Specialized Foster Care in Nevada

State Fiscal Year 2019

July 1, 2018 to June 30, 2019

Report Prepared by the
Nevada Division of Child & Family Services
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Contents

Executive Summary

Pursuant to NRS 424.041-424.043, the Division of Child and Family Services continues to act as an oversight and regulatory body over specialized foster care.

- During SFY19 all jurisdictions worked towards compliance with the new requirements for specialized foster care, including use of an evidence-based model such as Together Facing the Challenge (TFTC) and requirements for data collection and oversight.
- 842 youth were served in specialized foster care placements during SFY19 (i.e., were living in a specialized foster care placement for greater than 30 days). 748 of these were living in a specialized foster care placement for greater than 90 days at some time during the fiscal year and were therefore included in outcomes analyses.
- Nevada's Specialized Foster Care Program (SFCP) had a moderately positive effect on placement stability across jurisdictions and placement types. This is significant, as building relationships is an important component of the TFTC model. TFTC gives foster parents and youth the tools they need to cope with challenges in ways other than short-term or permanent placement disruption.
- Many youth transitioned to a permanent placement upon discharge, ranging from 33.3% of all discharged youth in Rural Specialized Foster Care (SFC) to 63.5% in Washoe County SFC.
- Legal involvement (arrests, detention, probation/parole) appears to decrease during SFCP compared to the time period prior to admission to SFCP.
- Psychotropic medication use was common, in particular the use of medications to focus attention. The average number of medications prescribed per youth at discharge/end-of-fiscal-year ranged from 2.4 to 3.8.
- Mental health billing claims data accessed from Nevada Medicaid indicated that SFCP youth utilize a significant quantity of mental/behavioral health services to support ongoing complex needs. Enrollment in SFCP appears to maintain or increase access to needed mental health services including psychotherapy and psychiatric management.
- Clinical standardized assessment tools indicated that the specialized foster care population in Nevada, including foster parents in SFCP homes, is a high-needs population. Exposure to adverse childhood experiences and other potentially traumatic events is common. Up to 100% of SFCP youth meet criteria for probable post-traumatic stress disorder (PTSD), depending upon jurisdiction and program type. Foster parents experience a high level of objective distress, or interference with everyday personal and family life as result of caregiving for a high-needs youth.
- Youth over the age of 11 as well as foster parents reported being satisfied with specialized foster care services. Areas for potential improvement are including youth in treatment planning according to youth self-report and building youth coping skills per foster parent report.
- 479 youth were enrolled in specialized foster care on the last day of the fiscal year.

Treatment Foster Care

Treatment foster care is a “specialized” or “advanced” version of foster care in which foster parents are provided with additional training and support in order to provide specialized care and support to high-needs youth. Like other programs within a system of care approach, a fundamental assumption of treatment foster care is that the most effective treatment environment for a youth is his/her home, community, and school. Within the specialized foster care model, foster parents pay close attention to the youth’s behavior on a daily basis and are in close communication with other members of the youth’s treatment team in order to provide individualized, coordinated treatment (Fisher & Chamberlain, 2000). Foster parents receive ongoing consultation and support, so they are able to maximize benefits to the youth and optimize outcomes.

Due to their complex mental and behavioral health needs, children who are recommended for treatment foster care have often experienced placement instability (e.g., an average of 4.75 previous placements before entering treatment foster care; Chamberlain, 2003). One important goal of specialized foster care is to improve placement stability for youth by providing extra training and support to foster parents, as well as in-home support and intervention, to proactively address problems that might otherwise result in placement disruption.

A systematic review of outcome studies in treatment foster care demonstrated that the intervention produced large positive effects on social skills and placement permanency (Reddy & Pfeiffer, 1997). More moderate positive effects were also found on behavior problems, level of restrictiveness of discharge placement, and psychological adjustment (e.g., emotional well-being, self-esteem, quality of sleep).

Program Description & History

A new model for specialized foster care was implemented on a pilot basis in 2013-2015 throughout Clark County, Washoe County, and the state’s rural regions. Following the successful completion of the pilot, creation of the new model of the Specialized Foster Care Program (SFCP) was approved through the 2015 Legislature, not only to improve outcomes for foster children with special needs, but to also improve the effectiveness of monies spent for foster children suffering severe emotional disturbance (SED) within Nevada’s Child Welfare System.

During the 2015 Legislative Session, legislation was passed authorizing the State Division of Child and Family Services (DCFS) to serve as the oversight body for SFCP. NRS 424.041-424.043 requires DCFS to conduct an annual review of the placement of children in specialized foster homes. NRS 424.041-424.043 also provides DCFS with the authority to require corrective action should a jurisdiction not meet their responsibilities in implementing SFCP.

Youth are admitted to SFCP based on a standardized assessment process. Youth admitted during State Fiscal Year 2019 (SFY19) were assessed using a comprehensive bio-psychosocial

assessment resulting in a DSM-5/ICD-10 or DC:0-5 diagnosis. Youth must also be considered Severely Emotionally Disturbed as defined by Nevada Medicaid Services. SFCP is intended to serve a target population of youth who have identified behavioral or mental health needs that cannot be met in traditional family foster care; those who are struggling to maintain placement in traditional family foster care due to behavioral and emotional needs; those who have disrupted from a placement due to behavioral and mental health needs; and/or those returning or stepping down from a higher level of care.

In Nevada, foster parents in SFCP homes and staff in specialized foster care agencies are trained in the Together Facing the Challenge (TFTC) model (Murray et al., 2007), a variant of treatment foster care. TFTC was developed through a partnership between Duke University and Penn State University. TFTC draws upon research findings to provide for the three factors that appear to be most influential in creating positive outcomes for youth in foster care. Those factors include: (1) Supportive and involved relationships between caseworkers and foster parents; (2) effective use of behavior management strategies by foster parents; and (3) supportive and involved relationships between foster parents and the youth in their care.

Throughout program implementation, specific metrics are gathered to track the youths' progress.

Please note that this report details services and outcomes for youth served in both Advanced Foster Care (AFC; family foster homes licensed directly by a child welfare agency) and Specialized Foster Care (SFC; specialized foster care agency homes).

Implementation of NRS 424.041-424.043 in SFY19

During SFY19, State of Nevada DCFS continued its efforts towards long-term oversight and sustainability of the Together Facing the Challenge model as the treatment model of choice for SFCP. A main component of sustainability is DCFS's role in monitoring and supporting agencies in becoming certified and maintaining certification in TFTC. Once certified, agencies may practice TFTC independently while continuing to train new staff and foster parents, provide in-home coaching, and maintain required fidelity responsibilities. The certification process involves attending 12 consultation calls with staff from DCFS as well as the developers of the TFTC model from Duke University. Topics discussed on the calls include training updates, check-in regarding model fidelity, and discussion regarding implementation challenges. Additionally, agencies seeking certification must submit implementation fidelity surveys at required intervals. The implementation fidelity survey is an agency self-assessment of the key benchmarks specified by Duke University that are required for certification. These benchmarks include guidelines on the supervision of TFTC in-home coaches, use of required fidelity forms, and training of both providers and foster parents, current and future. Finally, work samples of mandatory TFTC fidelity forms are required. Forms are reviewed by DCFS staff and Duke University representatives and

specific feedback is given to agencies on ways to improve practice and documentation. During SFY19, seven agencies achieved full TFTC certification and two agencies participated in the coaching process toward certification.

An additional important component to sustainability of the TFTC model is the presence of certified trainers throughout Nevada. Only certified trainers can train agency staff and foster parents outside of their own agency. There are currently five fully-certified statewide TFTC trainers: Two located in northern Nevada, two in southern Nevada, and one in rural Nevada. There is also one provisionally certified statewide TFTC trainer located in southern Nevada.

DCFS Quality & Oversight (Planning and Evaluation Unit) conducted eight onsite policy implementation reviews with SFC agencies during SFY19. During these reviews, two agencies were found not to be in compliance with the requirements of DCFS Policy 1603, Oversight of Statewide Specialized Foster Care Program. The main concern identified in both reviews was that neither agency was implementing TFTC nor was there a plan to move the agency towards implementation readiness. As a result, both agencies were placed on corrective action plans in September 2019 by the Clark County Department of Family Services at the request of DCFS. Onsite policy implementation reviews are ongoing with the goal of reviewing each agency on an annual basis.

Please see below for current status of NRS424.041-424.043 implementation in each jurisdiction.

Implementation in Clark County

Update Provided by Clark County Department of Family Services (CCDFS)

Clark County Department of Family Services (CCDFS) continued to implement its Advanced Foster Care (AFC) Program during SFY19. CCDFS started SFY19 with 41 AFC homes. Seventeen closed throughout the course of the year, resulting in a current count of 24 AFC homes. As AFC was designed and budgeted to be fully operational with 30 homes, CCDFS recognizes that the need to recruit and train new homes is minimized when current foster homes can be retained. CCDFS has undertaken a series of focus groups to better understand the ways that DFS can better support and team with foster parents to aid in retention of foster homes. CCDFS is currently implementing the recommendations, including creation of a foster parent retention panel, and efforts to improve the partnership and communication between the Resource Development and Support team and the Nevada Initial Assessment (NIA) and Permanency units.

Recruitment and training of AFC homes is ongoing, with a goal of developing six more homes over the next year. Recruitment of quality homes that are willing and able to address the needs of our children and youth with the highest behavioral and mental health needs is ongoing and being fulfilled with a targeted recruitment plan to identify families most likely to meet the needs of CCDFS' children. Staffing for the AFC program is complete, with all positions currently filled. Staff are trained in the TFTC model and CCDFS' AFC program was certified in early 2019. Currently, CCDFS Clinical staff has weekly meetings with the Placement team to discuss the AFC population and to review the needs of children who are in congregate care that need an AFC/SFC placement.

Upon entering congregate care, CCDFS Clinical assesses the needs of each child to see if they would benefit from SFCP.

CCDFS has continued to work closely with DCFS to improve its data reporting and to comply with all areas as set forth in NRS 424.041-424.043. CCDFS has implemented new processes to ensure that data is reported timely and appropriately within UNITY, the state data system. CCDFS has also streamlined the data and reporting structure to attain this goal.

Finally, CCDFS has worked diligently over the last year to improve its partnership with the eight local specialized foster care (SFC) agencies. These agencies currently have a combined total of 190 homes. CCDFS has partnered with the SFC agencies on a collaboration with DCFS to redesign the funding method for SFC and is supporting the state-led initiative to update the Medicaid State plan to allow for additional funding categories for children placed in SFC homes. CCDFS is also in the process of revising its SFC contracts for the next contract period to improve the contract requirements on documentation of treatment planning and coordination of care for children in SFC placements. CCDFS and SFC have also worked on aligning multiple procedures and practices to streamline the licensing process and ensure consistency amongst agencies. This effort has resulted in a universal home study and application process across agencies, and a shared family transfer process.

Implementation in Rural Counties

Update Provided by DCFS Rural Region Child Welfare

The DCFS Rural Advanced Foster Care (AFC) Program continues its development and implementation throughout the 15 rural counties in Nevada. The program is staffed by a Clinical Program Manager, four Mental Health Counselors (called Coaches), and an Administrative Assistant. All staff other than the Administrative Assistant are masters level professionals. Coaches are stationed in Carson City, Fallon, Elko, and Pahrump. The Clinical Program Manager and the Administrative Assistant are stationed in Carson City.

During the reporting period there were 13 SFC homes that were associated with a foster care agency (e.g., Eagle Quest, Mountain Circle). The number of these agency homes fluctuated but averaged about six at any given time. There were also 16 AFC homes in Fallon, Fernley, Dayton, Yerington, Winnemucca, Ely, Pahrump, and Amargosa Valley. These homes had between one and four specialized foster care children in them. Three AFC homes dropped out of the program during the year.

AFC homes in the Rural Region are trained in TFTC, as well as in a trauma informed program called, “Caring for Children Who Have Experienced Trauma.” Staff that work in the homes are trained in TFTC and trauma informed approaches to foster care and parenting. During the reporting period, the AFC Clinical Program Manager became certified as a TFTC trainer. The AFC team, as well as the Foster Care Agencies that are in the program are fully certified and in good standing with TFTC.

The program Coaches work collaboratively with other units of the Division. This includes coordinating services with the Intensive Family Services Unit, working with Caseworkers and the Wraparound in Nevada (WIN) team to coordinate services for children in the program, and collaborating with each DCFS District Office to review the cases of all children in higher levels of care, including AFC.

The program has developed a robust and well-organized data collection system that ensures all required data is collected timely and within the timeframes required by the Division. This data helps with overall program evaluation, but it also guides day-to-day program decisions and strategy.

The Advanced Foster Care Program continues to work toward full implementation of TFTC. In addition, the program is working to help children in need to remain in a family foster home that is equipped to help them address mental health and trauma related events in their life in order to live a happy and fulfilling life.

Implementation in Washoe County 2019

Update Provided by Washoe County Human Services Agency

In SFY19 Washoe County Human Services Agency (WCHSA) focused on the sustainability of its Specialized Foster Care Program (SFCP) by focusing on the three areas of previous reporting: Program Improvement, Work Force Development, and Quality Assurance/Outcomes. With continuous development and implementation of a Nevada specific model of implementing Together Facing the Challenge, WCHSA focused on achieving TFTC Fidelity Benchmarks with the goal of recertification by Duke University in November of 2020.

Program Improvement

Over SFY19 the process of WCHSA's previously formed Triage and Placement Review Team (TPRT) morphed into additional, existing agency meetings, with the option of calling an impromptu TPRT meeting on a case-by-case need. First, TPRT activities were incorporated into the weekly Emergency Placement Charter meetings to review the cases of children with behavioral/mental health needs that have entered care and/or are difficult to transition from the emergency shelter to community-based placements due to their additional support needs. Second, TPRT activities were incorporated into weekly Placement Support Team meetings to review children at risk of or disrupting from placement. As part of this process a new placement referral form was implemented to specifically identify the additional behavioral/mental health support needs. While the function of the new team remained (i.e., children referred to, or needing assessment for SFCP were reviewed for admission and placement options to determine SFCP eligibility), the different team meetings include additional agency staff from different program areas to ensure clear and comprehensive communication about children in possible need of SFCP placement in a timely manner. Actions related to program planning, implementation, and decision-making activities continued to occur in various Clinical Services

Team meetings on an ongoing basis, to improve upon WCHSA's SFCP processes. This resulted in the following changes over SFY19.

WCHSA stream-lined the placement and referral process in order to assure review of the needs of all children coming into care for both lower and higher levels of SFPC (AFC and Specialized). For children in care, WCHSA is enhancing focus on permanency by developing a new format to review permanency in reoccurring meetings starting in February 2020. WCHSA continued work on a multidisciplinary team to analyze and develop new procedures to successfully select, prepare, and support adoptive families for children in SFCP, with the goal of more successful, finalized adoptions, as well as more timely permanency for children placed in SFCP. Over SFY19, WCHSA staff partnered with DCFS Planning & Evaluation Unit to assist with development and implementation of revised TFTC Coaching forms specific to Nevada while TFTC Supervision was carried out under one staff (Program Specialist). Over SFY19 WCHSA held on-going meetings to plan for the changes likely to occur due to the Family First Prevention Services Act. Specifically, WCHSA established and implementation of reoccurring Provider Support meetings to engaged SFCP community providers. Over the SFY19 WCHSA monitored TFTC benchmarks/requirements in order to meet re-certification in November 2020.

Workforce Development

Over SFY19 WCHSA continued to utilize TFTC as the SFCP program model. Various activities took place with respect to efforts to sustain TFTC implementation.

In SFY19 WCHSA held TFTC 3-day trainings for SFCP providers on a quarterly basis. Additionally, impromptu TFTC 3-day trainings were scheduled for new providers/staff as needed. Refresher courses were offered in order to train both AFC and SFC foster parents/providers in Washoe County along with holding refresher courses for WCHSA staff previously trained in TFTC. A team of WCHSA staff trained in TFTC provided weekly in-home TFTC Coaching and some TFTC Supervision to foster parents/caregivers guided by the TFTC model. WCHSA staff participated in TFTC Coach/Supervisor trainings, with refreshers provided to all agency staff and community providers. Finally, a WCHSA staff was recertified as a certified TFTC trainer.

Additionally, WCHSA staff actively participated in monthly TFTC consultation and implementation calls with DCFS-PEU and Duke University-TFTC. Related, WCHSA continued to engage in activities to recruit, license, and train additional SFCP homes/providers. As of March 2019, there were a total of 47 SFCP homes (11 AFC, 36 SFC). Over SFY19 SFCP was staffed utilizing allocated SFC-funds from DCFS. As such, WCHSA continued to staff the SFPC as follows.

At WCHSA an Office Support Specialist was used for data collection/entry, tracking of various program components, and the organization and management of a variety of duties and program documents. A Social Worker III conducted implementation activities, general support, and liaison duties, facilitated TPRT/Placement meetings, performed data collection duties, helping to train TFTC model and provide consultation, provided further support to AFC children by coordinating and facilitating child and family team (CFT) meetings, engaged in targeted permanency efforts,

and helped with care coordination of children's services. Additionally, in SFY19 another Social Worker III was hired to conduct TFTC Coaching, participate in CFTs and help with Person Legally Responsible cases. WCHSA also utilized *Mental Health Counselors* to facilitate placement, provide Care Management, become trained in the TFTC model and conduct in-home coaching for AFC and SFC foster parents/caregivers, and provide crisis intervention.

Quality Assurance/Outcomes

For each child in SFCP, WCHSA staff continued to collect and reported out on all data collection elements per NRS 424.041-424.043 and DCFS Policy. WCHSA staff certified in the Child and Adolescent Needs and Strengths (NV-CANS) continued to conduct assessments at admission, every six months thereafter, and at discharge for all children enrolled in SFCP; and report CANS scores per data collection requirements. Throughout SFY19 WCHSA staff entered and reported data through the system created in UNITY and the lead staff continued to provide feedback and consultation to DCFS after the SFC system deployed. WCHSA staff also partnered with DCFS-PEU on the development of audit and review forms/tools and participated in new quality assurance activities as requested.

SFCP staff reviewed providers' prior authorization requests and treatment plans for children in SFCP, and reviewed Medicaid data when provided by DCFS to ensure that appropriate rehabilitative mental health services were utilized.

WCHSA is proud to continue to report 100% implementation of the SFC program as approved in the 2015 Legislative session.

Data Collection Procedures

While a child is enrolled in the specialized foster care program (SFCP), information regarding demographics, symptoms, functioning, placements, and outcomes is collected at admission, every 6 months thereafter, and at discharge. The following indicators were used to track a youth's progress in SFCP during SFY19:

- Runaways
- Psychiatric hospitalizations
- Placement changes
- Progress toward permanency: Discharge to permanent placement
- Legal involvement: Arrests; days in detention; parole/probation status
- Educational information: Special education status and classification; gifted status
- Psychotropic medication use
- Mental health service use
- Clinical standardized assessment tools: Child Post-Traumatic Symptom Scale (CPSS), Nevada Child and Adolescent Needs and Strengths Tool (NV-CANS), Caregiver Strain Questionnaire
- Consumer satisfaction

For youth discharged from the program during SFY19, data for the six months prior to admission were compared to data from the six months prior to discharge to determine outcomes. For youth currently enrolled in SFCP at the end of SFY19, data for the six months prior to admission were compared to the most recently available data as of the end of the fiscal year (i.e., the most current information about that youth's functioning). In some cases that is the youth's status on the last day of the fiscal year or the cumulative period six months prior to the end of the fiscal year, and in some cases that is information taken from the data collection that occurred most recently.

Per State of Nevada Family Programs Office Policy 1603A, Specialized Foster Care Evaluation and Reporting Process, reporting of demographic data is limited to youth who were in the program for 30 days or more. Outcomes analysis is limited to youth who were in the program for 90 days or more. This is because less than 90 days is an inadequate dose of SFCP such that we do not expect to see lasting behavior change in youth who receive small amounts of SFCP and Together Facing the Challenge.

Sample Description

A total of 842 youth were served in SFCP for at least 30 days at some time during SFY19. Four hundred seventy-nine youth were enrolled in SFCP on the last day of the fiscal year, June 30, 2019.

Table 1. Total Youth Served Statewide in SFY19
Number of youth admitted to AFC or SFC for at least 30 days at any time during the fiscal year

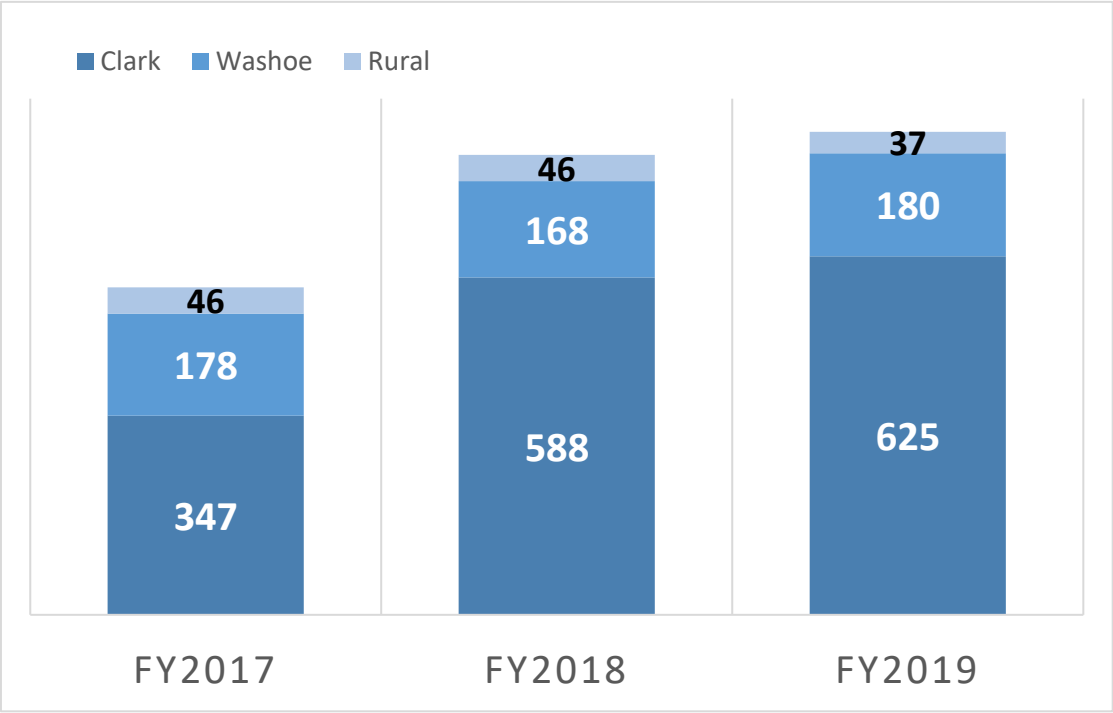
	AFC	SFC	Total
Clark	57	568	**625**
Washoe	25	155	**180**
Rural	24	13	**37**
STATEWIDE	**106**	**736**	**842**

Table 2. Total Youth Enrolled Statewide
Number of youth enrolled in SFCP on the last day of the fiscal year

	AFC	SFC	Total
Clark	48	305	**353**
Washoe	10	90	**100**
Rural	22	4	**26**
STATEWIDE	**80**	**399**	**479**

842 youth were served in Specialized Foster Care statewide during SFY19

Figure 1. Youth Served in SFCP Has Been Steadily Increasing for the Past Several Years



The mean age in SFCP ranged from 8.7 (Washoe AFC) to 12.4 years (Rural SFC). The youngest children in SFC were aged 1 year (Clark SFC). The average length of stay varied from approximately 341.7 days (Clark AFC) to 662.2 days (Washoe AFC). Race/ethnicity varied across jurisdictions. In Clark County, approximately half of SFCP youth were Caucasian and nearly half were African American/Black. Approximately 23.6% were Hispanic. In Washoe County, approximately 75% were Caucasian while 17.9% were African American/Black, and 21.7% were Hispanic. In Rural Nevada, 85.7% were Caucasian, 2.4% African American/Black, 9.5% American Indian, and 10.8% Hispanic. The most common reason for entry into the child welfare system in all jurisdictions was neglect; in the Rural child welfare program, parent incarceration was an equally common reason.

Please see Appendix A for all demographic information.

Outcomes

Table 3. Number of Youth Included in Outcome Comparisons

Youth described in this table spent 90 days or more in SFCP and are presumed to have received a "therapeutic dose" of the program. That is, they were in the program long enough to create lasting behavior change.

	AFC	SFC	Total
Clark	53	491	**544**
Washoe	24	147	**171**
Rural	23	10	**33**
Statewide	**100**	**648**	**748**

The analyses that follow are limited to the 748 youth with 90 days or more of treatment. Youth with less than 90 days in SFCP (*n* = 94) were excluded from outcomes analyses. Pre-post comparisons are made from admission to discharge in the case of youth who have exited SFCP. For youth who were still enrolled at the end of the fiscal year, pre-post comparisons are made using the most recently available data at the end of the fiscal year. In some cases that is the youth's status on the last day of the fiscal year, and in some cases that is information taken from the data collection that occurred most recently.

14-year-old Natosha* was placed in foster care at age 11 due to a history of severe sexual abuse. Due to serious behavioral health needs, she initially struggled in regular foster care, experiencing school failure, placement disruption, and long term stays in psychiatric inpatient care. She is currently thriving in an AFC home where she is responding well to positive relationships and structure from the parents in that home. She is no longer seeking out pornographic material on the internet, is doing well in school, and has developed positive peer relationships.

*Identifying details have been changed.

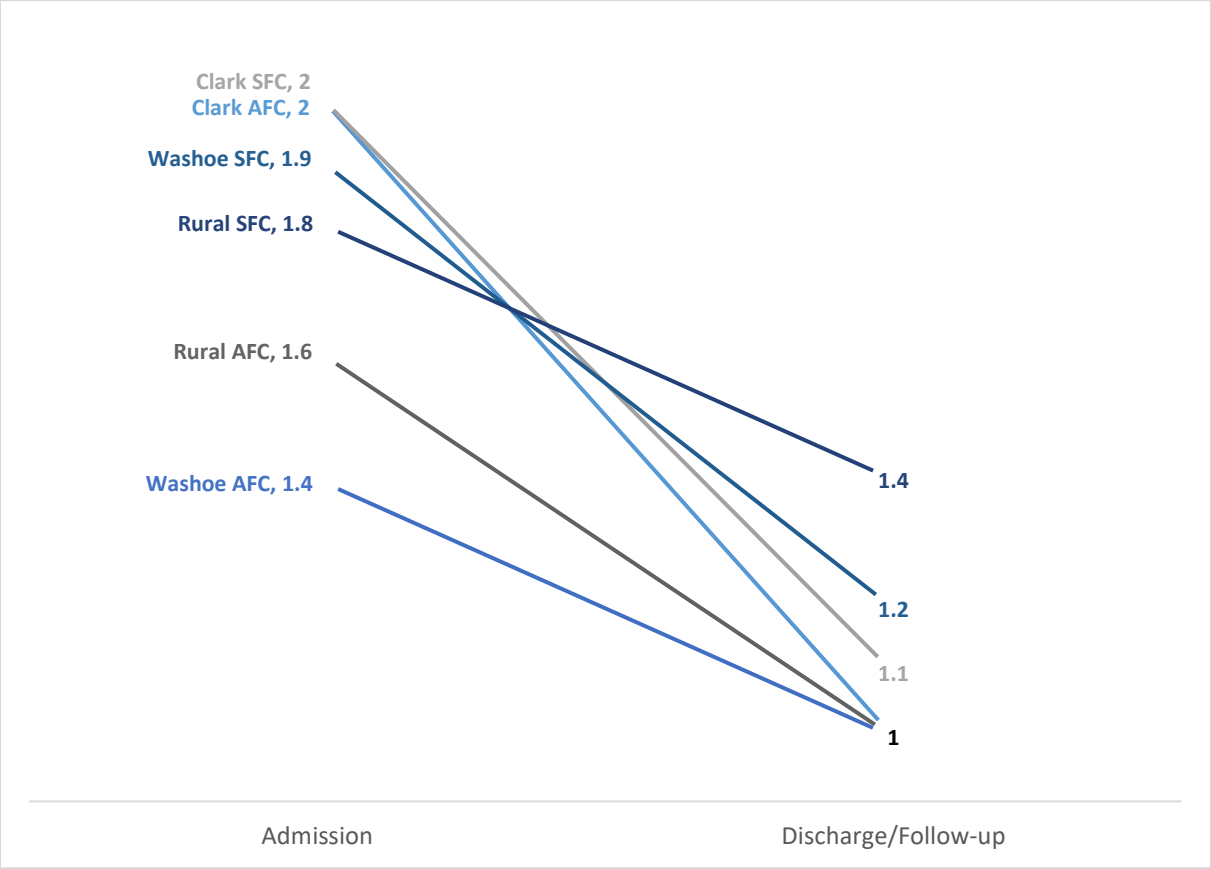
Elopement, Hospitalizations and Stability of Placement

Substantially fewer youth eloped between admission and discharge/end-of-fiscal-year (EOFY) in Clark SFC and Washoe SFC. In Clark AFC and Rural SFC, one youth with a history of elopement was observed at admission and zero elopements were observed at discharge/EOFY. Zero runaways were observed in Washoe AFC at admission, as well as Rural AFC at both admission and discharge/EOFY.

Psychiatric hospitalizations decreased between admission and discharge/EOFY in Clark SFC, Washoe SFC, Rural AFC, and Rural SFC. There was no change in Clark AFC from admission to discharge/EOFY. No hospitalizations were observed in Washoe AFC placements.

Average number of placements decreased in every program in every jurisdiction from admission to discharge/EOFY. Average number of placements per youth at discharge/EOFY ranged from 1.0 to 1.4, with standard deviations ranging from 0.0 to 0.8, indicating that in most cases youth remained in their initial SFCP placement without placement changes.

Figure 2. Average Number of Placements Decreases During SFCP across All Jurisdictions and Program Types



In summary, there appeared to be modest gains for SFCP youth in placement stability outcomes, particularly with respect to elopement from care and long-term stability of the foster care placement. During the six months prior to specialized foster care, a small proportion of SFCP youth tend to be frequently hospitalized, frequently in runaway status, and frequently disrupting from placements. Improvements in placement stability are significant, as building relationships is an important component of the TFTC model. Improvements in placement stability outcomes are among the central positive findings for specialized foster care, as placement instability is indicative of out-of-control behavior and inability of caregivers to cope with the youth's needs. TFTC gives foster parents and youth the tools they need to cope with challenges in ways other than short-term or permanent placement disruption.

Permanency Outcomes

Many youth transitioned to a permanent placement upon discharging from SFCP, ranging from 33.3% in Rural SFC to 63.5% in Washoe SFC. Relatively few youth must admit to a higher level of care from SFCP (3%). Please see Appendix B for full permanency outcomes.

Figure 2. Transitions to Permanent Placements Upon Discharge from SFCP

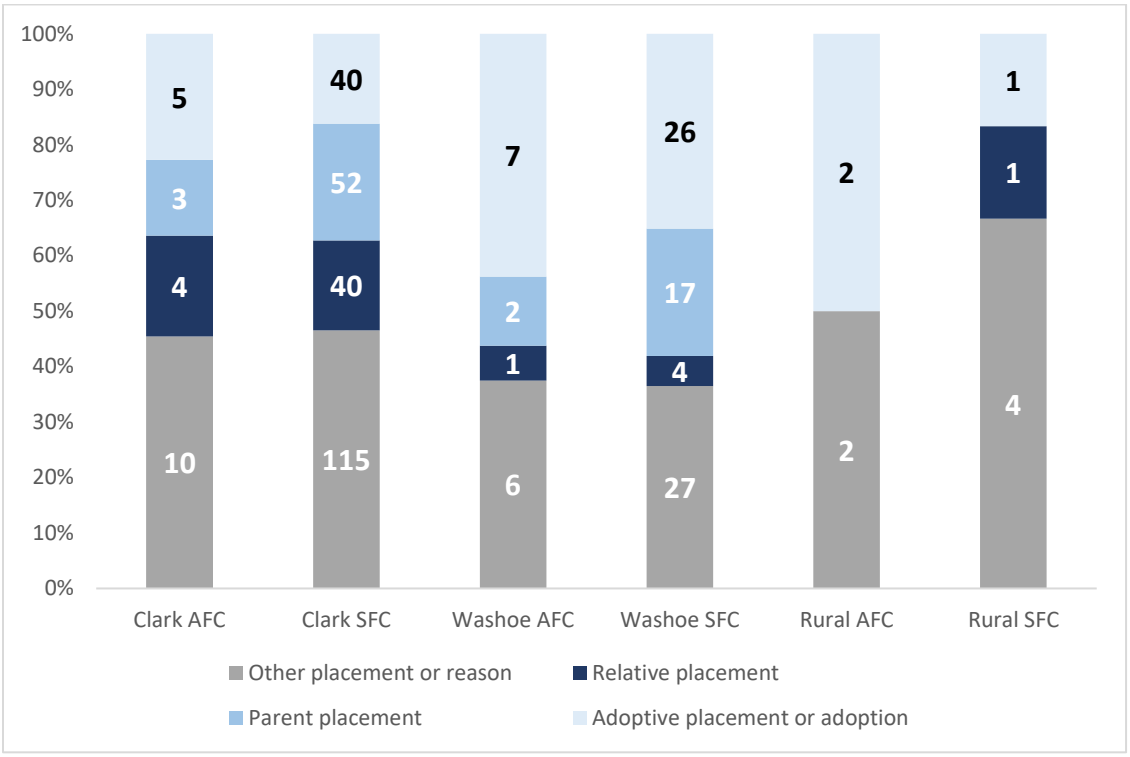
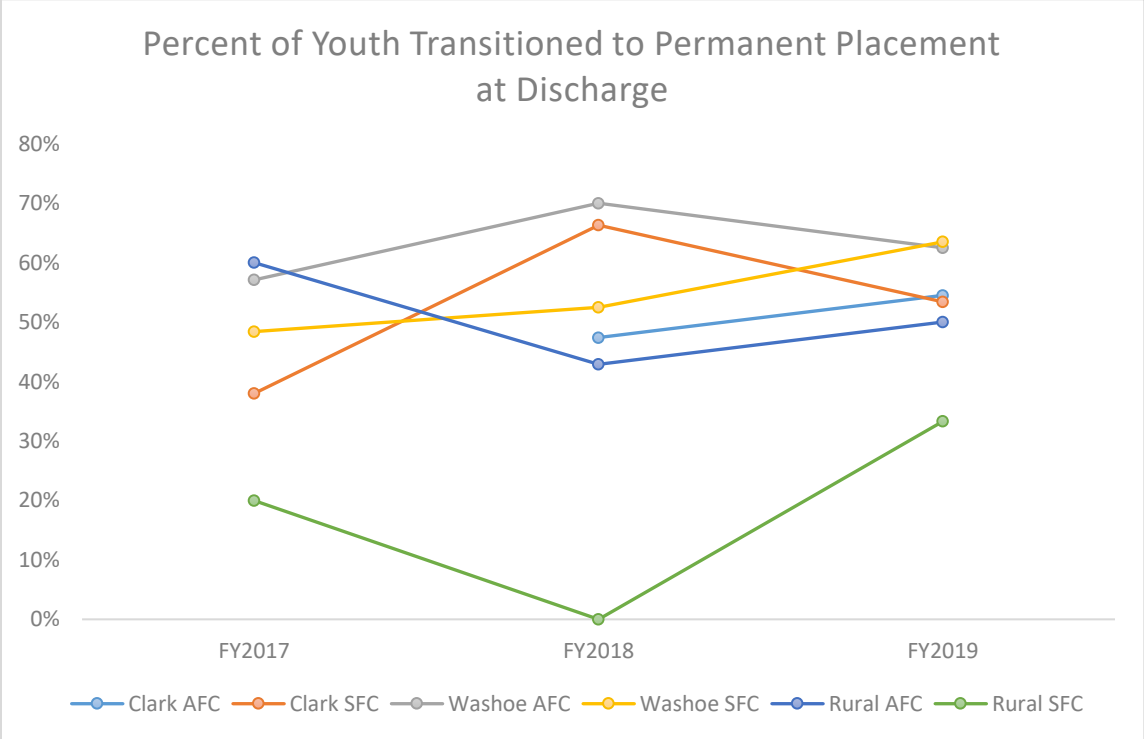


Figure 3. Change in Permanent Placement Trends Over Time



Legal Involvement

Legal involvement was a relatively rare occurrence at both admission and discharge/EOFY across all programs. No legal involvement was observed in Clark AFC at admission or discharge/EOFY. There appears to be a decrease in legal involvement during SFCP in nearly all programs where legal involvement was observed, including number of youth arrested, number of youth on probation, and number of youth with detention history. In some cases the decrease is substantial; for example, in the Clark SFC program there was approximately a 50% decrease in the number of youth with detention history, and the number of days in detention decreased for these youth from an average of 51 to an average of 16. In the Washoe SFC program, the number of youth on probation decreased from 10 to 5.

Please see Appendix B for legal involvement detail.

Education

A substantial proportion of SFCP receive special education services at school, primarily for learning disabilities (13.0% statewide), health impairment (8.6% statewide), and emotional disturbance (8.2% statewide). In some programs and jurisdictions, more than half of youth are classified as special education. A small number of SFCP youth (8 youth in SFY19) are identified as gifted. Unfortunately, this is not a status usually associated with SED foster youth, so it is important to ensure that these youth are receiving access to any special programming at school for which they qualify. Gifted youth who are unable to access appropriate academic accommodations often demonstrate acting-out behaviors in the classroom because they become bored. Additionally, as depression and anxiety are prevalent among gifted youth (Cross & Cross, 2015), at-risk gifted SFCP youth should be monitored.

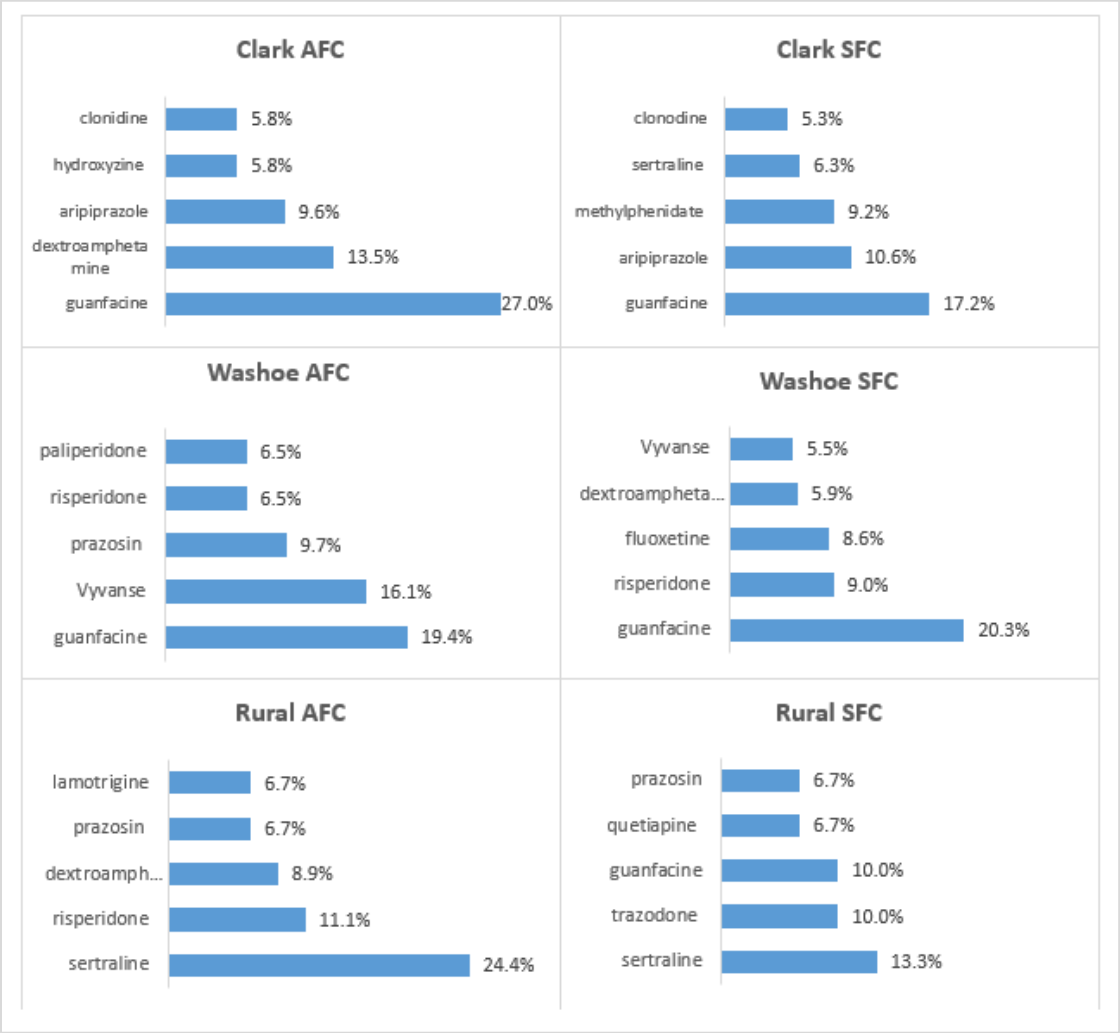
Please see Appendix B for full details.

Use of Psychotropic Medications

As reported in previous years, among youth in specialized foster care who take psychotropic medications, polypharmacy is common. Medications to focus attention were the most commonly prescribed across jurisdictions, which is consistent with prescribing patterns reported in the scientific literature on youth in treatment foster care (Brenner et al., 2014; see below). More youth receive psychotropic medications at discharge/EOFY than in the six months prior to admission. Between 37.7% and 80% of youth are taking psychotropic medications at discharge/EOFY, depending upon the jurisdiction/program, the average number of medications prescribed per youth is 2.9. This is relatively consistent with rates reported in the literature for youth in treatment foster care, with 59% of youth reporting recent medication use and 61% of those reporting use of two or more medications (Brenner et al., 2014).

Please see Appendix B for additional detail.

Figure 4. Most Commonly Prescribed Psychotropic Medications at Discharge



Darren, age 16, Caleb, age 14, and Trevor, age 12 grew up in an abusive household with parents who had severe untreated substance use problems. All of the boys struggle with serious emotional disturbance, particularly oppositional behaviors and acting out in home, school, and community environments. All three have been on Juvenile Probation. They have been in the care of DCFS for over four years and have been in numerous foster homes, although not usually together. Throughout their time in care, the boys have maintained a desire to stay together but when they finally were placed in one home, their behavior was so intense that the foster parent finally gave notice, saying, "I want these boys out of here right now!" The boys were then placed in a specialized foster home in another part of the state with a very experienced couple. The foster parents exposed the boys to camping, fishing, riding quads, and auto mechanics, as well as a family life that included structure, accountability, and unconditional love. Initially, Darren, Caleb, and Trevor were hesitant, and they did display some behaviors that were intended to test the new parents. But over time with weekly coaching through the AFC Program and the parents' loving, consistent, and patient mentoring along with regular coaching from the program, the boys have made great progress. They are attending mental health counseling and all of them are now off probation. They have developed new interests and friends, are doing well in school, and are no longer fighting or getting in trouble.

Mental Health Service Use

Overall, mental health billing claims data accessed from Nevada Medicaid indicated that SFCP youth utilize a significant quantity of mental/behavioral health services. Given that severe emotional disturbance is a prerequisite for specialized foster care, this is an anticipated finding. Enrollment in SFCP appears to maintain or increase access to necessary mental health services including psychotherapy and psychiatric management. Full data on mental health service use, detailed from Medicaid billing claims for SFY19, are available in Appendix C. Highlights include:

- **Clark AFC:** Use of crisis intervention increased from an average of 4.8 hours per 6 months at admission to 13.8 hours per 6 months at discharge/EOFY.
- **Clark SFC:** Whereas 276 youth were accessing individual therapy at admission, 411 were using this service at discharge/EOFY (83.7% of youth).
- **Washoe AFC:** Use of group therapy increased from an average of 4.4 hours per 6 months at admission to 6.3 hours per 6 months at discharge/EOFY.
- **Washoe SFC:** Whereas 50 youth had received a new patient visit with a psychiatrist at admission, 110 youth had done so at discharge/EOFY (74.8% of youth).
- **Rural AFC:** Use of individual therapy increased from an average of 8.5 hours per 6 months at admission to 11.9 hours per 6 months at discharge/EOFY.
- **Rural SFC:** Use of group therapy increased from an average of 2.7 hours per 6 months at admission to 10.5 hours per 6 months at discharge/EOFY.

Performance on Clinical Standardized Assessment Tools

Child Post-Traumatic Symptom Scale (CPSS)

The Child Post-Traumatic Symptom Scale (CPSS; Foa, Johnson, Feeny, & Treadwell, 2001) is a brief self-report instrument related to trauma that is filled out by SFCP youth age 11 or older. Youth first fill out a 15-item trauma screening, where they report lifetime exposure to potentially traumatic events. If there has been exposure to any potentially traumatic event, youth then fill out 17 items about symptoms of post-traumatic stress disorder (PTSD) and seven items related to functional impairment (e.g., "these problems have gotten in the way of schoolwork" or "these problems have gotten in the way of relationships with my family"). A symptom score at a certain threshold plus positive endorsement of functional impairment indicates a probable diagnosis of PTSD that should be confirmed by a clinician.

Regarding youth served during SFY19, there were 117 admission CPSS assessments (15.6% of the outcomes sample) and 269 follow-up CPSS assessments (36.0%). Eighty-two youth (11.0%) had both an admission and a follow-up CPSS. Potentially traumatic events assessed include physical and sexual abuse, interpersonal violence, sudden death of a close friend or family member, and frightening medical procedures. Lifetime number of potentially traumatic events endorsed by each youth at admission ranged from zero to 14. Averages within each jurisdiction and program ranged from 4.4 (Washoe SFC) to 7.3 (Rural SFC). Youth endorsing at least one potentially traumatic event ranged from 85% to 100% depending upon the jurisdiction and program and was 89% statewide. This is substantially higher than national estimates of the prevalence of exposure to trauma in childhood, which suggest that 62% of youth will experience at least one traumatic event in their lifetime (McLaughlin et al., 2013).

Prevalence of distress and impairment associated with probable PTSD in SFCP youth at admission ranged from 67% to 100% of youth depending upon jurisdiction/program. This greatly exceeds the typical rate of PTSD in trauma-exposed youth, which is 15.9% (Alisic et al., 2014). These results underscore the vulnerable nature of the SFCP population as well as the pronounced need for specialized, intensive, multidimensional treatment strategies.

It is important to note that there was a relatively low response rate for the CPSS assessments; only 16% of youth had an admission CPSS assessment on file. Anecdotally, DCFS has received feedback that clinicians are reluctant to administer the CPSS due to concerns about retraumatizing youth by screening and assessing for trauma. This may contribute to low response rates.

Please see Appendix B for more detail on the CPSS.

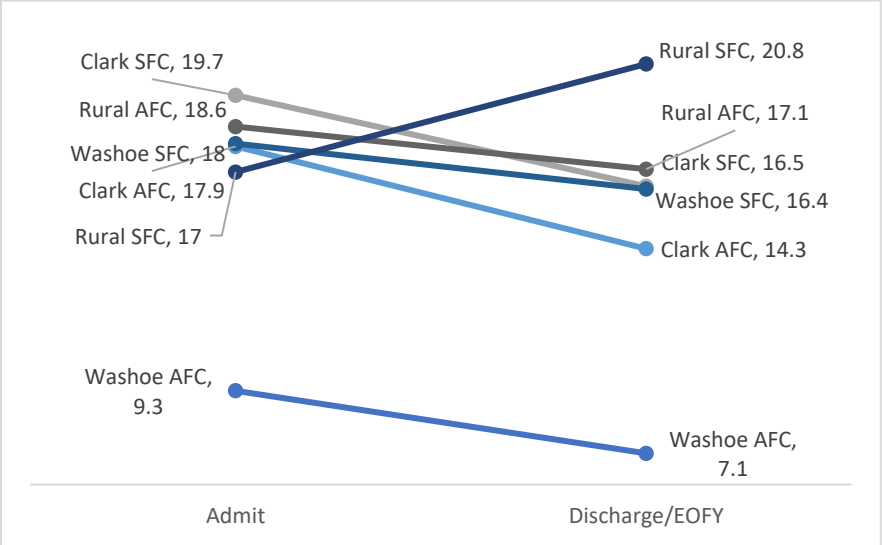
Nevada Child and Adolescent Needs and Strengths Tool (NV-CANS)

During SFY19, DCFS continued to prioritize statewide implementation of the Nevada Child and Adolescent Needs and Strengths Tool (NV-CANS) and its clinical framework, Transformational Collaborative Outcomes Management (TCOM). This includes providing technical assistance and training to providers serving SFCP youth. The CANS is an evidence-based, collaboratively completed, standardized assessment of child and family needs and strengths. The CANS is used for initial assessment and treatment planning, for measuring individual progress over time, and for aggregate outcomes evaluation. The CANS is used in all 50 states as well as internationally and has become the standard of care in child welfare and children's mental health.

With the exception of the domain measuring presence/absence of potentially traumatic events, the CANS is scored by observing "actionable treatment needs," that is, items in each domain that are rated either "moderate, action needed" or "severe, disabling, dangerous; immediate/intensive action needed." In the case of strengths, these are also scored "actionable" but are rated "build or develop" or "strength creation or identification may be indicated." There are a range of needs identified on the NV-CANS, including areas that might be targeted during specialized foster care such as behavioral/emotional needs and risk factors and behaviors.

300 youth (40.1%) had an NV-CANS at admission, 408 youth (54.5%) had an NV-CANS at discharge/EOFY, and 153 youth (20.5%) had both on record. Low rates of response provide an opportunity for the Division to follow up to ensure all youth are receiving CANS as required. Pre/post analyses were not possible due to small sample size, but there appear to be trends suggesting improvement on the CANS (i.e., fewer actionable treatment needs) from admission to discharge or EOFY (see figure). Please see Appendix B for full NV-CANS results.

Figure 5. Total Actionable Treatment Needs Decrease from Admission to Discharge



Caregiver Strain Questionnaire (CGSQ)

Although providing care to high-needs youth can be challenging and stressful, formal assessment of the needs of caregivers is not often done. The Caregiver Strain Questionnaire (CGSQ) is a brief 21-item questionnaire designed to capture the experiences of individuals caring for a child with emotional and behavioral disorders (Brannan, Heflinger, & Bickman, 1997). The CGSQ is scored on a scale of 1 (Not at all) to 5 (Very much).

For SFY2019, the most recent CGSQ regarding 260 SFCP youth, provided by their caregivers, were analyzed. At the time of the CGSQ, youth were most commonly at their 12-month (36.2%), 18-month (23.8%), or 24-month (16.2%) follow-up assessment.

Figure 6. CGSQ Objective Strain

Nevada SFCP parents score high compared to caregivers in an outpatient SED sample (comparison mean = 2.02) in negative experiences that result from caring for a high-needs child (e.g., interruption of personal time, missing work, disruption of family routines or relationships, caregiver or family members suffering mental or physical health effects, financial strain, social isolation).

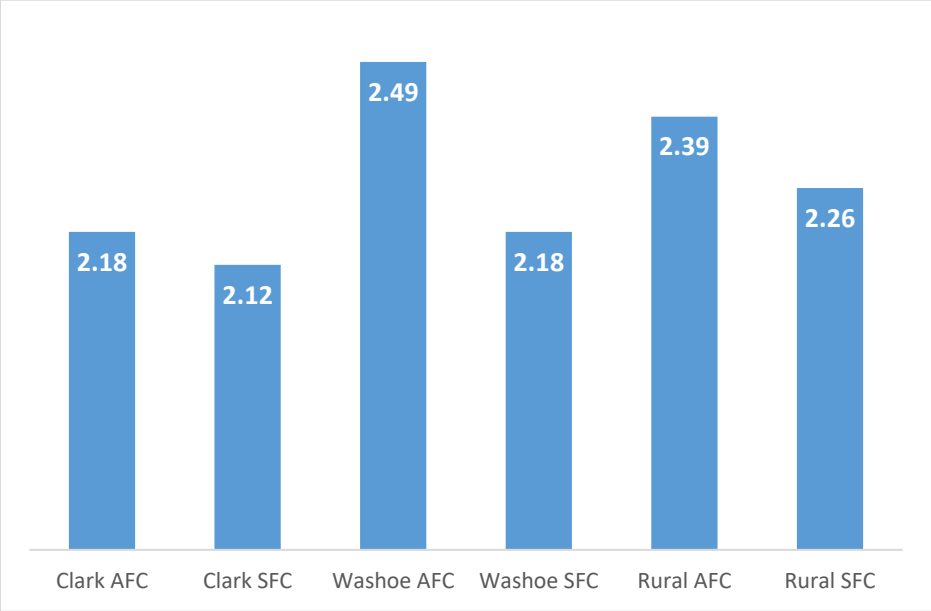


Figure 7. CGSQ Internalized Subjective Strain
Nevada SFCP parents scored lower relative to caregivers in an outpatient SED sample (comparison mean = 3.43) on negative feelings felt by the caregiver that are associated with caring for a high-needs child (e.g., feeling sad, worrying about the child or family's future, feeling guilty, feeling like a toll has been taken on the family).

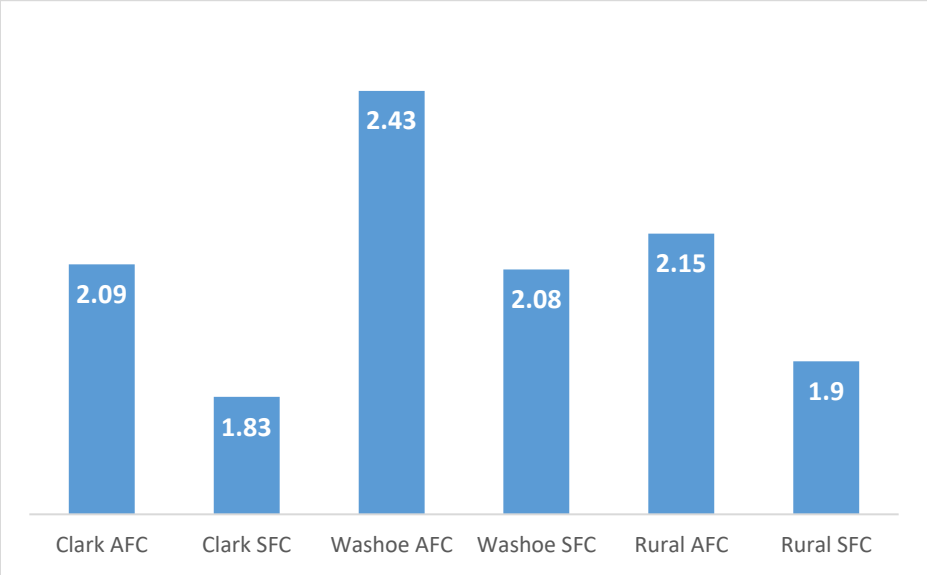
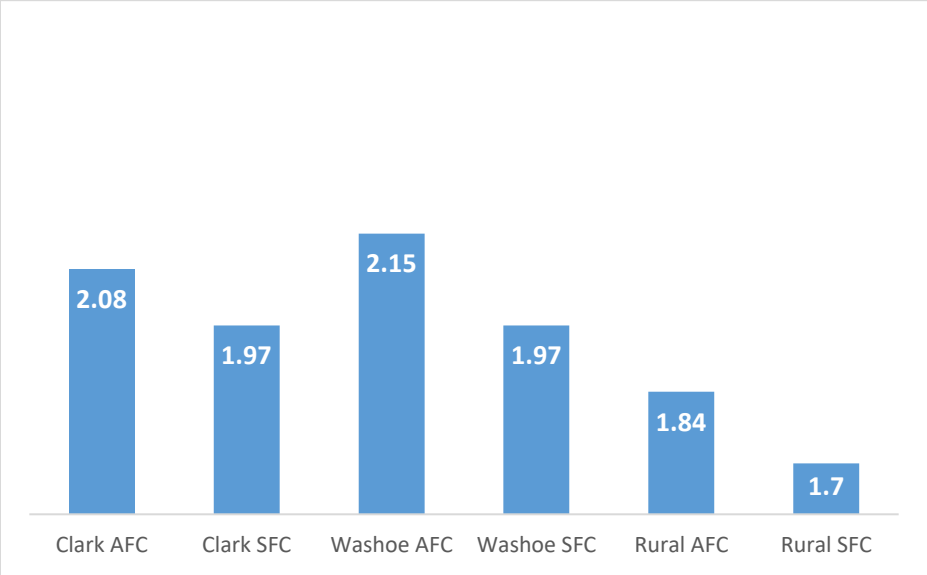


Figure 8. CGSQ Externalized Subjective Strain
Nevada SFCP parents scored lower relative to caregivers in an outpatient SED sample (comparison mean = 2.29) on negative feelings directed at the child (e.g., resentment, anger, embarrassment).



The mean values for Nevada's specialized foster care families on both internalized and externalized subjective strain (unpleasant feelings the caregiver feels related to caring for a high-needs youth) are lower than those of a comparison sample of 984 families entering outpatient treatment for youth SED (Brannan, Heflinger, & Bickman, 1997). It is likely that the support and coaching the families receive through the TFTC model are somewhat mitigating the subjective experience of stress that is often associated with this type of caregiving. However, foster parents

are still reporting a high level of objective strain, or disruption to everyday personal and family life such as disruption to family relationships and social activities, interruption of personal time, and the need for the foster parent to miss work. It may be that there are additional ways in which SFCP staff can support foster parents so that some of the additional burden is relieved.

Consumer Satisfaction

Foster parents and youth in all AFC and SFC homes statewide were asked to report on their satisfaction with SFCP and the services provided to them during SFY19. Consumer satisfaction data is collected in a completely anonymous fashion, so it is not possible to provide results broken down by jurisdiction or program, although there is a voluntary question regarding where the individual currently lives that is reported below. 236 foster parents (31.6% of outcomes group) and 156 youth (20.9% of outcomes group) provided consumer satisfaction surveys during SFY19.

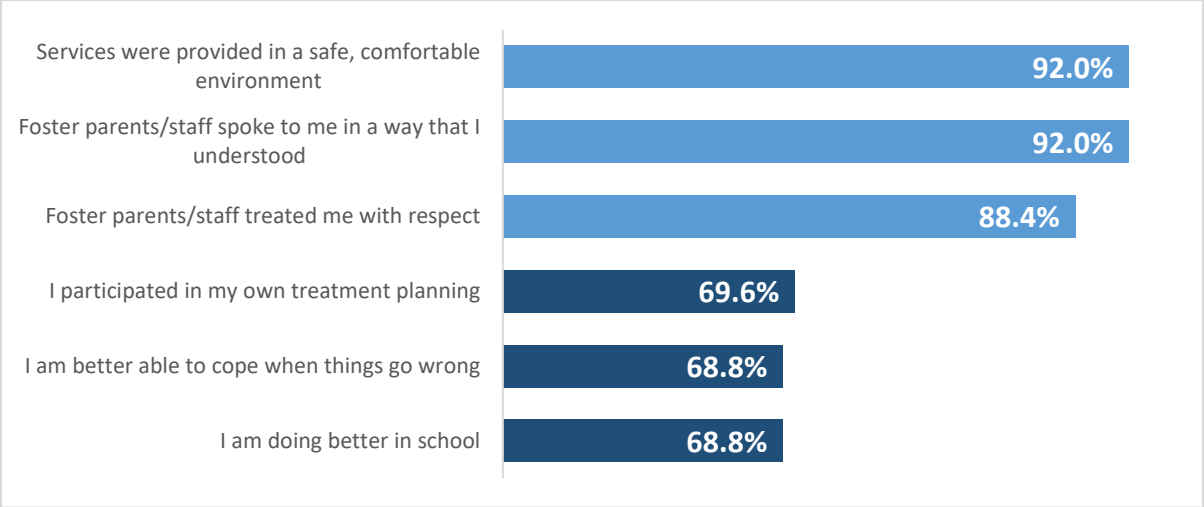
Youth Satisfaction

Of 156 youth surveys, 25 were excluded because the youth indicated he/she did not meet the age criteria (11 years old or older). An additional 19 surveys were excluded because the youth did not complete the satisfaction questions. The results that follow describe consumer satisfaction for the remaining 112 youth. On average, these youth had been in SFCP for 20.5 months. Demographic characteristics showed a relatively diverse sample, which was 38.7% female, 59.4% male, and 1.8% transgender. Youth were 55.0% Caucasian, 20.7% African American/Black, 2.7% American Indian/Alaskan Native, 0.9% Asian, 0.9% Native Hawaiian/Pacific Islander, 19.8% Other, and 22.5% Hispanic/Latino). The average age was 14.9 (range = 11 to 18). When asked where they were currently living, youth answered as follows: 35.8% Washoe County, 34.9% Clark County, 29.4% Rural Nevada.

On the satisfaction survey, youth indicated a number of areas where they felt the SFCP program could improve. Thirteen out of 25 items demonstrated 80% agreement or more by youth, with agreement representing a more positive experience with the program. It appears that involving youth in treatment planning is an area for potential improvement in service delivery. Providing youth with a wider array of coping strategies is also a priority.

Please see Appendix D for full youth consumer satisfaction results, and please see figure on next page for three highest and three lowest endorsed youth items.

Figure 9. Youth Consumer Satisfaction Items Showing Most and Least Agreement



Foster Parent Satisfaction

Of 236 parent surveys, 15 were excluded because the parent did not complete the satisfaction questions. Foster parents reported that on average, youth in their homes had been in SFCP for 16.5 months. The average age of their foster child(ren) was 12.2 (range = 4 to 18). When asked where they were currently living, foster parents answered as follows: 47.1% Washoe County, 35.8% Clark County, 16.7% Rural Nevada, and 0.5% Other.

Results of the foster parent satisfaction survey were moderately positive. Nineteen out of 29 items on the foster parent consumer satisfaction survey demonstrated 80% agreement or more by foster parents, with agreement representing a more positive experience with the program. Foster parents identified child functioning and coping as areas for growth and indicated that they were very pleased with SFCP staff and services.

Please see figures on next page for aspects of specialized foster care services with which foster parents were most and least satisfied.

Figure 10. Foster Parents Were Least Satisfied with Functioning and Coping Gains by Youth

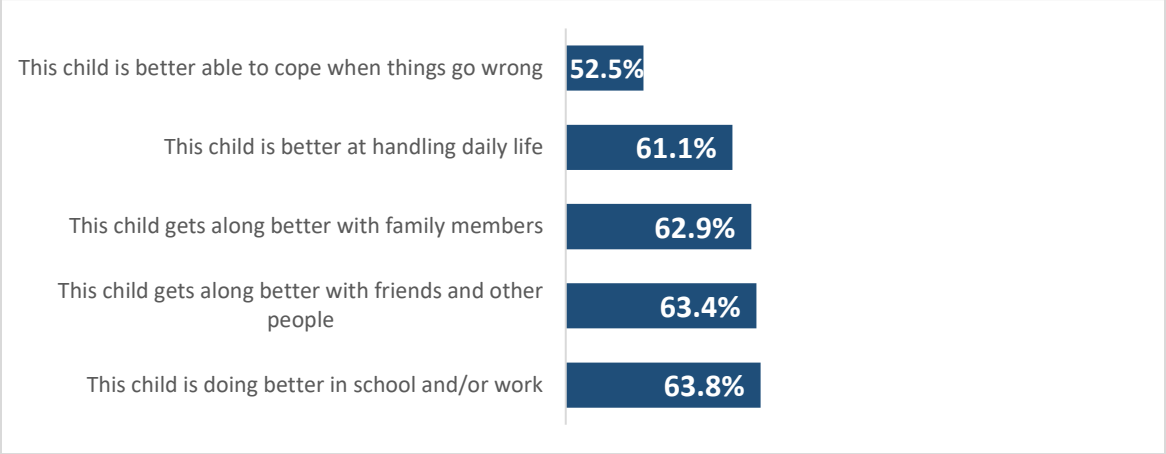
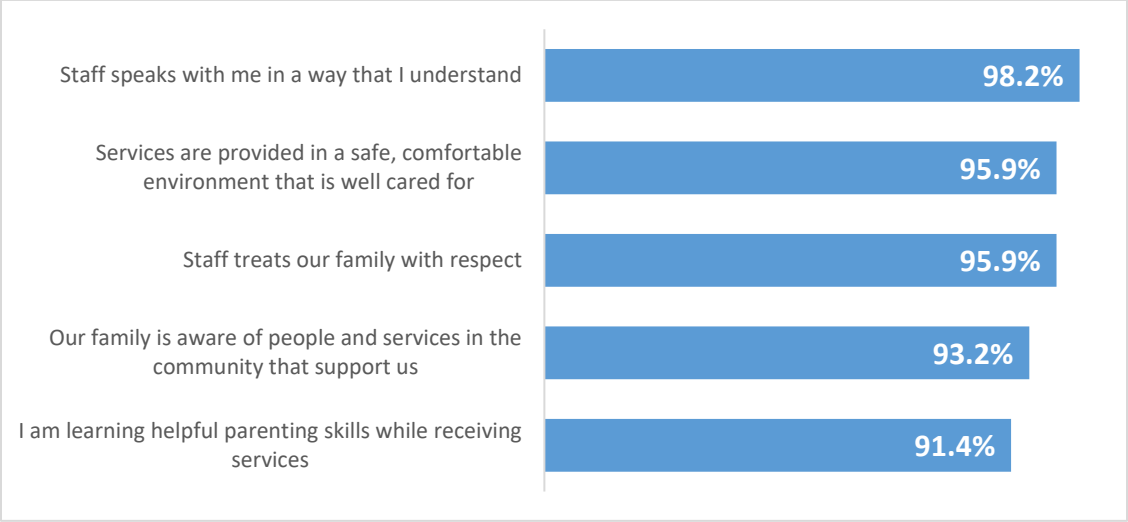


Figure 11. Foster Parents Were Most Satisfied with Quality of Services and Interactions with Program Staff



Please see Appendix D for full foster parent consumer satisfaction results.

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Appendix A: Demographics

Table 1. Demographics: Clark

	AFC	SFC
Age at Admission	mean = 9.0 (range = 2 to 18)	mean = 10.8 (range = 1 to 17)
Gender	43.9% female 56.1% male	45.4% female 54.6% male
Length of Stay in SFCP at Discharge or on June 30, 2019	mean = 341.7 days (range = 32 to 800)	mean = 434.0 days (range = 32 to 2,371)

Table 2. Demographics: Washoe

	AFC	SFC
Age at Admission	mean = 8.7 (range 2 to 15)	mean = 10.6 (range 3 to 17)
Gender	60% female 40% male	34.2% female 65.8% male
Length of Stay in SFCP at Discharge or on June 30, 2019	mean = 662.2 days (range = 83 to 1,712)	mean = 435.7 days (range = 41 to 1,298)

Table 3. Demographics: Rural

	AFC	SFC
Age at Admission	mean = 12.0 (range 5 to 16)	mean = 12.4 (range 4 to 17)
Gender	54.2% female 45.8% male	53.8% female 46.2% male
Length of Stay in SFCP at Discharge or on June 30, 2019	mean = 626.8 days (range = 67 to 2,340)	mean = 443.1 days (range = 31 to 2,105)

Table 4. Race/Ethnicity: Clark

	AFC	SFC	Total
*Race**			
African American/Black	30 (45.5%)	271 (43.2%)	301 (43.4%)
American Indian/Alaskan Native	1 (1.5%)	15 (2.4%)	16 (2.3%)
Asian	1 (1.5%)	19 (3.0%)	20 (2.9%)

Caucasian	34 (51.5%)	319 (50.8%)	353 (50.9%)
Native Hawaiian/Pacific Islander	0	4 (0.6%)	4 (0.6%)
Ethnicity			
Hispanic	6 (10.5%)	134 (23.6%)	140 (22.4%)
Non-Hispanic	51 (89.5%)	434 (76.4%)	485 (77.6%)

*Multiple races may be selected for a given youth.

Table 5. Race/Ethnicity: Washoe

	AFC	SFC	Total
*Race**			
African American/Black	5 (19.2%)	30 (17.6%)	35 (17.9%)
American Indian/Alaskan Native	0	6 (3.5%)	6 (3.1%)
Asian	0	1 (0.6%)	1 (0.5%)
Caucasian	21 (80.8%)	126 (74.1%)	147 (75.0%)
Native Hawaiian/Pacific Islander	0	7 (4.1%)	7 (3.6%)
Ethnicity			
Hispanic	4 (16.0%)	35 (22.6%)	39 (21.7%)
Non-Hispanic	21 (84.0%)	120 (77.4%)	141 (78.3%)

*Multiple races may be selected for a given youth.

Table 6. Race/Ethnicity: Rural

	AFC	SFC	Total
*Race**			
African American/Black	0	1 (6.3%)	1 (2.4%)
American Indian/Alaskan Native	2 (7.7%)	2 (12.5%)	4 (9.5%)
Asian	0	0	0
Caucasian	23 (88.5%)	13 (81.3%)	36 (85.7%)
Native Hawaiian/Pacific Islander	1 (3.8%)	0	1 (2.4%)
Ethnicity			
Hispanic	1 (4.2%)	3 (23.1%)	4 (10.8%)
Non-Hispanic	23 (95.8%)	10 (76.9%)	33 (89.2%)

*Multiple races may be selected for a given youth.

Table 7. Reasons for Entry into Child Welfare System: Clark

	AFC	SFC
Abandonment	3 (5.3%)	36 (6.3%)
Child's Alcohol Usage	0	0
Child's Behavior Problem	0	5 (0.9%)
Child Disability	0	2 (0.4%)
Child's Drug Usage	0	0
Domestic Violence	3 (5.3%)	36 (6.3%)
Emotional Abuse	6 (10.5%)	60 (10.6%)
Inadequate Housing	5 (8.8%)	51 (9.0%)
Infant Drug Affected	0	1 (0.2%)
Juvenile Justice Services	0	1 (0.2%)
Medical Neglect	2 (3.5%)	20 (3.5%)
Neglect	50 (87.7%)	483 (85.0%)
Parent Death	1 (1.8%)	6 (1.1%)
Parent Incarceration	5 (8.8%)	39 (6.9%)
Parental Alcohol Abuse	4 (7.0%)	8 (1.4%)
Parental Drug Abuse	5 (8.8%)	33 (5.8%)
Parental Methamphetamine Use	0	4 (0.7%)
Parent's Inability to Cope	4 (7.0%)	44 (7.7%)
Physical Abuse	4 (7.0%)	41 (7.2%)
Sexual Abuse	1 (1.8%)	18 (3.2%)

*Multiple reasons may be selected for a given youth.

Table 8. Reasons for Entry into Child Welfare System: Washoe

	AFC	SFC
Abandonment	1 (4.0%)	11 (7.1%)
Child's Alcohol Usage	0	1 (0.6%)
Child's Behavior Problem	0	9 (5.8%)
Child's Disability	0	0
Child's Drug Usage	0	1 (0.6%)
Domestic Violence	1 (4.0%)	13 (8.4%)
Emotional Abuse	1 (4.0%)	3 (1.9%)
Inadequate Housing	3 (12.0%)	33 (21.3%)
Infant Drug Affected	0	0
Juvenile Justice Services	0	0
Medical Neglect	1 (4.0%)	12 (7.7%)
Neglect	17 (68.0%)	93 (60.0%)
Parent Death	0	0

Parent Incarceration	8 (32.0%)	42 (27.1%)
Parental Alcohol Abuse	3 (12.0%)	12 (7.7%)
Parental Drug Abuse	6 (24.0%)	32 (20.6%)
Parental Methamphetamine Use	4 (16.0%)	6 (3.9%)
Parent's Inability to Cope	0	12 (7.7%)
Physical Abuse	3 (12.0%)	13 (8.4%)
Sexual Abuse	3 (12.0%)	15 (9.7%)

*Multiple reasons may be selected for a given youth.

Table 9. Reasons for Entry into Child Welfare System: Rural

	AFC	**SFC**
Abandonment	2 (8.3%)	3 (23.1%)
Child's Alcohol Usage	0	0
Child's Behavior Problem	0	1 (7.7%)
Child's Disability	0	0
Child's Drug Usage	0	0
Domestic Violence	0	0
Emotional Abuse	0	0
Inadequate Housing	4 (16.7%)	0
Infant Drug Affected	0	0
Juvenile Justice Services	0	0
Medical Neglect	1 (4.2%)	0
Neglect	15 (62.5%)	5 (38.5%)
Parent Death	0	0
Parent Incarceration	4 (16.7%)	5 (38.5%)
Parental Alcohol Abuse	2 (8.3%)	1 (7.7%)
Parental Drug Abuse	5 (20.8%)	2 (15.4%)
Parental Methamphetamine Use	0	0
Parent's Inability to Cope	0	0
Physical Abuse	4 (16.7%)	1 (7.7%)
Sexual Abuse	5 (20.8%)	3 (23.1%)

*Multiple reasons may be selected for a given youth.

Appendix B: Outcomes

Table 1. Runaway Status: Admission

Please note: No runaways were observed in Washoe AFC or Rural AFC placements.
Runaway duration of 0 indicates youth who was in runaway status for less than 24 hours.

	Clark AFC	Clark SFC	Washoe SFC	Rural SFC
Number of youth with history of running away	1 1.9%	62 12.6%	13 8.8%	1 10.0%
Number of episodes of elopement per youth	1	1 to 23 avg = 3.8	1 to 4 avg = 1.8	1
Days in runaway status per episode	0	0 to 404 avg = 15.8	0 to 346 avg = 27.1	5

Table 2. Runaway Status: Discharge or End-of-Fiscal Year

Please note: No runaways were observed in Clark AFC, Washoe AFC, Rural AFC, or Rural SFC placements.
Runaway duration of 0 indicates youth who was in runaway status for less than 24 hours.

	Clark SFC	Washoe SFC
Number of youth with history of running away	13 2.6%	2 1.4%
Number of episodes of elopement per youth	1 to 6 avg = 2.2	1 to 4 avg = 2.5
Days in runaway status per episode	1 to 17 avg 2.9	0 to 5 avg = 2.4

Table 3. Hospitalizations: Admission

Please note: No hospitalizations were observed in Washoe AFC placements.

	Clark AFC	Clark SFC	Washoe SFC	Rural AFC	Rural SFC
Number of youth with history of hospitalization	5	42	14	2	3
Number of episodes of hospitalization per youth	1 to 2 avg = 1.4	1 to 6 avg = 1.7	1	1 to 2 avg = 1.5	1

Table 4. Hospitalization: Discharge or End-of-Fiscal Year

Please note: No hospitalizations were observed in Washoe AFC, or Rural AFC placements.

	Clark AFC	Clark SFC	Washoe SFC	Rural SFC
Number of youth with history of hospitalization	5	34	8	2
Number of episodes of hospitalization per youth	1 to 3 avg = 1.4	1 to 4 avg = 1.4	1 to 4 avg = 1.6	1 to 2 avg = 1.5

Table 5. Placement Stability: Admission

	Clark AFC	Clark SFC	Washoe AFC	Washoe SFC	Rural AFC	Rural SFC
Average number of placements per youth (SD)	2.0 (1.3)	2.0 (1.1)	1.4 (0.6)	1.9 (1.2)	1.6 (0.7)	1.8 (1.3)
Maximum number of placements per youth	6	7	3	11	3	5

SD = standard deviation

Table 6. Placement Stability: Discharge or End-of-Fiscal Year

	Clark AFC	Clark SFC	Washoe AFC	Washoe SFC	Rural AFC	Rural SFC
Average number of placements per youth (SD)	1.0 (0.1)	1.1 (0.3)	1.0 (0.2)	1.2 (0.8)	1.0 (0)	1.4 (0.7)
Maximum number of placements per youth	2	4	2	6	1	3
Number of youth experiencing more placements after admission than prior to specialized foster care	0	11 2.2%	1 4.2%	11 7.5%	0	1 10.0%

SD = standard deviation

Table 7. Reason for Discharge from SFCP Including Transition to Permanent Placement

	Clark AFC	Clark SFC	Washoe AFC	Washoe SFC	Rural AFC	Rural SFC
Adoptive Placement or Adoption	**5 (22.7%)**	**40 (16.2%)**	**7 (43.8%)**	**26 (35.1%)**	**2 (50.0%)**	**1 (16.7%)**
Change in Child Case Plan	0	7 (2.8%)	0	0	0	0
Change in Funding	1 (4.5%)	2 (0.8%)	0	0	0	0
Child Dies	0	1 (0.4%)	0	0	0	0
Child is Arrested/ Incarcerated	0	2 (0.8%)	0	0	0	0
Child is Incompatible with Provider	2 (9.1%)	12 (4.9%)	0	0	0	0
Child is Placed with Sibling(s)	1 (4.5%)	0	0	0	0	0
Needs Higher Level of Care	0	1 (0.4%)	1 (6.3%)	7 (9.5%)	1 (25.0%)	1 (16.7%)
Needs Lower Level of Care	3 (13.6%)	12 (4.9%)	2 (12.5%)	1 (1.4%)	1 (25.0%)	0
Reached Age of Majority	2 (9.1%)	16 (6.5%)	0	6 (8.1%)	0	2 (33.3%)
Runaway	0	27 (10.9%)	1 (6.3%)	7 (9.5%)	0	0
Child/Family Member request a change in Provider	0	0	0	0	0	1 (16.7%)
Guardianship is Established by a Relative	**1 (4.5%)**	0	0	0	0	0
Other	1 (4.5%)	21 (8.5%)	2 (12.5%)	6 (8.1%)	0	0
Parent Placement	**3 (13.6%)**	**52 (21.1%)**	**2 (12.5%)**	**17 (23.0%)**	0	0
Provider Moves Out-of-State	0	4 (1.6%)	0	0	0	0
Provider Voluntarily Closes Home/Facility	0	1 (0.4%)	0	0	0	0

Relative Placement	**3 (13.6%)**	**40 (16.2%)**	**1 (6.3%)**	**4 (5.4%)**	0	**1 (16.7%)**
Returned Home	0	4 (1.6%)	0	0	0	0
Unable to Document Need for Services	0	5 (2.0%)	0	0	0	0
Total SFY19 Discharges	**22**	**247**	**16**	**74**	**4**	**6**
Percent to Permanent Placement	**54.5%**	**53.4%**	**62.5%**	**63.5%**	**50.0%**	**33.3%**

Percentages given as percentage of discharges within jurisdiction and program.

Table 8. Legal Involvement: Admission

Please note: No legal involvement was observed in Clark AFC or Rural SFC placements at admission.

	Clark SFC	**Washoe AFC**	**Washoe SFC**	**Rural AFC**
Number of youth on probation	32 7.9%	1 4.2%	10 7.3%	5 21.7%
Number of youth arrested	0	1 4.2%	4 2.9%	1 4.3%
Number of arrests each for youth with arrest history	0	1	1 to 2 avg = 1.5	1
Number of youth with detention history	26 6.4%	1 4.2%	5 3.6%	2 8.7%
Number of days in detention for youth with detention history	1 to 184 avg = 51.9	30	1 to 166 avg = 61.2	41 to 45 avg = 43.0

*Baseline information available for 651 youth statewide.

Table 9. Legal Involvement: Discharge or End-of-Fiscal Year*

Please note: No legal involvement was observed in Clark AFC or Washoe AFC placements at discharge.

	Clark SFC	Washoe SFC	Rural AFC	Rural SFC
Number of youth on probation	18 5.2%	5 3.6%	1 4.5%	0
Number of youth arrested	0	2 1.4%	1 4.5%	1 11.1%
Number of arrests each for youth with arrest history	0	1 to 2 avg = 1.5	1	1
Number of youth with detention history	13 3.8%	4 2.9%	1 4.5%	1 11.1%
Number of days in detention for youth with detention history	1 to 55 avg = 16.0	28	1 to 29 avg = 13.8	2

*Follow-up information available for 579 youth statewide.

Table 10. Disability Classification* for AFC/SFC Special Education Youth

	Clark AFC	Clark SFC	Washoe AFC	Washoe SFC	Rural AFC	Rural SFC	Statewide
Autism	0	5 1.4%	0	1 1.0%	0	0	**6** **1.1%**
Developmental Delay	6 15.4%	24 6.8%	0	1 1.0%	1 4.3%	0	**32** **5.9%**
Emotional Disturbance	3 7.7%	25 7.1%	0	14 13.5%	2 8.7%	1 12.5%	**45** **8.2%**
Health Impairments	4 10.3%	13 3.7%	7 33.3%	21 20.2%	0	2 25.0%	**47** **8.6%**
Hearing Impairment	0	1 0.3%	0	0	0	0	**1** **0.2%**
Intellectual Disability	0	5 1.4%	0	1 1.0%	0	0	**6** **1.1%**
Learning Disabilities	2 5.1%	52 14.8%	3 14.3%	11 10.6%	3 13.0%	0	**71** **13.0%**
Multiple Disabilities	0	1 0.3%	0	0	0	0	**1** **0.2%**
Speech/Language Impairment	1 2.6%	17 4.8%	1 4.8%	6 5.8%	0	0	**25** **4.6%**
Traumatic Brain Injury	0	1 0.3%	0	0	0	0	**1** **0.2%**
Totals	**16** **41.0%**	**144** **41.0%**	**11** **52.4%**	**55** **52.9%**	**6** **26.1%**	**3** **37.5%**	**235** **43.0%**

*One classification is given per youth. Percent given as percent of all SFC youth from that jurisdiction and program (including non-special education youth) reported as attending a Nevada Department of Education school (*n* = 390 Clark, *n* = 31 Rural, *n* = 125 Washoe; *N* = 546 statewide).

Table 11. Psychotropic Medication Use: Admission

	Clark AFC	Clark SFC	Washoe AFC	Washoe SFC	Rural AFC	Rural SFC
Number of youth prescribed medication	18 34.0%	137 27.9%	6 25.0%	72 49.0%	7 30.4%	6 60.0%
Average number of unique medications prescribed in prior six months (SD)	2.7 (1.8)	2.7 (1.9)	1.7 (0.5)	2.8 (1.5)	3.3 (2.1)	3.3 (0.8)
Maximum number of unique medications prescribed in prior six months	6	9	2	8	7	5

SD = standard deviation

Table 12. Psychotropic Medication Use: Discharge or End-of-Fiscal Year

	Clark AFC	Clark SFC	Washoe AFC	Washoe SFC	Rural AFC	Rural SFC
Number of youth prescribed medication	20 37.7%	200 40.7%	13 54.2%	96 65.3%	14 60.9%	8 80.0%
Average number of unique medications prescribed in prior six months (SD)	2.6 (1.5)	2.4 (1.4)	2.4 (2.0)	3.0 (1.5)	3.2 (1.7)	3.8 (1.3)
Maximum number of unique medications prescribed in prior six months	5	9	8	6	7	6
Number of youth taking medications at admission not taking at discharge/end of FY	3	26	0	7	1	0
Number of youth not taking medication at admission who were taking at discharge/end of FY	5	89	7	31	8	2

SD = standard deviation

Table 13. Child PTSD Symptom Scale (Admission)

	Clark AFC (n = 0)	Clark SFC (*n* = 41)	Washoe AFC (*n* = 6)	Washoe SFC (*n* = 54)	Rural AFC (*n* = 13)	Rural SFC (*n* = 3)	Statewide (n = 117)
Lifetime number of potentially traumatic events endorsed per youth	n/a	0 to 14 avg = 5.4	2 to 10 avg = 4.8	0 to 13 avg = 4.4	0 to 10 avg = 6.0	7 to 8 avg = 7.3	0 to 14 avg = 5.0
Number of youth endorsing 1+ events	n/a	37 90.2%	6 100%	46 85.2%	12 92.3%	3 100%	104 88.9%
Number of youth with probable PTSD	n/a	37 90.2%	6 100%	45 83.3%	12 92.3%	2 66.7%	102 87.2%

Table 14. Caregiver Strain Questionnaires Collected* – Most Recent

	AFC	SFC	Total
Clark	15	115	**130**
Washoe	20	84	**104**
Rural	16	5	**21**
STATEWIDE	**51**	**204**	**255**

*255 CGSQ were collected from 221 unique foster parents. Some foster parents filled out multiple CGSQ due to having multiple SFC youth in their home.

Table 15. CANS Actionable Treatment Needs at Admission (*N* = 300)

	Clark AFC (*n* = 27)	Clark SFC (*n* = 155)	Washoe AFC (*n* = 14)	Washoe SFC (*n* = 79)	Rural AFC (*n* = 19)	Rural SFC (*n* = 6)
Adverse Childhood Experiences & Potentially Traumatic Events (14 items)	3 to 9 avg = 7.1	1 to 11 avg = 6.5	5 to 11 avg = 7.4	0 to 11 avg = 6.6	5 to 11 avg = 8.4	6 to 10 avg = 7.3
Behavioral/Emotional Needs (15 items)	2 to 9 avg = 5.1	0 to 11 avg = 4.2	0 to 6 avg = 2.1	0 to 11 avg = 4.1	1 to 11 avg = 6.8	2 to 6 avg = 4.0
Life Functioning (15 items)	0 to 12 avg = 3.0	0 to 8 avg = 3.3	0 to 5 avg = 2.1	0 to 12 avg = 3.3	0 to 8 avg = 3.4	1 to 6 avg = 3.3
Youth Strengths (13 items)	0 to 13 avg = 4.7	0 to 13 avg = 7.9	1 to 13 avg = 4.1	0 to 13 avg = 7.9	1 to 9 avg = 5.6	5 to 10 avg = 8.0
Cultural Factors (4 items)	0 to 4 avg = 0.2	0 to 4 avg = 0.2	no identified needs	0 to 4 avg = 0.1	0 to 2 avg = 0.3	no identified needs
Risk Factors & Behaviors (11 items)	0 to 11 avg = 1.6	0 to 7 avg = 1.4	0 to 3 avg = 0.9	0 to 5 avg = 1.3	0 to 4 avg = 1.9	0 to 4 avg = 1.3
Caregiver Resources & Needs (16 items)	0 to 5 avg = 0.6	0 to 14 avg = 1.5	0 to 2 avg = 0.2	0 to 13 avg = 1.9	0 to 1 avg = 0.2	no identified needs

Table 16. CANS Actionable Treatment Needs at Discharge/End-of-FY (*N* = 408)

	Clark AFC (*n* = 20)	Clark SFC (*n* = 293)	Washoe AFC (*n* = 14)	Washoe SFC (*n* = 58)	Rural AFC (*n* = 18)	Rural SFC (*n* = 5)
Adverse Childhood Experiences & Potentially Traumatic Events (14 items)	4 to 10 avg = 7.1	1 to 12 avg = 6.8	4 to 11 avg = 8.4	2 to 11 avg = 6.8	7 to 11 avg = 9.6	6 to 10 avg = 7.8
Behavioral/Emotional Needs (15 items)	0 to 10 avg = 5.2	0 to 11 avg = 4.4	0 to 4 avg = 1.0	0 to 10 avg = 3.9	1 to 11 avg = 7.4	4 to 8 avg = 5.4
Life Functioning (15 items)	0 to 7 avg = 2.3	0 to 10 avg = 2.8	0 to 2 avg = 0.8	0 to 11 avg = 2.9	1 to 8 avg = 3.3	1 to 8 avg = 3.4
Youth Strengths (13 items)	0 to 11 avg = 5.3	0 to 13 avg = 7.0	1 to 6 avg = 2.5	1 to 13 avg = 7.1	0 to 9 avg = 4.0	5 to 10 avg = 7.8
Cultural Factors (4 items)	0 to 4 avg = 0.3	0 to 3 avg = 0.1	0 to 2 avg = 0.3	0 to 4 avg = 0.3	no identified needs	no identified needs
Risk Factors & Behaviors (11 items)	0 to 5 avg = 1.4	0 to 10 avg = 1.4	0 to 2 avg = 0.4	0 to 5 avg = 1.0	0 to 7 avg = 2.5	0 to 6 avg = 2.0
Caregiver Resources & Needs (16 items)	0 to 1 avg = 0.3	0 to 14 avg = 0.6	no identified needs	0 to 11 avg = 0.8	0 to 1 avg = 0.1	no identified needs

Appendix C: Mental Health Service Use

Table 1. Mental Health Service Use: Clark – Assessment

Service use is presented in **number of units billed** per 6 month period. Number of youth utilizing each service is also presented.

	AFC - Admission	AFC - Discharge	SFC - Admission	SFC - Discharge
Behavioral health screening	avg = 1.6 min = 1.0 max = 3.0 # youth = 33	avg = 1.3 min = 1.0 max = 4.0 # youth = 32	avg = 1.8 min = 1.0 max = 7.0 # youth = 255	avg = 2.3 min = 1.0 max = 7.0 # youth = 354
Neuropsychological testing	avg = 6.3 min = 4.0 max = 9.0 # youth = 4	none	avg = 5.8 min = 5.0 max = 6.0 # youth = 4	avg = 7.0 min = 7.0 max = 7.0 # youth = 2
Psychiatric diagnostic evaluation	avg = 1.3 min = 1.0 max = 3.0 # youth = 27	avg = 1.1 min = 1.0 max = 2.0 # youth = 20	avg = 1.2 min = 1.0 max = 5.0 # youth = 257	avg = 1.2 min = 1.0 max = 4.0 # youth = 169
Psychological testing	avg = 4.5 min = 4.0 max = 5.0 # youth = 2	none	avg = 4.5 min = 4.0 max = 5.0 # youth = 8	none

Table 2. Mental Health Service Use: Clark – Treatment

Service use is presented in **number of hours utilized** per 6 month period (except intensive outpatient and partial hospitalization, given in days). Number of youth utilizing each service is also presented.

	AFC - Admission	AFC - Discharge	SFC - Admission	SFC - Discharge
Psychotherapy & Psychiatry				
Individual therapy	avg = 11.9 min = 0.5 max = 49.0 # youth = 31	avg = 8.4 min = 0.5 max = 48.0 # youth = 37	avg = 7.6 min = 0.5 max = 56.5 # youth = 276	avg = 10.9 min = 0.5 max = 30.0 # youth = 411
Family therapy	avg = 5.9 min = 0.8 max = 33.3 # youth = 29	avg = 9.3 min = 0.8 max = 24.2 # youth = 31	avg = 4.6 min = 0.8 max = 25.0 # youth = 144	avg = 5.3 min = 0.8 max = 45.8 # youth = 169
Group therapy	avg = 12.2 min = 1.0 max = 36.0	avg = 11.5 min = 1.0 max = 25.0	avg = 9.5 min = 0.3 max = 41.0	avg = 10.1 min = 0.3 max = 44.0

	# youth = 29	# youth = 21	# youth = 148	# youth = 187
Psychiatry – New Patient Management	avg = 0.7 min = 0.3 max = 1.0 # youth = 18	avg = 0.8 min = 0.3 max = 1.0 # youth = 14	avg = 0.9 min = 0.3 max = 3.0 # youth = 162	avg = 0.8 min = 0.3 max = 2.0 # youth = 114
Psychiatry – Established Patient Management	avg = 1.2 min = 0.2 max = 4.7 # youth = 36	avg = 1.5 min = 0.3 max = 4.8 # youth = 38	avg = 1.2 min = 0.1 max = 6.0 # youth = 271	avg = 1.4 min = 0.2 max = 4.8 # youth = 344
Intensive Services				
Crisis intervention	avg = 4.8 min = 0.5 max = 15.0 # youth = 6	avg = 13.8 min = 1.0 max = 61.0 # youth = 5	avg = 6.9 min = 0.3 max = 99.0 # youth = 64	avg = 5.7 min = 0.5 max = 33.0 # youth = 42
Day treatment	avg = 53.0 min = 22.0 max = 84.0 # youth = 2	avg = 50.5 min = 15.0 max = 86.0 # youth = 2	avg = 113.3 min = 12.0 max = 308.0 # youth = 10	avg = 118.7 min = 27.0 max = 198.0 # youth = 6
Intensive outpatient	avg = 26.0 min = 10.0 max = 42.0 # youth = 3	avg = 14.5 min = 6.0 max = 23.0 # youth = 2	avg = 50.3 min = 1.0 max = 98.0 # youth = 15	avg = 47.4 min = 24.0 max = 63.0 # youth = 5
Partial hospitalization	avg = 67.0 min = 48.0 max = 102.0 # youth = 6	avg = 5.0 min = 5.0 max = 5.0 # youth = 1	avg = 51.6 min = 12.0 max = 90.0 # youth = 23	avg = 39.4 min = 7.0 max = 62.0 # youth = 7
Rehabilitative Services				
Case management	avg = 2.6 min = 0.3 max = 38.5 # youth = 51	avg = 2.9 min = 0.5 max = 25.3 # youth = 42	avg = 2.7 min = 0.3 max = 111.5 # youth = 456	avg = 2.4 min = 0.3 max = 89.0 # youth = 428
Psychosocial rehabilitation	avg = 27.1 min = 6.0 max = 86.5 # youth = 20	avg = 33.0 min = 5.5 max = 78.0 # youth = 17	avg = 35.7 min = 1.0 max = 178.3 # youth = 128	avg = 47.3 min = 0.8 max = 162.0 # youth = 332
Basic skills training	avg = 132.2 min = 2.0 max = 338.0 # youth = 22	avg = 34.2 min = 2.0 max = 110.0 # youth = 10	avg = 68.4 min = 1.8 max = 430.0 # youth = 364	avg = 249.7 min = 1.0 max = 457.0 # youth = 479

Table 3. Mental Health Service Use: Washoe – Assessment

Service use is presented in **number of units billed** per 6 month period. Number of youth utilizing each service is also presented.

	AFC - Admission	AFC - Discharge	SFC - Admission	SFC - Discharge
Behavioral health screening	avg = 1.2 min = 1.0 max = 2.0 # youth = 10	avg = 1.3 min = 1.0 max = 2.0 # youth = 4	avg = 1.4 min = 1.0 max = 3.0 # youth = 49	avg = 1.4 min = 1.0 max = 5.0 # youth = 50
Neuropsychological testing	none	avg = 6.0 min = 6.0 max = 6.0 # youth = 1	avg = 5.0 min = 5.0 max = 5.0 # of youth = 1	avg = 6.0 min = 6.0 max = 6.0 # youth = 1
Psychiatric diagnostic evaluation	avg = 1.4 min = 1.0 max = 2.0 # youth = 12	avg = 1.2 min = 1.0 max = 3.0 # youth = 9	avg = 1.4 min = 1 max = 4 # youth = 62	avg = 1.1 min = 1.0 max = 2.0 # youth = 26
Psychological testing	none	none	none	none

Table 4. Mental Health Service Use: Washoe – Treatment

Service use is presented in **number of hours utilized** per 6 month period (except intensive outpatient and partial hospitalization, given in days). Number of youth utilizing each service is also presented.

	AFC - Admission	AFC - Discharge	SFC - Admission	SFC - Discharge
Psychotherapy & Psychiatry				
Individual therapy	avg = 10.0 min = 0.8 max = 21.0 # youth = 23	avg = 8.4 min = 2.0 max = 23.0 # youth = 17	avg = 9.6 min = 0.5 max = 31.8 # youth = 103	avg = 9.9 min = 0.5 max = 25.0 # youth = 118
Family therapy	avg = 2.6 min = 0.8 max = 7.5 # youth = 13	avg = 1.7 min = 0.8 max = 3.3 # youth = 8	avg = 2.8 min = 0.8 max = 16.7 # youth = 43	avg = 2.4 min = 0.8 max = 10.0 # youth = 36
Group therapy	avg = 4.4 min = 1.0 max = 9.0 # youth = 5	avg = 6.3 min = 2.0 max = 14.0 # youth = 3	avg = 22.8 min = 1.0 max = 134.0 # youth = 57	avg = 35.0 min = 1.0 max = 132.0 # youth = 50
Psychiatry – New Patient Management	avg = 0.6 min = 0.3 max = 1.0 # youth = 6	avg = 0.8 min = 0.5 max = 1.0 # youth = 4	avg = 0.7 min = 0.3 max = 1.6 # youth = 50	avg = 0.7 min = 0.3 max = 1.8 # youth = 36
Psychiatry –	avg = 1.4	avg = 1.8	avg = 1.7	avg = 1.6

Established Patient Management	min = 0.3 max = 4.3 # youth = 14	min = 0.4 max = 3.8 # youth = 14	min = 0.1 max = 6.8 # youth = 95	min = 0.3 max = 4.6 # youth = 110
Intensive services				
Crisis intervention	avg = 3.5 min = 3.5 max = 3.5 # youth = 1	avg = 4.0 min = 4.0 max = 4.0 # youth = 1	avg = 4.4 min = 0.5 max = 28.0 # youth = 11	avg = 1.5 min = 0.3 max = 3.0 # youth = 9
Day treatment	none	avg = 72.0 min = 72.0 max = 72.0 # youth = 1	avg = 351.9 min = 69.0 max = 650.0 # youth = 15	avg = 390.0 min = 140.0 max = 760.0 # youth = 18
Intensive outpatient	none	none	avg = 50.0 min = 1.0 max = 205.0 # youth = 7	avg = 10.0 min = 6.0 max = 16.0 # of youth = 3
Partial hospitalization	none	none	none	none
Rehabilitative services				
Case management	avg = 9.9 min = 0.3 max = 34.3 # youth = 16	avg = 6.5 min = 1.0 max = 31.3 # youth = 12	avg = 11.5 min = 0.3 max = 102.0 # youth = 80	avg = 9.6 min = 0.3 max = 61.5 # youth = 80
Psychosocial rehabilitation	avg = 57.3 min = 12.8 max = 132.0 # youth = 10	avg = 31.0 min = 4.0 max = 60.0 # youth = 7	avg = 73.0 min = 1.5 max = 214.3 # youth = 38	avg = 114.3 min = 0.8 max = 332.5 # youth = 72
Basic skills training	avg = 145.5 min = 8.0 max = 422.0 # youth = 8	avg = 12.4 min = 12.3 max = 12.5 # youth = 2	avg = 230.5 min = 15.0 max = 426.0 # youth = 29	avg = 89.0 min = 79.0 max = 102.0 # youth = 4

Table 5. Mental Health Service Use: Rural – Assessment

Service use is presented in **number of units billed** per 6 month period. Number of youth utilizing each service is also presented.

	AFC - Admission	AFC - Discharge	SFC - Admission	SFC - Discharge
Behavioral health screening	avg = 1.1 min = 1.0 max = 2.0 # youth = 10	avg = 1.7 min = 1.0 max = 3.0 # youth = 15	avg = 1.0 min = 1.0 max = 1.0 # youth = 4	avg = 2.3 min = 1.0 max = 4.0 # youth = 4
Neuropsychological testing	avg = 6.5 min = 6.0 max = 7.0 # youth = 2	none	none	none
Psychiatric diagnostic evaluation	avg = 1.3 min = 1.0 max = 2.0 # youth = 9	avg = 1.3 min = 1.0 max = 2.0 # youth = 14	avg = 2.5 min = 1.0 max = 4.0 # youth = 2	avg = 1.0 min = 1.0 max = 1.0 # youth = 3
Psychological testing	none	none	none	none

Table 6. Mental Health Service Use: Rural – Treatment

Service use is presented in **number of hours utilized** per 6 month period (except intensive outpatient and partial hospitalization, given in days). Number of youth utilizing each service is also presented.

	AFC - Admission	AFC - Discharge	SFC - Admission	SFC - Discharge
Psychotherapy & Psychiatry				
Individual therapy	avg = 8.5 min = 1.0 max = 21.5 # youth = 16	avg = 11.9 min = 1.0 max = 28.5 # youth = 20	avg = 14.3 min = 6.0 max = 29.5 # youth = 6	avg = 12.5 min = 7.0 max = 22.5 # youth = 7
Family therapy	avg = 1.7 min = 0.8 max = 3.3 # youth = 6	avg = 2.9 min = 1.7 max = 5.8 # youth = 4	avg = 1.4 min = 0.8 max = 1.7 # youth = 3	avg = 0.8 min = 0.8 max = 0.8 # youth = 1
Group therapy	avg = 6.0 min = 6.0 max = 6.0 # youth = 1	None	avg = 2.7 min = 2.0 max = 4.5 # youth = 4	avg = 10.5 min = 3.0 max = 25.8 # youth = 5
Psychiatry – New Patient Management	avg = 0.5 min = 0.3 max = 0.8 # youth = 3	avg = 0.8 min = 0.5 max = 1.1 # youth = 4	avg = 1.0 min = 0.5 max = 2.5 # youth = 6	avg = 0.8 min = 0.5 max = 1.1 # youth = 2

Psychiatry – Established Patient Management	avg = 1.2 min = 0.3 max = 2.3 # youth = 13	avg = 1.1 min = 0.3 max = 3.8 # youth = 15	avg = 2.3 min = 0.3 max = 7.8 # youth = 8	avg = 1.4 min = 0.3 max = 3.9 # youth = 8
Intensive services				
Crisis intervention	avg = 1.8 min = 1.5 max = 2.0 # youth = 2	none	none	none
Day treatment	none	none	none	none
Intensive outpatient	avg = 15.0 min = 15.0 max = 15.0 # youth = 1	none	none	none
Partial hospitalization	none	none	none	none
Rehabilitative services				
Case management	avg = 34.8 min = 0.8 max = 112.5 # youth = 11	avg = 8.7 min = 0.5 max = 31.0 # youth = 5	avg = 33.4 min = 9.3 max = 80.8 # youth = 6	avg = 17.2 min = 7.3 max = 27.5 # youth = 4
Psychosocial rehabilitation	avg = 44.2 min = 4.0 max = 124.5 # youth = 6	avg = 42.6 min = 5.5 max = 97.5 # youth = 4	avg = 44.3 min = 3.0 max = 108.5 # youth = 6	avg = 66.0 min = 24.8 max = 97.0 # youth = 6
Basic skills training	avg = 62.3 min = 5.0 max = 94.5 # youth = 3	none	avg = 83.5 min = 2.0 max = 160.0 # youth = 6	avg = 44.3 min = 0.5 max = 88.0 # youth = 2

Appendix D: Consumer Satisfaction

Table 1. Youth Satisfaction Survey Results

*__Bold__ = Total % agreement less than 80%

Item	Total % Agree*
Overall, I am pleased with the services I received.	83.0
My educational needs were met during my stay.	85.7
I participated in selecting some of my activities and services.	81.3
I helped choose my treatment goals.	**75.9**
The foster parents/staff helping me stuck with me no matter what.	87.5
I felt I had someone to talk to when I was troubled.	**78.6**
I participated in my own treatment planning.	**69.6**
I received services that were right for me.	**76.8**
Foster parents/Staff explained my diagnosis, medication and treatment services and options.	**77.7**
Foster parents/Staff explained my rights, safety and the confidentiality issues.	86.6
Services were scheduled at times that were right for me and my family.	84.8
I got the help I wanted.	81.3
I got as much help as I needed.	83.0
Foster Parents/Staff treated me with respect.	88.4
Foster parents/staff respected me and my family's religious and spiritual beliefs.	87.5
Foster parents/Staff spoke with me in a way that I understood.	92.0
Foster parents/Staff were sensitive to my cultural and ethnic background.	**79.5**
Services were provided in a safe, comfortable environment that was well cared for.	92.0
I am better at handling daily life.	**74.1**
I get along better with family members.	**70.5**
I get along better with friends and other people.	**75.0**
I am doing better in school.	**68.8**
I am better able to cope when things go wrong.	**68.8**
I am satisfied with my family life right now.	**71.4**

I am aware of people and services in the community that support me.	81.3

Table 2. Foster Parent Satisfaction Survey Results

*__Bold__ = Total % agreement less than 80%

Item	Total % Agree*
Overall, I am pleased with the services this child and/or family receive.	86.0
This child's educational needs are being met.	86.0
I helped to choose this child and family's services.	**76.9**
I help to choose this child and/or family's treatment goals.	**76.0**
The people helping this child and family stick with us no matter what.	80.5
I feel this child and family have someone to talk to when we are troubled.	91.0
I participate in this child's and family's treatment.	86.0
The services this child and family receive are right for us.	81.0
Staff explained this child's diagnosis, medication and treatment options.	81.0
Staff explained this child and my family's rights, safety, and confidentiality issues.	86.9
Services are scheduled at times that are right for us.	88.7
I receive the help I want for this child.	80.1
My family gets as much help as we need for this child.	**77.8**
Staff treats our family with respect.	95.9
Staff respects our family's religious/spiritual beliefs.	86.9
Staff speaks with me in a way that I understand.	98.2
Staff is sensitive to my family's cultural and ethnic background.	87.8
Services are provided in a safe, comfortable environment that is well cared for.	95.9
This child is better at handling daily life.	**61.1**
This child gets along better with family members.	**62.9**
This child gets along better with friends and other people.	**63.4**
This child is able to do the things he/she wants to do.	**73.3**
This child is doing better in school and/or work.	**63.8**
This child is better able to cope when things go wrong.	**52.5**
I am satisfied with our family life right now.	**76.0**
Our family is aware of people and services in the community that support us.	93.2
I am better able to handle our family issues.	87.8
I am learning helpful parenting skills while receiving services.	91.4
I have information about this child's developmental expectations and needs.	86.0

Appendix E: Nevada Revised Statutes

[Part 2:185:1939; 1931 NCL § 1061.01] — (NRS A 1963, 909; 1967, 1154; 1973, 1166, 1406; 1993, 2698; 2001 Special Session, 26; 2009, 1489;2013, 1449)

NRS 424.041 Money allocated for specialized foster care not to be used for any other purpose; report of expenditures; data concerning children to be provided to Division upon request.

1. Each agency which provides child welfare services shall ensure that money allocated to pay for the cost of providing care to children placed in a specialized foster home is not used for any other purpose.

2. On or before August 1 of each year, each agency which provides child welfare services shall prepare and submit to the Division and the Fiscal Analysis Division of the Legislative Counsel Bureau a report listing all expenditures relating to the placement of children in specialized foster homes for the previous fiscal year.

3. Each agency which provides child welfare services shall provide to the Division any data concerning children who are placed in a specialized foster home by the agency upon the request of the Division.

(Added to NRS by 2015, 3064)

NRS 424.042 Division to periodically review placement of children in specialized foster homes by agency which provides child welfare services; corrective action when placements are determined not appropriate.

1. The Division shall periodically review the placement of children in specialized foster homes by each agency which provides child welfare services to determine whether children are being appropriately placed in such foster homes and are receiving the care and services that they need. Such a review may include, without limitation, an examination of:

(a) Demographics of children who are placed in specialized foster homes;

(b) Information from clinical evaluations of children who are placed in specialized foster homes;

(c) Relevant information submitted to the Department of Health and Human Services pursuant to the State Plan for Medicaid;

(d) Case files maintained by the agency which provides child welfare services for children who are placed in specialized foster homes; and

(e) Any other information determined to be relevant by the Division.

2. If, after conducting a review pursuant to subsection 1, the Division determines that an agency which provides child welfare services is inappropriately placing children in specialized foster homes or that children placed in such foster homes are not receiving the care and services that they need, the Administrator of the Division shall require the agency which provides child welfare services to take corrective action. If an agency fails to take the corrective action required by the Administrator, the Division may require the agency which provides child welfare services to develop a corrective action plan pursuant to NRS 432B.2155.

(Added to NRS by 2015, 3065)

NRS 424.043 Division to prepare report concerning placement of children in specialized foster homes and provision of services to children placed in such homes. [Effective July 1, 2016, through June 30, 2021.]

1. The Division shall, on or before January 31 of each year, prepare and submit to the Governor and the Director of the Legislative Counsel Bureau for transmittal to the Legislature a report concerning the placement of children in specialized foster homes and the provision of services to children placed in such foster homes for the previous fiscal year. The report must include, without limitation:

(a) The number of times a child who has been placed in a specialized foster home has been hospitalized;

(b) The number of times a child who has been placed in a specialized foster home has run away from the specialized foster home;

(c) Information concerning the use of psychotropic medications by children who have been placed in specialized foster homes;

(d) The progress of children who have been placed in specialized foster homes towards permanent living arrangements;

(e) The performance of children who have been placed in specialized foster homes on clinical standardized assessment tools;

(f) Information concerning the academic standing and performance of children who have been placed in specialized foster homes;

(g) The number of children who have been placed in specialized foster homes who have been adjudicated delinquent; and

(h) The results of the reviews conducted pursuant to NRS 424.042.

2. All information in the report prepared pursuant to subsection 1 must be aggregated and the report must exclude any personally identifiable information about a child.

(Added to NRS by 2015, 3065, effective July 1, 2016)