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BREAKING POINT

Conditions in the Colorado Division of Youth Services September 2021–October 2025

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EXECUTIVE SUMMARY

This report examines conditions in Colorado's Division of Youth Services (DYS) facilities between September 2021 and October 2025. During this period, Disability Law Colorado (DLC) conducted 35 monitoring visits and 112 interviews with youth.

Our key findings:

- The youth population in secure facilities declined, yet the number of mechanical and more invasive physical restraints increased by 54% and 60%, respectively.
- Youth-on-staff assaults, youth-on-youth assaults, and youth-on-youth fights increased between 2022 and 2025.
- The number of direct care staff declined over the same period, while overtime and missed work hours were substantial.
- Youth described instances of staff slamming them to the ground, pinning them to the ground, pushing their head into the ground, choking them, and striking them with a knee to the stomach or head — all at odds with DYS policy.
- Youth consistently reported injuries during restraints, inconsistent rule enforcement, staff escalation of conflicts, and difficulty building stable relationships due to staff turnover.
- Most youth in DYS custody have significant mental health and substance use treatment needs.
- Hundreds of youth — as many as 53% of those in detention last year — are eligible for release; they remain in custody because alternative placements are so scarce.
- Institutional funding has increased by 34% since FY 2017, while funding for community programs has decreased by 50%.

After four years of monitoring and engagement with DYS leaders, we conclude that improvements within facilities alone are unlikely to address the systemic challenges we identified. Reducing reliance on secure confinement and strengthening community-based services should be central components of Colorado's youth justice strategy.

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I. BACKGROUND

A. Colorado Division of Youth Services

The Colorado Division of Youth Services (DYS) oversees and manages 12 secure facilities as well as juvenile parole. The agency's mission is to: "protect, restore and improve public safety by utilizing a continuum of care that provides effective supervision, promotes accountability to victims and communities, and helps youth lead constructive lives through positive youth development."[1]

DYS serves youth between the ages of 10 and 21. In fiscal years[2] 2022 to 2024, DYS served an average of 2,491 youth per year in detention or commitment.[3]

Courtyard at a DYS facility

[1] Colorado Division of Youth Services.
[2] The state fiscal year, referenced by its end date throughout this report, begins on July 1 and ends on June 30.
[3] 2025 DYS Statistical Report.

The DYS budget covers both institutional and community-based services. Institutional funding has increased by 34% since FY 2017.[4]

Funding for DYS's community-based services fell by 50% during that time.[5] These services — including placements with contracted providers, supervision on parole, and alternatives to secure detention — enable youth to remain in the community instead of being confined to locked facilities.

Joint Budget Committee (JBC) staff attribute the decrease in community funding to reductions in commitment caseloads and community placements.[6]

B. Population Trends[7]

The average daily population of DYS has been falling for four of the last five years. The population was 10% lower in FY 2025 than in FY 2021.

Average Daily Population

Year	Detention	Commitment	TOTAL
FY 2021	147	343	489
FY 2022	159	284	443
FY 2023	179	260	439
FY 2024	193	269	462
FY 2025	178	262	440

C. Youth Treatment Needs

The youth in DYS custody form a high-acuity population, requiring consistent clinical support. According to DYS Annual Reports (FY 2022, FY 2023, FY 2024):

- 67–75% of youth presented co-occurring mental health and substance use needs.
- 80–87% required formal mental health intervention.
- 78–84% required substance use treatment.[8]

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[4] Joint Budget Committee Staff Budget Briefing FY 2026-27, p. 10.
[5] JBC Staff Budget Briefing FY 2026-27, p. 10.
[6] JBC Staff Budget Briefing FY 2026-27, p. 10.
[7] 2025 DYS Statistical Report.
[8] DYS Annual Reports.

D. Monitoring Scope

Disability Law Colorado (DLC) advocates on behalf of people with disabilities and investigates allegations of abuse and neglect.[9] As the state-designated Protection and Advocacy system, we have unique authority to monitor facilities that serve people with disabilities — including DYS.

In our monitoring visits, we speak with both providers and recipients of services. We can generally enter any part of a facility to which people with disabilities have access.[10]

DLC conducted 35 monitoring visits between September 2021 and October 2025. We visited each Youth Services Center (YSC) at least once:

- Gilliam — April 2022, December 2024, July 2025
- Grand Mesa — March 2022, July 2023, October 2025
- Lookout Mountain[11] — August 2021, September 2021, April 2025, August 2025
- Marvin W. Foote — September 2021, January 2024, December 2024, July 2025
- Mount View[12] — September 2021, March 2022, August 2022, April 2024, July 2025
- Platte Valley — August 2021, May 2022, November 2023, December 2024, March 2025, July 2025
- Prairie Vista — August 2022, May 2024, July 2025
- Pueblo — May 2022
- Spring Creek — May 2022, December 2024
- Zebulon Pike — September 2021, June 2022, July 2024, July 2025

We interviewed staff and undertook a detailed examination of each facility. We conducted 112 interviews with youth, including youth in custody and those released in recent years.

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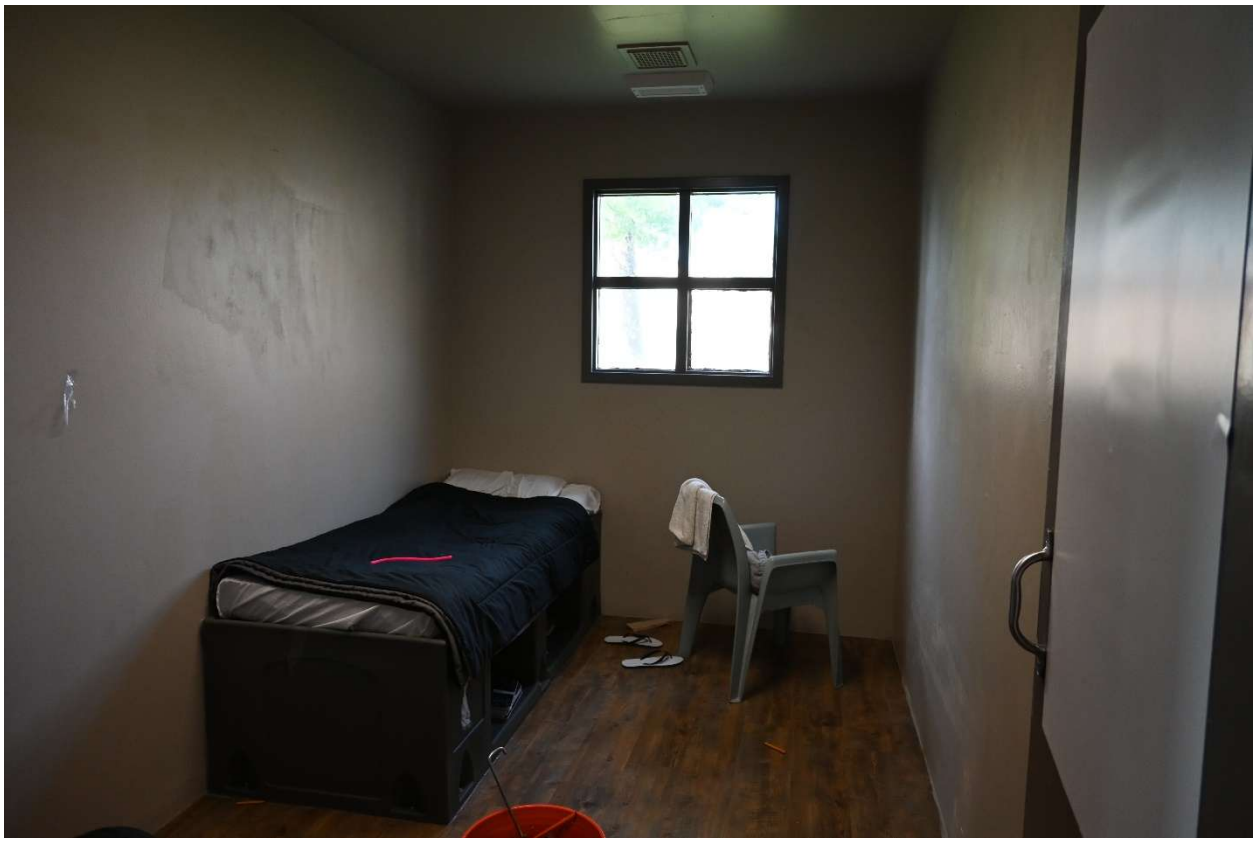
[9] Our authority for monitoring comes under the Protection and Advocacy for Persons with Developmental Disabilities, 42 U.S. Code § 15043; the Protection and Advocacy for Individuals with Mental Illness Act, 42 U.S.C. § 10801, et seq., as amended, 42 C.F.R. § 51; and the Protection and Advocacy for Individual Rights Act, 29 U.S.C. § 794e.

[10] *See* 45 C.F.R. § 1326.27(c)(2)(ii); 42 C.F.R. § 51.42(c)(2).

[11] This includes Aspire YSC, Golden Peak YSC, and Summit YSC, which at times have been considered separate centers located on the Campus at Lookout Mountain.

[12] This includes Phoenix YSC, Rocky Mountain YSC, and Betty K. Marler YSC, which are on the Campus at Mount View.



Bedroom in a DYS facility

In the living units, we took detailed account of the physical environment — the room layouts, the furnishings, the amount of personal space — as well as privacy measures and opportunities for rest and relaxation. We engaged with youth to understand their daily routines, social interactions, and access to recreational or educational activities.

In classrooms, we observed teaching methods, the availability of learning materials, and the level of student engagement. We spoke with youth to gauge the effectiveness of instruction and the support provided for diverse learning needs.

We assessed courtyards and outdoor spaces for safety and suitability for physical activity or socializing. We noted the presence of supervision, seating, and recreational equipment, and spoke with youth about their use of these areas.

In the intake processing areas, we reviewed procedures for new admissions and the clarity of information provided to youth.

Throughout the visits, we maintained a balance between structured observation and informal conversations. That enabled us to gather both operational details and personal perspectives, deepening our understanding of DYS's environment and practices.

We met with DYS leaders 11 times between September 2021 and October 2025. We issued internal reports to the agency in 2021 and 2022.

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II. FINDINGS

To track DYS practices, we reviewed Colorado Department of Human Services (CDHS) reports to the Joint Budget Committee and periodic reports from the DYS Seclusion and Restraint Workgroup. That group, formed in 2016, monitors and advises DYS on the use of restraint and seclusion.[13]

A. Restraint

The workgroup tracks every instance in which "hands are placed on youth."[14] That encompasses the use of both physical and mechanical restraints. DYS notes that a single incident may involve multiple techniques.[15]

Colorado law allows restraint to be used only in emergencies and only "[a]fter the failure of less restrictive alternatives; or [a]fter a determination that such alternatives would be inappropriate or ineffective under the circumstances."[16]

The two least invasive techniques, often described as touching a youth to guide them from one area to another, account for more than half of the techniques used during each reporting period.[17]

But the use of more invasive physical restraints increased by 60% from 2021 to 2025. In such cases, multiple staff might hold a youth on the ground by the arms and legs, or one staff person might hold a youth's arms behind the back.

The use of mechanical restraints rose by 54% during this period. Mechanical restraints include handcuffs, shackles, and spit hoods.

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[13] Many of our findings are based on public reports. Specifically, Youth Seclusion & Restraint Working Group Semi-Annual Reports, January 2024 Report, and August 2025 Report, as well as CDHS Reports to the JBC in 2024 and 2025. The CDHS RFI report for FY 2023 was obtained through a Colorado Open Records request and can be provided upon request.

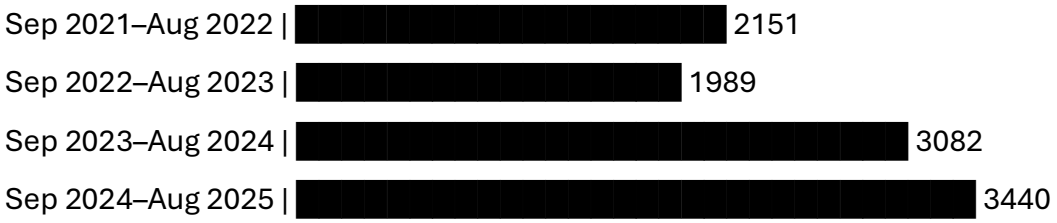
[14] 01.13.26 Meeting Minutes Seclusion and Restraint, p. 14.

[15] 01.13.26 Meeting Minutes Seclusion and Restraint, p. 14.

[16] C.R.S. § 26-20-103(1).

[17] 01.13.26 Meeting Minutes Seclusion and Restraint, p. 14.

More Invasive Physical Restraints[18]



Mechanical Restraints[19]

The average daily population at DYS fluctuated during this period. The population reached its lowest point in 2025 — when the number of restraints peaked.

In some of our conversations, DYS leaders acknowledged that staff had acted inappropriately. The leaders told us that DYS had disciplined or terminated such staff. We were not equipped to verify these claims.

At other times, DYS leaders justified the use of restraint as a necessary response to security violations and aggression. In its January 13, 2026, meeting, the DYS Seclusion and Restraint Workgroup noted that the current population presented higher levels of aggression and trauma.[20]

DYS reports provide some evidence to that effect. Between FY 2022 and FY 2025, the number of youth considered violent offenders rose by 12%.[21]

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[18] Youth Seclusion & Restraint Working Group Reports, January 2024 Report, and August 2025 Report.
[19] Youth Seclusion & Restraint Working Group Reports, January 2024 Report, and August 2025 Report.
[20] 01.13.26 Meeting Minutes Seclusion and Restraint.
[21] 2025 DYS Statistical Report.

Violent Offenders — Detention and Commitment Combined

B. Youth-Reported Injuries

Of the youth we interviewed, 36% said that they had been injured, or had seen another youth injured, during a physical restraint. Among the most common injuries reported: bruises and rug burns on the arms or face. Some youth reported handcuffs being applied too tightly, causing bruises or cuts on their wrists.

Many youth also described restraint practices that violate DYS policy. Of the youth we interviewed, 34% said that they had experienced or witnessed: staff slamming youth to the ground, pinning them to the ground, pushing their head into the ground, choking them, punching them in the face, or striking them with a knee to the stomach or head.

We did not witness such incidents ourselves. But the agency's policy on physical response and protective devices prohibits offensive strikes, excessive pressure that could impede breathing, and mistreatment of youth.[22]

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[22] DYS Policy S-9-4 states, "The use of pressure point pain compliance techniques, offensive strikes, and full body restraint equipment is prohibited." "Employees shall not place excessive pressure on the youth's chest, abdomen, or back, or inhibit or impede the youth's ability to breathe. If the youth's breathing is compromised in any way, and/or the signs of life monitor directs the employee to disengage, the physical response skill shall be discontinued immediately, and employees shall immediately notify health staff that a health assessment of the youth is needed. When health staff is not on-site, a supervisor shall be notified and respond to assess the youth and contact the on-call physician or on-call health staff." "Because of the vulnerability of the youth during a physical response, the youth shall be treated with dignity and respect at all times and shall be protected from mistreatment, antagonism, or harm from another person." "Only responses and skills trained in the PSI [Protective Supports and Interventions] program are authorized to be used in accordance with the Situational Response Matrix. In rare and emergent situations in which the employee has no other option than to use an unauthorized technique, there shall be a review by the youth center administration. The youth center administrator may utilize a PSI instructor and/or an Office of Staff Development trainer in their review. The employee utilizing the unauthorized technique must clearly explain in writing their assessment why it was the safest and most efficient option in that particular situation and why the approved technique(s) trained in the PSI program were not used."

C. Emergencies, Escalation, and the Reactionary Gap

Colorado law defines an emergency as "a serious, probable, imminent threat of bodily harm to self or others where there is the present ability to effect such bodily harm."[23]

Youth reported inconsistency in how staff determine emergencies. Some staff members, they said, were more aggressive and quicker to use physical restraint than others.

A specific point of contention: the "reactionary gap." While the term does not appear in DYS policy, it typically means the distance that allows someone enough time to perceive and respond effectively to a potential threat.

Youth told us that some staff members verbally escalate conflicts — taunting youth to approach them and break the reactionary gap. If a youth took the bait, a staff member would then find justification to use physical restraint.

D. Seclusion[24]

The youth we interviewed did not cite seclusion (sometimes called isolation or solitary confinement) as a primary concern. Reported cases of seclusion decreased substantially last year.

Cases of Seclusion

The average and median length of seclusion remained under one hour. Any amount of seclusion, however, may pose a developmental risk; being "in the hole" can be especially traumatizing to adolescents.

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[23] C.R.S. § 26-20-102(3).

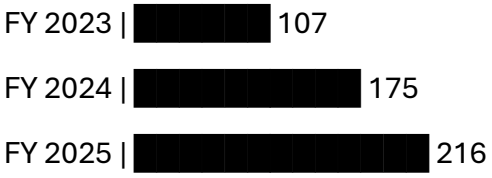
[24] Youth Seclusion & Restraint Working Group Semi-Annual Reports, January 2024 Report, August 2025 Report .

E. Safety Indicators[25]

Data reported to the JBC show a series of troubling trends. Taken together, these indicators depict an increasingly unsafe environment.

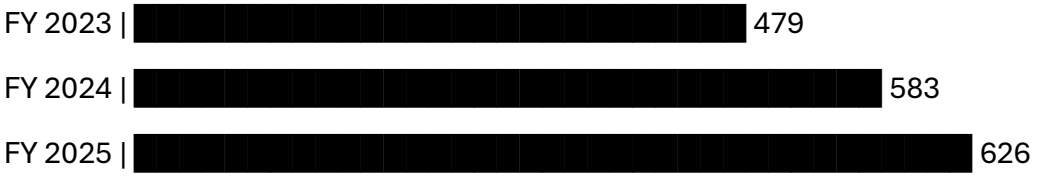
DYS reported an increase in youth-on-staff assaults, youth-on-youth assaults, and youth-on-youth fights over the last three years. The number of new youth crimes reported to police also spiked in FY 2025.

Youth-on-Staff Assaults



Youth-on-Youth Assaults

Youth-on-Youth Fights



New Youth Crimes Reported to Police

[25] CDHS Reports to the JBC in 2024 and 2025. The CDHS RFI report for FY 2023 was obtained through a Colorado Open Records request and can be provided upon request.

Newly required reports show 15 suspected overdoses — and one death due to a suspected overdose — in FY 2025.

Confirmed allegations of child abuse increased over the last three years:

- FY 2023: 4
- FY 2024: 6
- FY 2025: 7

The number of unsubstantiated sexual assault allegations also rose in FY 2024.

F. Staffing Capacity[26]

While safety concerns at DYS have been rising, the number of direct care staff has been falling:

Direct Care Staff

Direct care staff missed more than 297,000 hours of work and worked more than 114,000 hours of overtime in FY 2025 (the only year for which we have such data). At the same time, staff reported 531 worker's compensation injuries and missed 22,421 hours of work because of workplace injuries.

G. Inconsistent Rules and Enforcement

Youth consistently described frustration with a lack of uniformity across facilities and among staff. Rules and expectations reportedly vary not only from one facility to another, but also between staff members within the same unit. Some facilities, for example, require youth to request permission before standing, while others do not. Level systems and

[26] CDHS Reports to the JBC in 2024 and 2025. The CDHS RFI report for FY 2023 was obtained through a Colorado Open Records request and can be provided upon request.

privilege structures also differ, creating confusion and adjustment challenges when youth are transferred between facilities.

Within individual facilities, youth described inconsistent enforcement of rules. Several youth said that some staff members appeared to have "favorites," whom they treated better than others. Others reported perceived "double standards," grudges, or animosity from particular staff members.

One youth explained that the inconsistency made it difficult to "do good," while another said, "one day one thing, next day another." Youth also expressed frustration with collective consequences, such as requiring all youth on a unit to return to their rooms, sometimes for hours, when a single individual engaged in misconduct.

H. Staff Conduct and Youth Safety Concerns

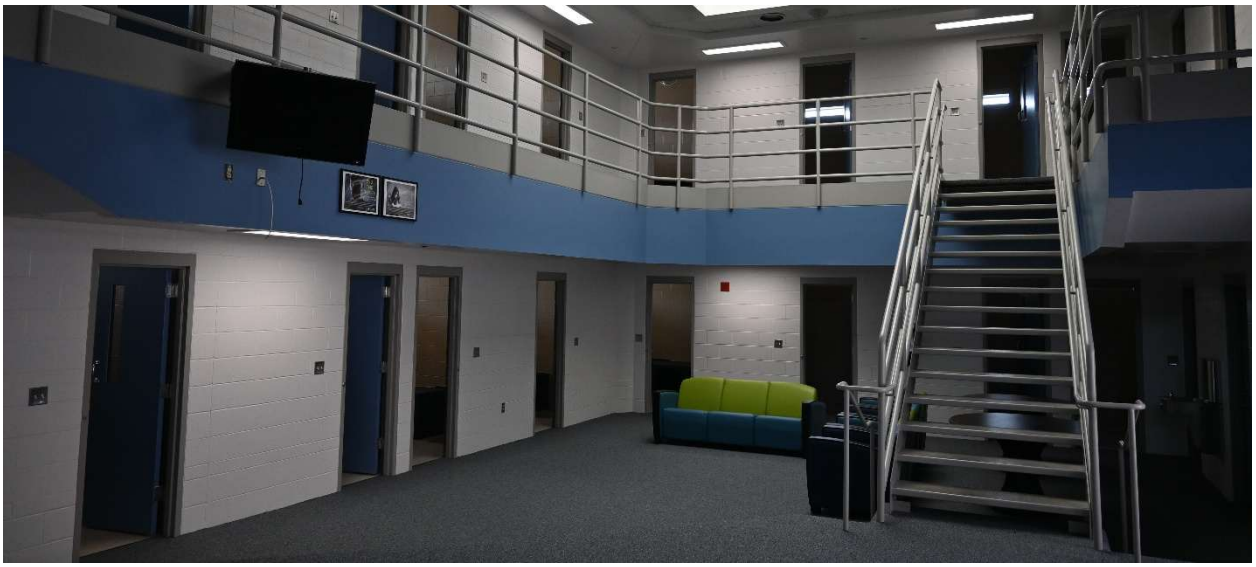
Multiple youth reported that some staff members engaged in verbal confrontations, used profanity toward youth, or escalated situations rather than de-escalating them. Some youth alleged that staff instigated or exacerbated conflicts between youth. One youth described feeling that staff treated youth "like shit." Several youth said that certain staff appeared disengaged or indifferent to their wellbeing.

Youth also reported concerns regarding staff responsiveness to safety issues. Some said that staff were not always timely in intervening when bullying or conflicts occurred. Others indicated that when they submitted complaints or grievances, they did not believe those concerns were meaningfully addressed.

I. Relationship Disruption and Turnover

Youth identified frequent staff turnover as a significant barrier to forming supportive relationships. Many youth described avoiding emotional attachment to staff because they anticipated that those staff would leave. Youth with trauma and attachment-related histories described feelings of disappointment and loss when trusted staff departed.

An important exception: Youth also identified staff members who were kind, supportive, and trusted. Some youth described positive relationships and individual staff who provided meaningful support. Even those staff, however, were frequently described as overworked and operating in a high-stress environment. These reports suggest that while individual strengths exist, systemic conditions may limit consistency and stability.



Living unit ("pod") in a DYS facility

J. Programming, Education, and Accessibility

Youth commonly reported boredom outside school hours. Watching television and recreation were the most frequently cited activities.

Many youth reported regular access to Behavioral Health Specialists and identified Dialectical Behavior Therapy as helpful.

Educational experiences were mixed:

- Some found school appropriate.
- Others reported repetitive worksheets or insufficient challenge.
- Some reported lack of individualized academic support.

We identified barriers to physical accessibility, such as stairs in the living units, in all but one facility (Prairie Vista was the lone exception). Most problematic: The committed school at Mount View is located on the second floor, which lacks elevator access.

Obtaining a reasonable accommodation also seemed to be a matter of some confusion. A youth whose disability made it difficult to concentrate, for example, may find it hard to get

headphones. According to DYS leaders, the agency is now developing a policy to explain how youth can request reasonable accommodations.

Food drew ratings of “okay” or “good” from four times as many youth as those who rated it “bad.” Reports were split regarding whether youth received sufficient food.

III. SYSTEMIC CONCERNS

Over the course of four years, we monitored every DYS facility; conducted interviews with youth and staff; and analyzed administrative data, staffing records, and incident reports. Our research raises several systemic concerns — serious challenges that involve safety, supervision, and quality of care.

Between 2021 and 2025, we note:

- The use of more invasive physical restraints increased by 60%.
- The use of mechanical restraints increased by 54%.
- Youth reported injuries during some restraint events and described inappropriate staff responses to behavioral incidents.
- Reported assaults and fights increased across facilities.
- Direct care staffing declined. In FY 2025, staff missed more than 297,000 hours of work and recorded more than 114,000 hours of overtime.
- Youth described differing rules, inconsistent enforcement, favoritism, and collective punishments.
- Staff turnover affected continuity of supervision and relationship development.
- Youth presented complex behavioral health needs, including mental health and substance use disorders.

Individual incidents vary by facility. The confluence of multiple indicators, however, points to systemic challenges rather than isolated events.

Taken together, these indicators reveal a pattern of staffing instability, workload pressures, and operational irregularities. That pattern calls into question DYS's ability to provide consistently safe, therapeutic, and developmentally appropriate supervision.

The following sections examine DYS's challenges in greater detail: specifically, around staffing capacity and workload, staff turnover and continuity of care, staff training and preparation, supervisory oversight and accountability, consistency in rules and enforcement, and institutional culture and climate.

A. Staffing Capacity and Workload

Declining direct care staffing, high absenteeism, and substantial reliance on overtime may significantly limit the ability of facilities to provide consistent supervision and timely intervention during youth conflicts. Facilities operating under sustained shortages frequently rely on overtime and temporary reassignments to maintain minimum coverage.

Research on congregate care and correctional environments consistently demonstrates that staff fatigue and burnout can undermine patience, situational awareness, and the capacity to employ effective de-escalation strategies. When staff operate under sustained workload pressures, opportunities for early intervention in conflicts are reduced, increasing the likelihood that routine behavioral incidents escalate into physical altercations.

These conditions also increase the likelihood that staff rely on restrictive interventions, including physical restraint, rather than preventative or therapeutic responses to behavioral challenges.

B. Staff Turnover and Continuity of Care

Frequent staff departures undermine relationship-based approaches that are widely recognized as central to effective youth rehabilitation.

Youth in custody often present extensive trauma histories, attachment disruptions, and complex behavioral health needs. Consistent relationships with trained staff are critical for building trust, promoting emotional regulation, and sustaining engagement in treatment and programming.

The interviews we conducted indicate that youth often experience repeated changes in assigned staff. When supportive relationships develop and staff subsequently depart, youth may experience a loss of stability and become less willing to form new connections. These disruptions can contribute to emotional dysregulation, reduce engagement in programming, and increase behavioral volatility within facilities.

High turnover also reduces the overall experience level of the workforce, further complicating the management of complex youth behavior.

C. Staff Training and Preparation

Youth reports of staff escalation, verbal hostility, or conflict instigation raise concerns regarding the adequacy and consistency of staff training in several critical areas, including:

- trauma-informed care
- adolescent development
- de-escalation strategies
- disability-responsive behavioral supports

Residential environments serving youth with significant behavioral health needs require specialized training and continuous supervisory reinforcement. When staff lack consistent preparation in these areas, responses to youth behavior may become reactive, punitive, or inconsistent.

Such conditions increase the risk that routine behavioral incidents escalate unnecessarily and may contribute to higher rates of restrictive interventions.

D. Supervisory Oversight and Accountability

Youth reported that complaints and grievances were not always taken seriously or consistently addressed. Effective grievance systems, incident review processes, and supervisory oversight serve as essential safeguards in residential care environments.

When oversight systems are inconsistent or ineffective, problematic practices may persist without timely review or corrective action. Weak accountability structures can allow inappropriate staff conduct, inconsistent discipline, or unsafe practices to continue unchecked.

Robust supervision and transparent incident review processes are necessary to ensure that facility practices remain aligned with established safety standards and rehabilitative goals.

E. Consistency in Rules and Enforcement

Youth described differing rules among facilities and inconsistent enforcement among staff within the same facility, including perceived favoritism, double standards, and collective punishments.

Inconsistent enforcement undermines clarity regarding expectations and can foster perceptions of unfairness among youth. These perceptions frequently contribute to conflict, resistance to authority, and behavioral escalation within congregate settings.

Clear expectations and consistent enforcement are fundamental components of safe and stable residential environments.

F. Institutional Culture and Climate

Sustained staffing shortages, extensive reliance on overtime, and ongoing operational strain can significantly affect workplace morale and the overall climate within facilities.

Institutional culture plays a central role in shaping daily interactions between staff and youth. Facilities experiencing prolonged operational stress may struggle to maintain the supportive, relationship-centered environment necessary for effective rehabilitation.

Under such conditions, staff-youth interactions may become increasingly reactive or punitive rather than therapeutic and developmental.

Consequences

The trends we found — including the increased use of restraint, rising incidents of violence, staffing instability, high absenteeism, workforce turnover, and youth-reported concerns — can produce serious consequences. These conditions:

- Increase the risk of harm to both youth and staff
- Increase the likelihood of youth being charged with additional infractions based on interactions with staff that result in injury
- Reduce consistency in supervision and behavioral management
- Weaken relationship-based and trauma-informed approaches to care
- Compromise the ability of facilities to provide safe, therapeutic, and developmentally appropriate environments

These conditions also raise potential concerns regarding compliance with statutory and regulatory requirements governing youth detention, restraint practices, and protections for youth with disabilities. The following section discusses the legal implications of these findings.

IV. LEGAL IMPLICATIONS

The systemic issues identified in this report implicate obligations under Colorado statutes and regulations governing juvenile facilities, as well as federal disability rights law. Youth in DYS facilities are entitled to statutory protections related to safety, restraint limitations, equitable treatment, and access to appropriate behavioral health services.

A. Restraint and Seclusion Practices

Under C.R.S. § 26-20-103, restraint and seclusion may be used only in an emergency — defined as "a serious, probable, imminent threat of bodily harm to self or others where there is the present ability to effect such bodily harm" — and only after less restrictive alternatives have failed or are inappropriate. These interventions may not be used for punishment, retaliation, coercion, or routine behavior management.

Under C.R.S. § 26-20-104.5, facilities must comply with strict limits on duration, require qualified staff oversight, and ensure detailed documentation of each incident, including justification, duration, supervisory approval, and reporting.

We found cause for concern about DYS's compliance:

- Youth reported frequent use of restraint, including physical techniques prohibited by DYS policy.
- Reports of staff verbal escalation and instigation of conflict raise concerns that some incidents may not meet the statutory definition of an "emergency."
- Rising restraint use despite a declining youth population suggests potential overreliance inconsistent with statutory intent.
- High staff turnover, absenteeism, and reliance on overtime raise concerns about whether interventions are consistently administered by qualified, properly trained personnel as required by statute.

Collectively, these conditions may raise compliance concerns under Colorado's restraint and seclusion framework.

B. Safety, Supervision, and Detention Criteria

The Colorado Children's Code limits detention to youth who meet statutory criteria and requires provision of appropriate care and treatment within secure facilities. DYS regulations emphasize safety, equitable treatment, and trauma-informed rehabilitative services.

Youth in DYS custody present high behavioral health needs (including high rates of co-occurring mental health and substance use conditions), increasing the legal obligation to provide consistent, therapeutic, and supportive care.

Compliance Concerns

- Systemic staffing shortages and high turnover may undermine safe supervision and timely intervention.
- Inconsistent rule enforcement, "favorites," and unequal privilege systems suggest potential violations of equitable treatment mandates under Colorado regulations.
- Disruptions in continuity of care due to turnover may impair trauma-informed approaches required to meet statutory rehabilitative objectives.
- Increased confirmed child abuse findings heighten concern regarding overall safety compliance.

These factors suggest systemic risks that may compromise adherence to Colorado statutory and regulatory requirements governing youth detention and treatment.

C. Federal Disability Rights

DYS facilities must comply with both the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973.

These federal laws require nondiscriminatory access to services, reasonable accommodations, and equal opportunity to benefit from programs and treatment.

Compliance Concerns

- Excessive or disproportionate restraint exposure may have disparate impact on youth with mental health, cognitive, or developmental disabilities.
- Accessibility barriers in programming spaces may limit full participation.
- Barriers to reasonable accommodations may limit full participation.

Such conditions may raise compliance concerns under federal disability protections if youth with disabilities are not receiving appropriate accommodations or are disproportionately subjected to restrictive interventions.

D. Systemic Legal Risk Profile

The convergence of the following indicators suggests systemic — not isolated — legal risk:

- Declining direct care staffing and high absenteeism.
- Increased use of mechanical and physical restraint despite declining population.
- Youth reports of staff escalation and inconsistent enforcement.
- Disrupted continuity of care due to turnover.

Together, these conditions may materially impact youth safety, violate statutory limits on restraint, undermine equitable treatment obligations, and impair compliance with federal disability law.

V. RECOMMENDATIONS

In July 2024, the Colorado Child Protection Ombudsman reported on the use of physical restraints in DYS facilities. The report noted that youth had "sustained broken bones, abrasions, concussions and broken teeth" during restraints.[27]

The Ombudsman advised DYS to overhaul its surveillance systems — including the provision of audio, in addition to video, within the facilities. The Ombudsman also recommended that DYS publish quality assurance audits and the number of justified versus unjustified restraints.

Nearly two years have passed since the Ombudsman issued its report. The state has implemented few of these recommendations. DYS did launch a pilot program for body-worn cameras at two facilities (Prairie Vista and Spring Creek).[28]

Heeding the Ombudsman's advice would be a good place to start. To address the systemic concerns we identified — and to ensure compliance with state and federal law — we implore DYS to take the following actions as well.

A. Improve Direct Care Staffing and Reduce Turnover

Adequate staffing is essential to comply with supervision, safety, and qualified personnel requirements under Colorado law.

Actions:

- Conduct a staffing needs assessment to ensure safe staff-to-youth ratios (day and night).
- Audit current retention strategies (competitive pay, professional development, support for staff wellbeing) for effectiveness.
- Reduce reliance on overtime and temporary staffing to minimize fatigue-related risk.

[27] Surveillance Within the Division of Youth Services: How current efforts to monitor the use of physical restraints fall short.
[28] S-9-25 Body Worn Camera Pilot Policy.

B. Strengthen Staff Training and Professional Development

Adequate staff training is essential for compliance.

Actions:

- Evaluate training in trauma-informed care, adolescent development, and de-escalation to determine effectiveness.
- Provide refresher and scenario-based training on statutory restraint limits.
- Include ADA and Section 504 training focused on disability accommodations and nondiscriminatory treatment.
- Provide training on the Bill of Rights for Youth in a Juvenile Facility, C.R.S. § 19-2.5.1502.5.

C. Improve Documentation, Oversight, and Accountability

Colorado law requires detailed documentation and review of restraint and seclusion.

Actions:

- Ensure complete documentation of all restraint incidents, including justification and duration.
- Conduct independent audits of restraint use.
- Publicly report data to the Youth Restraint and Seclusion Working Group regarding justified versus unjustified restraints. This should include the number of times youth are injured during a restraint, as well as whether the youth has a disability.
- Strengthen grievance procedures to ensure prompt and transparent resolution.
- Publicly report the number of staff who are terminated by DYS on an annual basis.

D. Promote Consistency in Rules and Enforcement

Equitable treatment is essential to regulatory compliance and conflict reduction.

Actions:

- Standardize core rules and level systems across facilities.

- Train staff on consistent and impartial enforcement.
- Monitor for disparities, including those affecting youth with disabilities.

E. Support Relationship-Based, Trauma-Informed Care

Stability and continuity are essential to meeting rehabilitative and statutory objectives.

Actions:

- Develop mentorship and relationship-building models.
- Assign primary staff contacts for each youth.

F. Enhance Surveillance, Accessibility, and Program Quality

Safety and accessibility are foundational legal requirements.

Actions:

- Upgrade surveillance systems, including audio and video monitoring where appropriate.
- Ensure physical and programmatic accessibility.
- Expand educational, recreational, and therapeutic programming.
- Implement and train on reasonable accommodation process.

G. Implement Continuous Monitoring and Policy Review

Ongoing oversight is necessary to ensure sustained statutory compliance.

Actions:

- Conduct periodic internal and external reviews of staff conduct and restraint practices.
- Evaluate policies annually for alignment with Colorado statutes and federal law.
- Report findings and corrective actions to oversight bodies, including the Joint Budget Committee and the Child Protection Ombudsman.

"It's you versus the staff in there." — Youth formerly in DYS custody

VI. CONCLUSION

Reforming DYS is essential not only to improve safety and therapeutic outcomes but also to ensure compliance with the law. Effective reform would decrease legal exposure, stabilize staff-youth relationships, and produce more consistent, equitable, and trauma-informed care across DYS facilities.

Ultimately, operational improvements are not enough. The danger and dysfunction we observed at DYS reflect an agency at the breaking point.

A better strategy lies beyond the agency's walls. To address the needs of Colorado's youth and to promote long-term public safety, Colorado must reduce its reliance on confinement and increase investment in community programs.

Unfortunately, Colorado has been shortchanging such programs — cutting DYS's community-based services by more than 50% in less than a decade. That has left hundreds of youth in custody with nowhere else to go.

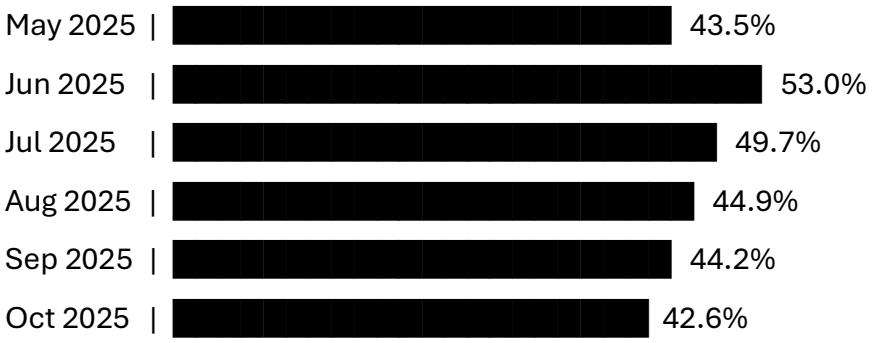
The scarcity of placements is well documented, as are its consequences. A 2023 report found that Colorado was detaining youth for longer than legally necessary — in many cases, for as long as a month or more:

> "The state is so short on treatment beds and foster homes that about one-third of young people are held past their release date, on average for 20 additional days. ... About one-quarter of children and teens were kept 30 days or longer than required."[29]

This problem has only gotten worse. Recent DYS data show that as many as 53% of youth in detention were otherwise eligible for release.

[29] *The Colorado Sun*, "One-third of teens in Colorado juvenile corrections held an average of 20 extra days," July 19, 2023.

Youth Detained for Lack of Placements[30]



Decreasing the number of youth in custody could reduce pressure on staff, lower the likelihood of force, and improve conditions for those who remain. That would, in turn, help DYS fulfill its mission — and help Colorado's youth lead constructive lives.

[30] Youth in Detention Awaiting Mitigating Services Status and Emergency Bed Reports.

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APPENDIX A

DYS DATA[31]	FY 2023	FY 2024	FY 2025
Youth-on-staff assaults	107	175	216
Youth-on-youth assaults	346	456	506
Youth-on-youth fights	479	583	626
Unsubstantiated allegations of child abuse	17	23	25
Substantiated cases of child abuse	4	6	7
Unsubstantiated allegations of sexual assault	12	32	16
Substantiated cases of staff-on-youth sexual assault	1	2	1
Substantiated cases of youth-on-youth sexual assault	6	4	3
Suicides	0	0	0
Homicides	0	0	0
Suspected overdoses*	n/a	n/a	15
Deaths due to suspected overdoses*	n/a	n/a	1
New crimes reported to local police	87	77	130
Direct care staff	705	675	624
Average length of service YSS I (years)	2.7	2.8	3.2
Average length of service YSS II (years)	7.2	6.8	5.8
Average length of service YSS III (years)	10.2	9.5	8.7
Ratio of direct care staff to youth (day)*	n/a	n/a	1:8
Ratio of direct care staff to youth (night)*	n/a	n/a	1:16
Hours missed by direct care staff*	n/a	n/a	297,699
Overtime hours by direct care staff*	n/a	n/a	114,404
Temporary help hours for direct care*	n/a	n/a	0
Worker's compensation injuries*	n/a	n/a	531
Hours missed due to workplace injuries*	n/a	n/a	22,421

* Data not required until FY 2025 report.

[31] CDHS Reports to the JBC in 2024 and 2025. The CDHS RFI report for FY 2023 was obtained through a Colorado Open Records request and can be provided upon request.