

Steve Sisolak
Governor

Richard Whitley, MS
Director



DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF CHILD AND FAMILY SERVICES
Helping people. It's who we are and what we do.



Cindy Pitlock, DNP
Administrator

February 23, 2022

Director Brenda Erdoes
Legislative Counsel Bureau
401 South Carson Street
Carson City, NV 89701

Dear Director Erdoes:

Please find enclosed the Division of Child and Family Services annual Specialized Foster Care report pursuant to Nevada Revised Statutes 424.043. As required, the Division of Child and Family Services must annually submit to the Governor and the Director of the Legislative Counsel Bureau 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.

Should there be any questions, I can be reached at (775) 684-4440 or c.pitlock@dcsf.nv.gov.

Sincerely,

A handwritten signature in blue ink, appearing to read "Cindy Pitlock".

Cindy Pitlock
Administrator

cc: Richard Whitley, Director, Department of Health and Human Services

Specialized Foster Care in Nevada



State Fiscal Year 2021

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Executive Summary

In accordance with 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 SFY21, all jurisdictions worked towards compliance with 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.

766 youth were served in specialized foster care placements during SFY21 (i.e., were living in a specialized foster care placement for greater than 30 days). 708 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 20.0% of all discharged youth in Rural Specialized Foster Care (SFC) to 75.0% in Washoe County AFC.

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 averaged 1.0 across all jurisdictions.

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.

Youth over the age of 11 reported similar satisfaction rates to SFY20, whereas foster parents reported lower satisfaction rates with specialized foster care services compared to SFY20. Areas for potential improvement according to youth are building coping skills, helping them do better in school, and foster parent/staff training in cultural sensitivity. In addition, this year foster parents identified educational functioning and coping as areas for growth.

480 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). Another systematic review of treatment foster care indicated that there are significant reductions in days in locked settings (e.g., detention, corrections) for youth in treatment foster care compared to youth in group care settings (Turner & Macdonald, 2011).



Program Description and History

Following a successful pilot phase, a new model for specialized foster care was proposed during the 2015 Legislative Session. The goal of the proposed changes was 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 Nevada’s Specialized Foster Care Program (SFCP). NRS 424.041-424.043 requires DCFS to conduct an annual review of the placement of children in specialized foster homes and 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 2021 (SFY21) 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

During SFY21, 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. Initial certification is good for two years, and then agencies can achieve recertification every two years following. 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 SFY21, there have been 10 agencies that have maintained their respective TFTC certifications in order to provide specialized foster care services to youth in Nevada. Seven of the 10 agencies achieved TFTC recertification for the 1st time during SFY21. One achieved TFTC recertification prior to SFY 2021, and the other two have achieved or are on schedule to achieve TFTC recertification in SFY22.

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 four fully certified statewide TFTC trainers: One is located in northern Nevada, two in southern Nevada, and one in rural Nevada.

DCFS Quality & Oversight (Planning and Evaluation Unit [PEU]) typically conducts ongoing onsite policy implementation reviews with SFC agencies and SFC foster homes to ensure compliance with DCFS Policy 1603 and NRS 424 Foster Homes for Children. Due to the COVID-19 pandemic onsite policy implementation reviews were not conducted in FY20 and most of FY21. DCFS PEU updated procedures that allow for virtual policy implementation reviews that began in May 2021. We expect that there will be review results available in FY22.

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) continues to operate Advanced Foster Care (AFC), its internal Specialized Foster Care Program (SFCP). AFC currently has 41 homes, with another 5 families ready to take Together Facing the Challenge (TFTC), the required training for SFCP licensure. CCDFS started SFY20 with 29 homes, with 4 homes closing during the year: two due to the children reaching permanency within the home (adoption) or returning to their biological parents and two due to licensing issues.

AFC also had 5 other AFC kids adopted within 3 different AFC homes; these 3 homes have continued to foster additional AFC kids. AFC has maintained an average disruption rate of about 3%, which is significantly lower than most SFCs in Nevada. The CCDFS program was initially designed and budgeted for 30 homes. Specialized recruitment has been helping to increase the number of new AFC homes and to aid in retention of homes. CCDFS has also made several changes to improve overall retention of foster homes, including better partnership and communication between Resource Development and Support team (RDS), the Nevada Initial Assessment (NIA) and Permanency units, as well as creating a foster parent retention panel. AFC also created a monthly “AFC networking Hour” group to provide a supportive outlet to our caregivers, offer requested didactics, and create peer driven sharing of helpful fostering tips. The AFC Networking Hour has increased support, provided a sense of community, and overall, has increased AFC caregiver satisfaction.

Recruitment and training for AFC occurs continually, with the goal of maintaining 30 AFC homes at all times during the year. Staffing for AFC is complete, except for one vacant AFC coach position, which is waiting for background. This position was on hold for about a year, due to a COVID-related budget hiring freeze. AFC has maintained certification in TFTC since early 2019; re-certification was recently completed. The AFC program clinicians work closely with the RDS SFC team and the Placement unit, meeting together bi-weekly to staff homes and to match children with higher-level-of-care (HLOC) needs with the AFC caregivers that can best meet their needs. Child referrals come to AFC through caseworkers or are children who are in congregate care. Placement and CCDFS clinicians assess the needs of each child that enters congregate care to identify who would benefit from the increased support of SFC through AFC or one of the contracted SFC community partners. Many of the new AFC homes have come about as a referral to provide additional caregiver support to preserve placement of children in who are struggling with mental health challenges. By providing AFC support and training to the caregivers, many disruptions have been prevented, children have stabilized, and caregiver satisfaction has improved.

CCDFS has continued to work with 7 specialized foster care agencies over this last year. In addition, we have added three new SFC agencies to the current foster care contract. There are now 10 specialized foster care agencies. One of the new agencies has added a home. There are currently 195 licensed specialized foster homes. There has been consistent communication with the SFC agencies and CCDFS licensing regarding new homes, renewals, and non-renewals with consistent processes. CCDFS hosts a monthly round table meeting with current licensed SFC agencies and DCFS which allows for open communication regarding updates, barriers, and successes. There is also clinical roundtable group that meets to discuss and solve clinically related barriers for youth served through AFC and CCSFC programs. SFC agencies also host a monthly open meeting with CCDFS, DCFS, Medicaid, and other community partners.

There have been continued efforts made on updating the foster home contract with the SFC agencies to include performance measures to improve and track recruitment, treatment planning, and well-being of children placed into their homes. This should be completed in the next reporting year 2022.

The payment structure to SFC agencies is in the process of being changed to a Waiver, due to pending updates to Medicaid structure of services available to children placed into SFC homes. CCDFS has continued to collaborate with DCFS regarding Medicaid updates and what services are available to SFC agencies and the children placed into their homes.

Implementation in Rural Counties

Update Provided by DCFS Rural Region Child Welfare

The DCFS Rural Advanced Foster Care (AFC) Program has been in operation since July 2016. The Program's mission is, "To provide support for foster parents in specialized foster homes to increase placement stability and permanency for children experiencing and living with a Serious Emotional Disturbance."



The program is staffed by a Clinical Program Manager, four Mental Health Counselors (called Coaches), and an Administrative Assistant. A Coach is stationed in the Carson City District Office, the Fallon District Office, the Elko District Office, and the Pahrump District Office. The Clinical Program Manager and the Administrative Assistant are stationed in Carson City. All positions are filled, with staff tenure ranging from five months to over five years. The average AFC staff member has been in the job for over three years.

The AFC Program utilizes the Together Facing the Challenge (TFTC) evidence-based parenting program to train the AFC parents to work with children with high behavioral and mental health needs. In January 2021, the Program completed its re-certification as a TFTC provider with Duke University in North Carolina. That certification is in effect until December 2022. In addition, AFC homes are trained in the trauma informed curriculum, "Caring for Children Who Have Experienced Trauma."

The model includes each Coach visiting the home weekly to provide mentoring, coaching, training, and support to the foster parent or parents. This emphasis and focus on foster parent training and mentoring is unique in the DCFS system.

During the reporting period and due to the COVID-19 pandemic, the AFC Coaches initially held their weekly meetings with parents via telephone or a platform such as Microsoft Teams. These methods of contact have been effective from the perspective that the Coach was able to maintain regular contact with the parent or parents in the home. However, starting in the spring of 2021 the Coaches began to return to working with parents in the home, splitting their visits between virtual and in-person sessions.

In addition to weekly visits with the AFC parents, Coaches attend Child and Family Team (CFT) meetings, Placement Review Team (PRT) meetings, school related meetings, clinical staffing, court, and any other relevant meeting or event that is related to the child's case. During COVID, these meetings have primarily been held via teleconference, Microsoft Teams, or another platform.

During the reporting period, there were 16 AFC homes with a total capacity of 46 beds. Some of these beds are utilized by non-AFC children. Use of AFC beds by children not in the program is due to sibling groups where one of the children qualifies for AFC and another doesn't, foster children that were already in the home, and the fact that some of the beds in AFC homes are needed for regular foster placements. Six homes left the program during the year ending June 30, 2021. No homes were added during that timeframe.

Twenty-nine children that qualified for AFC placement were served in AFC homes during the year. At the end of June 2021, 29 children were in AFC placement and six non-AFC children were in AFC homes. Seventeen children

left the program or moved to another AFC placement during the reporting year. The breakdown of outcomes for the 17 children that left an AFC placement is as follows:

- Five transferred to an adoptive or guardianship placement. Unfortunately, four of the adoptive placements (i.e., two sets of siblings) did not work out and those children came back to AFC or another higher level of care in Nevada
- Three children returned to parents or relatives.
- Three aged out with one remaining in their current home but not in foster status and two moving out into the community.
- Three were moved to enroll in a higher level of care (i.e., residential treatment center, psychiatric hospital, or other residential treatment)
- Two moved to another AFC or SFC foster placement
- One stepped down to regular family foster care (i.e., stayed in the same placement)

In addition, DCFS placed children in several Specialized Foster Care Agency homes that utilize the same foster care model and use of the TFTC parenting program. These homes included Tahoe House and Sierra Nevada Connections (aka Mountain Circle) in Carson City, Eagle Quest in Pahrump, Henderson, and Las Vegas, SAFY in North Las Vegas, and St. Judes Ranch in Boulder City. From July 1, 2020 to June 30, 2021, 13 children in DCFS care were served in eight Specialized Foster Care Agency Homes.

The AFC Manager and Coaches are also involved in various related duties in the Division.

- One Coach oversees the Placement Review Team (PRT), which is a meeting held to review each child in care who is placed in a higher level of care (HLOC), including AFC or in a Specialized Foster Care Agency home.
- Another Coach oversees the process of referring DCFS children to a HLOC, including residential, psychiatric, and AFC/SFC placements.
- All Coaches are involved in providing TFTC type coaching to first time foster parents taking in their first placement. This helps to stabilize that family in taking in a first placement and increases the opportunity for a longer lasting and helpful placement.
- In addition, all Coaches are called upon from time-to-time to engage with a non-AFC family that needs assistance with a high needs foster child. The services offered include training and support in TFTC and trauma informed principles.
- The Clinical Program Manager and one of the Coaches is involved in developing the trauma informed foster parent Pre-Service Training.
- Finally, two Coaches are developing post licensing trainings that address important topics related to foster care such as attachment, conflict management, trauma, dealing with uncooperative behavior, and more. These Post-Licensing trainings are designed to help new foster homes better conceptualize and work with children with mental health, behavioral, and/or development issues. The goal is to retain more homes by helping foster parents develop a deeper skill set.

Overall, the Program Coaches work collaboratively with other units of the Division. This includes coordinating services with the Intensive Family Services Unit (IFS), 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.

In the last five years, the program has developed and maintained a robust and well-organized data collection

system that ensures all required data is collected timely and within timeframes required by the Division and by Nevada Senate Bill 107 (2015). This data helps with overall program evaluation, but it also guides day-to-day program decisions and strategy.

In conclusion, the Advanced Foster Care Program is staffed by mature and skilled clinicians who are able to train, and mentor foster parents in raising foster children who experience significant mental health and behavioral problems. The program's design and aim is to help children achieve stable placements by increasing the skill level of the foster parents living in those homes. The result is to help children in need to live a happy and fulfilling childhood in a home that loves them unconditionally and that parents them with understanding.

Implementation in Washoe County

Update Provided by Washoe County Human Services Agency

In SFY21 Washoe County Human Services Agency (WCHSA) focused on maintenance of its Specialized Foster Care Program (SFCP) by continued focus on the three areas of previous reporting: Program Improvement, Work Force Development, and Quality Assurance/Outcomes. WCHSA's values and focus are on the continuous development and implementation of a Nevada specific model of implementing Together Facing the Challenge. With focus on achieving TFTC Fidelity Benchmarks, WCHSA was re-certified by TFTC inc. in SFY21 (i.e., November of 2020).

Program Improvement

During SFY21 WCHSA continued to realize efficiencies to identify placement options sooner for children in need of additional supports and services. The Triage and Placement Review Team (TPRT) staffing process was utilized during multiple agency meetings. These meetings included the Emergency Charter meetings for WCHSA's three emergency shelter providers (by specifically focusing on the children first entering care); the Placement Support meetings that help identify additional supports and services for children identified to be unstable and/or at-risk of disruption; the Permanency Review meetings utilized to review children in terms of their length of stay/permanency options; and utilizing an email group for document submission and review by all placement staff to consider the best options to meet children's needs. Additionally, during SFY21 WCHSA revitalized the Triage and Placement Review Team (TPRT) to review the best placement options for children at the lowest level of care (i.e., WCHSA's "Enhanced homes or SFC).

Work Force Development

WCHSA's staff collaborated with DCFS-PEU staff on TFTC program improvement activities and TFTC Trainings, which were held quarterly on-line due to COVID-19 restrictions. WCHSA staff trained in TFTC continued to provide weekly in-home TFTC Coaching and some TFTC Supervision to foster parents/caregivers guided by the TFTC model. WCHSA continues to work with licensed/contracted SFC providers to move toward their own certification through TFTC inc.

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 SFY21 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. 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 2016 (i.e., for SFC providers to bill for Basic Skills Training).



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 SFY21:

- Elopements
- 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 (CGSQ)
- Youth and family satisfaction

For youth discharged from the program during SFY21, 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 SFY21, 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 766 youth were served in SFCP for at least 30 days at some time during SFY21. 480 youth were enrolled in SFCP on the last day of the fiscal year, June 30, 2021.

Table 1. Total Youth Served Statewide in SFY21

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

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

	Total Youth Served* in SFY21			Total Youth Enrolled** as of 6/30/21		
	AFC	SFC	Total	AFC	SFC	Total
Clark	71	520	591	59	295	354
Washoe	5	133	138	1	103	104
Rural	25	12	37	15	7	22
Statewide	101	665	766	75	405	480

766 youth served statewide
by Specialized
Foster Care
during SFY21

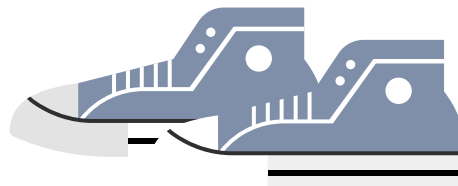
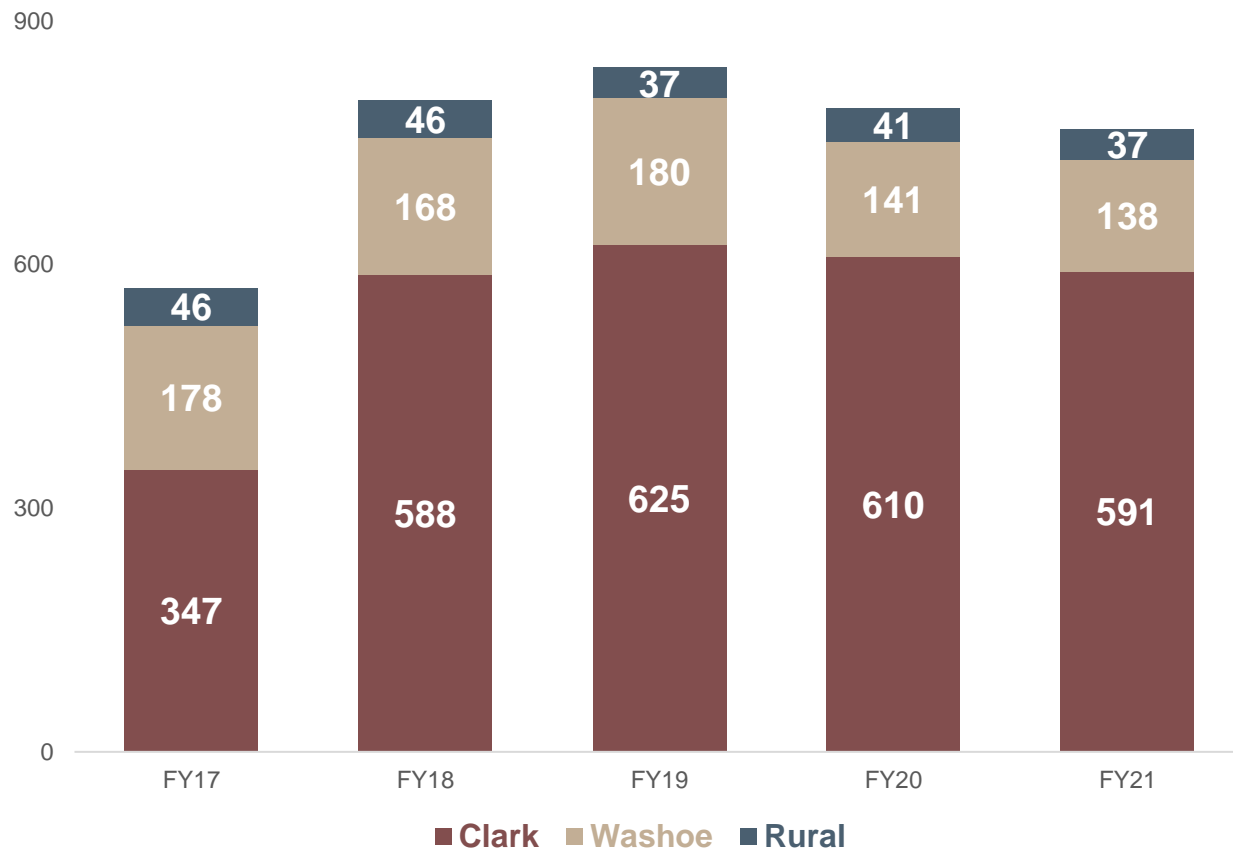


Figure 1. Youth served in SFCP has been decreasing since FY19



The mean age in SFCP ranged from 7.4 (Washoe AFC) to 13.8 years (Rural SFC). The youngest children in SFC were aged 2 years (Clark AFC, Clark SFC, and Washoe AFC). The average length of stay varied from approximately 367.2 days (Washoe AFC) to 648.3 days (Rural AFC). Race/ethnicity varied across jurisdictions. In Clark County, approximately half of SFCP youth were Caucasian and nearly half were African American/Black. Approximately 25% were Hispanic. In Washoe County, 69% were Caucasian while 21.3% were African American/Black, and about 17% were Hispanic. In Rural Nevada, 63.4% were Caucasian, 4.9% African American/Black, 7.3% American Indian, and 10.8% Hispanic. The most common reason for entry into the child welfare system in all jurisdictions was neglect, with the exception of Rural SFC, where the most common reason for entry was abandonment.

Please see Appendix A for all demographic information.

Outcomes

Table 2. 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	69	487	547
Washoe	4	124	128
Rural	23	10	33
Statewide	96	612	708

The analyses that follow are limited to the 708 youth with 90 days or more of treatment. Youth with less than 90 days in SFCP ($n = 58$) 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.

Elopement, Hospitalizations and Stability of Placement

Fewer youth eloped between admission and discharge/end-of-fiscal-year (EOFY) in Clark SFC. In Washoe SFC, seven youth with a history of elopement was observed at admission and 14 elopements were observed at discharge/EOFY. Zero elopements were observed in Clark, Washoe and Rural AFC, and Rural SFC at both admission and discharge/ EOFY.

Psychiatric hospitalizations decreased between admission and discharge/EOFY in Clark SFC, Clark AFC, Washoe SFC, Rural SFC and Rural AFC. No hospitalizations were observed in Washoe AFC.

Average number of placements decreased in every program in every jurisdiction from admission to discharge/EOFY, except for Washoe AFC, which stayed the same. Average number of placements per youth at discharge/EOFY ranged from 1.0 to 1.3, with standard deviations ranging from 0.0 to 0.6, indicating that in most cases youth remained in their initial SFCP placement without placement changes.

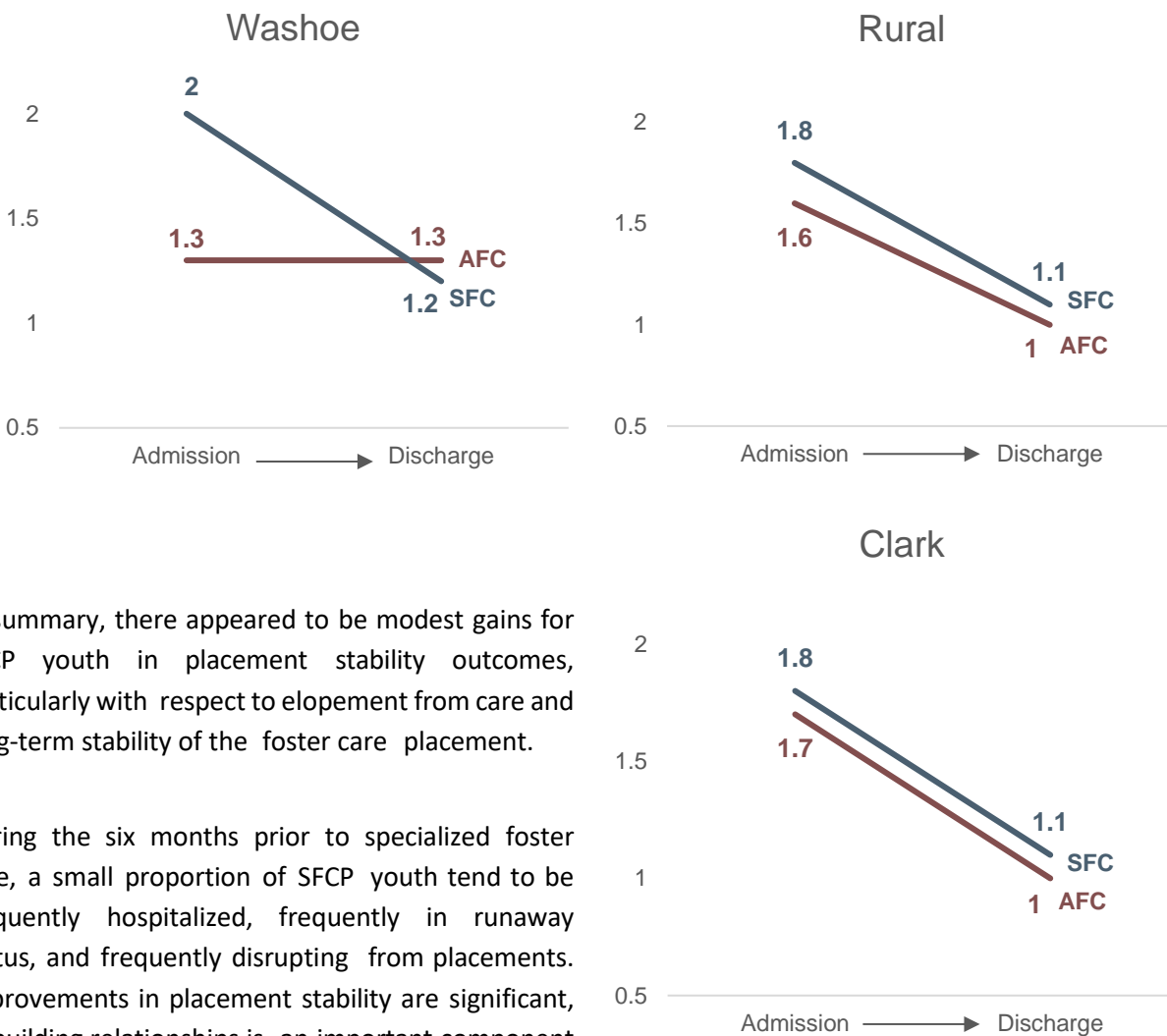
Success Story

Hunter is 17 years old. He was raised in a very abusive family and suffered a traumatic brain injury (TBI) from being struck in the head by his father as a little boy. Hunter has a history of anger issues, depression, and Post Traumatic Stress Disorder (PTSD). He has been in DCFS custody since age 14 but due to angry outbursts and volatile demeanor, he has been in over **20 placements in just three years**. These include foster homes, juvenile detention, treatment centers, and psychiatric hospitals.

Hunter has been in the latest placement for two months now. That is the longest he has been in a home setting in quite some time. His **foster parent Amy has learned valuable skills through training, weekly coaching from AFC staff**, and from experience how to meet his needs in the home. Amy works with Hunter daily on regulating his emotions and managing his behavior. Amy has advocated for him at school and the school accommodates his needs as much as possible. He is doing better at school than previously and is involved in some extra-curricular activities with his peers. **Hunter is making great progress!**

Identifying details within the story have been changed.

Figure 2. Average Number of Placements Decreases During SFCP across Nearly 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.

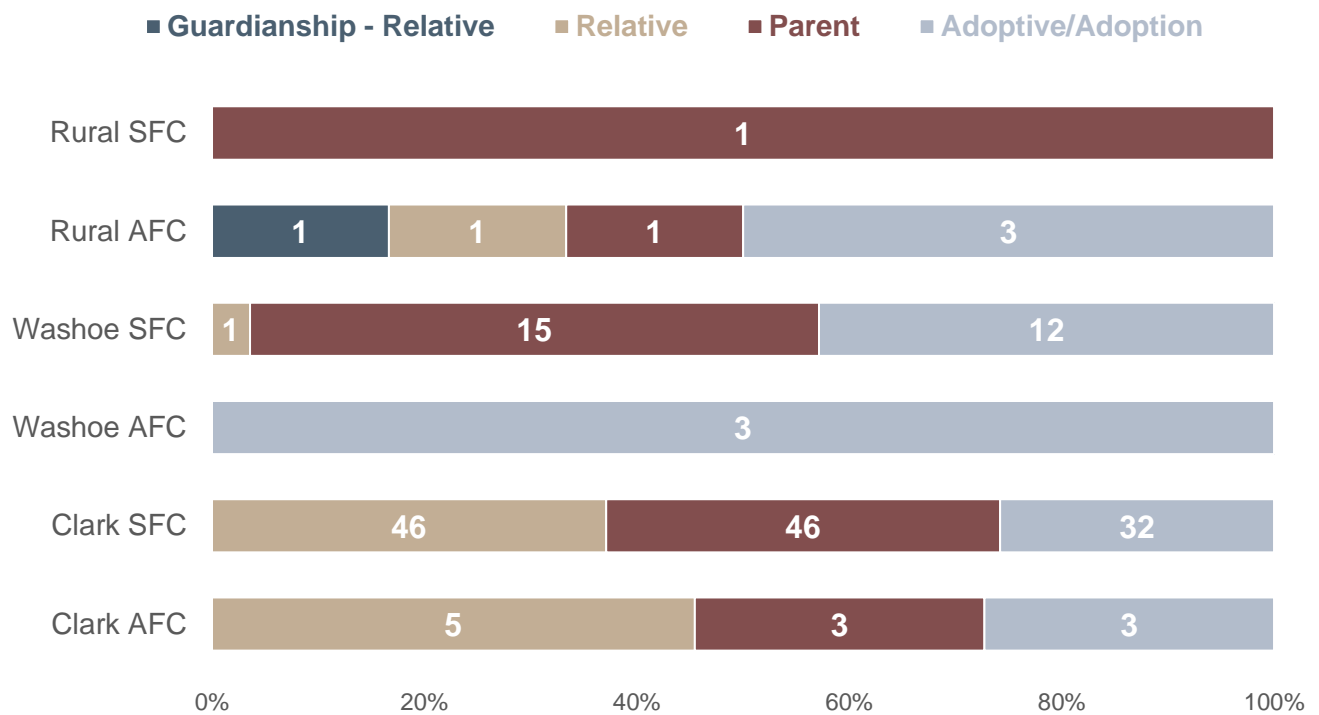
Improvements in placement stability outcomes are among the central positive findings for specialized foster care, as placement instability is indicative of intensive behavioral health need and inability of caregivers to cope with the youth’s needs. TFTC gives foster parents and youth the tools they need to cope with challenges in ways other than short-term or permanent placement disruption.

Permanency Outcomes

A varying number of youths transitioned to a permanent placement upon discharging from SFCP, ranging from 20% of all discharged youth in Rural SFC to 75.0% in Washoe County AFC.

Please see Appendix B for full permanency outcomes.

Figure 3. Transitions to Permanent Placements Upon Discharge from SFCP



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, Washoe AFC, or Rural SFC at admission or discharge/EOFY. There appears to be a decrease in number of youth on probation for Clark AFC, Washoe SFC, and Rural AFC. Number of youth with detention history and number of days in detention for youth decreased for Clark SFC and Rural AFC. In some cases the decrease is substantial; for example, in the Clark SFC program there was a 87% decrease in the number of youth with detention history, and the number of days in detention decreased for these youth from an average of 37.7 to an average of 2.5. The number of youth on probation decreased from 13 to 6 in the Clark SFC program. In the Rural AFC program, the average number of days in detention dropped from 127 to zero from admission to discharge/EOFY.

Please see Appendix B for legal involvement detail.



Education

A substantial proportion of SFCP youth receive special education services at school, primarily for learning disabilities (11.6% statewide), emotional disturbance (10.5% statewide) and health impairments (9.1% statewide). In all programs and jurisdictions, a third of youth or more are classified as special education. There were no SFCP youth identified as gifted. Unfortunately, this is not a status usually associated with SED foster youth, so it is important to ensure that any youth identified as gifted are receiving access to 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.

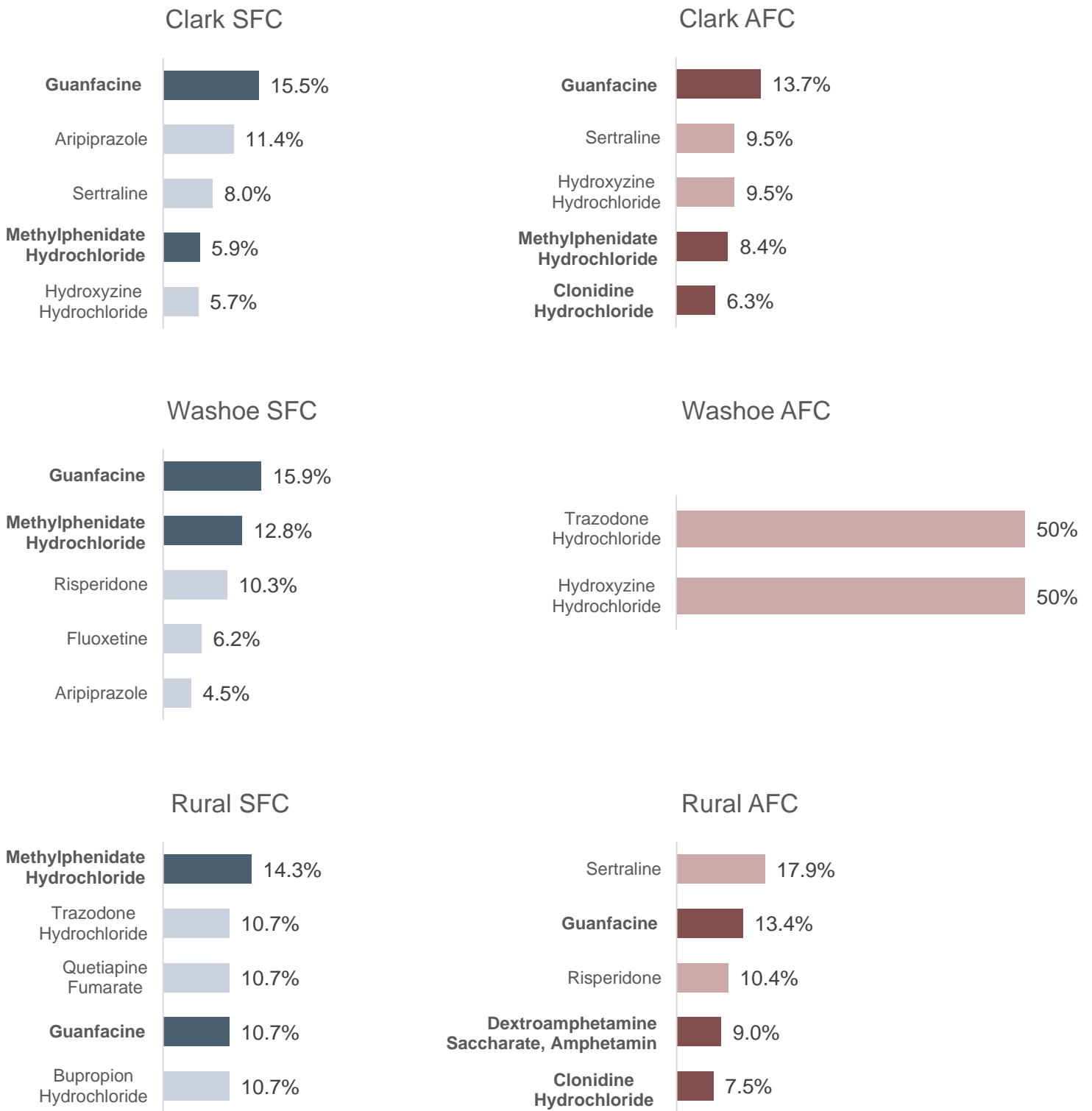
Please see Appendix B for full details.

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, such as guanfacine, 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 25% and 82.6% of youth are prescribed psychotropic medications at discharge/EOFY, depending upon the jurisdiction/program. This is relatively consistent with rates reported in the literature for youth in treatment foster care, with 59% of youth reporting recent medication use (Brenner et al., 2014). The average number of medications prescribed per youth decreased from 1.3 in FY20 to 1.0 in FY21.

Please see Appendix B for additional detail.

Figure 5. Most Commonly Prescribed Psychotropic Medications at Discharge



Dark colored bars indicate medications prescribed to focus attention.

Success Story

Madison is 13 years old. As a very young child, she was physically abused by an aunt and there was alleged sexual abuse by her mother's partner. At age nine she was placed into the Advanced Foster Care (AFC) home of Jennifer and William where she has been for the past five years. Madison has been diagnosed with Fetal Alcohol Spectrum Disorder (FASD), Post Traumatic Stress Disorder (PTSD), and Mood Disorder. When first in their home, Madison's hygiene was very poor, she was failing in school, she was prone to extreme mood swings, and she generally had an attitude of, "I don't care about anything."

Jennifer and William meet with their AFC Coach on a regular basis and discuss ways to help Madison in the home while the therapy she receives helps by addressing the abuse as well as other issues she has experienced in her life. Her AFC Coach says, "**There has been a whole team of people that have rallied around her.**" In addition to the AFC Coach and her foster parents, efforts to help Madison have included a whole team of dedicated and skilled supports like the Court Appointed Special Advocate (CASA) worker, a Psychosocial Rehabilitation (PSR) worker, her mental health therapist, and the school system.

In the last five years, Madison's grades are up, her hygiene is much better, and her outlook and attitude about her life has improved. She has become interested in the arts and creates stories and the graphics that go with them on the computer. Madison responds well to encouragement and reminders. She has learned to follow the rules of the house. She has been in two school plays, has developed a circle of friends, and can be very social. In the past few months, her mother has become part of her life again and she spends scheduled time with Madison. These visits have gone well and there is a strong possibility that mother and daughter will be reunited. If that option does not materialize, Jennifer and William are interested in guardianship of Madison. Either way, this young girl has a bright future that includes permanency and people that love her.

Identifying details within the story have been changed.

Mental Health Service Use

Overall, mental health billing claims data for SFY21 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 are available in Appendix C. Highlights include:

Clark AFC: Use of psychosocial rehabilitation increased from an average of 27.8 hours per 6 months at admission to 30.3 hours per 6 months at discharge/EOFY.

Clark SFC: Whereas 282 youth were accessing basic skills training at admission, 434 were using this service at discharge/EOFY (65.0% of youth).

Washoe AFC: Whereas 7 youth were accessing individual therapy at admission, 3 youth was using this service at discharge/EOFY (4.3% of youth).

Washoe SFC: Whereas 312.8 youth had received day treatment at admission, 415.1 youth had done so at discharge/EOFY (75.4% of youth).

Rural AFC: Use of case management decreased from an average of 22.1 hours per 6 months at admission to 9.8 hours per 6 months at discharge/EOFY.

Rural SFC: Use of psychosocial rehabilitation decreased from an average of 75.8 hours per 6 months at admission to 35.7 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 ages 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 SFY21, there were 127 admission CPSS assessments (15.8% of the outcomes sample) and 351 follow-up CPSS assessments (43.7%). One hundred and twenty-four youth (16.7%) 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 15. Averages within each jurisdiction and program ranged from 3.6 (Clark SFC) to 7.5 (Clark AFC). Youth endorsing at least one potentially traumatic event ranged from 88% to 100% depending upon the jurisdiction and program and was 98% 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 0% to 100% of youth depending upon jurisdiction/program, with a mean score of 4.16 (scores between 0 and 7) or 59.4%; the higher the score, the greater the functional impairment. This far 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, as has been the case in previous years, there was a relatively low response rate for the CPSS assessments; less than 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 SFY21, 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). 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.

521 youth (73.6%) had an NV-CANS at admission, 357 youth (50.4%) had an NV-CANS at discharge/EOFY, and 263 youth (37.1%) had both on record. Pre/post analyses indicated that total actionable treatment needs decreased significantly from admission to discharge or EOFY ($t[262] = 4.94, p < .001$). Further analysis indicated that Specialized Foster Care statewide saw 54.8% of cases improved and the average decrease in the number of actionable treatment needs was 38.63%. The data suggests that youth are experiencing improved functioning, as a result of specialized foster care. Actionable treatment need outcomes were examined from the domains of behavioral/emotional needs, life functioning, cultural factors, risk factors and behaviors, and caregiver resources and needs. The youth strengths domain was excluded from the total due to outliers. The potentially traumatic experiences items are considered background needs or exposures and not treatment targets, so these were also not included. In cases where there has been exposure to potentially traumatic events, associated needs in the behavioral/emotional needs, life functioning, and/or risk factors and behaviors domains would be targeted in treatment. Please see Appendix B for all NV-CANS domain scores and performance outcome measures.

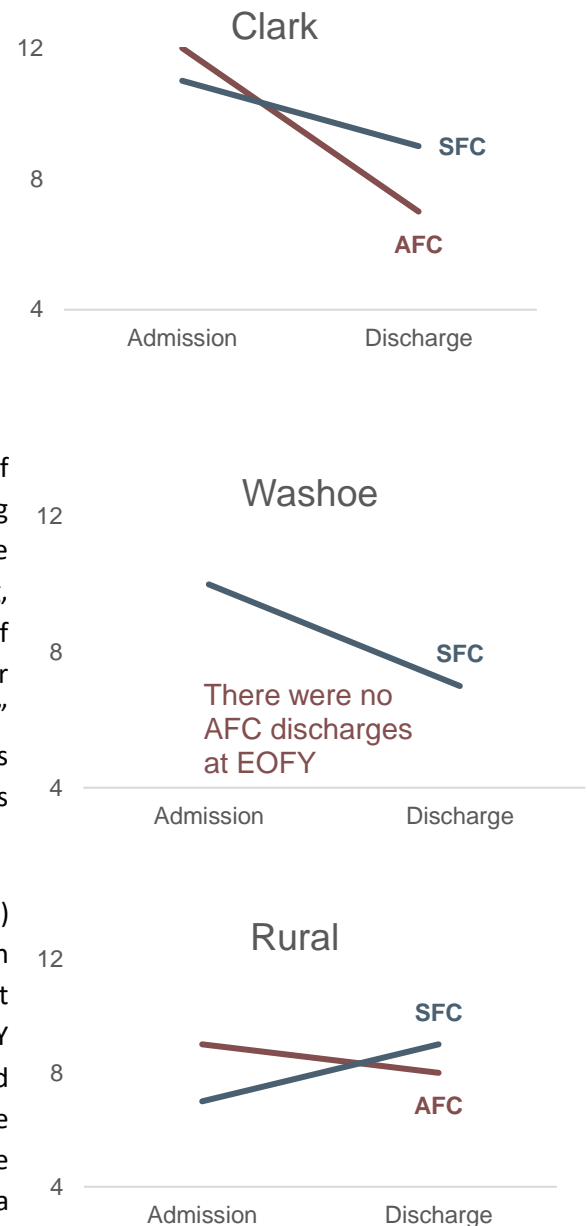


Figure 6. Total Actionable Treatment Needs Decrease from Admission to Discharge

Youth and Family 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 SFY21. 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. 241 foster parents (34.0% of outcomes group) and 121 youth (17.1% of outcomes group) provided satisfaction surveys during SFY21.

Youth Satisfaction

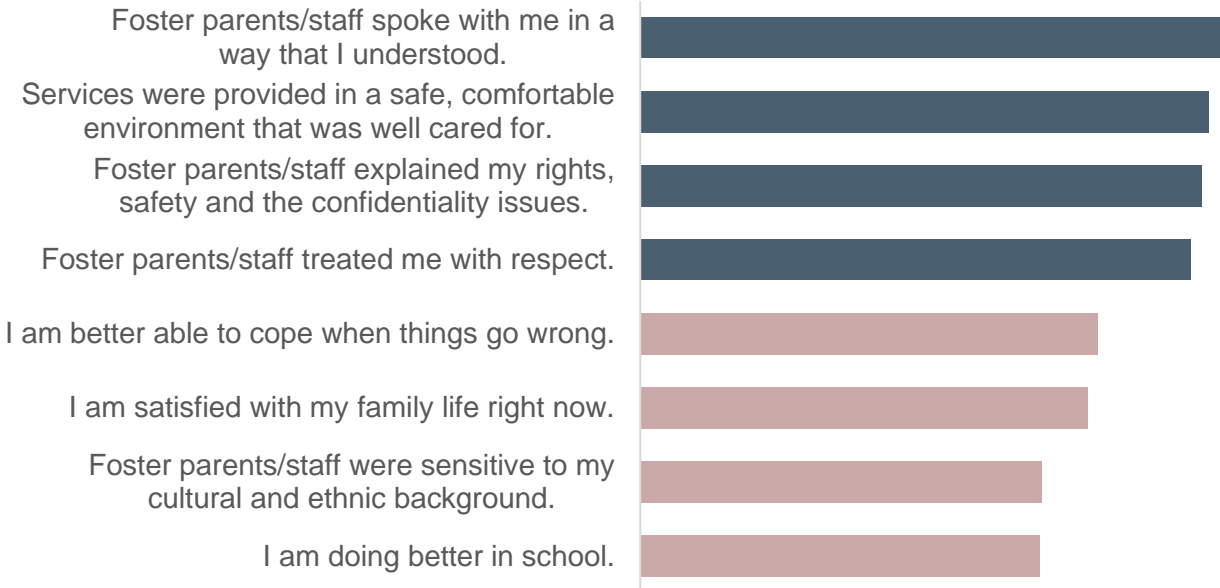
Of 121 youth surveys, 7 were excluded because the youth indicated he/she did not meet the age criteria (11 years old or older). An additional 11 surveys were excluded because the youth did not complete the satisfaction questions. The results that follow describe satisfaction for the remaining 103 youth. On average, these youth had been in SFCP for 23.2 months. Demographic characteristics showed a relatively diverse sample, which was 52.8% female, 42.6% male, 3.7% transgender, and 1% other. Youth were 46.3% Caucasian, 32.4% African American/Black, 1.9% American Indian/Alaskan Native, 3.7% Asian, 0.9% Native Hawaiian/Pacific Islander, 14.8% Other, and 24.1% Hispanic/Latino. The average age was 14.4 (range = 11 to 18). When asked where they were currently living, youth answered as follows: 34.6% Washoe County, 40.2% Clark County, 23.4% Rural Nevada, and 1.9% Other.

On the satisfaction survey, youth indicated a number of areas where they felt the SFCP program could improve. 7 out of 25 items demonstrated 80% agreement or more by youth, with agreement representing a more positive experience with the program. It appears that foster parent/staff training on cultural sensitivity is an area for potential improvement in service delivery. Providing youth with a wider array of coping strategies and helping them do better in school are also priorities.



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

Figure 10. Youth Satisfaction Items Showing Most and Least Agreement



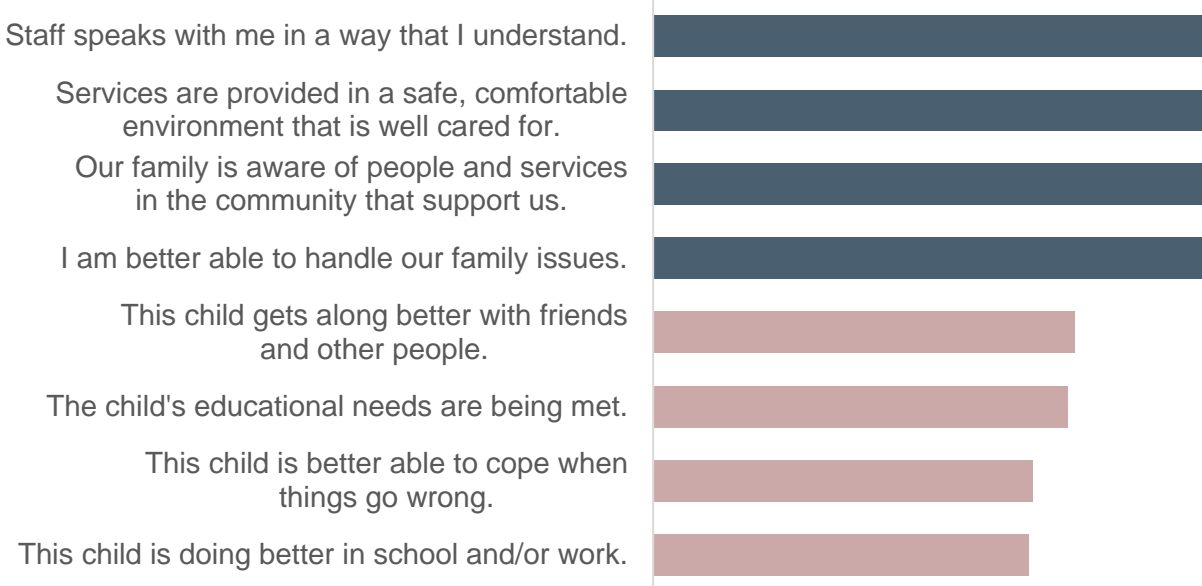
Foster Parent Satisfaction

Of 241 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 18.6 months. The average age of their foster child(ren) was 12.3 (range = 0 to 18). When asked where they were currently living, foster parents answered as follows: 42.1% Washoe County, 42.9% Clark County, 13.3% Rural Nevada, and 1.7% Other.

On the satisfaction survey, parents indicated a number of areas where they felt the SFCP program could improve. 15 out of 29 items on the foster parent satisfaction survey demonstrated 80% agreement or more by foster parents, with agreement representing a more positive experience with the program. In comparison, during SFY20 foster parents rated 11 out of 29 items positively on the satisfaction survey. This year, foster parents identified educational functioning and coping as areas for growth.

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

Figure 11. Foster Parent Satisfaction Items Showing Most and Least Agreement



Please see Appendix D for full foster parent satisfaction results.

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.
- 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.
- 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.
- Turner, W. & Macdonald, G. (2011). Treatment foster care for improving outcomes in children and young people: A systematic review. *Research on Social Work Practice*, 21(5), 501-527.

Appendix A: Demographics

Table 1. Demographics: Clark

	AFC	SFC
Age at Admission	mean = 9 range = 2 to 17	mean = 10.7 range = 2 to 18
Gender	39 (54.9%) female 32 (45.1%) male	239 (46%) female 281 (54%) male
Length of Stay in SFCP at Discharge or on June 30, 2021	mean = 418.2 days range = 46 to 1,406	mean = 472 days range = 31 to 3,102

Table 2. Demographics: Washoe

	AFC	SFC
Age at Admission	mean = 7.4 range 2 to 14	mean = 11.3 range 4 to 17
Gender	2 (40%) female 3 (60%) male	49 (36.8%) female 84 (63.2%) male
Length of Stay in SFCP at Discharge or on June 30, 2021	mean = 367.2 days range = 36 to 581	mean = 567.1 days range = 34 to 2,209

Table 3. Demographics: Rural

	AFC	SFC
Age at Admission	mean = 11.4 range 4 to 17	mean = 13.8 range 8 to 17
Gender	12 (48%) female 13 (52%) male	3 (25%) female 9 (75%) male
Length of Stay in SFCP at Discharge or on June 30, 2021	mean = 648.3 days range = 36 to 3,071	mean = 378 days range = 40 to 1,098

Table 4. Race/Ethnicity: Clark

	AFC	SFC	Total
<i>Race*</i>			
African American/Black	30 (36.6%)	237 (40.1%)	267 (39.7%)
American Indian/Alaskan Native	0	18 (3%)	18 (2.7%)
Asian	2 (2.4%)	18 (3%)	20 (3%)

Caucasian	49 (59.8%)	307 (51.9%)	356 (52.9%)
Native Hawaiian/Pacific Islander	1 (1.4%)	10 (1.7%)	11 (1.6%)
Declined to Answer	0	1 (0.2%)	1 (0.1%)
<i>Ethnicity</i>			
Hispanic	13 (18.3%)	132 (25.4%)	145 (24.5%)
Non-Hispanic	58 (81.7%)	388 (74.6%)	446 (75.5%)

*Multiple races may be selected for a given youth.

Table 5. Race/Ethnicity: Washoe

	AFC	SFC	Total
<i>Race*</i>			
African American/Black	0	33 (22.3%)	33 (21.3%)
American Indian/Alaskan Native	2 (28.6%)	6 (4.1%)	8 (5.2%)
Asian	0	2 (1.4%)	2 (1.3%)
Caucasian	5 (71.4%)	102 (68.9%)	107 (69%)
Native Hawaiian/Pacific Islander	0	5 (3.4%)	5 (3.2%)
<i>Ethnicity</i>			
Hispanic	0	23 (17.3%)	23 (16.7%)
Non-Hispanic	5 (100%)	110 (82.7%)	115 (83.3%)

*Multiple races may be selected for a given youth.

Table 6. Race/Ethnicity: Rural

	AFC	SFC	Total
<i>Race*</i>			
African American/Black	1 (3.7%)	1 (7.1%)	2 (4.9%)
American Indian/Alaskan Native	1 (3.7%)	2 (14.3%)	3 (7.3%)
Asian	0	0	0
Caucasian	25 (92.6%)	11 (78.6%)	26 (63.4%)
Native Hawaiian/Pacific Islander	0	0	0
<i>Ethnicity</i>			
Hispanic	3 (12%)	1 (8.3%)	4 (10.8%)
Non-Hispanic	22 (88%)	11 (91.7%)	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	1 (1.4%)	23 (4.4%)
Child's Alcohol Usage	0	0
Child's Behavior Problem	0	5 (1.0%)
Child Disability	0	1 (0.2%)
Child's Drug Usage	0	0
Child's Methamphetamine Use	0	0
Domestic Violence	1 (1.4%)	39 (7.5%)
Emotional Abuse	4 (5.6%)	52 (10.0%)
Inadequate Housing	2 (2.8%)	41 (7.9%)
Infant Drug Affected	0	2 (0.4%)
Juvenile Justice Services	0	1 (0.2%)
Medical Neglect	0	9 (1.7%)
Neglect	64 (90.1%)	460 (88.5%)
Parent Death	0	5 (1.0%)
Parent Incarceration	2 (2.8%)	33 (6.3%)
Parental Alcohol Abuse	3 (4.2%)	5 (1.0%)
Parental Drug Abuse	2 (2.8%)	23 (4.4%)
Parental Methamphetamine Use	2 (2.8%)	3 (0.6%)
Parent's Inability to Cope	4 (5.6%)	44 (8.5%)
Physical Abuse	0	23 (4.4%)
Sexual Abuse	3 (4.2%)	7 (1.3%)

*Multiple reasons may be selected for a given youth.

Percentages based on the percent of unique youth having that reason.

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

	AFC	SFC
Abandonment	0	14 (10.5%)
Child's Alcohol Usage	0	1 (0.8%)
Child's Behavior Problem	0	12 (9.0%)
Child's Disability	0	0
Child's Drug Usage	0	0
Child's Methamphetamine Use	0	0
Domestic Violence	0	13 (9.8%)
Emotional Abuse	2 (40.0%)	6 (4.5%)
Inadequate Housing	0	25 (18.8%)
Infant Drug Affected	0	0
Juvenile Justice Services	0	0
Medical Neglect	0	9 (6.8%)

Neglect	3 (60.0%)	86 (64.7%)
Parent Death	0	1 (0.8%)
Parent Incarceration	2 (40.0%)	37 (27.8%)
Parental Alcohol Abuse	0	8 (6.0%)
Parental Drug Abuse	0	27 (20.3%)
Parental Methamphetamine Use	0	8 (6.0%)
Parent's Inability to Cope	0	10 (7.5%)
Physical Abuse	2 (40.0%)	14 (10.5%)
Sexual Abuse	0	9 (6.8%)

*Multiple reasons may be selected for a given youth.
Percentages based on the percent of unique youth having that reason.

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

	AFC	SFC
Abandonment	5 (20.0%)	6 (50.0%)
Child's Alcohol Usage	0	0
Child's Behavior Problem	1 (4.0%)	1 (8.3%)
Child's Disability	0	0
Child's Drug Usage	0	0
Child's Methamphetamine Use	0	0
Domestic Violence	0	1 (8.3%)
Emotional Abuse	0	1 (8.3%)
Inadequate Housing	0	0
Infant Drug Affected	0	0
Juvenile Justice Services	0	0
Medical Neglect	1 (4.0%)	0
Neglect	17 (68.0%)	3 (25.0%)
Parent Death	0	0
Parent Incarceration	4 (16.0%)	0
Parental Alcohol Abuse	0	0
Parental Drug Abuse	1 (4.0%)	2 (16.7%)
Parental Methamphetamine Use	0	0
Parent's Inability to Cope	0	0
Physical Abuse	1 (4.0%)	1 (8.3%)
Sexual Abuse	5 (20.0%)	2 (16.7%)

*Multiple reasons may be selected for a given youth.
Percentages based on the percent of unique youth having that reason.

Appendix B: Outcomes

Table 1. Runaway Status: Admission*

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	45 9.4% [†]	7 5.6% [†]
Number of episodes of elopement per youth	1 to 24 avg = 3.9	1 to 5 avg = 1.7
Days in runaway status per episode	0 to 39 avg = 2.6	0 to 296 avg = 59.9

*Runaway status (admission & discharge) includes youth with a runaway duration of zero days.

[†]Percentage based on youth included in SFC Outcomes Population.

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	26 5.4% [†]	14 11.3% [†]
Number of episodes of elopement per youth	1 to 23 avg = 2.6	1 to 7 avg = 2.2
Days in runaway status per episode	1 to 299 avg 19.8	0 to 111 avg = 15.8

*Runaway status (admission & discharge) includes youth with a runaway duration of zero days.

[†]Percentage based on youth included in SFC Outcomes Population.

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	9	39	11	4	1
Number of episodes of hospitalization per youth	1 to 5 avg = 2.6	1 to 5 avg = 1.4	1 to 3 avg = 1.3	1 to 2 avg = 1.3	1

Table 4. Hospitalizations: 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	7	23	8	1
Number of episodes of hospitalization per youth	1 to 3 avg = 1.4	1 to 6 avg = 1.8	1 avg = 1.0	1

Table 5. Placement Stability: Admission

	Clark AFC	Clark SFC	Washoe AFC	Washoe SFC	Rural AFC	Rural SFC
Average of placements per youth (SD)	1.7 (1.5)	1.8 (1.0)	1.3 (0.5)	2.0 (1.1)	1.6 (0.6)	1.8 (1.0)
Maximum number of placements per youth	9	5	2	6	3	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)	1.0 (0.0)	1.1 (0.6)	1.3 (0.5)	1.2 (0.5)	1.0 (0.2)	1.1 (0.3)
Maximum number of placements per youth	1	9	2	4	2	2
Number of youth experiencing more placements after admission than prior to specialized foster care	0	17 (3.6%)	1 (25%)	6 (4.8%)	0	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
Absent without Leave from Juvenile Facility	0	9 (4.5%)	0	0	0	0
Adoptive Placement or Adoption	3 (15.8%)	32 (15.9%)	3 (75.0%)	12 (21.4%)	3 (23.1%)	0
Case Closed	0	1 (0.5%)	0	0	0	0
Change in Child Case Plan	0	1 (0.5%)	0	0	0	0
Child Health Reasons	0	3 (1.5%)	0	0	0	0
Child is Arrested/ Incarcerated	0	1 (0.5%)	0	1 (1.8%)	0	0
Child is Incompatible with Provider	2 (10.5%)	10 (5.0%)	0	0	0	0
Child is Placed with Sibling(s)	0	0	0	0	1 (7.7%)	0
Needs Higher Level of Care	0	0	0	3 (5.4%)	2 (15.4%)	1 (20.0%)
Needs Lower Level of Care	2 (10.5%)	8 (4.0%)	0	0	1 (7.7%)	1 (20.0%)
Reached Age of Majority	2 (10.5%)	25 (12.4%)	0	7 (12.5%)	1 (7.7%)	1 (20.0%)
Child Runs Away	2 (10.5%)	10 (5.0%)	0	6 (10.7%)	0	0
Court Jurisdiction (Voluntary Jurisdiction)	0	0	0	0	1 (7.7%)	1 (20.0%)
Guardianship is Established by a Relative	0	0	0	0	1 (7.7%)	0
Kids Kottage Transfer	0	0	1 (25.0%)	7 (12.5%)	0	0
Other	0	4 (2.0%)	0	4 (7.1%)	0	0
Parent Placement	3 (15.8%)	46 (22.6%)	0	15 (26.8%)	1 (7.7%)	1 (20.0%)

Participant Fails to Cooperate	0	3 (1.5%)	0	0	0	0
Provider Voluntarily Close Home/Facility	0	2 (1.0%)	0	0	0	0
Relative Placement	5 (26.3%)	46 (22.9%)	0	1 (1.8%)	1 (7.7%)	0
Returned Home	0	0	0	0	1 (7.7%)	0
Total SFY20 Discharges	19	201	4	56	13	5
Percent to Permanent Placement	57.9%	61.7%	75.0%	50.0%	46.2%	20.0%

*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
Number of youth on probation	13 3.0%	8 6.6%	0
Number of youth arrested	0	0	1 4.3%
Number of arrests each for youth with arrest history	0	0	9
Number of youth with detention history	15 3.5%	4 3.3%	1 4.3%
Number of days in detention for youth with detention history	1 to 148 avg = 37.7	1 to 181 avg = 73.3	127 to 127 avg = 127

*Baseline information available for 673 youth statewide.

Table 9. Legal Involvement: Discharge or End-of-Fiscal Year**Please note: No legal involvement was observed in Clark AFC, Washoe AFC, or Rural SFC placements at discharge.*

	Clark SFC	Washoe SFC	Rural AFC
Number of youth on probation	6 1.5%	13 11.2%	4 4.5%
Number of youth arrested	0	0	0
Number of arrests each for youth with arrest history	0	0	0
Number of youth with detention history	2 0.5%	6 5.2%	0
Number of days in detention for youth with detention history	2 to 3 avg = 2.5	1 to 58 avg = 19.8	0

*Follow-up information available for 628 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	2 2.9%	8 1.7%	0	2 1.6%	1 4.3%	0	13 1.8%
Developmental Delay	9 13.0%	26 5.5%	3 75.0%	3 2.4%	2 8.7%	0	43 6.1%
Emotional Disturbance	7 10.1%	40 8.4%	0	25 21.0%	1 4.3%	1 10.0%	74 10.5%
Health Impairments	5 7.2%	31 6.5%	0	26 21.0%	1 4.3%	1 10.0%	64 9.1%
Hearing Impairment	0	1 0.2%	0	0	0	0	1 0.1%
Intellectual Disability	0	8 1.7%	0	3 2.4%	1 4.3%	0	12 1.7%
Learning Disabilities	10 14.5%	55 11.6%	0	11 8.9%	5 21.7%	1 10.0%	82 11.6%
Multiple Disabilities	0	1 0.2%	0	1 0.8%	0	2 20.0%	4 0.7%
Speech/Language Impairment	2 0.9%	7 1.5%	0	5 4.0%	1 4.3%	0	15 2.1%
Traumatic Brain Injury	0	0	0	0	0	1 10.0%	1 0.1%
Totals	35 50.7%	177 37.3%	3 75%	76 61.3%	12 52.2%	6 60%	309 43.8%

*A youth may have multiple disability classifications however not all youth with a disability classification are flagged as being in special education. All youths flagged as special education do have a disability classification. 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 = 544 Clark, n = 33 Rural, n = 128 Washoe; N = 705 statewide).

[†]There are no youth with disability classifications of Deaf Blind, Orthopedic Impairment, or Visual Impairment.

Table 11. Psychotropic Medication Use: Admission

	Clark AFC	Clark SFC	Washoe AFC	Washoe SFC	Rural AFC	Rural SFC
Number of youth prescribed medication	21 30.4%	122 25.5%	1 25.0%	73 58.9%	10 43.5%	7 70.0%
Average number of unique medications prescribed in prior six months (SD)	avg = 1.0	avg = 1.0	avg = 1.0	avg = 1.0	avg = 1.2	avg = 1.0
Maximum number of unique medications prescribed in prior six months	1	3	1	1	3	1

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	35 50.7%	186 38.9%	3 25.0%	101 81.5%	19 82.6%	8 80.0%
Average number of unique medications prescribed in prior six months (SD)	avg = 1.0	avg = 1.0	avg = 1.0	avg = 1.0	avg = 1.0	avg = 1.0
Maximum number of unique medications prescribed in prior six months	1	5	1	1	1	1
Number of youth <u>taking</u> medications at admission <u>not taking</u> at discharge/end of FY	1	29	0	1	0	1
Number of youth <u>not taking</u> medication at admission who <u>were taking</u> at discharge/end of FY	14	91	0	28	9	2

SD = standard deviation

Table 13. Child PTSD Symptom Scale (Admission)

	Clark AFC (n = 2)	Clark SFC (n = 60)	Washoe AFC (n = 1)	Washoe SFC (n = 45)	Rural AFC (n = 14)	Rural SFC (n = 5)	Statewide (n = 127)
Lifetime number of potentially traumatic events endorsed per youth	5 to 10 avg = 7.5	0 to 13 avg = 3.6	avg = 7.0	0 to 14 avg = 5.6	2 to 9 avg = 5.6	4 to 9 avg = 6.4	0 to 14 avg = 4.8
Number of youth endorsing 1+ events	2 100%	44 73.3%	1 100%	43 95.6%	14 100%	5 100%	106 90.6%
Number of youth with probable PTSD	2 100%	7 10.0%	1 100%	9 20.0%	2 14.3%	0 0%	21 16.5%

Table 14. Caregiver Strain Questionnaires Collected* – Most Recent

	AFC	SFC	Total
Clark	13	148	159
Washoe	3	55	58
Rural	16	9	24
STATEWIDE	32	210	239

*The total does NOT equal the sum because a few caregivers have a youth in AFC and another in SFC. There are also caregivers that have youths in multiple jurisdictions.

Table 15. CANS Actionable Treatment Needs at Admission (N = 521)

	Clark AFC (n = 44)	Clark SFC (n = 384)	Washoe AFC (n = 2)	Washoe SFC (n = 64)	Rural AFC (n = 19)	Rural SFC (n = 8)
Adverse Childhood Experiences & Potentially Traumatic Events (14 items)	0 to 11 avg = 5.9	0 to 12 avg = 6.2	5 to 6 avg = 5.5	2 to 11 avg = 7.1	5 to 11 avg = 8.7	4 to 10 avg = 7.5
Behavioral/Emotional Needs (15 items)	0 to 11 avg = 4.4	0 to 17 avg = 4.5	0 to 2 avg = 1.0	0 to 11 avg = 4.4	0 to 11 avg = 5.4	1 to 8 avg = 3.8
Life Functioning (15 items)	0 to 9 avg = 3.0	0 to 14 avg = 3.2	3 avg = 3.0	0 to 8 avg = 2.9	0 to 7 avg = 2.1	1 to 8 avg = 3.1
Youth Strengths (13 items)	0 to 13 avg = 6.6	0 to 18 avg = 7.5	3 to 4 avg = 3.5	2 to 13 avg = 9.0	0 to 12 avg = 5.1	0 to 12 avg = 7.5
Cultural Factors (4 items)	0 to 8 avg = 0.2	0 to 12 avg = 0.3	no identified needs	0 to 4 avg = 0.2	no identified needs	no identified needs
Risk Factors & Behaviors (11 items)	0 to 4 avg = 1.0	0 to 20 avg = 1.2	0 to 2 avg = 1.0	0 to 5 avg = 1.3	0 to 4 avg = 1.6	0 to 2 avg = 0.4
Caregiver Resources & Needs (16 items)	0 to 9 avg = 2.2	0 to 15 avg = 1.3	no identified needs	0 to 9 avg = 1.0	0 to 1 avg = 0.2	0 to 1 avg = 0.1

Table 16. CANS Actionable Treatment Needs at Discharge/End-of-FY (N = 357)

	Clark AFC (n = 29)	Clark SFC (n = 229)	Washoe AFC (n = 2)	Washoe SFC (n = 81)	Rural AFC (n = 12)	Rural SFC (n = 4)
Adverse Childhood Experiences & Potentially Traumatic Events (14 items)	0 to 10 avg = 6.1	0 to 11 avg = 6.8	no identified needs	0 to 10 avg = 7.0	4 to 12 avg = 9.3	7 to 12 avg = 8.8
Behavioral/Emotional Needs (15 items)	0 to 7 avg = 3.6	0 to 11 avg = 4.6	no identified needs	0 to 9 avg = 4.5	0 to 9 avg = 4.0	0 to 8 avg = 3.3
Life Functioning (15 items)	0 to 6 avg = 2.6	0 to 9 avg = 2.7	no identified needs	0 to 7 avg = 1.9	0 to 7 avg = 2.5	1 to 6 avg = 3.0
Youth Strengths (13 items)	0 to 12 avg = 6.4	0 to 13 avg = 7.2	no identified needs	0 to 13 avg = 8.3	0 to 11 avg = 4.7	5 to 13 avg = 8.5
Cultural Factors (4 items)	0 to 2 avg = 0.1	0 to 3 avg = 0.1	no identified needs	0 to 2 avg = 0.0	no identified needs	no identified needs
Risk Factors & Behaviors (11 items)	0 to 4 avg = 0.8	0 to 7 avg = 1.0	no identified needs	0 to 7 avg = 0.7	0 to 4 avg = 1.0	0 to 1 avg = 0.3
Caregiver Resources & Needs (16 items)	0 to 4 avg = 0.6	0 to 8 avg = 0.3	no identified needs	0 to 3 avg = 0.1	0 to 1 avg = 0.3	0 to 1 avg = 0.3

Table 17. FY21 SFC CANS Performance Outcome Measures (N = 272)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Regressed	102	37.5	37.5	37.5
	No Change	21	7.7	7.7	45.2
		149	54.8	54.8	100.0
	Total	272	100.0	100.0	

outcome1		
N	Valid	149
	Missing	0
Mean		
	Std. Error of Mean	2.12840
	Median	31.2500
	Mode	100.00
	Std. Deviation	25.98043
	Minimum	4.17
	Maximum	100.00

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 = 1.7 min = 1.0 max = 5.0 # youth = 21	avg = 1.3 min = 1.0 max = 2.0 # youth = 28	avg = 1.7 min = 1.0 max = 23.0 # youth = 211	avg = 2.0 min = 1.0 max = 6.0 # youth = 340
Neuropsychological testing	avg = 6.0 min = 6.0 max = 6.0 # youth = 2	none	none	none
Psychiatric diagnostic evaluation	avg = 1.2 min = 1.0 max = 3.0 # youth = 29	avg = 1.2 min = 1.0 max = 3.0 # youth = 30	avg = 1.2 min = 1.0 max = 5.0 # youth = 223	avg = 1.2 min = 1.0 max = 3.0 # youth = 182
Psychological testing	none	none	none	none

*among youth who utilized this service

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 = 10.0 min = 0.5 max = 29.0 # youth = 36	avg = 11.0 min = 0.5 max = 32.0 # youth = 46	avg = 7.4 min = 0.5 max = 32.3 # youth = 239	avg = 12.2 min = 0.5 max = 31.5 # youth = 387

Family therapy	avg = 6.8 min = 0.8 max = 20.0 # youth = 38	avg = 7.5 min = 0.8 max = 25.0 # youth = 45	avg = 5.1 min = 0.8 max = 22.5 # youth = 136	avg = 5.1 min = 0.8 max = 22.5 # youth = 142
Group therapy	avg = 12.4 min = 1.0 max = 48.0 # youth = 25	avg = 7.9 min = 0.5 max = 16.0 # youth = 26	avg = 9.7 min = 0.3 max = 45.5 # youth = 133	avg = 8.5 min = 0.8 max = 30.0 # youth = 150
Psychiatry – New Patient Management	avg = 0.8 min = 0.3 max = 1.8 # youth = 19	avg = 1.2 min = 0.3 max = 4.8 # youth = 15	avg = 0.8 min = 0.3 max = 3.0 # youth = 139	avg = 0.8 min = 0.3 max = 2.3 # youth = 116
Psychiatry – Established Patient Management	avg = 1.3 min = 0.1 max = 5.8 # youth = 39	avg = 1.6 min = 0.2 max = 4.7 # youth = 47	avg = 1.1 min = 0.1 max = 5.7 # youth = 270	avg = 1.3 min = 0.1 max = 5.0 # youth = 292
Intensive Services				
Crisis intervention	avg = 2.5 min = 0.8 max = 5.5 # youth = 5	avg = 3.0 min = 1.0 max = 11.8 # youth = 9	avg = 6.4 min = 0.3 max = 25.0 # youth = 60	avg = 11.2 min = 0.3 max = 60.0 # youth = 48
Day treatment	avg = 86.0 min = 86.0 max = 86.0 # youth = 1	none	avg = 88.3 min = 22.0 max = 170.0 # youth = 6	none
Intensive outpatient	none	none	avg = 23.8 min = 1.0 max = 102.0 # youth = 11	avg = 9.2 min = 3.0 max = 17.0 # youth = 5
Partial hospitalization	avg = 4.0 min = 1.0 max = 7.0 # youth = 2	none	none	none
Rehabilitative Services				
Case management	avg = 2.4 min = 0.3 max = 28.3 # youth = 61	avg = 1.4 min = 0.3 max = 10.3 # youth = 63	avg = 1.9 min = 0.3 max = 39.0 # youth = 449	avg = 2.1 min = 0.3 max = 34.0 # youth = 402

Psychosocial rehabilitation	avg = 27.8 min = 2.0 max = 86.5 # youth = 14	avg = 30.3 min = 3.0 max = 74.0 # youth = 13	avg = 33.9 min = 0.3 max = 223.0 # youth = 124	avg = 44.6 min = 1.0 max = 150.0 # youth = 330
Basic skills training	avg = 62.5 min = 2.0 max = 104.0 # youth = 10	avg = 85.3 min = 2.0 max = 262.0 # youth = 6	avg = 57.7 min = 1.0 max = 360.0 # youth = 282	avg = 275.4 min = 14.0 max = 424.0 # youth = 434

*among youth who utilized this service

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	none	avg = 1.0 min = 1.0 max = 1.0 # youth = 2	avg = 1.3 min = 1.0 max = 2.0 # youth = 32	avg = 1.4 min = 1.0 max = 4.0 # youth = 34
Neuropsychological testing	none	none	none	none
Psychiatric diagnostic evaluation	avg = 1.0 min = 1.0 max = 1.0 # youth = 3	avg = 2.0 min = 2.0 max = 2.0 # youth = 1	avg = 1.4 min = 1.0 max = 3.0 # youth = 37	avg = 1.4 min = 1.0 max = 3.0 # youth = 28
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 = 6.4	avg = 6.9	avg = 9.6	avg = 8.7
	min = 1.0	min = 2.0	min = 0.5	min = 0.5
	max = 23.0	max = 10.5	max = 31.8	max = 21.5
	# youth = 7	# youth = 3	# youth = 73	# youth = 95
Family therapy	none	none	avg = 2.6	avg = 3.8
			min = 0.8	min = 0.8
			max = 14.2	max = 23.3
			# youth = 30	# youth = 30
Group therapy	none	avg = 1.3	avg = 22.0	avg = 59.9
		min = 1.3	min = 1.0	min = 1.0
		max = 1.3	max = 126.0	max = 137.0
		# youth = 2	# youth = 28	# youth = 36
Psychiatry – New Patient Management	avg = 0.5	avg = 1.3	avg = 0.6	avg = 0.8
	min = 0.5	min = 1.3	min = 0.3	min = 0.5
	max = 0.5	max = 1.3	max = 1.5	max = 2.3
	# youth = 1	# youth = 1	# youth = 44	# youth = 16
Psychiatry – Established Patient Management	avg = 1.0	avg = 0.8	avg = 1.4	avg = 1.7
	min = 0.5	min = 0.8	min = 0.1	min = 0.2
	max = 1.7	max = 0.8	max = 3.3	max = 4.0
	# youth = 3	# youth = 1	# youth = 75	# youth = 88
Intensive services				
Crisis intervention	none	none	avg = 4.5	avg = 2.4
			min = 0.3	min = 0.5
			max = 28.0	max = 5.5
			# youth = 16	# youth = 8
Day treatment	none	none	avg = 312.8	avg = 415.1
			min = 42.0	min = 60.0
			max = 621.0	max = 566.0
			# youth = 6	# youth = 19
Intensive outpatient	none	none	avg = 62.0	avg = 6.0
			min = 4.0	min = 6.0
			max = 189.0	max = 6.0
			# youth = 4	# of youth = 1
Partial hospitalization	none	none	none	none
Rehabilitative services				

Case management	avg = 2.5 min = 1.3 max = 4.5 # youth = 3	avg = 0.9 min = 0.5 max = 1.3 # youth = 2	avg = 4.8==59.2 min = 0.3 max = 51.3 # youth = 66	avg = 5.8 min = 0.3 max = 76.8 # youth = 65
Psychosocial rehabilitation	avg = 62. min = 53.3 max = 72.5 # youth = 2	avg = 0.5 min = 0.5 max = 0.5 # youth = 1	avg = 58.2 min = 1.3 max = 199.0 # youth = 39	avg = 89.5 min = 1.0 max = 305.0 # youth = 38
Basic skills training	avg = 43.6 min = 39.3 max = 48.0 # youth = 2	avg = 1.3 min = 0.5 max = 2.0 # youth = 2	avg= 154.2 min = 1.3 max = 418.0 # youth = 19	none

*among youth who utilized this service

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 = 7	avg = 1.4 min = 1.0 max = 3.0 # youth = 16	avg = 1.0 min = 1.0 max = 1.0 # youth = 3	avg = 1.3 min = 1.0 max = 2.0 # youth = 4
Neuropsychological testing	avg = 6.0 min = 6.0 max = 6.0 # youth = 1	none	none	None
Psychiatric diagnostic evaluation	avg = 1.1 min = 1.0 max = 2.0 # youth = 9	avg = 1.1 min = 1.0 max = 2.0 # youth = 11	avg = 1.0 min = 1.0 max = 1.0 # youth = 1	avg = 1.0 min = 1.0 max = 1.0 # youth = 1
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 = 9.3 min = 1.0 max = 25.0 # youth = 13	avg = 11.5 min = 1.3 max = 27.0 # youth = 19	avg = 10.0 min = 0.5 max = 24.3 # youth = 8	avg = 15.6 min = 7.5 max = 22.5 # youth = 8
Family therapy	avg = 3.3 min = 0.8 max = 10.0 # youth = 5	avg = 2.8 min = 0.8 max = 8.3 # youth = 6	avg = 4.0 min = 0.8 max = 10.0 # youth = 4	avg = 3.6 min = 1.7 max = 5.0 # youth = 3
Group therapy	avg = 5.7 min = 2.0 max = 9.0 # youth = 3	avg = 9.8 min = 3.0 max = 14.3 # youth = 4	avg = 4.5 min = 4.5 max = 4.5 # youth = 1	avg = 2.0 min = 2.0 max = 2.0 # youth = 1
Psychiatry – New Patient Management	avg = 0.4 min = 0.3 max = 0.5 # youth = 2	avg = 0.6 min = 0.5 max = 0.8 # youth = 5	avg = 0.9 min = 0.5 max = 1.8 # youth = 4	avg = 0.7 min = 0.5 max = 1.3 # youth = 6
Psychiatry – Established Patient Management	avg = 1.0 min = 0.3 max = 1.9 # youth = 11	avg = 0.9 min = 0.1 max = 2.8 # youth = 12	avg = 1.5 min = 0.4 max = 3.2 # youth = 6	avg = 1.1 min = 0.3 max = 2.5 # youth = 8
Intensive services				
Crisis intervention	avg = 1.5 min = 1.5 max = 1.5 # youth = 1	avg = 1 min = 1 max = 1 # youth = 1	none	none
Day treatment	none	none	none	avg = 67.0 min = 67.0 max = 67.0 # youth = 1
Intensive outpatient	none	none	none	avg = 6.0 min = 1.0 max = 11.0 # youth = 2
Partial hospitalization	none	none	none	none
Rehabilitative services				

Case management	avg = 22.1 min = 0.3 max = 48.3 # youth = 6	avg = 9.8 min = 9.8 max = 9.8 # youth = 1	avg = 63.9 min = 47.0 max = 80.8 # youth = 2	avg = 0.3 min = 0.3 max = 0.3 # youth = 1
Psychosocial rehabilitation	avg = 105.5 min = 4.0 max = 267.5 # youth = 4	avg = 66.6 min = 2.0 max = 158.0 # youth = 6	avg = 75.8 min = 3.0 max = 148.5 # youth = 2	avg = 35.7 min = 8.8 max = 61.3 # youth = 5
Basic skills training	avg = 154.7 min = 87.5 max = 192.0 # youth = 3	none	avg = 127.4 min = 100.0 max = 154.8 # youth = 2	none

*among youth who utilized this service

Appendix D: Youth and Family Satisfaction

Table 1. Youth Satisfaction Survey Results

Bold = Total % agreement less than 80%

* = Agree and Strongly Agree

Item	Total % Agree*
Overall, I am pleased with the services I received.	75.5
My educational needs were met during my stay.	81.4
I participated in selecting some of my activities and services.	78.4
I helped choose my treatment goals.	79.4
The foster parents/staff helping me stuck with me no matter what.	84.3
I felt I had someone to talk to when I was troubled.	76.5
I participated in my own treatment planning.	72.5
I received services that were right for me.	77.5
Foster parents/Staff explained my diagnosis, medication and treatment services and options.	76.5
Foster parents/Staff explained my rights, safety and the confidentiality issues.	88.2
Services were scheduled at times that were right for me and my family.	77.7
I got the help I wanted.	79.6
I got as much help as I needed.	75.5
Foster Parents/Staff treated me with respect.	86.4
Foster parents/staff respected me and my family's religious and spiritual beliefs.	81.4
Foster parents/Staff spoke with me in a way that I understood.	91.2
Foster parents/Staff were sensitive to my cultural and ethnic background.	63.1
Services were provided in a safe, comfortable environment that was well cared for.	89.3
I am better at handling daily life.	75.7
I get along better with family members.	73.8
I get along better with friends and other people.	76.7
I am doing better in school.	62.7
I am better able to cope when things go wrong.	71.8
I am satisfied with my family life right now.	70.3
I am aware of people and services in the community that support me.	77.7

Table 2. Foster Parent Satisfaction Survey Results**Bold** = Total % agreement less than 80%

* = Agree and Strongly Agree

Item	Total % Agree*
Overall, I am pleased with the services this child and/or family receive.	82.3
This child's educational needs are being met.	66.4
I helped to choose this child and family's services.	69.6
I help to choose this child and/or family's treatment goals.	70.7
The people helping this child and family stick with us no matter what.	78.8
I feel this child and family have someone to talk to when we are troubled.	83.6
I participate in this child's and family's treatment.	83.1
The services this child and family receive are right for us.	77.8
Staff explained this child's diagnosis, medication and treatment options.	74.2
Staff explained this child and my family's rights, safety, and confidentiality issues.	82.7
Services are scheduled at times that are right for us.	85.3
I receive the help I want for this child.	81.9
My family gets as much help as we need for this child.	79.2
Staff treats our family with respect.	87.1
Staff respects our family's religious/spiritual beliefs.	80.9
Staff speaks with me in a way that I understand.	88.5
Staff is sensitive to my family's cultural and ethnic background.	76.1
Services are provided in a safe, comfortable environment that is well cared for.	88.5
This child is better at handling daily life.	71.1
This child gets along better with family members.	73.2
This child gets along better with friends and other people.	67.6
This child is able to do the things he/she wants to do.	72.9
This child is doing better in school and/or work.	60.3
This child is better able to cope when things go wrong.	60.9
I am satisfied with our family life right now.	80.9
Our family is aware of people and services in the community that support us.	88.0
I am better able to handle our family issues.	87.9
I am learning helpful parenting skills while receiving services.	84.4
I have information about this child's developmental expectations and needs.	81.7

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)