Specialized Foster Care in Nevada

State Fiscal Year 2018

July 1, 2017 to June 30, 2018

Report Prepared by the
Nevada Division of Child & Family Services
January 31, 2019

Contents

Executive Summary 3
Treatment Foster Care 4
Program Description & History 4
Implementation of NRS 424.041-424.043 in SFY18 5
Data Collection Procedures 10
Sample Description 11
Outcomes 12
Runaways, Hospitalizations and Stability of Placement 12
Permanency Outcomes 13
Legal Involvement 14
Education 14
Use of Psychotropic Medications 15
Mental Health Service Use 16
Performance on Clinical Standardized Assessment Tools 16
Consumer Satisfaction 21
Youth Satisfaction 22
Foster Parent Satisfaction 22
Summary & Conclusions 24
References 25
Appendix A: Demographics 27
Appendix B: Outcomes 31
Appendix C: Mental Health Service Use 38
Appendix D: Consumer Satisfaction Results 45
Appendix E: Nevada Revised Statutes 47

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 SFY18 all jurisdictions continued to maintain 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.
- Eight hundred two (802) youth were served in specialized foster care placements during SFY18 (i.e., were present in a specialized foster care placement for greater than 30 days). Seven hundred ten (710) of these were present 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 substantial 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 42.9% of all discharged youth in Rural Advanced Foster Care (AFC) to 70.0% in Washoe AFC.
- Legal involvement (arrests, detention, probation/parole) appears to decrease during 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 was 2.7.
- 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 55% of SFCP youth meet criteria for probable post-traumatic stress disorder (PTSD). 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.
- Five hundred twenty-nine (529) 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 this 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 provide the best possible environment for the youth.

Due to their complex mental and behavioral health needs, children who are recommended for treatment foster care or specialized 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 specialized foster care. 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 specialized foster care.

Youth with complex needs and multiple system involvement are admitted to SFCP based on a standardized assessment process. Children admitted during State Fiscal Year 2018 (SFY18)

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. Specialized foster care 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.

Foster parents in specialized foster homes and staff in specialized foster care agencies in Nevada have undergone or will undergo training 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 throughout this report, 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) may be referred to as youth receiving "specialized foster care." Both "specialized foster care" and "SFCP" are terms used throughout this report to refer to all youth in both AFC and SFC homes.

Implementation of NRS 424.041-424.043 in SFY18

During SFY18, 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 in specialized foster care homes. A main component of sustainability is DCFS's role in monitoring and supporting agencies in their quest to become certified 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 required fidelity forms, 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 staff and specific feedback is given to agencies on ways to improve practice and documentation.

As of the last day of SFY18, 12 of 12 monthly consultation calls had been completed. All nine agencies participating in the certification process returned their respective Implementation Surveys during Fall 2017. Of the nine agencies that were previously on track to be eligible to achieve TFTC Full Certification, three completed the requirements by June 30, 2018 and are now fully certified, including DCFS. The other six agencies had either achieved full certification by the time of this report (*n* = 3) or are on track to achieve TFTC Full Certification during winter 2019 (*n* = 3). Two additional agencies began the coaching process toward certification during SFY18 and are likely to achieve TFTC Full Certification by summer 2019.

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. Certified trainers will also assume responsibility for consultation calls and oversight of agency certification once Duke University is no longer involved in TFTC implementation in Nevada, which is scheduled to happen during SFY19. As of June 30, 2018, there were five fully-certified statewide TFTC trainers: Three located in northern Nevada, one in southern Nevada, and one in rural Nevada. There was also one provisionally-certified statewide TFTC trainer located in southern Nevada.

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

Implementation in Clark County

Provided by Clark County Department of Family Services (CCDFS)

Clark County Department of Family Services (CCDFS) has continued with its implementation of the Advanced Foster Care (AFC) Program. There are currently 20 AFC homes, with seven homes that closed over the course of the last year. As the program was designed to be fully operational with 30 homes, retaining homes is a current focus, as CCDFS recognizes that the need to recruit and train new homes is minimized when current foster homes can be retained. CCDFS is undergoing a series of focus groups to better understand the ways that the Department can better support and team with foster parents to aid in retention of foster homes.

In addition, recruitment and training of AFC homes is ongoing, with a goal of developing 10 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 continue to work with the purveyor on certification in the model.

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.

Implementation in Rural Counties

Provided by DCFS Rural Region Child Welfare

The Specialized Foster Program has continued within the DCFS-Rural Region. Currently there are 22 homes at this level of care. The Advanced Foster Care Program (AFC) within the overall Specialized Foster Care program currently serves 16 homes across the Rural Region. These homes are in Pahrump, Amargosa Valley, Ely, Winnemucca, Fallon, Fernley, Yerington, and Dayton. Additionally, some DCFS children are served in agency foster homes located in Washoe and Clark Counties.

Last year, the program had a peak of 26 AFC homes. The program has experienced some home turnover due to the fact that this work can be stressful to a caregiver and his/her family. Despite training, mentoring, and support from the Coach, sometimes a home decides to take a temporary hiatus or to leave the program altogether. Some realize that they just don't have the time.

In order to address the shortage of SFC/AFC homes, program staff are working closely with the Foster Home Licensing Unit and the Foster Home Recruiter to formulate a plan to recruit and retain more foster homes, including SFC/AFC homes. Efforts started in the spring of 2018 and are continuing. A work group has been put together to help formulate strategies to reach out to the various communities in the Rural Region to recruit new homes.

The program began an ongoing time study in July of 2017. One of the revealing pieces of information from the study shows that program Coaches serving homes in the Rural Region spend as much time traveling to and from homes as they do delivering coaching services in the homes. This important information points out the fact that with such large distances to cover, travel and driving is part of the program. For instance, Yerington is 63 miles from Carson City and Ely is 180 miles from Elko. This means that a Coach could drive over two hours round trip (Carson to Yerington and back, for instance) to deliver one coaching session. A trip to Ely from Elko to see the two homes there usually results in an overnight trip, plus the six- to seven-hour round trip drive.

Rural AFC/SFC has developed an efficient system of data collection that provides what is required by NRS in the prescribed timeframes. This data not only provides the Division with the data needed to oversee the program but it provides information to the program that helps in day-to-day management. Additionally, SFC/AFC homes often care for children who do not have special needs. The Clinical Program Manager and the DCFS Planning and Evaluation Unit (PEU) are

exploring outcomes for children in SFC/AFC homes who are not in the SFC program in order to help ascertain if all children in the home are benefitting from Coaching services and trainings delivered to the foster parents.

A final data point is that the program sends an annual survey to all SFC homes. The intent of the survey is to ascertain foster parent satisfaction with the program as well as to obtain a better view of how foster parents use the program in their homes and daily lives. Two rounds of surveys have been collected and analyzed, showing that foster parents express a high degree of satisfaction with the program, especially with their Coach. Most importantly, the surveys show that foster parents value the face-to-face contact with their Coach.

Implementation in Washoe County

Provided by Washoe County Human Services Agency (WCHSA)

In SFY18 Washoe County Human Services Agency (WCHSA) continued to participate in various activities related to the continued evolution and growth of the Specialized Foster Care Program (SFCP), with the ultimate goal of sustainability. These activities centered on three primary areas: Program Improvement; Workforce Development; and Quality Assurance/Outcomes.

Program Improvement

WCHSA's Triage and Placement Review Team (TPRT) continued to meet weekly over SFY18, wherein children referred to, or needing assessment for, SFCP were reviewed for admission and placement options to determine SFCP eligibility. During TPRT meetings, program planning, implementation, and decision-making activities also took place on an ongoing basis to improve upon WCHSA's SFCP processes. This resulted in:

- A more cohesive placement team structure and new placement and referral processes.
- Large focus on permanency by conducting permanency reviews to analyze trends and provide support/intervention toward permanency where applicable; additional tracking of ultimate permanency outcomes.
- An ongoing, active multidisciplinary workgroup to analyze and develop new procedures to successfully select, prepare, and support adoptive families for children in SFCP, which should lead to more successful finalized adoptions, as well as more timely permanency for children placed in SFCP.
- WCHSA staff partnered with DCFS PEU to assist with development of new TFTC coaching forms.
- Meetings to plan ahead for the changes that will result from the Family First Prevention Services Act.
- Continued efforts and progress toward agency certification in TFTC.

Workforce Development

Over SFY18, WCHSA continued to focus utilizing Together Facing the Challenge (TFTC) as the SFCP program model. Various activities took place with respect to TFTC:

Training

- Together Facing the Challenge (TFTC) trainings for SFCP providers were hosted/conducted by WCHSA on a quarterly basis.
- Refresher courses were offered in order to train both AFC and SFC foster parents/providers.
- Refresher courses were offered to WCHSA staff previously trained in TFTC.
- A team of WCHSA staff trained in TFTC provided weekly in-home coaching to foster parents/caregivers, and these staff members received supervision guided by the TFTC fidelity model.
- A new WCHSA staff is working toward TFTC certification, a second WCHSA staff is working on TFTC re-certification; and a third WCHSA staff was re-certified.
- WCHSA staff helped with the development of a TFTC Coach and Supervisor training. The training was piloted in Washoe County and then conducted in Clark County.

Other

- WCHSA staff actively participated in monthly TFTC consultation and implementation calls with DCFS-PEU/Duke-TFTC (Mr. Thomas Holahan and Ms. Maureen Murray).
- WCHSA continued to engage in activities to recruit, license, and train additional SFCP homes/providers
- 1 new AFC and 3 new SFC homes were added
- As of July 1st 2018, there were a total of 54 SFCP homes (13 AFC, 41 SFC).

Over SFY18 SFCP was staffed utilizing allocated SFC-funds from DCFS. As such, WCHSA continued to staff the SFPC as follows:

An Office Support Specialist for:

- Data collection/entry,
- Tracking of various program components, and
- Organization and management of a variety of duties and program documents.

A Social Worker III utilized to:

- Conduct implementation activities, general support, and liaison duties, facilitate TPRT meetings, performing data collection duties, helping to train TFTC model and provide consultation,
- Provide further support to AFC children by coordinating and facilitating CFTs
- Engaging in targeted permanency efforts, and
- Helping with care coordination of children's services.

Mental Health Counselors utilized 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 NV-CANS continued to conduct assessments at admission, every six months, and discharge for all children enrolled in SFCP; and reported NV-CANS scores per data collection requirements. Throughout SFY18 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 the start of new quality assurance activities.

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, with the exception of Basic Skills Training.

WCHSA is proud to continue to report 100% implementation of the SFC program as approved in the 2015 Legislative session, with no BST claims and the provision of TFTC Coaching/Supervision to the foster parents/caregivers of children placed in SFCP.

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 after admission, and at discharge. The following indicators were used to track a youth's progress in SFCP during SFY18:

- 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 SFY18, admission values were compared to discharge values to determine outcomes. For youth currently enrolled in specialized foster care at the end of SFY18, admission values 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).

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, i.e., 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 802 youth were served in specialized foster care for at least 30 days at some time during SFY18. Five hundred twenty-nine (529) youth were enrolled in specialized foster care on the last day of the fiscal year, June 30, 2018. Please see tables below for more details.

Table 1. Total Youth Served Statewide in SFY18

Number of youth admitted to AFC or SFC for at least 30 days at any time during the fiscal year

	AFC	SFC	Total
Clark	40	548	**588**
Washoe	29	139	**168**
Rural	31	15	**46**
STATEWIDE	**100**	**702**	**802**

802 youth were served in Specialized Foster Care statewide during SFY18

Table 2. Total Youth Enrolled Statewide

Number of youth enrolled in SFCP on the last day of the fiscal year

	AFC	SFC	Total
Clark	40	345	**385**
Washoe	20	98	**118**
Rural	17	9	**26**
STATEWIDE	**77**	**452**	**529**

The mean age in specialized foster care ranged from 8.0 (Washoe AFC) to 14.2 years (Rural SFC). The youngest children in SFC were aged 2 years, which was seen in several programs. The average length of stay varied from approximately 217 days (Clark AFC) to 848 days (Rural SFC). Race/ethnicity varied across jurisdictions. In Clark County, approximately half of SFC youth were Caucasian and nearly half were African-American. Approximately 22% were Hispanic. In Washoe County, approximately 77% were Caucasian while 16% were African American, and 18% were Hispanic. In Rural Nevada, 82% were Caucasian, 7% African American, 6% American Indian, and 11% Hispanic. The most common reason for entry into the child welfare system in all jurisdictions was neglect.

Please see Appendix A for all demographic results.

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	35	476	**511**
Washoe	29	125	**154**
Rural	31	14	**45**
Statewide	**95**	**615**	**710**

The analyses that follow are limited to the 710 youth with 90 days or more of treatment. Youth with less than 90 days in SFCP (*n* = 92) 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.

8-year-old Jackson had disrupted from 5 foster placements before entering an Advanced Foster Care home. Upon entering AFC, his acting-out behaviors were so difficult that his foster parent, Mrs. Taylor, didn't know what to do and was considering asking DCFS to remove Jackson from her home. The AFC coach worked with Mrs. Taylor to develop a behavioral system to successfully handle the acting-out behavior. Jackson was able to stay in Mrs. Taylor's home for 14 months, the longest he had ever stayed in any foster placement, and was no longer displaying the inappropriate behavior. He then transitioned to an adoptive placement, where he was able to maintain the behavioral gains he had made while in AFC.

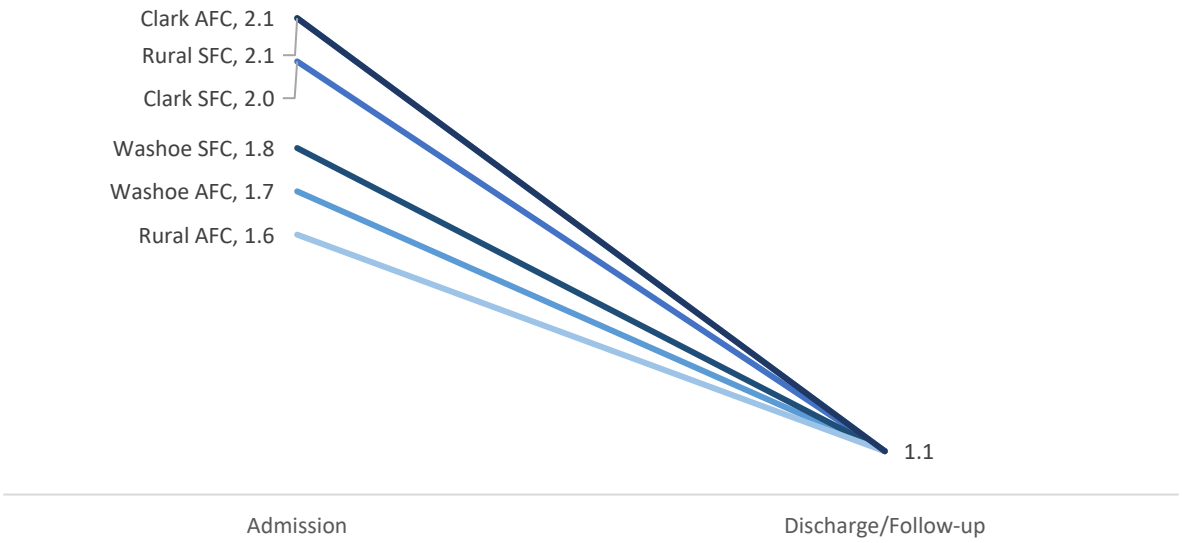
Runaways, Hospitalizations and Stability of Placement

Fewer runaways were seen between admission and discharge/end-of-fiscal-year (EOFY) in Clark SFC and Washoe SFC. There was no change in Clark AFC or Rural AFC. There was a slight increase from 0 runaways at admission to 1 runaway at discharge/EOFY in Washoe AFC. No runaways were observed in Washoe AFC at admission, or Rural SFC at admission or discharge/EOFY.

Psychiatric hospitalizations decreased in Clark SFC, Washoe SFC and Rural SFC. There were slight increases in Clark AFC and Washoe AFC, and no change in Rural AFC.

Number of average placements decreased in every program in every jurisdiction from admission to discharge/EOFY. Average number of placements per youth at discharge/EOFY in every program in every jurisdiction was 1.1, with standard deviations ranging from 0.3 to 0.5, indicating that in most cases youth remained in their initial SFCP placement without placement changes.

Figure 1. Average Number of Placements Decreases During SFCP across All Jurisdictions and Program Types

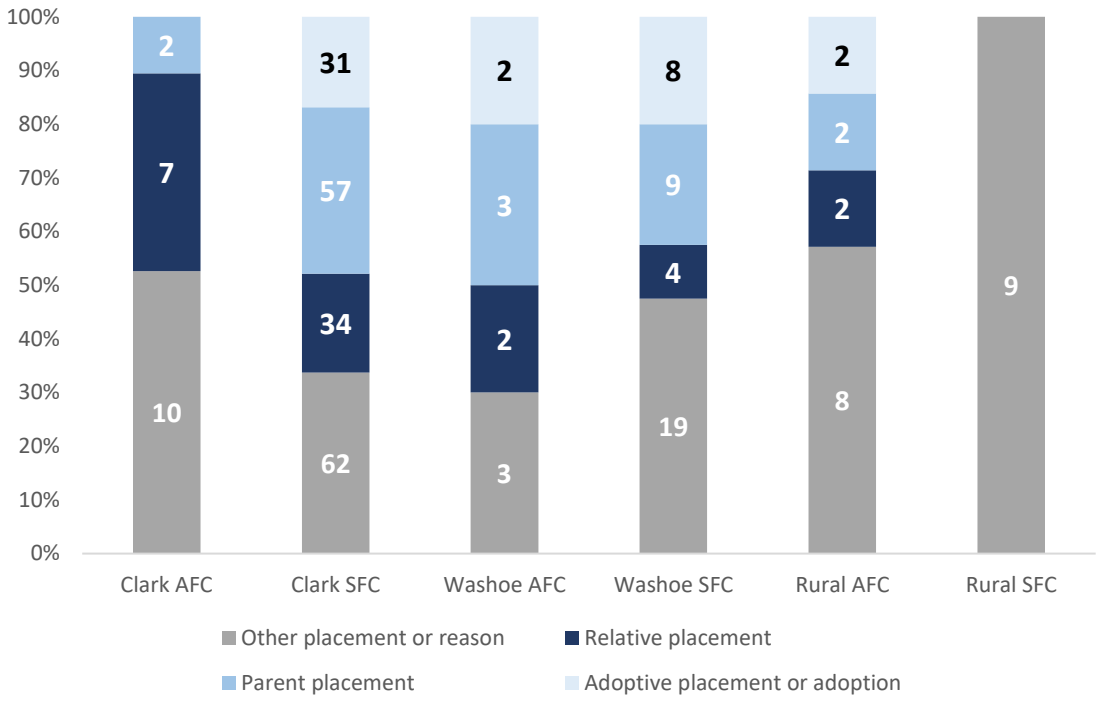


In summary, as in previous years, some of the largest gains for SFCP youth were observed in placement stability outcomes. During the six months prior to specialized foster care, a small proportion of SFCP youth tend to be frequently hospitalized, frequently in runaway status, and frequently disrupting from placements. Across all programs in all jurisdictions, youth experienced greater placement stability overall while in specialized foster care. This is 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 42.9% in Rural AFC to 70.0% in Washoe AFC. Relatively few youth must admit to a higher level of care from SFCP, while youth reaching the age of majority are an important sub-population. Unfortunately, no youth discharged from Rural SFC transitioned to a permanent placement during SFY18. Please see Appendix B for full permanency outcomes.

Figure 2. Transitions to Permanent Placements Upon Discharge from SFCP



Legal Involvement

Legal involvement was a rare occurrence at both admission and discharge/EOFY across all programs. No legal involvement was observed in AFC placements in Clark or Washoe 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. It is possible that legal involvement was not recorded during the six months prior to admission for Rural SFC youth, leading to an apparent increase during SFC. In fact, it is more likely that legal involvement is simply being more accurately reported for youth enrolled in SFCP. Please see Appendix B for detail.

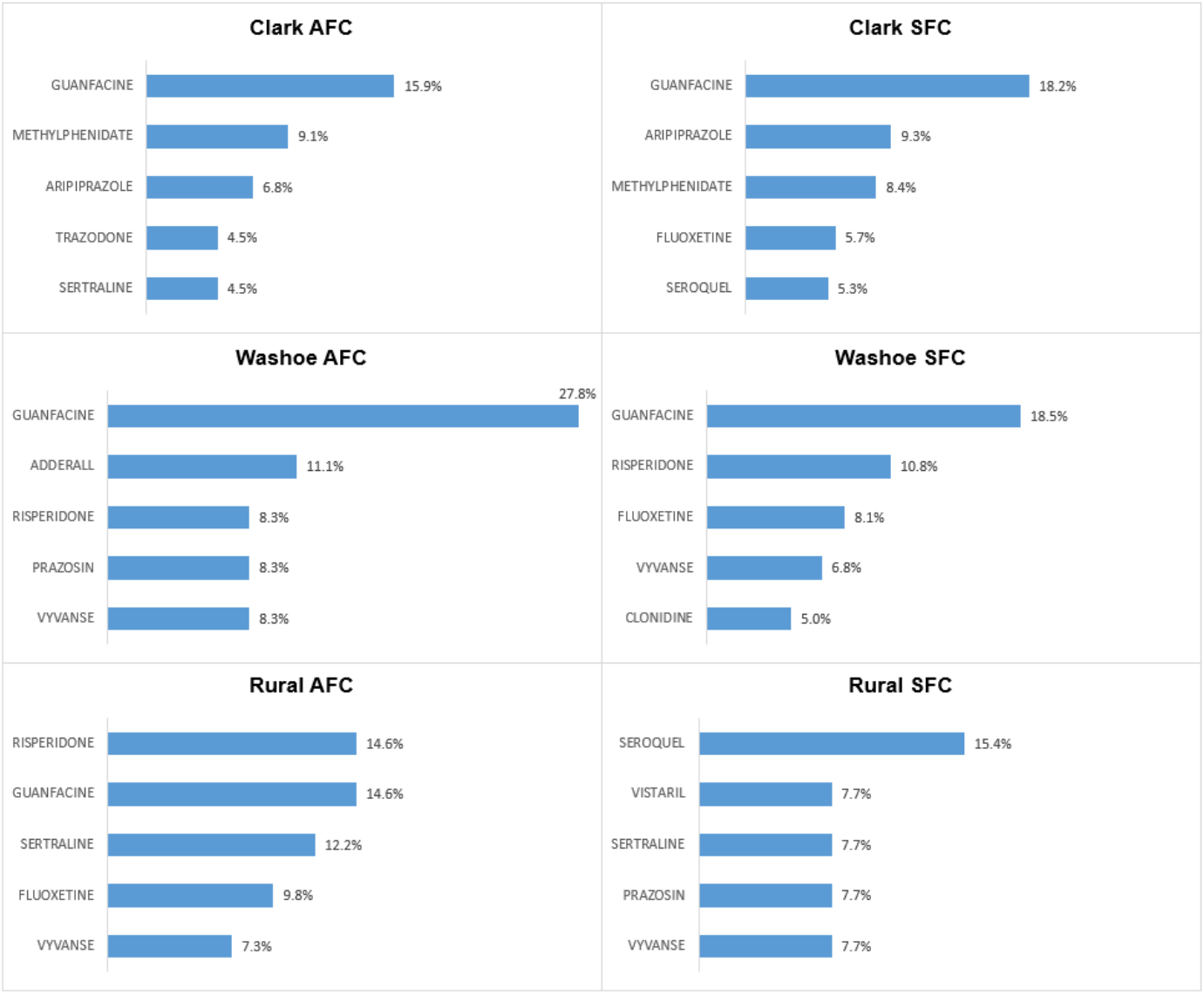
Education

Many youth in SFCP receive special education services at school, primarily for learning disabilities, emotional disturbance, and health impairment. In some programs and jurisdictions, more than half of youth are classified as special education. A small number of SFCP youth 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, 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 has been seen in previous years, surveillance of specialized foster care youth reveals that among those youth 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 scientific literature (Brenner et al., 2014; see Figure 3). More youth receive psychotropic medications at discharge/EOFY than in the six months prior to admission. Between 39% and 71% of youth are taking psychotropic medications at discharge/EOFY, depending upon the jurisdiction and program, with the average number of medications prescribed per youth being approximately 2.7. 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 3. Most Commonly Prescribed Psychotropic Medications at Discharge



15-year-old Keisha had been in 7 placements over the last four years. She has a history of oppositional behaviors, running away, and aggression. When she was first placed into an AFC home, Keisha acted out and threatened to run away. She was surprised when her foster mother responded, "I don't allow children to leave my home. I love you and I want you to stay and be safe." The AFC coach characterizes this foster mother as the "perfect" AFC parent because she has good boundaries, she loves Keisha, and she "lets her be a teenager," but provides strong and appropriate rules and structure. After encountering this unexpected response from her foster mother, Keisha opted not to run away. In time, she began to share with her some of the burdens and traumas she has experienced in her life. Keisha's grades are improving and her functioning with peers has improved. After just 8 months in her AFC placement, options for permanency are being explored.

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 SFY18, are available in Appendix C. Highlights include:

- **Clark SFC:** Whereas 169 youth were accessing individual therapy at admission, 311 were using this service at discharge/EOFY (65.3% of youth).
- **Clark SFC:** 147 youth were attending psychiatry sessions for medication management at admission; at discharge or EOFY, 229 youth accessed this service (48.1% of youth).
- **Washoe AFC:** Use of group therapy increased from an average of 6.2 hours per 6 months at admission to 50.6 hours per 6 months at discharge/EOFY.
- **Washoe SFC:** Whereas 18 youth had received a new patient visit with a psychiatrist at admission, 90 youth had done so at discharge/EOFY (72.0% of youth).
- **Rural AFC:** Use of individual therapy increased substantially from an average of 6.5 hours per 6 months at admission to 12.8 hours per 6 months at discharge/EOFY.
- **Rural SFC:** Whereas 5 youth were accessing individual therapy at admission, 12 youth were using this service at discharge/EOFY (85.7% of youth).

Performance on Clinical Standardized Assessment Tools

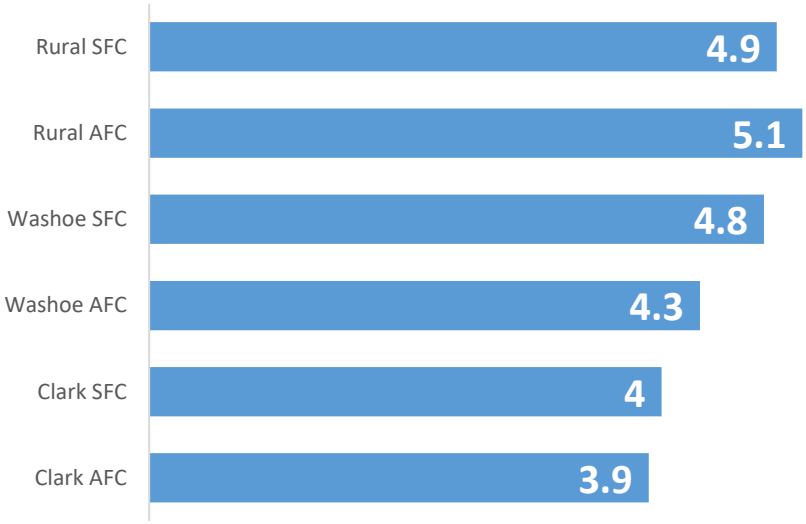
Child Post-Traumatic Symptom Scale (CPSS)

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 SFY18, there were 91 admission CPSS and 269 follow-up CPSS. Fifty-seven (57) youth (8.0%) 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 ranged from zero to 13. Averages within each jurisdiction and program were largely consistent, ranging from 3.9 to 5.1. Youth endorsing at least one potentially traumatic event ranged from 71% to 90% depending upon the jurisdiction and program and was approximately 82% 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 SFC youth ranged from 31% to 55% 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 specialized foster care population as well as the pronounced need for specialized, intensive, multidimensional treatment strategies. Please see Appendix B for more detail.

Figure 4. Average Number of Potentially Traumatic Events Endorsed (max possible = 15)



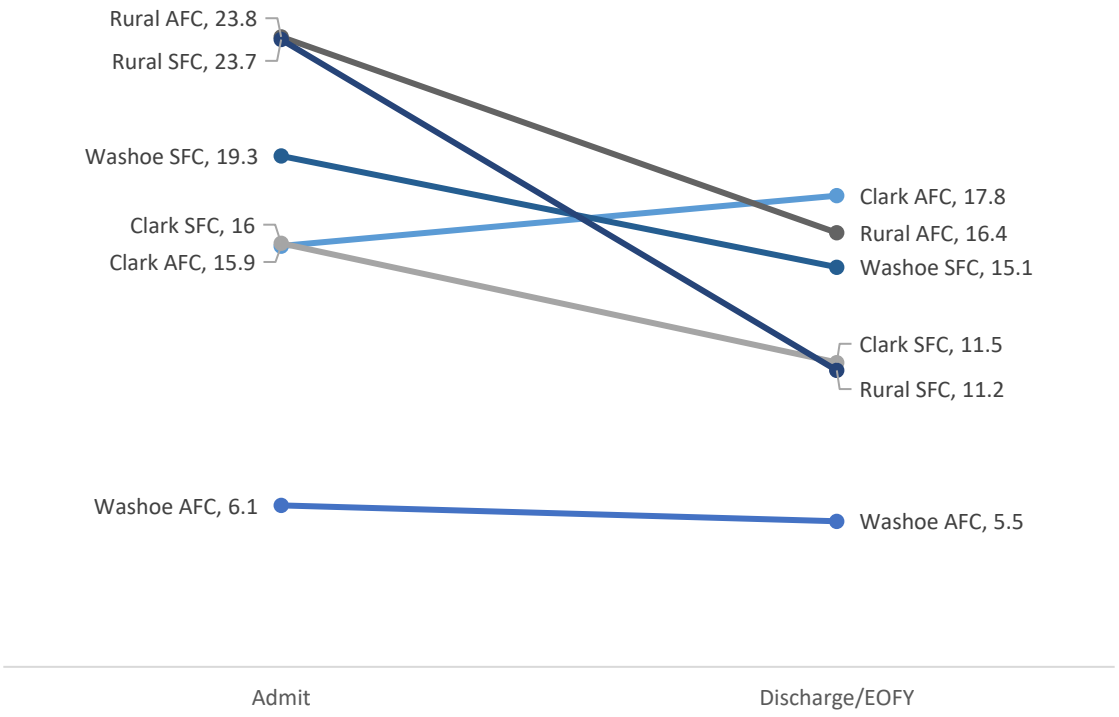
Nevada Child and Adolescent Needs and Strengths Tool (NV-CANS)

During SFY18, 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 and has become the standard of care in child welfare and children's mental health. The Nevada CANS was developed with the help of stakeholders from child-serving systems across Nevada so that it would meet the specific needs of our state. Washoe County Human Services Agency was an early adopter of the NV-CANS, and Rural AFC/SFC also began using the CANS in SFY17. Clark County AFC and SFC began using the CANS during SFY18.

With the exception of one domain, 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 is one domain scored differently, Adverse Childhood Experiences & Potentially Traumatic Events, which is simply a count of "Yes" answers.

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. Statewide across both admission and discharge/EOFY, collaboratively generated ratings that utilized collateral report from caregivers yielded even higher endorsements of exposure to potentially traumatic events on the NV-CANS than what youth reported independently on the CPSS—averages ranging from 6.4 to 8.8 events. Forty-five youth (6.3%) had both an admission and a discharge/EOFY NV-CANS on record. 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 on next page). 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 FY2018, 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 (45.4%), 18-month (20.4%), or 24-month (15.4%) follow-up assessment.

Figure 6. CGSQ Objective Strain

Negative experiences that resulted 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).

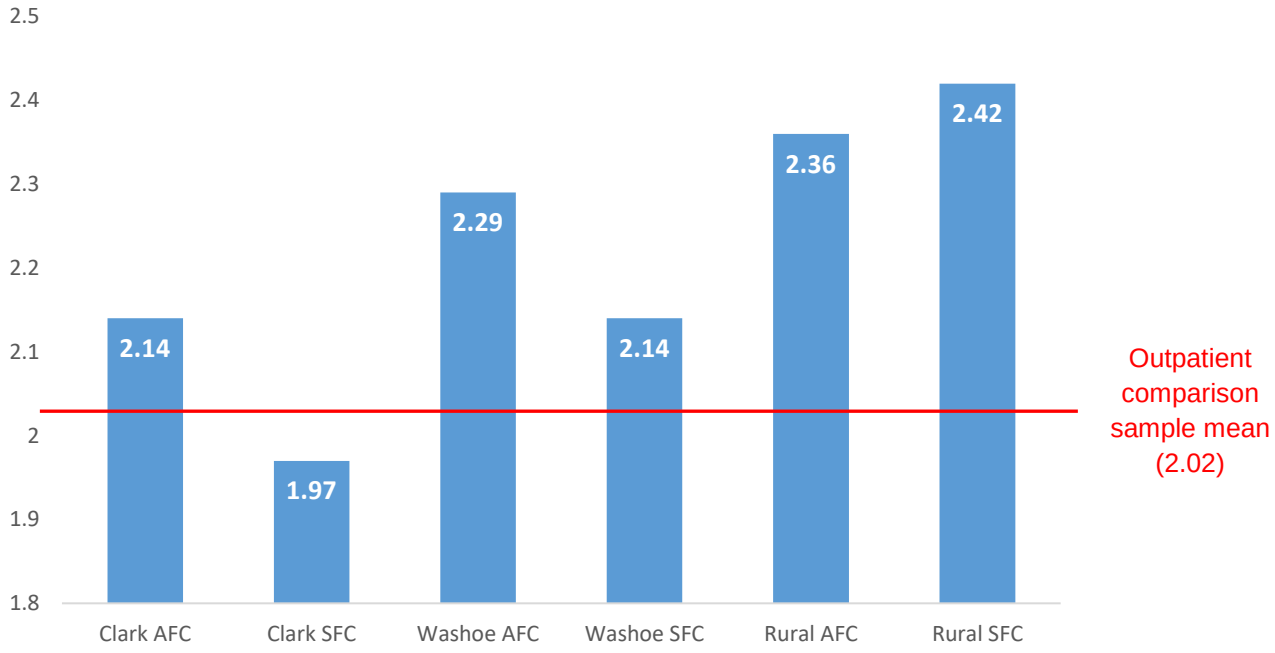


Figure 7. CGSQ Internalized Subjective Strain

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). Outpatient comparison sample mean = 3.43.

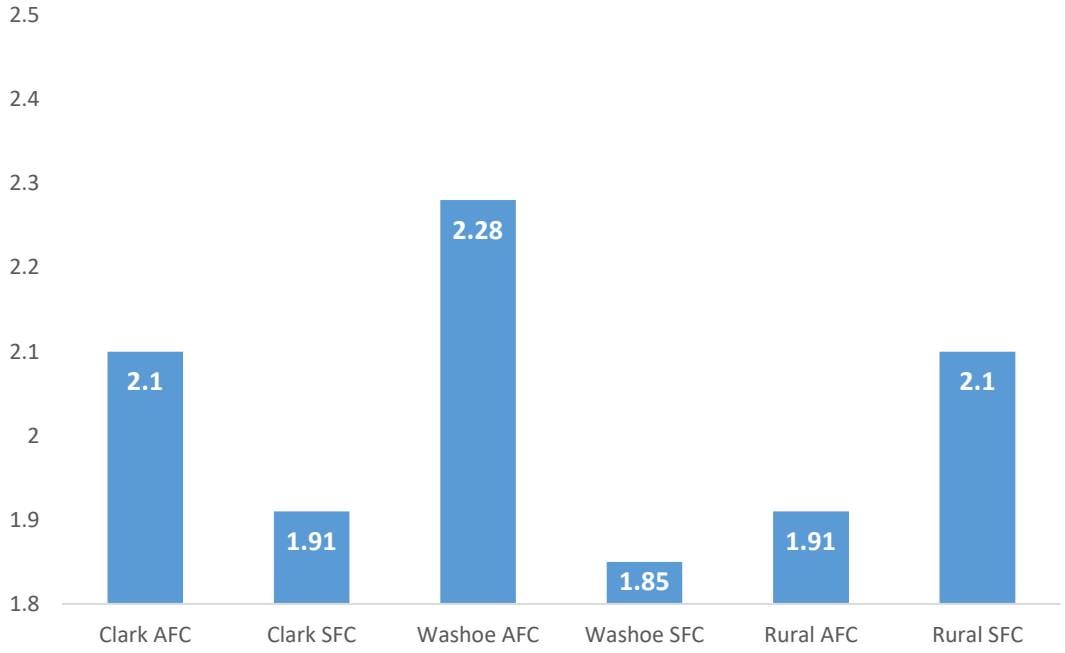
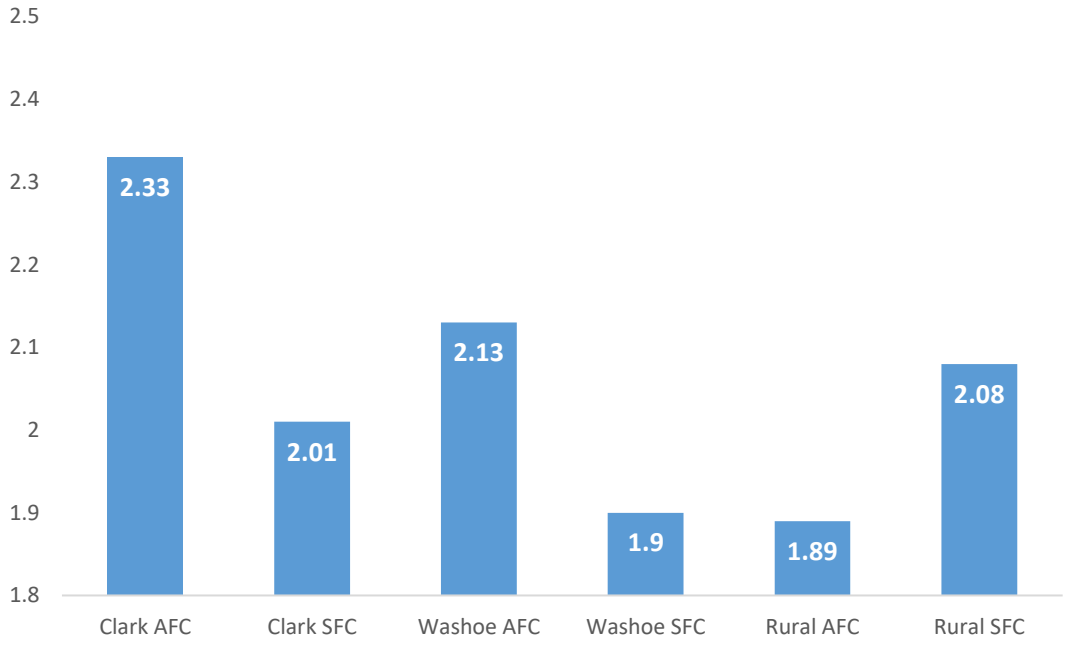


Figure 8. CGSQ Externalized Subjective Strain
Negative feelings directed at the child (e.g., resentment, anger, embarrassment). Outpatient comparison sample mean = 2.29.



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

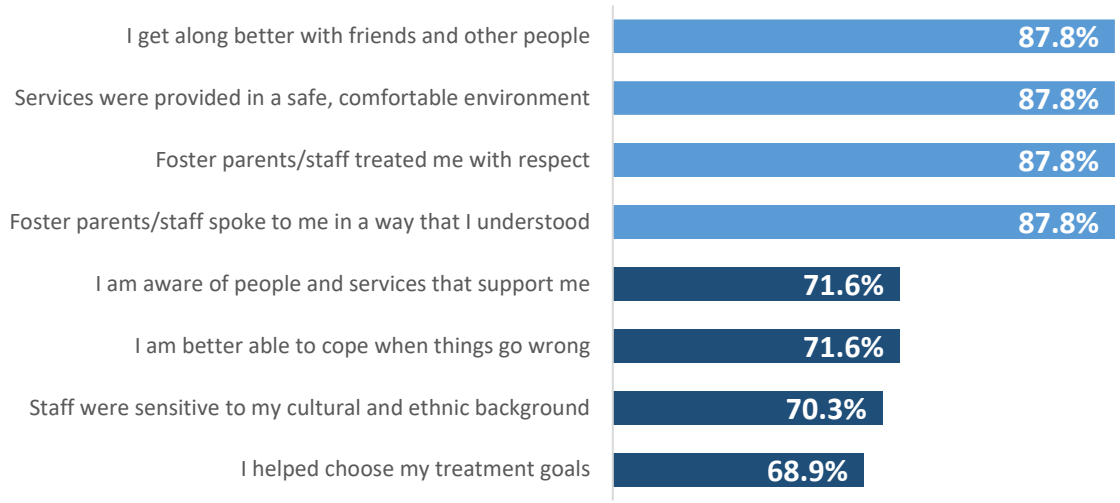
Foster parents and youth in all AFC and SFC homes statewide were asked to report on their satisfaction with the specialized foster care program and services provided to them during SFY18. Consumer satisfaction data is collected in a completely anonymous fashion, so it is not possible to provide results broken down by jurisdiction or program, although there is a voluntary question regarding where the individual currently lives that is reported below. One hundred thirty-nine (139) foster parents and 91 youth provided completed consumer satisfaction surveys during SFY18.

Youth Satisfaction

Of 91 youth surveys, 8 were excluded because the youth indicated he/she did not meet the age criteria (11 years old or older). An additional 9 surveys were excluded because the youth did not complete the satisfaction questions. The results that follow describe consumer satisfaction for the remaining 74 youth. On average, these youth had been in SFCP for 25.7 months. Demographic characteristics showed a relatively racially and ethnically diverse sample (47% male; 64% Caucasian, 15% African American, 4% American Indian/Alaskan Native, 3% Asian, 14% Other; 20% Hispanic/Latino). The average age was 14.9 (range = 11 to 19). When asked where they were currently living, youth answered as follows: 22% Clark County, 41% Washoe County, 38% Rural Nevada.

On the satisfaction survey, youth indicated a number of areas where they felt the SFCP program could improve. Thirteen (13) 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. Attention to cultural competence also appears to be an area to attend to in our service to youth.

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



Please see Appendix D for full youth consumer satisfaction results.

Foster Parent Satisfaction

Foster parents reported that on average, youth in their homes had been in SFCP for 20.8 months. The average age was 11.9 (range = 1 to 19). When asked where they were currently living, foster parents answered as follows: 19% Clark County, 57% Washoe County, and 24% Rural Nevada.

Results of the foster parent satisfaction survey were very positive overall. Twenty-three 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.

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

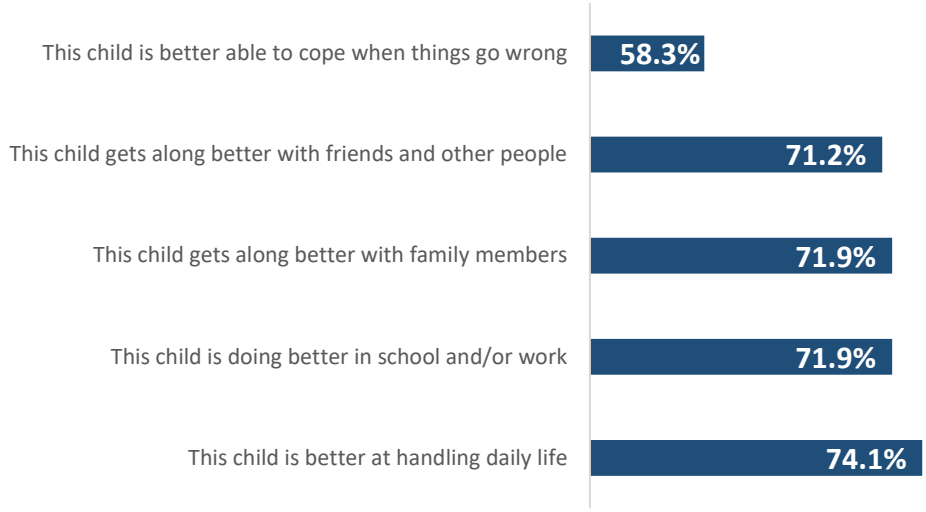


Figure 10. Foster Parents Were Most Satisfied with Quality of Services and Interactions with Program Staff

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

Summary & Conclusions

The Specialized Foster Care Program (SFCP) in Nevada had another successful year across both Specialized Foster Care agency homes and Advanced Foster Care family foster homes. Staff in all three jurisdictions worked diligently to administer the program as legislatively mandated, including maintaining compliance with program evaluation requirements.

DCFS continued to work towards long-term sustainability of the Together Facing the Challenge (TFTC) evidence-based treatment foster care model. All of the specialized foster care agencies and providers in Nevada have become fully certified in TFTC or are working towards certification. Consultation calls occurred on a regularly scheduled basis, and there is a complement of certified trainers available across the state.

Eight hundred two (802) youth were served in specialized foster care placements during SFY18 (i.e., were present in a specialized foster care placement for greater than 30 days). Seven hundred ten (710) of these were present 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. Outcomes analyses suggested that as expected, the specialized foster care population in Nevada is a high-needs population. There is a high rate of exposure to trauma. Many youth receive special education services. Foster parents experience a high level of caregiving-related burden due to negative experiences such as interruption of personal time, missing work, disruption of family routines or relationships, and financial strain. Examining service utilization data, it is clear that participation SFCP maintains or increases access to necessary mental and behavioral health services, including access to psychotropic medications, to facilitate management of complex, ongoing needs.

Despite the challenges inherent in supporting a high-needs population, SFCP had a substantial 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 42.9% of all discharged youth in Rural AFC to 70.0% in Washoe AFC.

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.

Five hundred twenty-nine (529) youth were enrolled in specialized foster care on the last day of the fiscal year.

References

Alisic, E., Zalta, A.K., van Wesel, F, Larsen, S.E., Hafstad, G.S., Hassanpour, K., & Smid, G.E. (2014). *British Journal of Psychiatry, 204*, 335-340.

Brannan, A.M., Heflinger, C.A., & Bickman, L. (1997). The Caregiver Strain Questionnaire: Measuring the impact on the family of living with a child with serious emotional disturbance. *Journal of Emotional and Behavioral Disorders, 5*(4), 212-222.

Brenner, S.L., Southerland, D.G., Burns, B.J., Wagner, R. & Farmer, E.M.Z. (2014). Use of psychotropic medications among youth in treatment foster care. *Journal of Child and Family Studies, 23*(4), 666-674.

Chamberlain, P. (2003). The Oregon Multidimensional Treatment Foster Care model: Features, outcomes, and progress in dissemination. *Cognitive and Behavioral Practice, 10*, 303-312.

Cross, J.R. & Cross, T. (2015). Clinical and mental health issues in counseling the gifted individual. *Journal of Counseling & Development, 93*, 163-172.

Fisher, P.A. & Chamberlain, P. (2000). Multidimensional Treatment Foster Care: A program for intensive parenting, family support, and skill building. *Journal of Emotional and Behavioral Disorders, 8*(3), 155-164.

Foa, E.B., Johnson, K.M., Feeny, N.C. & Treadwell, K.R. (2001). The Child PTSD Symptom Scale: A preliminary examination of its psychometric properties. *Journal of Clinical Child Psychology, 30*(3), 376-384.

Jonas, B.S., Gu, Q., & Albertorio-Diaz, J.R. (2013). Psychotropic medication use among adolescents: United States, 2005-2010. NCHS Data Brief, No. 135. Hyattsville, MD: U.S. Department of Health and Human Services, National Center for Health Statistics. Available from: https://www.cdc.gov/nchs/data/databriefs/db135.pdf

McLaughlin, K.A., Koenen, K.C., Hill, E.D., Petukhova, M., Sampson, N.A., Zaslavsky, A.M., & Kessler, R.C. (2013). Trauma exposure and posttraumatic stress disorder in a national sample of adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry, 52*(8), 815-830.

Murray, M., Dorsey, S., Farmer, M.Z., Potter, E., Burns, B.J., & Kelsey, K.L. (2007). *Together facing the challenge: A therapeutic foster care resource toolkit.* Durham, NC: Duke University School of Medicine Services Effectiveness Research Program.

Reddy, L.A. & Pfeiffer, S.I. (1997). Effectiveness of treatment foster care with children and adolescents: A review of outcome studies. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*(5), 581-588.

Substance Abuse and Mental Health Services Association (2017, September 5). Adverse Childhood Experiences. Available at https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/adverse-childhood-experiences.

Appendix A: Demographics

Table 1. Demographics: Clark

	AFC	SFC
Age at Admission	mean = 10.1 (range = 2 to 18)	mean = 10.5 (range = 1 to 17)
Gender	45.0% male	56.6% male
Length of Stay in SFCP at Discharge or on June 30, 2018	mean = 216.9 days (range = 38 to 692)	mean = 406.8 days (range = 31 to 2,006)

Table 2. Demographics: Washoe

	AFC	SFC
Age at Admission	mean = 8.0 (range 2 to 14)	mean = 11.4 (range 3 to 17)
Gender	41.4% male	56.8% male
Length of Stay in SFCP at Discharge or on June 30, 2018	mean = 478.5 days (range = 116 to 1,369)	mean = 396.6 days (range = 35 to 1,641)

Table 3. Demographics: Rural

	AFC	SFC
Age at Admission	mean = 11.6 (range 3 to 17)	mean = 14.2 (range 11 to 17)
Gender	35.5% male	40.0% male
Length of Stay in SFCP at Discharge or on June 30, 2018	mean = 403.4 days (range = 51 to 1,975)	mean = 848.2 days (range = 123 to 2,006)

Table 4. Race/Ethnicity: Clark

	AFC	SFC	Total
*Race**			
African-American	21 (47.7%)	260 (42.9%)	281 (43.2%)
American Indian/Alaskan Native	1 (2.3%)	13 (2.1%)	14 (2.2%)
Asian	1 (2.3%)	13 (2.1%)	14 (2.2%)
Caucasian	21 (47.7%)	316 (52.1%)	337 (51.8%)
Native Hawaiian/Pacific Islander	0	3 (0.5%)	3 (0.5%)
Declined to Answer	0	1 (0.2%)	1 (0.2%)
Ethnicity			

Hispanic	3 (7.5%)	124 (22.6%)	127 (21.6%)
Non-Hispanic	37 (92.5%)	423 (77.2%)	460 (78.2%)
Declined to Answer	0	1 (0.2%)	1 (0.2%)

*Multiple races may be selected for a given youth.

Table 5. Race/Ethnicity: Washoe

	AFC	SFC	Total
*Race**			
African-American	5 (16.7%)	24 (17.4%)	29 (15.8%)
American Indian/Alaskan Native	0	5 (3.6%)	5 (2.7%)
Asian	0	1 (0.7%)	1 (0.5%)
Caucasian	24 (80.0%)	119 (85.6%)	143 (76.9%)
Native Hawaiian/Pacific Islander	1 (3.3%)	6 (4.3%)	7 (3.8%)
Declined to Answer	0	0	0
Ethnicity			
Hispanic	3 (10.3%)	27 (19.6%)	30 (18.0%)
Non-Hispanic	26 (89.7%)	110 (79.1%)	136 (81.0%)
Declined to Answer	0	2 (1.4%)	2 (1.2%)

*Multiple races may be selected for a given youth.

Table 6. Race/Ethnicity: Rural

	AFC	SFC	Total
*Race**			
African-American	1 (2.9%)	3 (15.8%)	4 (7.4%)
American Indian/Alaskan Native	3 (8.6%)	0	3 (5.6%)
Asian	0	1 (5.3%)	1 (1.9%)
Caucasian	30 (85.7%)	14 (73.7%)	44 (81.5%)
Native Hawaiian/Pacific Islander	1 (2.9%)	1 (5.3%)	2 (3.7%)
Declined to Answer	0	0	0
Ethnicity			
Hispanic	2 (6.5%)	3 (20.0%)	5 (10.9%)
Non-Hispanic	27 (87.1%)	12 (80.0%)	39 (84.8%)
Declined to Answer	2 (6.5%)	0	2 (4.3%)

*Multiple races may be selected for a given youth.

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

	AFC	SFC
Abandonment	3 (7.5%)	32 (5.8%)
Child's Behavior Problem	0	7 (1.3%)
Child Disability	0	3 (0.5%)
Domestic Violence	3 (7.5%)	30 (5.5%)
Emotional Abuse	7 (17.5%)	68 (12.4%)
Inadequate Housing	6 (15.0%)	54 (9.9%)
Juvenile Justice Services	0	2 (0.4%)
Medical Neglect	3 (7.5%)	11 (2.0%)
Neglect	35 (87.5%)	440 (80.3%)
Parent Death	0	4 (0.7%)
Parent Incarceration	5 (12.5%)	52 (9.5%)
Parental Alcohol Abuse	2 (5.0%)	11 (2.0%)
Parent's Inability to Cope	5 (12.5%)	74 (13.5%)
Parental Drug Abuse	7 (17.5%)	33 (6.0%)
Physical Abuse	6 (15.0%)	56 (10.2%)
Parental Methamphetamine Use	0	5 (0.9%)
Sexual Abuse	1 (2.5%)	20 (3.6%)

*Multiple reasons may be selected for a given youth.

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

	AFC	SFC
Abandonment	1 (3.4%)	16 (11.5%)
Child's Behavior Problem	0	10 (7.2%)
Child's Alcohol Usage	0	2 (1.4%)
Child's Drug Usage	0	3 (2.2%)
Domestic Violence	3 (10.3%)	12 (8.6%)
Emotional Abuse	0	3 (2.2%)
Inadequate Housing	1 (3.4%)	21 (15.1%)
Juvenile Justice Services	0	1 (0.7%)
Medical Neglect	0	15 (10.8%)
Neglect	20 (69.0%)	87 (62.6%)
Parent Incarceration	8 (27.6%)	48 (34.5%)
Parental Alcohol Abuse	4 (13.8%)	12 (8.6%)
Parent's Inability to Cope	0	11 (7.9%)
Parental Drug Abuse	6 (20.7%)	32 (23.0%)
Physical Abuse	3 (10.3%)	15 (10.8%)

Parental Methamphetamine Use	4 (13.8%)	5 (3.6%)
Sexual Abuse	4 (13.8%)	14 (10.1%)

*Multiple reasons may be selected for a given youth.

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

	AFC	SFC
Abandonment	5 (16.1%)	4 (26.7%)
Child's Behavior Problem	2 (6.5%)	1 (6.7%)
Domestic Violence	1 (3.2%)	0
Inadequate Housing	6 (19.4%)	1 (6.7%)
Medical Neglect	1 (3.2%)	1 (6.7%)
Neglect	16 (51.6%)	8 (53.3%)
Parent Incarceration	7 (22.6%)	2 (13.3%)
Parental Alcohol Abuse	2 (6.5%)	0
Parent's Inability to Cope	1 (3.2%)	1 (6.7%)
Parental Drug Abuse	5 (16.1%)	1 (6.7%)
Physical Abuse	5 (16.1%)	2 (13.3%)
Parental Methamphetamine Use	0	1 (6.7%)
Sexual Abuse	6 (19.4%)	4 (26.7%)

*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 SFC placements.
Runaway duration of 0 indicates youth who was in runaway status for less than 24 hours.

	Clark AFC	**Clark SFC**	**Washoe AFC**	**Washoe SFC**	**Rural AFC**
Number of youth with history of running away	3 8.6%	41 8.6%	0	12 9.6%	1 3.2%
Number of episodes of elopement per youth	1 to 4 avg = 2.0	1 to 25 avg = 3.6	n/a	1 to 4 avg = 1.8	1
Days in runaway status per episode	2 to 26 avg = 9.0	0 to 279 avg = 12.8	n/a	0 to 15 avg = 2.1	3

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

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

	Clark AFC	Clark SFC	Washoe AFC	Washoe SFC	Rural AFC
Number of youth with history of running away	3 8.6%	10 2.1%	1 3.4%	8 6.4%	1 3.2%
Number of episodes of elopement per youth	1	1 to 6 avg = 1.9	5	1 to 6 avg = 1.9	1
Days in runaway status per episode	0 to 4 avg = 2.0	1 to 80 avg 10.4	1 to 19 avg = 7.2	0 to 15 avg = 4.7	20

Table 3. Hospitalizations: Admission

	Clark AFC	**Clark SFC**	**Washoe AFC**	**Washoe SFC**	**Rural AFC**	**Rural SFC**
Number of youth with history of hospitalization	6 17.0%	43 9.0%	0	8 6.4%	2 6.5%	4 28.5%
Number of episodes of hospitalization per youth	1 to 2 avg = 1.3	1 to 5 avg = 1.5	n/a	1	1 to 2 avg = 1.5	1 to 2 avg = 1.3

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

	Clark AFC	Clark SFC	Washoe AFC	Washoe SFC	Rural AFC	Rural SFC
Number of youth with history of hospitalization	8 22.9%	38 8.0%	1 3.4%	5 4.0%	2 6.5%	2 14.3%
Number of episodes of hospitalization per youth	1 to 2 avg = 1.4	1 to 6 avg = 1.7	1	1	1	1

Table 5. Placement Stability: Admission

	Clark AFC	Clark SFC	Washoe AFC	Washoe SFC	Rural AFC	Rural SFC
Average number of placements per youth (SD)	2.1 (1.7)	2.0 (1.1)	1.7 (1.0)	1.8 (1.2)	1.6 (0.7)	2.1 (1.0)
Maximum number of placements per youth	7	8	6	11	4	4

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)	1.1 (0.4)	1.1 (0.5)	1.1 (0.3)	1.1 (0.5)	1.1 (0.3)	1.1 (0.4)
Maximum number of placements per youth	3	6	2	4	2	2
Number of youth experiencing more placements after admission than prior to specialized foster care	0	19 4.0%	1 3.4%	10 8.1%	1 3.4%	0

SD = standard deviation

Table 7. Reason for Discharge from Specialized Foster Care Including Transition to Permanent Placement

	Clark AFC	Clark SFC	Washoe AFC	Washoe SFC	Rural AFC	Rural SFC
Adoptive Placement or Adoption	0	**31 (16.8%)**	**2 (20.0%)**	**8 (10.0%)**	**2 (14.3%)**	0
Change in Child Case Plan	1 (5.3%)	2 (1.1%)	0	0	1 (7.1%)	3 (33.3%)
Child is Arrested/ Incarcerated	0	1 (0.5%)	0	1 (2.5%)	1 (7.1%)	1 (11.1%)
Child is Incompatible with Provider	3 (15.8%)	6 (3.3%)	0	0	0	0
Needs Higher Level of Care	0	1 (0.5%)	1 (10.0%)	4 (10.0%)	3 (21.4%)	1 (11.1%)
Needs Lower Level of Care	1 (5.3%)	3 (1.6%)	1 (10.0%)	0	1 (7.1%)	1 (11.1%)

Parent Placement	**2 (10.5%)**	**57 (31.0%)**	**3 (30.0%)**	**9 (22.5%)**	**2 (14.3%)**	0
Participant Fails to Cooperate	0	1 (0.5%)	0	0	1 (7.1%)	0
Reached Age of Majority	0	9 (4.9%)	0	7 (17.5%)	1 (7.1%)	3 (33.3%)
Relative Placement	**7 (36.8%)**	**34 (18.5%)**	**2 (20.0%)**	**4 (10.0%)**	**2 (14.3%)**	0
Runaway	2 (10.5%)	12 (6.5%)	0	5 (12.5%)	0	0
Unable to Document Need for Services	1 (5.3%)	3 (1.6%)	0	0	0	0
Other	2 (10.5%)	24 (13.0%)	1 (10.0%)	2 (5.0%)	0	0
Total SFY18 Discharges	**19**	**184**	**10**	**40**	**14**	**9**
	47.4% to perm plcmnt	**66.3% to perm plcmnt**	**70.0% to perm plcmnt**	**52.5% to perm plcmnt**	**42.9% to perm plcmnt**	0% to perm plcmnt

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, Washoe AFC, or Rural SFC placements at admission.

	Clark SFC	Washoe SFC	Rural AFC	Rural SFC+
Number of youth on probation	8 2.4%	9 8.0%	2 6.9%	0
Number of youth arrested	2 0.6%	6 5.3%	1 3.4%	0
Number of arrests each for youth with arrest history	1 to 3 avg = 2.0	1 to 3 avg = 1.8	1 arrest	n/a
Number of youth with detention history	20 6.0%	7 6.2%	1 3.4%	0
Number of days in detention for youth with detention history	1 to 162 avg = 37.5	1 to 188 avg = 36.9	23	n/a

*Baseline information available for 453 youth statewide (63.8%).

+Given the magnitude of the discrepancy between admission and discharge in Rural SFC youth, it is likely that rather than an absence of legal involvement at admission, there was an absence of reporting.

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	5 1.2%	2 1.8%	2 6.9%	2 14.3%
Number of youth arrested	0	3 2.7%	2 6.9%	4 28.6%
Number of arrests each for youth with arrest history	n/a	1 each	1 to 2 avg = 1.5	1 to 4 avg = 2.0
Number of youth with detention history	7 1.7%	6 5.5%	2 6.9%	4 28.6%
Number of days in detention for youth with detention history	1 to 83 avg = 26.9	1 to 202 avg = 42.0	10 to 30 avg = 20.0	2 to 30 avg = 11.0

*Follow-up information available for 545 youth statewide (76.8%).

Table 10. Exceptional Status of SFCP Youth

	Clark AFC	**Clark SFC**	**Washoe AFC**	**Washoe SFC**	**Rural AFC**	**Rural SFC**
Number of youth in special education	7 26.9%	109 30.2%	8 29.6%	42 40.8%	6 22.2%	4 36.4%
Number of youth identified as gifted	1 3.8%	7 1.9%	0	1 1.0%	2 7.4%	0

Percent given as percent of all SFC youth from that jurisdiction reported as attending a Nevada Department of Education school (*n* = 387 Clark, *n* = 38 Rural, *n* = 130 Washoe; *N* = 555 statewide).

Table 11. Disability Classification* for AFC/SFC Special Education Youth

	Clark AFC	**Clark SFC**	**Washoe AFC**	**Washoe SFC**	**Rural AFC**	**Rural SFC**	**Total**
Autism	1 3.8%	5 1.4%	1 3.7%	0	0	0	**7** **1.3%**
Developmental Delay	4 15.4%	26 7.2%	0	1 1.0%	2 7.4%	0	**33** **5.9%**
Emotional Disturbance	3 11.5	31 8.6%	0	15 14.6%	2 7.4%	2 18.2%	**53** **9.5%**
Health Impairments	0	15 4.2%	8 29.6%	19 18.4%	2 7.4%	0	**44** **7.9%**
Hearing Impairment	0	1 0.3%	0	0	0	0	**1** **0.2%**
Intellectual Disability	0	5 1.4%	0	1 1.0%	0	1 9.1%	**7** **1.3%**

Learning Disabilities	0	55 15.2%	2 7.4%	15 14.6%	3 11.1%	2 18.2%	**77** **13.9%**
Multiple Disabilities	0	1 0.3%	0	0	0	0	**1** **0.2%**
Orthopedic Impairment	0	0	0	0	1 3.7%	0	**1** **0.2%**
Speech/Language Impairment	1 3.8%	19 5.3%	2 7.4%	4 3.9%	0	1 9.1%	**27 4.9%**
Traumatic Brain Injury	0	1 0.3%	0	0	0	0	**1** **0.2%**
Statewide	**9** **34.6%**	**159** **44.0%**	**13** **48.1%**	**55** **53.4%**	**10** **37.0%**	**6** **54.5%**	**252** **45.4%**

*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* = 387 Clark, *n* = 38 Rural, *n* = 130 Washoe; *N* = 555 statewide).

Table 12. Psychotropic Medication Use: Admission

	Clark AFC	**Clark SFC**	**Washoe AFC**	**Washoe SFC**	**Rural AFC**	**Rural SFC**
Number of youth prescribed medication	14 40.0%	110 23.1%	9 31.0%	73 58.4%	11 35.5%	7 50.0%
Average number of unique medications prescribed in prior six months (SD)	3.4 (2.1)	2.6 (1.8)	2.2 (1.6)	2.5 (1.3)	3.0 (1.5)	2.1 (0.9)
Maximum number of unique medications prescribed in prior six months	9	12	6	7	6	3

SD = standard deviation

Table 13. 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	17 48.6%	187 39.3%	14 48.3%	85 68.0%	16 51.6%	10 71.4%
Average number of unique medications prescribed in prior six months (SD)	2.7 (1.6)	2.3 (1.6)	2.7 (1.4)	2.7 (1.4)	2.6 (1.7)	2.6 (1.0)
Maximum number of unique medications prescribed in prior six months	6	12	5	7	6	4
Number of youth taking medications at admission	2	7	0	5	0	0

not taking at discharge/end of FY						
Number of youth not taking medication at admission who were taking at discharge/end of FY	5 14.3%	84 17.6%	5 17.2%	17 13.6%	5 16.1%	3 21.4%

SD = standard deviation

Table 14. Child PTSD Symptom Scale, Outcomes at Follow-Up

	Clark AFC (n = 7)	Clark SFC (*n* = 140)	Washoe AFC (*n* = 16)	Washoe SFC (*n* = 49)	Rural AFC (*n* = 16)	Rural SFC (*n* = 40)	Statewide (n = 268)
Lifetime number of potentially traumatic events endorsed per youth	0 to 8 avg = 3.9	0 to 13 avg = 4.0	0 to 10 avg = 4.3	0 to 11 avg = 4.8	1 to 12 avg = 5.1	0 to 12 avg = 4.9	0 to 13 avg = 4.3
Number of youth endorsing 1+ events	5 71.4%	108 77.1%	14 87.5%	40 81.6%	15 93.8%	36 90.0%	219 81.7%
Number of youth with probable PTSD	3 42.9%	62 44.3%	5 31.3%	20 40.8%	7 43.8%	22 55.0%	119 44.4%

Table 15. Caregiver Strain Questionnaires Collected

	AFC	SFC	Total
Clark	3	151	**154**
Washoe	20	66	**86**
Rural	11	9	**20**
STATEWIDE	**34**	**226**	**260**

Table 16. CANS Actionable Treatment Needs at Admission (*N* = 106)

	Clark AFC (*n* = 13)	Clark SFC (*n* = 22)	Washoe AFC (*n* = 11)	Washoe SFC (*n* = 44)	Rural AFC (*n* = 13)	Rural SFC (*n* = 3)
Adverse Childhood Experiences & Potentially Traumatic Events (14 items)	5 to 10 avg = 7.9	4 to 11 avg = 6.9	5 to 10 avg = 8.1	0 to 11 avg = 6.8	5 to 11 avg = 8.4	7 to 10 avg = 8.7
Behavioral/Emotional Needs (15 items)	3 to 8 avg = 4.6	1 to 10 avg = 4.1	0 to 4 avg = 1.5	0 to 10 avg = 3.8	1 to 12 avg = 7.0	3 to 7 avg = 5.0
Life Functioning (15 items)	0 to 9 avg = 2.8	0 to 8 avg = 2.9	0 to 3 avg = 1.2	0 to 11 avg = 3.2	0 to 11 avg = 4.3	3 to 13 avg = 6.3

Youth Strengths (13 items)	2 to 12 avg = 5.5	3 to 12 avg = 8.2	1 to 7 avg = 2.5	1 to 13 avg = 7.9	5 to 12 avg = 8.8	9 to 12 avg = 10.3
Cultural Factors (4 items)	0 to 2 avg = 0.3	0 to 1 avg = 0.1	no identified needs	0 to 1 avg = 0.1	0 to 1 avg = 0.2	no identified needs
Risk Factors & Behaviors (11 items)	0 to 3 avg = 0.8	0 to 7 avg = 1.0	0 to 2 avg = 0.7	0 to 5 avg = 1.2	0 to 8 avg = 3.2	2
Caregiver Resources & Needs (16 items)	0 to 12 avg = 1.9	0 to 3 avg = 0.2	0 to 1 avg = 0.3	0 to 13 avg = 3.1	0 to 1 avg = 0.3	no identified needs
Total Actionable Treatment Needs*	7 to 34 avg = 15.9	7 to 31 avg = 16.0	1 to 14 avg = 6.1	1 to 36 avg = 19.3	9 to 43 avg = 23.8	17 to 34 avg = 23.7

*Excludes adverse childhood experiences & potentially traumatic events

Table 17. CANS Actionable Treatment Needs at Discharge/End-of-FY (*N* = 302)

	Clark AFC (*n* = 10)	Clark SFC (*n* = 158)	Washoe AFC (*n* = 23)	Washoe SFC (*n* = 71)	Rural AFC (*n* = 27)	Rural SFC (*n* = 13)
Adverse Childhood Experiences & Potentially Traumatic Events (14 items)	5 to 9 avg = 7.0	0 to 12 avg = 5.9	0 to 11 avg = 7.8	0 to 11 avg = 6.4	5 to 11 avg = 8.8	6 to 11 avg = 8.1
Behavioral/Emotional Needs (15 items)	1 to 9 avg = 5.5	0 to 11 avg = 3.3	0 to 5 avg = 1.3	0 to 11 avg = 3.7	0 to 10 avg = 6.0	0 to 7 avg = 3.5
Life Functioning (15 items)	1 to 7 avg = 3.2	0 to 9 avg = 2.0	0 to 3 avg = 0.7	0 to 11 avg = 2.7	0 to 8 avg = 3.1	0 to 8 avg = 2.0
Youth Strengths (13 items)	2 to 12 avg = 6.3	0 to 13 avg = 5.2	1 to 8 avg = 2.8	0 to 13 avg = 7.1	2 to 10 avg = 5.4	1 to 10 avg = 5.1
Cultural Factors (4 items)	0 to 2 avg = 0.3	0 to 4 avg = 0.1	0 to 1 avg = 0.1	0 to 4 avg = 0.2	0 to 1 avg = 0.1	no identified needs
Risk Factors & Behaviors (11 items)	0 to 4 avg = 1.4	0 to 8 avg = 0.8	0 to 3 avg = 0.6	0 to 6 avg = 1.0	0 to 6 avg = 1.5	0 to 3 avg = 0.9
Caregiver Resources & Needs (16 items)	0 to 8 avg = 1.1	0 to 10 avg = 0.3	0 to 1 avg = 0.0	0 to 11 avg = 0.6	0 to 2 avg = 0.3	0 to 1 avg = 0.1
Total Actionable Treatment Needs*	7 to 29 avg = 17.8	1 to 34 avg = 11.5	1 to 16 avg = 5.5	0 to 36 avg = 15.1	4 to 33 avg = 16.4	1 to 21 avg = 11.2

*Excludes adverse childhood experiences & potentially traumatic events

Appendix C: Mental Health Service Use

Table 1. Mental Health Service Use by All Youth During SFCP

Jurisdiction	Program	Behavioral Health Screen		Psychiatric Diagnostic Evaluation		Psychiatric E&M of New Patient		Psychiatric E&M of Established Patient		Individual Psychotherapy	
		n	%	*n*	%	*n*	%	*n*	%	*n*	%
Clark	AFC	23	66%	20	57%	15	43%	25	71%	21	60%
	SFC	315	66%	233	49%	172	36%	307	64%	366	77%
Washoe	AFC	18	62%	17	59%	9	31%	24	83%	28	97%
	SFC	65	52%	48	38%	48	38%	104	83%	104	83%
Rural	AFC	12	39%	19	61%	13	42%	22	71%	26	84%
	SFC	8	57%	10	71%	6	43%	13	93%	13	93%
Unduplicated Statewide Total	710	441	62%	347	49%	263	37%	495	70%	558	79%

Percents given as percent of all youth in that program in that jurisdiction utilizing the service at any point during SFCP.

Table 1 continued. Mental Health Service Use by All Youth During SFCP

Jurisdiction	Program	Family Psychotherapy		Group Psychotherapy		Psychosocial Rehabilitation	
		n	%	*n*	%	*n*	%
Clark	AFC	19	54%	16	46%	15	43%
	SFC	205	43%	160	34%	302	63%
Washoe	AFC	19	66%	8	28%	14	48%
	SFC	67	54%	65	52%	72	58%
Rural	AFC	10	32%	7	23%	8	26%
	SFC	7	50%	5	36%	9	64%
Unduplicated Statewide Total	710	327	46%	261	37%	420	59%

Percents given as percent of all youth in that program in that jurisdiction utilizing the service at any point during SFCP.

Table 2. 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* = 1.8 min = 1 max = 3 # youth = 16	avg = 1.8 min = 1 max = 5 # youth = 13	avg* = 1.6 min = 1 max = 7 # youth = 167	avg = 1.9 min = 1 max = 6 # youth = 238
Neuropsychological testing	none	none	avg = 6 min = 6 max = 6 # of youth = 3	avg = 6 min = 5 max = 7 # of youth = 3
Psychiatric diagnostic evaluation	avg = 1 min = 1 max = 1 # youth = 14	avg = 1.4 min = 1 max = 4 # youth = 9	avg = 1.1 min = 1 max = 3 # youth = 139	avg = 1.2 min = 1 max = 3 # youth = 99
Psychological testing	none	none	avg = 4.3 min = 4 max = 5 # of youth = 4	avg = 3.7 min = 1 max = 6 # of youth = 7

*among youth who utilized this service

Table 3. 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* = 11.8 min = 1 max = 42 # youth = 17	avg = 11.8 min = 1 max = 37 # youth = 17	avg = 6.5 min = 0.5 max = 49 # youth = 169	avg = 9.1 min = 0.5 max = 30 # youth = 311
Family therapy	avg = 8.8 min = 0.8 max = 22.5 # of youth = 16	avg = 7.3 min = 0.8 max = 23.3 # of youth = 16	avg = 5.8 min = 0.8 max = 106.7 # of youth = 99	avg = 4.5 min = 0.8 max = 17.5 # youth = 125
Group therapy	avg = 16.6 min = 1 max = 42 # of youth = 14	avg = 10.7 min = 1 max = 23 # of youth = 16	avg = 10.3 min = 0.3 max = 62 # of youth = 90	avg = 9.8 min = 0.3 max = 48 # of youth = 84
Psychiatry – New Patient Management	avg = 0.8 min = 0.3 max = 1.0	avg = 0.9 min = 0.5 max = 1.1	avg = 0.8 min = 0.3 max = 2.6	avg = 0.7 min = 0.3 max = 1.8

	# youth = 9	# youth = 6	# youth = 65	# youth = 84
Psychiatry – Established Patient Management	avg = 1.5 min = 0.2 max = 4.6 # youth = 20	avg = 1.4 min = 0.2 max = 3.3 # youth = 18	avg = 1.1 min = 0.1 max = 6 # youth = 147	avg = 1.3 min = 0.2 max = 5.5 # youth = 229
Intensive Services				
Crisis intervention	avg = 2.6 min = 0.5 max = 7.3 # of youth = 4	avg = 3.1 min = 0.5 max = 7 # of youth = 6	avg = 4.5 min = 0.3 max = 21.8 # of youth = 17	avg = 5.2 min = 0.3 max = 28 # of youth = 13
Day treatment	avg = 86.3 min = 34 max = 141 # of youth = 3	avg = 142.7 min = 115 max = 184 # of youth = 3	avg = 107.1 min = 28 max = 170 # of youth = 7	avg = 117.8 min = 11 max = 235 # of youth = 10
Intensive outpatient	1 youth 7 days	avg = 30 min = 14 max = 56 # of youth = 4	avg = 3.5 min = 1 max = 6 # of youth = 2	avg = 13.1 min = 1 max = 48 # of youth = 9
Partial hospitalization	1 youth 60 days	1 youth 30 days	avg = 61.1 min = 24 max = 144 # of youth = 11	avg = 51.4 min = 42 max = 60 # of youth = 7
Rehabilitative Services				
Case management	avg = 5.9 min = 3 max = 8.5 # of youth = 4	avg = 8 min = 1 max = 15 # of youth = 2	avg = 12.4 min = 1 max = 38 # of youth = 13	avg = 11.9 min = 1 max = 22 # of youth = 6
Psychosocial rehabilitation	avg = 51.4 min = 9 max = 150.5 # of youth = 12	avg = 43.8 min = 15.5 max = 104.8 # youth = 6	avg = 31.3 min = 1 max = 132 # of youth = 88	avg = 41.4 min = 1.5 max = 134 # youth = 246

*among youth who utilized this service

Table 4. 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* = 1.1 min = 1 max = 2 # youth = 10	avg = 1.3 min = 1 max = 2 # of youth = 11	avg = 1.3 min = 1 max = 2 # of youth = 38	avg = 1.5 min = 1 max = 3 # of youth = 33
Neuropsychological testing	none	none	avg = 6 min = 5 max = 7 # of youth = 2	1 youth 6 units
Psychiatric diagnostic evaluation	avg = 1.1 min = 1 max = 2 # youth = 10	avg = 1.1 min = 1 max = 2 # youth = 9	avg = 1.4 min = 1 max = 4 # youth = 31	avg = 1.3 min = 1 max = 4 # youth = 21
Psychological testing	none	none	none	none

*among youth who utilized this service

Table 5. 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 = 9 min = 0.8 max = 18 # youth = 23	avg = 8.1 min = 0.8 max = 22.5 # youth = 25	avg = 11.0 min = 0.8 max = 33.8 # of youth = 79	avg = 9.5 min = 0.5 max = 38.5 # of youth = 93
Family therapy	avg = 2.8 min = 0.8 max = 8.3 # youth = 17	avg = 3.6 min = 0.8 max = 12.5 # youth = 15	avg = 3.6 min = 0.8 max = 14.2 # of youth = 35	avg = 1.9 min = 0.8 max = 7.5 # of youth = 42
Group therapy	avg = 6.2 min = 1 max = 23 # of youth = 6	avg = 50.6 min = 1 max = 98 # of youth = 5	avg = 20.2 min = 1 max = 120 # of youth = 48	avg = 30.5 min = 1 max = 117 # of youth = 38
Psychiatry – New Patient Management	1 youth 0.8 hours	avg = 0.8 min = 0.3 max = 1 # youth = 6	avg = 0.7 min = 0.3 max = 1 # youth = 18	avg = 1.6 min = 0.2 max = 5.5 # youth = 90

	AFC - Admission	AFC - Discharge	SFC - Admission	SFC - Discharge
Psychiatry – Established Patient Management	avg = 1.3 min = 0.2 max = 3.8 # youth = 14	avg = 1.4 min = 0.2 max = 2.9 # youth = 18	avg = 1.5 min = 0.2 max = 5.3 # youth = 76	avg = 1.6 min = 0.2 max = 5.5 # youth = 90
Intensive services				
Crisis intervention	none	none	avg = 2.7 min = 1 max = 8.5 # of youth = 7	avg = 2.6 min = 1 max = 5 # of youth = 11
Day treatment	1 youth 130 hours	avg = 447.7 min = 254 max = 556 # of youth = 3	avg = 421.3 min = 266 max = 565 # of youth = 9	avg = 356.7 min = 45 max = 614 # of youth = 12
Intensive outpatient	none	none	none	avg = 24 min = 12 max = 33 # of youth = 4
Partial hospitalization	none	none	none	none
Rehabilitative services				
Case management	none	none	1 youth 30 hours	none
Psychosocial rehabilitation	avg = 46.9 min = 3 max = 114 # youth = 7	avg = 53.6 min = 0.5 max = 146 # of youth = 6	avg = 64.9 min = 3.5 max = 218 # of youth = 37	avg = 97.4 min = 1 max = 282.3 # of youth = 52

*among youth who utilized this service

Table 6. 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 max = 2 # youth = 8	avg = 1.2 min = 1 max = 2 # youth = 6	3 youth 1 unit each	avg = 1.5 min = 1 max = 2 # youth = 6
Neuropsychological testing	none	1 youth 1 unit	none	none
Psychiatric diagnostic evaluation	avg = 1.3 min = 1 max = 2 # youth = 10	avg = 1.2 min = 1 max = 3 # youth = 13	1 youth 1 unit	avg = 1.2 min = 1 max = 2 # youth = 5
Psychological testing	none	none	none	none

*among youth who utilized this service

Table 7. 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 = 6.5 min = 1 max = 19.5 # youth = 18	avg = 12.8 min = 0.5 max = 28 # youth = 21	avg = 8.4 min = 2 max = 13.8 # youth = 5	avg = 8.1 min = 0.8 max = 21.3 # youth = 12
Family therapy	avg = 1.7 min = 0.8 max = 3.3 # youth = 6	avg = 1.8 min = 0.8 max = 2.5 # youth = 5	avg = 1.7 min = 1.7 max = 1.7 # youth = 2	avg = 1.3 min = 0.8 max = 1.7 # youth = 2
Group therapy	avg = 9.6 min = 4 max = 17 # youth = 4	avg = 11.5 min = 9 max = 14 # youth = 2	1 youth 9 hours	avg = 3.3 min = 2 max = 6 # youth = 3
Psychiatry – New Patient Management	avg = 0.8 min = 0.3 max = 1.5 # youth = 5	avg = 0.9 min = 0.8 max = 1.3 # youth = 3	avg = 0.8 min = 0.8 max = 0.8 # youth = 3	avg = 0.8 min = 0.5 max = 1.3 # youth = 3
Psychiatry – Established Patient	avg = 1.4 min = 0.3	avg = 2.1 min = 0.3	avg = 1 min = 0.2	avg = 1.2 min = 0.4

Management	max = 3.9 # youth = 10	max = 5.1 # youth = 20	max = 2.3 # youth = 9	max = 2.8 # youth = 10
Intensive services				
Crisis intervention	1 youth 1.5 hours	none	none	none
Day treatment	none	none	none	none
Intensive outpatient	none	1 youth 4 days	none	1 youth 6 days
Partial hospitalization	none	none	none	none
Rehabilitative services				
Case management	avg = 47.8 min = 2 max = 112.5 # youth = 3	1 youth 0.5 hours	none	none
Psychosocial rehabilitation	avg = 61.5 min = 4 max = 140.8 # youth = 6	1 youth 6 hours	avg = 61.5 min = 26 max = 97 # youth = 2	avg = 49.8 min = 6.3 max = 90.5 # youth = 8

*among youth who utilized this service

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.	83.8
My educational needs were met during my stay.	86.5
I participated in selecting some of my activities and services.	82.4
I helped choose my treatment goals.	**68.9**
The foster parents/staff helping me stuck with me no matter what.	86.5
I felt I had someone to talk to when I was troubled.	86.5
I participated in my own treatment planning.	**75.7**
I received services that were right for me.	**78.4**
Foster parents/Staff explained my diagnosis, medication and treatment services and options.	**79.7**
Foster parents/Staff explained my rights, safety and the confidentiality issues.	83.8
Services were scheduled at times that were right for me and my family.	86.5
I got the help I wanted.	**79.7**
I got as much help as I needed.	**79.7**
Foster Parents/Staff treated me with respect.	87.8
Foster parents/staff respected me and my family's religious and spiritual beliefs.	82.4
Foster parents/Staff spoke with me in a way that I understood.	87.8
Foster parents/Staff were sensitive to my cultural and ethnic background.	**70.3**
Services were provided in a safe, comfortable environment that was well cared for.	87.8
I am better at handling daily life.	81.1
I get along better with family members.	**74.3**
I get along better with friends and other people.	87.8
I am doing better in school.	**78.4**
I am better able to cope when things go wrong.	**71.6**
I am satisfied with my family life right now.	**78.4**
I am aware of people and services in the community that support me.	**71.6**

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.	89.2
This child's educational needs are being met.	82.7
I helped to choose this child and family's services.	83.5
I help to choose this child and/or family's treatment goals.	85.6
The people helping this child and family stick with us no matter what.	92.1
I feel this child and family have someone to talk to when we are troubled.	95.7
I participate in this child's and family's treatment.	92.8
The services this child and family receive are right for us.	86.3
Staff explained this child's diagnosis, medication and treatment options.	79.9
Staff explained this child and my family's rights, safety, and confidentiality issues.	90.6
Services are scheduled at times that are right for us.	91.4
I receive the help I want for this child.	88.5
My family gets as much help as we need for this child.	87.1
Staff treats our family with respect.	95.0
Staff respects our family's religious/spiritual beliefs.	87.8
Staff speaks with me in a way that I understand.	97.8
Staff is sensitive to my family's cultural and ethnic background.	88.5
Services are provided in a safe, comfortable environment that is well cared for.	95.7
This child is better at handling daily life.	**74.1**
This child gets along better with family members.	**71.9**
This child gets along better with friends and other people.	**71.2**
This child is able to do the things he/she wants to do.	**79.1**
This child is doing better in school and/or work.	**71.9**
This child is better able to cope when things go wrong.	**58.3**
I am satisfied with our family life right now.	84.2
Our family is aware of people and services in the community that support us.	95.7
I am better able to handle our family issues.	90.6
I am learning helpful parenting skills while receiving services.	89.9
I have information about this child's developmental expectations and needs.	85.6

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)