants who died was 2.8 times higher in 2017-2021 (159.06 per 100,000 live births) than for non-Hispanic white infants who died (55.88 per 100,000 live births). Deaths among Hispanic infants have been steadily increasing at a statistically significant rate over the past decade from 62.7 for 2012-2016 to 89.2 for 2017-2021. SUID rates were highest among American Indian and Alaska Native (AI/AN) infants in Colorado (275.2 per 100,000 live births), although small case and population numbers make the rates unstable. Over-reliance on statistical significance, however, can lead programs to ignore important disparities. When looking at national data, the AI/AN community suffers the highest rates of SUID at 213.5 per 100,000 live births.[52]

Systems, programs and professionals that interact with expectant parents, infants, and their caregivers including public health professionals; health care providers; child care providers; home visitors; birthing providers and hospitals; lactation consultants; child care licensing programs; family, friend and neighbor child care networks; emergency shelters; and other community-based organizations all play a critical role in educating and modeling infant safe sleep environments.

According to a comprehensive review of effective safe sleep interventions conducted by the National Institute for Children's Health Quality, the most effective educational programs included not just safe sleep messaging, but one-to-one and group education, modeling a safe sleep environment, support from a wide range of health care providers at different times of perinatal care, such as before and after birth, and acknowledgement of cultural and traditional practices relating to infant sleep that impact a family's decision to practice safe infant sleep.[53]

Given the significant racial and ethnic disparities in SUID, it is also critical that safe sleep messaging, education, and programs are culturally informed and responsive to be effective in promoting safe sleep behaviors and to meet the needs of the families they hope to reach. It is important to recognize that cultural beliefs and practices may influence safe sleep practices and provide education that takes into account these factors. This includes developing materials that are culturally and linguistically appropriate and reflect the cultural practices and beliefs of the intended population. Relatedly, messaging must consider that parents are often not the only family members caring for infants. Anyone caring for an infant should be familiar with and practice safe sleep, including grandparents, siblings, and other family members.

Additionally, it is important to recognize that not all families may be able to adhere to the recommended safe sleep practices due to various factors such as housing insecurity, which could result in families not having a safe, stable place to live; poverty, which could limit resources to purchase a separate sleeping space such as a bassinet or crib; and other social determinants of health. Therefore, it is important to use harm reduction approaches that prioritize reducing the risk of unsafe sleep rather than expecting perfect adherence to guidelines. Similar to the way that hospitals screen families for car seat safety before discharge, hospitals could screen families for access to safe sleeping spaces and other social and economic needs to support safe sleep and family well-being. Offering practical solutions that families can implement to promote safe sleep environments, such as sleep sacks, providing information on how to create a safe sleep environment with limited resources, offering referrals to programs that can provide a crib, and providing information on alternative sleeping arrangements that are safe, can help to minimize risks. It is also

important to talk to parents about risks involved with items they may not associate with unsafe sleep such as nursing pillows, car seats, baby swings and rockers, etc.

How families chose to put their infants to sleep is a deeply personal matter; however, families should have the information and knowledge about infant safe sleep environments to make the best decisions for themselves and based on their needs. One way to ensure that families have this knowledge is by providing infant safe sleep information in culturally and linguistically appropriate ways and through a harm reduction lens to minimize risk.

Motor Vehicle Safety

Partner with new parents, youth, and families to promote safe driving practices through:

1. **child passenger safety programs, including car seat distribution,**
2. **young driver safety programs, and**
3. **strengthened graduated drivers license systems.**

Across the state, infants, children, and youth spend a substantial amount of time in cars and other motorized vehicles. It is critical that when riding in vehicles, they are as safe as possible to prevent injuries and deaths. Motor vehicle deaths were the second leading cause of death for child deaths reviewed by CFPS from 2017-2021. During this period, 246 motor vehicle and other transportation deaths occurred among infants, children, and youth ages 0-17 in Colorado. Of these deaths, nearly three-quarters (n=158) died as a result of passenger vehicle crashes. The majority of passenger vehicle deaths occurred among youth ages 15-17, at a rate more than 5.4 times greater than any other age group. Recklessness, speeding over the limit, substance use, and vehicle rollover are the leading causes of passenger vehicle deaths. Prevention strategies that address these factors among young drivers can prevent injuries and ultimately deaths.

Child passenger safety programs, including car seat distribution

These programs focus on promoting proper use of child car seats and booster seats and provide education and resources to parents and caregivers on how to correctly install and use them. Car seats can be expensive, particularly those that meet the highest safety standards. For parents with low incomes, purchasing a car seat can be a financial burden. Additional financial resources are needed for child passenger safety programs to distribute free or low-cost car seats and booster seats. Also it is important to continue to provide education to families on appropriate use of car seats and boosters until the child reaches a weight and height where a seat is no longer indicated.

Young driver safety programs

Injury and crash prevention programs that focus on young driver safety can be effective for preventing serious and fatal crashes involving young drivers. These programs educate young drivers, their parents and caregivers, and other adults and community members on the

dangers of distracted driving, speeding, impaired driving, and the importance of seat belt use. Driver's education programs that involve classroom learning as well as behind the wheel training may improve motor vehicle safety.[54] However, traditional driver's education courses are typically high-cost, creating significant barriers and unequal access to these programs. In addition, driver's education may not be available to all youth both in the language they speak and in their own communities. This creates significant gaps and barriers for rural, frontier, and non-English speaking young drivers. Working with community-based organizations, young driver safety nonprofits, state and local agencies and private sector partners (such as insurance companies) to provide free or low cost driver's education courses can increase access to programming for families least likely to be able to afford these services.

Colorado is also working to improve young driver safety by strengthening interpersonal and systemic protective factors that increase the likelihood of youth engaging in safe driving behaviors and reducing risk factors that increase their likelihood of engaging in unsafe driving behaviors. Identified through CDC research[55,56] and analysis of Colorado high school student survey data from the Healthy Kids Colorado Survey (HKCS), protective factors such as having relationships with adults they trust, experiencing safety within their communities and schools, having access to stable housing, and having good behavioral health, are correlated with safer driving behaviors among youth. HKCS results[57] show that risk factors correlated with riskier young driver and passenger behavior among Colorado youth include not feeling safe at school, experiencing housing instability, not having a trusted adult they can go to with a serious problem, not having enough food to eat, and experiencing depression. For example:

- Youth who report not having trusted adults in their lives were over 1.5-2 times as likely to not wear their seat belts, drive after drinking or using cannabis, and ride with an impaired driver.
- Youth who experience depression are over twice as likely to drive after drinking alcohol or consuming cannabis, ride with an impaired driver, and report never or rarely wearing their seat belt.

Strengthen graduated driver license systems

Graduated driver license (GDL) laws are designed to help new drivers gain experience and become safe drivers over time. The step-wise approach offers young drivers the opportunity to gain valuable and needed on-the-road experience before driving under more challenging conditions. By restricting the number of passengers, banning cell phone use, and setting driving curfew hours, these laws help limit dangers and potential risks young drivers face while learning to drive safely.

In Colorado, promoting young driver safety through stronger GDL systems includes: 1) increasing the minimum age for a learner's permit from age 15 to 16 and the minimum age for an intermediate (restricted) license from age 16 to 17; 2) expanding the restricted hours for intermediate drivers from between 12 a.m. and 5 a.m. to between 10 p.m. and 5 a.m.; 3) increasing access to GDL resources and education for young drivers, their families, and entire communities; and 4) increasing peer-to-peer education on GDL laws, seat belt safety, distracted driving, and speeding. It is also important to educate not just young drivers, but the additional systems they interact with such as schools, law enforcement, and health care providers about young driver safety. A comprehensive, holistic approach is needed to prevent motor vehicle deaths among young people in Colorado.

While the GDL laws themselves are important, strengthening GDL systems requires working with community organizations and partners to increase known protective factors for youth that are shown to positively impact young driver safety, in addition to passing laws.

Drowning Prevention

Improve knowledge and skills for parents and caregivers, children and youth, to follow water safety practices through expanded availability and affordability of safe swim programming.

Drowning is a leading cause of death for infants, children and youth among deaths reviewed by CFPS. From 2017-2021 there were 51 children and youth who drowned in Colorado, ranging from a high of 14 in 2018 to a low of 6 in 2021. The rate of drowning is highest for children under the age of 5 (1.65 per 100,000 population). Drowning location varies by age group: among infants who drowned, 89% were located in a bathtub, the majority of children ages 1-9 who drowned were in a pool, hot tub, or spa, and youth ages 10-17 were most often in an open water environment. It is important that parents and caregivers, children and youth have access to knowledge and resources needed to follow water safety practices, including safe swimming skills.

Every child and adult should be equipped with the skills to protect themselves in water by learning and enhancing their basic water safety skills to reduce the risk of drowning. And yet, not all communities have equitable access to quality, safe swim instruction, and there is currently a nationwide shortage of lifeguards and swim instructors, which has further limited families' access to safe swim programming. This is particularly important for children at a higher risk of drowning, including children on the autism spectrum, children who are first-generation swimmers, and children of color.

Children on the autism spectrum may have difficulty with social communication and understanding safety rules, which can make it harder for them to understand the risks of drowning. Additionally, some children with autism may be more drawn to water because of the sensory experience, making it harder for them to stay away from water without supervision. Children with autism may exhibit wandering or elopement behaviors, where they wander away from caregivers or safe environments. If a child wanders near a body of water without supervision, they are at a heightened risk of drowning. A review by the National Autism Association found that 91% of deaths of children ages 14 and younger with autism that occurred subsequent to wandering were due to drowning.[58]

First-generation swimmers may not have the same level of experience and comfort around water as children from families with a history of swimming. They may not possess sufficient

knowledge about water safety practices, including recognizing dangerous conditions, understanding buoyancy, and knowing how to respond in emergencies. This lack of knowledge can hinder their ability to protect themselves in potentially hazardous situations. As a result, they may be more likely to panic or struggle in the water, which can increase the risk of drowning. In addition, family members of these children are less likely to be able to appropriately and quickly respond themselves in emergency situations because of their own lack of skill in navigating water safely.

Children of color are at higher risk of drowning due to a number of factors. During the early 19th century, Black people were often denied access to swimming pools due to racial segregation and discrimination and pools were not built in predominantly Black neighborhoods. When the Civil Rights Act of 1964 abolished segregation, many of the large public pools were closed and private swim clubs were established in their place, in an effort to continue to exclude Black families.[59] This extensive history of limited access to swimming pools and as a result, limited knowledge of safe swimming skills, continues to drive disparities in the number of Black families with someone in the household who knows how to swim. One study found that Black and Hispanic parents were half as likely as white parents to be comfortable with their own swimming skills and far fewer Black and Hispanic children had swimming lessons compared to white children.[60] Public swimming pools continue to be limited in communities with lower incomes, which are often neighborhoods with a higher proportion of people of color. Coupled with limited access to affordable swim lessons, the chances for a child of color to learn to swim safely is decreased even further. For families for whom English is not their first language, there may also be a language barrier, which can make it harder to access swimming lessons and water safety education.

Expand swim lesson programming

Local communities should identify key partners who would work together to expand access to lessons on safe swim practices including local parks and recreation centers, community centers, schools, non-profit organizations, and for-profit organizations providing safe swim programming. Communities should ensure that swim lesson programs are offered at facilities that are accessible to all, including those with disabilities. Consider making lessons available at apartment and condo complexes and neighborhood associations with swimming pools. It is critical that learn-to-swim programs have experienced, certified, and qualified instructors.

Primary care and pediatric practices should incorporate messaging to parents about the importance of swim lessons starting at a young age, with a special emphasis for children diagnosed with autism. The American Academy of Pediatrics recommends starting swim lessons as early as age 1.[61] By taking formal swimming lessons, children ages 1-4 can reduce their drowning risk by 88%.

Support families with limited incomes to enroll their children in swim lessons

State and local policy makers should expand funding to support access to safe swim programming for families with limited incomes. Swim lessons are often limited to individuals with additional financial resources to pay for lessons through for-profit swim organizations. Even local community centers charge for swim lessons and have limited availability due to staffing shortages. To decrease inequities in drowning deaths, all families regardless of financial resources should have access to quality swim instruction.

Drowning deaths are preventable if children and their families are provided quality, affordable, and accessible swim lessons and water access. Every effort should be made to support people who may be especially at risk of drowning including children with disabilities like autism, first generation swimmers, and children of color.

CFPS Recommendations to Improve Data Quality

Pursuant to §25-20.5-407 (1)(g) Colorado Revised Statutes (C.R.S.), CFPS is required to report on system strengths and weaknesses identified during the child death review process. For the purpose of the report, "system" is defined as state and local agencies or Colorado laws that potentially impact the health and well-being of children. "Systematic child-related issues" means any issues involving one or more agencies. System strengths are included in Appendix A: CFPS Prevention Activities: Analysis and Updates on Prevention Recommendations.

CFPS identified weaknesses primarily related to how data is collected, shared, analyzed, and used by different systems. CFPS prioritized four recommendations to strengthen the quality of child death data. These recommendations call for improving child death investigations, data collection, and data analysis. Better data helps our state understand how and why children die in Colorado and improves data-informed decisions about which prevention programs and policies to recommend and implement.

Encourage and incentivize law enforcement agencies and coroner offices to use the sudden unexpected infant death investigation reporting form (SUIDIRF) during infant death scene investigations.

Infant death scene investigations are critical to a comprehensive understanding of how and why an infant dies. A full infant death scene investigation includes a thorough examination of the death scene, a review of clinical history, and an autopsy. The CDC created the Sudden Unexpected Infant Death Investigation Reporting Form (SUIDIRF) (www.cdc.gov/sids/SUIDRF.htm) to assist investigative agencies in understanding the circumstances and factors contributing to unexpected infant deaths and to establish a standardized death scene investigation protocol for the investigation of all SUID.[50] The form guides investigators through the steps involved in an investigation, produces information that researchers can use to recognize new threats and risk factors for SUID, and improves the classification of infant deaths that occur in a sleep environment. Information collected on the SUIDIRF includes infant demographics, pregnancy history, infant history, incident scene investigation, incident circumstances, and investigation diagrams.

Although the SUIDIRF is a useful tool for death scene investigators, Colorado historically has among the lowest rates of all states for completing the SUIDIRF.[62] This may in part be due to death scene investigators' lack of awareness of the form and training on how to use it. According to the most recent information collected by the National Conference of State Legislatures, only 12 states require special SUID training for infant death scene investigators.[63] Due to promoting the use of the SUIDIRF, Colorado has seen an increase in investigations where the SUIDIRF was used (51.0% of investigations in 2017 compared to 63.8% in 2021). Colorado has also seen an increase in the proportion of investigations where doll reenactments, considered a gold standard practice during infant death investigations, were performed (28.6% of investigations in 2017 compared to 51.1% in 2021).

Despite improvements in SUIDIRF use and doll reenactments, continuing to encourage and incentivize law enforcement agencies and coroner offices to use the SUIDIRF in Colorado will improve information collected about unexplained infant deaths and enhance SUID prevention efforts across the state. CFPS is committed to ensuring that training is not a barrier to investigators' ability to use the SUIDIRF form. CFPS provides training resources and opportunities to support Colorado's investigators learning about and using this form to support data quality. In FY 2021-22, the CFPS Investigative and Data Quality Subcommittee finalized a free, web-based training module on infant death investigation, with a particular focus on using the SUIDIRF. CFPS will continue widely promoting the training to a variety of professions (e.g., coroner and medical examiner staff, law enforcement, human services, district attorney offices).

Encourage and incentivize law enforcement agencies and coroner offices to use the Colorado suicide death investigation form when investigating suicide deaths.

Data systems in Colorado like CFPS often have missing and unknown data related to suicide deaths. Missing or unknown information includes information on peoples' identities such as a child or youth's sexual orientation and/or gender identity, life stressors or circumstances that may have contributed to suicidal dispair, mental health history, and access to lethal means. As data collection is currently limited on these types of information, there is a important opportunity to collect more detailed information about people who die by suicide and their lives that would help inform suicide prevention efforts in Colorado. As an example for suicide deaths by firearm, CFPS is often missing information on how firearms are stored and accessed.

For the 118 youth suicide deaths by firearm occuring from 2017-2021, information regarding whether the weapon was stored locked was missing for 24.6% of the deaths, and information regarding whether the firearm was stored loaded was missing for 50.0% of these deaths.

To improve information collection, CFPS recommends that law enforcement agencies and coroner offices implement standardized use of the Colorado Suicide Death Investigation Form (cdphe.colorado.gov/suicide-prevention/suicide-investigation-form). Widespread use of this form would ensure investigators consistently collect information like sexual orientation, gender identity, and detailed circumstance data when investigating a suicide death. This form was developed in partnership between the CFPS Investigative and Data Quality Subcommittee, CDPHE Office of Suicide Prevention (OSP), and Colorado Violent Death Reporting System (CoVDRS) in FY 2016-17. Content experts from numerous organizations worked collaboratively to produce this comprehensive investigation tool, and 10 counties across Colorado piloted the form. Feedback gathered from death scene investigators who piloted the form was used to improve the form, and CDPHE made the form and a guidance manual available online.

In FY 2020-21, CFPS and OSP implemented a mini-grant program to encourage and incentivize death scene investigators across the state to utilize the form across all age groups. CDPHE awarded mini-grant funding to 10 coroner/medical examiner offices in Colorado with the goals of: 1) increasing utilization of the Suicide Death Investigation Form for all suicide fatalities in the county, 2) bringing staff from coroner agencies and medical examiner offices into local or regional suicide prevention coalitions and working groups, 3) supporting suicide loss survivors, and 4) improving the Suicide Death Investigation Form. CDPHE gathered feedback from the 10 grantees and made improvements to the form based on their suggestions and experience using the form. The new version of the form is available online (cdphe.colorado.gov/suicide-prevention/suicide-investigation-form). CFPS, OSP, and CoVDRS partners continue to promote the form to investigators through presentations at the Colorado Coroners Association and other meetings. In FY 2021-22 OSP continued to offer mini-grants. CFPS is committed to ensuring that training is not a barrier to investigators' ability to use the Suicide Death Investigation Form and will continue to provide training resources and opportunities to support Colorado's law enforcement and death scene investigators learning about and using this form.

Strengthen CFPS data quality and prevention recommendations by encouraging local teams to use an equity lens.

Conducting multidisciplinary child death reviews promotes a better understanding of how to prevent future deaths and improve the lives of families and communities. Convening a multidisciplinary review team in Colorado has historically meant bringing together members with a wide variety of professional backgrounds and expertise. This includes coroners, legal professionals, public health, human services, law enforcement, medical staff, and school representatives. Many professionals on the team bring valuable personal and lived experiences to the review. However, the widening disparities in deaths of infants, children, and youth signals the urgent need to conduct training and include more voices in the child death review process. CFPS continues its commitment to comprehensive and equitable child death review processes, which will help teams to recommend upstream prevention strategies focused on addressing the social determinants of health.

Including community representatives

Child death review teams are more effective when additional team members with lived experiences and who represent the ethnic and cultural diversity in the community participate in the review.[64] Community input at the child death review helps to bring families' lived experiences to the surface and leads to improved understanding of the social and environmental determinants of child deaths. For instance, young people and community representatives may reframe causation of the death to social responsibility, rather than placing blame on individuals (e.g., parents, caregivers). To effectively engage community members in these discussions, teams should follow best practices for community engagement including compensation for time spent in the meeting and offering additional supports or accommodations to remove participation barriers.

In April 2020, CFPS added two questions to the "Review Meeting Process" section of the National Center for Fatality Review and Prevention's (NCFRP) Case Reporting System (CRS), the national data collection tool. For each death, the questions ask if a young person, community representative, and/or family leader were present at the review meeting. This will allow the system to measure progress on this recommendation. Data indicate that, for deaths that occurred in 2020, young people participated in 1.2% (n=3) of case reviews and community representatives participated in 12.4% (n=31) of case reviews. This data remained

consistent in 2021, with young people participating in 1.2% (n=3) of case reviews and community representatives participating in 12.2% (n=30) of case reviews, indicating significant room for improvement.

Ongoing equity training

Regular training should occur with the entire CFPS system including state and local partners (both team coordinators and local team members) to build knowledge about equity and address internal biases. The whole team should be accountable for shifting toward a social (vs individual) responsibility lens. Training to develop a shared understanding helps teams create a safe and inclusive space that celebrates and values diversity, including youth and community representatives.

CFPS partners have engaged in a variety of equity-based trainings and resources. To support learning about equity and child deaths, CFPS state support team staff created the CFPS Equity Learning Series, an eight-week virtual learning opportunity that introduces equity and its importance in child death reviews in spring 2020. Beginning in February 2020, system partners participate in two equity-focused trainings each year: one in February and another in September. In February 2021, the system went through a facilitated assessment of the strengths, weaknesses, opportunities, and concerns (SWOC) of current equity work, which resulted in an equity training plan. CFPS is committed to offering additional training and learning opportunities that will cover additional equity topics.

Family interviews

Conducting interviews with the members of a young person's family should also be prioritized as a way to center equity and justice in child death review. Confidential family interviews provide powerful personal stories and key details of the family and young person's experiences. Personal experiences have profound impacts on outcomes for infants, children, and youth, and public health professionals will only learn about them through listening to families' stories. Family interviews can shed light on the social determinants of health, including experiences of unstable housing, poverty, racism, and discrimination. These insights are typically not available from any other source and provide critical information about the conditions affecting health within a given community. Valuing the stories that family members share allows child death review teams to better understand the context of the deaths and the resulting fatality review data. Family members' ideas for prevention can also lead to more

equitable and culturally relevant recommendations. Interviews also provide an opportunity to link surviving family members to needed resources and provide bereavement support. With compassion, teams will hear stories of loss and maximize the impact of stories of loss by using them to craft effective, relevant interventions to increase the health and safety of their communities.[65]

To assess feasibility and current best practices in family interviews for the public health child death review process, CFPS spoke with professionals from cities and states outside of Colorado who use family interviews. Colleagues in other jurisdictions consistently highlighted the value of including the first-hand experience of families to inform the review and recommendation process, which helped clarify what this practice might look like in Colorado. CFPS identified that the Denver local team, coordinated by the Office of the Medical Examiner, was uniquely positioned to pilot family interviews. Including family advocates at coroner's and medical examiner's offices is an innovative practice, and Denver's pilot is the first and only one in the state.[66] Because the Denver coordinator already interacts with families following the death of a loved one to offer resources, starting in Fiscal Year 2022-23 they will offer families who have lost children the opportunity to provide additional information that will be included in the child death review process. Additionally, the El Paso County Coroner's Office now includes a question about experiences of discrimination in the standard questions that families are asked following the death of a child. Lessons learned from local partners and partners in other jurisdictions will inform CFPS' ability to expand the use of direct information from families and family interviews.

Improve CFPS data quality on disability and special health care needs by providing technical assistance to local teams and supplementing CFPS data with other data sources.

Based on the 2020-2021 prevalence estimate from the National Survey of Children's Health (NSCH), conducted by the U.S. Census Bureau, roughly 249,000 children under the age of 18 in Colorado have special health care needs. However, little information is collected or considered about the special health care needs of infants, children, and youth when they die in Colorado from causes related to injury, violence, or undetermined causes. When reviewing these cases, CFPS teams may not have enough information to determine if a child has a special need or on the types of needs a child may have. This is especially concerning because children with special health care needs may be at an increased risk of experiencing negative

health outcomes such as adverse childhood experiences (ACEs),[67] which may put them at greater risk of death. This increased risk is not inherent in the individual children or even necessarily the result of the disability or special health care need, but rather the result of systemic, avoidable, and unjust inequities such as ableism experienced by people with disabilities or chronic conditions, including mental health concerns and substance misuse.[68,69] In the same way that CFPS currently reports data on disparities by race, ethnicity, sexual orientation, gender identity, and geography, CFPS should also report any observed disparities based on special health care needs and as with other disparities, explain the social inequities that deepen or lead to these differences.

The first step is collecting more information on the health status of children with special health care needs who die and the role that those needs played in their death. The National Center for Fatality Review and Prevention (NCFRP) created Guidance for Reviewing Deaths of Infants/Children with Disabilities and/or Special Health Care Needs. This document outlines recommendations for comprehensive death reviews, including suggestions for the types of records and partner to have for the reviews, considerations for specific types of deaths caused by child maltreatment, injuries, and medical or natural causes, and sample recommendations to prevent similar deaths from occurring in the future. CFPS recommends focused training and technical assistance efforts including:

1. Widely disseminating the NCFRP guidance;
2. Looking specifically at the questions in the Case Reporting System, the national database CFPS uses, that address special health care needs and disability to see where CFPS can improve data collection;
3. Building partnerships with agencies and organizations to better understand special health care needs;
4. Hosting meetings such as the quarterly convenings of local team coordinators and bi-annual equity trainings on considerations for death reviews of children with special health care needs and inviting subject matter experts on disability and special health care needs; and
5. Exploring ways to link or enhance CFPS data with other data sources that more fully collect information on special health care needs including Colorado's oversample of the National Survey of Children's Health, Medicaid claims data, and Colorado Responds to Children with Special Needs among others.

By collecting more information about special health care needs, CFPS can better understand how special health care needs among infants, children, and youth in Colorado may be a factor in their deaths, shed more light on any observed disparities, and develop meaningful, specific recommendations to prevent deaths among those with special health care needs.

Policy Updates per 25-20.5-407(1)(g) C.R.S.

Overdose prevention

HB22-1326 (Fentanyl Accountability and Prevention Act) allocated $5 million for a statewide prevention and education campaign to address fentanyl outreach and awareness needs in Colorado. Educational efforts will include development of a statewide fentanyl prevention and education campaign. The bill also included over $26 million for harm reduction resources, including naloxone and fentanyl test strips, expanded the types of entities eligible to receive naloxone at no cost from the state's Naloxone Bulk Purchase Fund, and expanded the types of eligible entities and permissible uses of the Harm Reduction Grant Program. The efforts outlined in the bill will be evaluated by an independent body for effectiveness.

Behavioral health

SB22-177 (Investments in Care Coordination Infrastructure) charged the Behavioral Health Administration (BHA) with training new and existing health navigators on the behavioral health safety net system services for children, youth, and adults, ensuring individuals know where to access in person or virtual supports, and reducing the administrative burden for providers.

HB22-1289 (Health Benefits for Colorado Children and Pregnant Persons) recognizes the disparities in birth outcomes among Black, Indigenous, People of Color communities in Colorado which can be associated with the lack of proper health care coverage and experiences with discrimination within the medical establishment. This bill expands state-funded health and medical care (Medicaid and Children's Basic Health Plan) to cover low income pregnant people (extends to 12 months post-partum), and children less than 19 years of age regardless of immigration status. This bill also makes the Colorado Department of Public Health and Environment (CDPHE) health survey for birthing people permanent (formerly known as Health eMoms), in order to better understand various social determinants of health and experiences of discrimination, and their impact during and after pregnancy.

HB22-1267 (Culturally Relevant Training Health Professionals) charged the Office of Health Equity (OHE) housed in CDPHE to create a grant program with the intent of providing culturally responsive training to health care professionals. OHE must contract with a third-party

administrator that will issue grant applications for nonprofit entities and statewide associations of health care providers that wish to develop the training.

SB22-181 (Behavioral Health Care Workforce) invested $72 million into bolstering and stabilizing the state's behavioral health care workforce. The funding was directed towards recruiting diverse providers, funding internships and job shadowing, training, and expanding peer support and development programs. The bill also appropriated an additional $20 million to workforce incentives through the Colorado Health Service Corps loan repayment program, housed in CDPHE, which provides additional incentives for providers to work in medically underserved, and underinsured areas of the state.

Child maltreatment prevention

HB22-1369 (Children's Mental Health Programs) recognized the role protective factors such as trusted adults have on reducing the negative impact adverse childhood experiences (ACEs) have on the behavioral health outcomes of children. This bill therefore charges the newly formed Department of Early Childhood to contract with a Colorado-based nonprofit to provide children's mental health programs. The nonprofit must have pre-existing infrastructure to connect families to essential services, care coordination, and psychotherapy for the child and parent or caregiver.

Conclusion

Over the past nine years, CFPS developed 49 child fatality prevention recommendations and made significant progress toward successfully implementing those recommendations using and developing statewide partnerships and resources. This report reflects the culmination of the collective expertise of system partners across Colorado. The structure of CFPS ensures coordination at the state and local levels and provides an opportunity to advance prevention strategies and improve systems. Changes in policy are effective prevention strategies for many types of child deaths. By supporting and adopting the recommendations outlined in this report, policymakers can save lives and make Colorado families more resilient to stresses caused by major life events.

Additionally, all Coloradans can play a role in increasing public support for policies supportive of children and families, especially policymakers. A focus on collective responsibility for the

well-being and health of young people and their families will help shift the norm that places responsibility for children solely on parents and caregivers to a norm that considers caring for and protecting children as a shared, community responsibility.

Safeguarding the health and well-being of Colorado’s infants, children, youth, and families is an increasing concern. With Colorado families facing long-lasting social, psychological, and economic impacts of the pandemic, implementing policies that increase access to concrete supports for young people and their families, especially behavioral health care, is vitally important.

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