

2015 Children's Legislative Briefing Book

“Whether it’s making sure that families have access to quality health care and child care, or making sure that our children receive the best educational opportunities we can give them, we must remain committed to these needs because our children are our future.”

♥ *Blanche Lincoln*



A collaborative effort between:



2015 Children's Legislative Briefing Book

This briefing book was prepared by the Children's Advocacy Alliance (CAA) and the Nevada Institute for Children's Research and Policy (NICRP), with the assistance and contributions of individuals and organizations throughout Nevada.

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"Nothing you do for a child is ever wasted"
♥ Garrison Keillor

The purpose of this Legislative Briefing Book is to provide a snapshot of some of the most pressing issues facing Nevada's children in order to assist advocates and policymakers in creating positive changes to improve the lives of Nevada's children. While this book will not cover every issue our children face, it is intended to highlight some of the areas in which state policy might have an impact, particularly in the areas of education, health, and safety. This book is a compilation of statistics and policy recommendations from across the state, with contributions from practitioners, agencies, organizations, individuals and others who work with and advocate for the well-being of children in Nevada. Special Issues briefs are included in several of the issue areas to highlight topics of special interest, including specific recommendations for policy change at the state level. In addition, this book is aligned with the 2014 Nevada Children's Report Card which grades the State of Nevada on specific indicators in each of these areas.

Diligent efforts need to be made during the 2015 Legislative Session to improve policies, procedures and services for Nevada's children. Nevada has continually been ranked as one of the most deficient states when it comes to statistics regarding children and social policy. Given the current economic strains on our state, it is vitally important to focus on preventing cuts to necessary programs while looking ahead to see what improvements can be made. Although most advocates and policymakers would like to create policies that provide immediate results, it is important to realize that effective social change takes time. As such, emphasis should be placed on developing quality, comprehensive systems and implementing evidence-based preventive strategies.

Thank you for your support – together we can improve the lives of all of Nevada's children!

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2014 NEVADA CHILDREN'S REPORT CARD

State Overall Grade: D

The Children's Report Card is published biennially, and highlights where Nevada ranks in comparison to other states in regard to child development indicators and behaviors. The information is compiled by the Children's Advocacy Alliance (CAA) utilizing current national data and statistics and provides a platform in which to effectively advocate for policy changes that benefit Nevada's children and families. The Report Card helps to highlight the need for evidence-based policies in order to improve the lives of children in Nevada. By collaborating with organizations, agencies and decision-makers, we can address these issues and challenges and focus on opportunities for improvement.

The Children's Report Card is a useful tool that can help strengthen the systems that support the well-being of Nevada's children and their families. It also provides insight to help identify potential policy changes and updates that can keep kids safe and help them grow. With that in mind, the CAA and the Nevada Institute for Children's Research & Policy (NICRP) have collaborated on the Legislative Briefing Book to highlight some of those key policy issues. Included are policy recommendations provided by organizations, providers, agencies and advocates for children from across the State of Nevada. Improving and updating legislation around issues facing our kids is vitally important to creating long-term, positive change. The impact extends well beyond a few children or a few families, but to potentially every child and family in our state.

2014 NEVADA GRADE	D
EDUCATION	F
HEALTH	D
SAFETY	D

Education 2015

"The task of the modern educator is not to cut down jungles, but to irrigate deserts"
♥ C.S. Lewis

Education Overview

1. School Readiness
2. Student Achievement
3. High School Completion
4. Funding

EDUCATION OVERVIEW

Nevada Children's Report Card Grade: F

Investing in quality education affords our children with critical skills and tools to provide for themselves and for their future families, increases their abilities to create opportunities for employment, reduces the spread of communicable diseases, reduces mother and child infant mortality, and improves overall health. Finally, an increase in the years of education our youth receive lowers the rates at which youth enter the criminal justice system.¹

Nevada's education system is largely unfunded and thus struggles to prepare all students to be successful in their endeavors post high school. As measured by the Department of Education via Criterion Reference Test (CRT) scores, only 36.7% of Nevada's 8th grade students were proficient in mathematics, 52.6% were proficient in reading, and 57.2% were proficient in science. In addition, proficiency scores were disproportionate in low-income and minority families. Specifically, the percentage of White children proficient in math, reading, and science almost doubles compared to children who are Black, Hispanic, or American Indian/Alaskan Native, and children who are Asian have the highest proficiency rates in all three subjects. With regards to income, children who are NOT eligible for free or reduced price lunch (math-50.4%, reading-66.3%, science-71.7%) are almost twice as likely to be proficient as compared to those children that are eligible for free or reduced price lunch (math-25.4%, reading-41.7%, science-45.4%).³

Despite the fact that a college degree is more and more important in today's economy, only 51.8% of Nevada's high school graduates go on to attend college. However, according to the Nevada Department of Education, Nevada's graduation rates have increased over the past three years, from 61.96% in 2012 to 70.65% in 2014 which is a move in the right direction.⁵

There are several areas within education which need improvement and contribute to the Overall Children's Education Grade of F, which the state received on the 2014 Children's Report Card. Details in each of these areas are provided in the sections below in addition to recommendations to make improvements in the state. These areas include:

1. **School Readiness**
2. **Student Achievement**
3. **High School Completion**
4. **Funding**

¹ "The State of America's Children," <http://www.childrensdefense.org/child-research-data-publications/data/2014-soac.pdf> (2014)

² Nevada Department of Education "Nevada Annual Reports of Accountability," <http://www.nevadareportcard.com/di/>

³ The National Institute for early Education Research, "The State of Preschool 2013" <http://nieer.org/sites/nieer/files/yearbook2013.pdf> #/-1/ (2013)

⁴ National Information Center for Higher Education, "College-Going Rates of High School Graduates-Directly from High School," <http://www.higheredinfo.org/dbrowser/?year=2010&level=nation&mode=data&state=0&submeasure=63>

⁵ Nevada Department of Education, "Annual Reports College-Going and College Credit Accumulation Rates," http://www.doe.nv.gov/DataCenter/Annual_Rpts_College_Going_College_Credit_Accum_Rates/ (2014)

1. SCHOOL READINESS

Nevada Children's Report Card Grade: F

The school readiness grade is based on preschool enrollment, availability, and spending per capita. Nevada is currently 50th out of 50 states in the nation in preschool enrollment, with only 30.0% of 3- and 4-year olds enrolled. Of the 30.0% of enrolled students, only 2.3% are enrolled⁶ in state preschool.

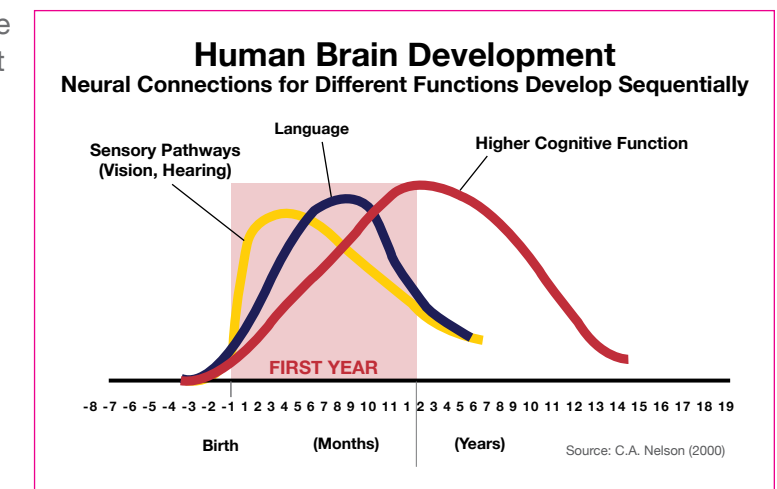
Every child in Nevada deserves the opportunity to enter school ready to learn. Nevada is in need of a comprehensive early childhood system that supports families by making sure they have high quality options for their children's early care and learning—whether their children spend their days at home, in formal child care, or with family and friends. Providing children with the right start will lead to less intervention and remediation in later grades – ultimately resulting to increased rates of graduation and success in adulthood.

Experiences during the first five years of a child's life are crucial to their development and can be indicative of future success due to early brain development and growth. For example, in the first few years of a child's life, 700 new neural connections are formed every second. These connections are dependent upon an interaction of genes as well as the child's environment and are the

base structures which all future learning, behavior, and health are dependent upon.⁷ Given that a child's development is quite extensive during the first few years of life, it is vital that they are exposed to high quality early learning experiences.

"Several decades of research clearly demonstrate that high quality; developmentally appropriate early childhood programs produce short- and long-term positive effects on children's cognitive and social development. Specifically, children who experience high-quality, stable child care engage in more complex play, demonstrate more secure attachments to adults and other children, and score higher on measures of thinking ability and language development. High quality child care can predict academic success, adjustment to school, and reduced behavioral

Chart from: Center on the Developing Child - Harvard University



⁶ <http://www.childrensdefense.org/child-research-data-publications/data/2014-soac.pdf>

⁷ Center on the Developing Child-Harvard University, "Five Numbers to Remember About Early Childhood Development" http://developingchild.harvard.edu/resources/multimedia/interactive_features/five-numbers/

problems for children in first grade. Studies demonstrate that children’s success or failure during the first years of school often predicts the course of later schooling. A growing body of research indicates that more developmentally appropriate teaching in preschool and kindergarten predicts greater success in the early grades.”⁸

“Although education and the acquisition of skills is a lifelong process, starting early in life is crucial. Recent research...has documented the high returns that early childhood programs can pay in terms of subsequent educational attainment and in lower rates of social programs, such as teenage pregnancy and welfare dependency.”

♥ *Ben Bernanke, Chairman of the Federal Reserve Board*

RECOMMENDATIONS FOR IMPROVEMENT:

- Increase access to high quality early childhood education for all children- birth through kindergarten, in Nevada.
 - Current market rates should be used to determine subsidy reimbursements. The Child Care Development and Block Grant (CCDBG) mandates that states review the current market rate every two years, but does not require states to set the reimbursement rate based on the results. Nevada must legislatively mandate setting the reimbursement rate to the most recent market rate every two years to ensure equal access to quality early childhood education programs.
- Continue to support investments in programs that assess quality of care, such as the Silver State Stars Quality Rating Improvement System.
 - Require childhood subsidies to be used at child care programs participating in the Nevada Silver State Stars Quality Rating and Improvement System (QRIS) to ensure children are receiving high quality care. Currently, child care subsidies may be used at any licensed program and in some instances unlicensed homes. These programs may do more harm than good to a child’s development if they do not promote a safe and enriching environment.

Additional information is available in the Early Education and Care Imperatives for Nevada developed by the Nevada Education for the Association of Young Children.⁹

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The following sections include a special focus on two specific elements of school readiness; (1) Quality, and (2) Access. Each of these “Special Issues” provides additional information and recommendations related to improving school readiness in Nevada.

⁸ The National Association for the Education of Young Children, “A Call for Excellence in Early Education,” <http://www.naeyc.org/policy/excellence>

⁹ <http://nic.unlv.edu/files/NevAEYC%20Public%20Policy%20Agenda%202014-15>

SCHOOL READINESS - SPECIAL ISSUE

Quality Rating Improvement Systems (QRIS)

A QRIS is a systematic approach to assess, improve, and communicate the level of quality in early care and school-age programs. Similar to rating systems for restaurants and hotels, QRIS awards quality star ratings to early care and school age programs that meet a set of defined program standards. These systems provide an opportunity for States to increase the quality of care for children, increase parents' understanding and demand for higher quality care, and increase professional development of child care providers. A QRIS can also be a strategy for aligning components of the early care and school-age system for increased accountability in improving quality of care (NCCIC, 2009).

Quality Rating Improvement Systems (QRIS) are being developed across the country to improve the quality of early childhood education programs. These systems have been developed to provide a more objective way to assess quality in a facility providing child care. Currently, there are Quality Rating Improvement Systems (QRIS) in 38 states and local jurisdictions, including Nevada, and the remaining 18 are in the process of developing a QRIS.¹⁰ Each of these systems varies slightly in its requirements and protocols, but all have the goal of improving the quality of early childhood education.

In July 2012, the Division of Welfare and Supportive Services, Office of Early Care and Education officially launched the Silver State Stars QRIS in Southern Nevada. This quality initiative has since been expanded and is open to all licensed child care centers in Nevada. The centers are awarded stars depending on their quality in four categories: Policies & Procedures, Administration & Staff Development, Health & Safety, and Families & Community. When the initiative started, it was determined that all licensed centers would automatically be considered a one star center once they agreed to participate in QRIS.

In order for a center to attempt to increase their star rating, they must complete the Silver State Stars QRIS process and make improvements, as necessary, in each of the four categories outlined above. The specific star rating is dependent upon the number of quality indicators met in each category: 2-star programs must meet 4 additional (16 total) quality indicators, 3-star programs must meet 8 additional (32 total) quality indicators, 4-star star programs must meet 12 additional (48 total) quality indicators, and 5-star programs must be nationally accredited thus they have met the majority of additional quality indicators.¹¹

As of April 2014, forty-nine centers throughout Nevada have participated in the Silver State Stars QRIS. Participating centers receive: training by coaches who develop a Quality Improvement Plan for the center and who visit at least once every other week to evaluate progress and train staff; a one-time initial quality improvement grant (\$4,000-\$8,500) based on the maximum number of children allowed by licensing; advancement bonus at renewal; and eligibility for increased child care subsidy rates of 6, 9, or 12% depending on their final star rating level.

Star Level Definitions

- ★★★★★ **HIGHEST QUALITY** (Far exceeds high quality)
- ☆★★★★ **QUALITY PLUS** (Exceeds high quality standards)
- ☆☆★★★★ **QUALITY** (Meets high quality standards)
- ☆☆☆★★★ **PROGRESSING STAR** (Approaching high quality standards)
- ☆☆☆☆★ **RISING STAR** (Committed to quality improvement)
- NO RATING** (Program has chosen not to participate in the QRIS)

*Adapted from the Nevada Silver State Stars Website, <http://www.nvsilverstatestars.org/>

RECOMMENDATIONS FOR IMPROVEMENT:

Nevada's Silver State Stars Quality Rating Improvement System (QRIS), which is designed to establish a structure and accountability system for ensuring the provision of high quality early childhood education in Nevada, currently lacks the appropriate resources for full participation by licensed centers, family child care centers, licensed exempt, and tribal child care centers.

- Statewide expansion of the Silver State Stars QRIS should be implemented on a gradual basis, with continued assessment, evaluation and improvement to further refine the process.
- Further funding of the Silver State Stars QRIS is needed to increase the number of participating centers and to expand the program to include family child care, licensed exempt and tribal child care centers.
- Efforts should also be made to include appropriate resources for marketing and outreach to ensure that parents are aware of and understand the Silver State Stars QRIS rating system.
- When a sufficient number of centers are rated, direct alignment between QRIS and child care subsidy reimbursements will ensure that state funds are being used both efficiently and effectively to provide the highest level of quality care and education to our state's most vulnerable children.

¹⁰ Quality Rating and Improvement System, "QRIS State Contacts & Map," <http://qrisnetwork.org/qris-state-contacts-map> (2014)

¹¹ Nevada Institute for Children's Research and Policy, Silver State Stars: Quality Rating Improvement System Project," http://www.nvsilverstatestars.org/public/files/Year_4_Evaluation_Report_FINAL.pdf (June 28, 2013)

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SCHOOL READINESS - SPECIAL ISSUE

Accessibility & Affordability – Child Care Subsidy Programs

In Nevada, over 61% of children ages 0-5 live in families where all available parents are in the workforce. These working parents face the challenge of finding quality child care that they can afford. Currently, the average annual cost of child care in licensed centers in Nevada ranges from \$7,894 for preschoolers (age 3-5) to \$9,751 for an infant. These high costs place a huge financial burden on all working families, especially those in poverty. Today, a single mom with an infant and preschooler making \$1,820 a month (118% of poverty) would have to spend 79% of her income on center-based care for her children.¹² Many families in this situation cannot afford to work.

To help reduce this financial burden, the Federal Child Care and Development Fund provides child care subsidies to families with children (up to age 13) living in poverty (up to 75% of Nevada’s median income).¹³ There are two types of subsidies provided to families, mandatory and discretionary. Mandatory subsidies are provided to children who have a parent participating in the New Employees of Nevada (NEON) Program; the state is required to provide subsidies to all NEON families who apply. Discretionary subsidies are provided to all other eligible at-risk families.

Cost Comparisons	
♥	\$59,413: Median Family Income (with children under the age of 18)
♥	\$9,751: Annual average cost for infant center care in Nevada
♥	\$7,894: Annual average cost for preschool center care in Nevada
♥	\$6,683: Average annual cost of UNLV/UNR tuition for an in-state undergraduate student

Unfortunately, the subsidy program is lacking the proper funding to reach those in need. Nevada’s subsidy program currently only serves 1.15% of eligible children (70.97% of mandatory and .79% of discretionary). Access to quality care is also limited due to the State’s subsidy reimbursement rate currently being set to 2004 market rates.¹⁴ Only 3 states have reimbursement rates that are set on older market rates.¹⁵ The Federal Register (1998) specifically states that a “biennial market rate survey (be) relied upon to determine that the rates provided are sufficient to ensure equal access” (pg. 39986). In Clark County, the reimbursement rate for center-based preschool care only represents 4.04% of the available market. To access care outside of what the state will reimburse, parents must pay the overage between the State’s maximum reimbursement rate and providers’ actual market

¹² Children’s Cabinet, “2012 Nevada State Child Care Demographics” <http://www.childrencabinet.org/wp-content/uploads/2013/04/2012DemographicsNevada.pdf>

¹³ Hobbs, Ong & Associates- Analysis on Nevada’s Child Assistance and Development Program <http://caanv.org/wp-content/uploads/2014/08/Hobbs-Subsidy-Report-FINAL.pdf>

¹⁴ Ibid.

¹⁵ Schulman K, Blank H, National Women’s Law Center “State Child Care Assistance Policies 2011: Reduced Support for Families in Challenging Times” (October 2011)

rate. The 2011 75th percentile rate is \$12.53 a day. This coverage alone is 22% of income for a single mom with a preschooler living at 100% of poverty.¹⁶ Because higher quality child care is often times more expensive than lower quality care, families on the subsidy program are being forced to use lower quality care due to the increased responsibility to cover the overage.

The Child Care Development Fund Subsidies provide parents with the necessary resources needed to become productive members of society and allows at-risk children to gain a strong start. Research shows that high quality pre-kindergarten education, especially for disadvantaged children can:¹⁷

- Decrease special education placement by 49% and reduce grade retention by 50%;
- Decrease child abuse and neglect by 51% and juvenile arrests by 33%;
- Increase high school graduation by 31% and college attendance by more than 80%;
- Increase employment by 23%;
- Increase parent employment rates by 13%; and
- Reduce worker turnover, absenteeism and increase productivity.¹⁸

RECOMMENDATIONS FOR IMPROVEMENT:

- Increase the percentage of eligible children served by subsidies, including those children under 13 years old who live at or below 75% of Nevada's median income in single-earner or dual earner households.
- Require current market rates be used to determine subsidy reimbursements (utilize market rates determined by the most recent market rates). The Child Care Development and Block Grant (CCDBG) mandates that states review the current market rate every two years, but does not require states to set the reimbursement rate based on the results. Nevada must legislatively mandate setting the reimbursement rate to the most recent market rate every two years to ensure equal access to quality early childhood education programs. The Children's Cabinet and Las Vegas Urban League currently conduct the statewide market rate survey every two years and share these results with the state.
- Upon full implementation of the Nevada Silver State Stars Quality Rating and Improvement System (QRIS), only allow rated centers to receive child care subsidies to ensure children are receiving high quality care. Currently,

child care subsidies may be used at any licensed program and in some instances unlicensed homes. These programs may do more harm than good to a child's development if they do not promote a safe and enriching environment.

**Adapted from the Nevada Silver State Stars Website,
<http://www.nvsilverstatestars.org>*

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¹⁶ NevAEYC "Early Education and Care Imperatives for Nevada".
<http://www.nevaeyc.org/downloads/publicpolicy/NevAEYC%20White%20Paper%20V2.pdf>

¹⁷ Ready Nation, "Business Case" http://www.readynation.org/uploads/20120409_ReadyNationBusinessCaseLowRes.pdf

¹⁸ Child Action, "Building a Quality Workforce,"
<http://www.childaction.org/providers/booklets/docs/solutions%20for%20employee%20child%20care.pdf>

2. STUDENT ACHIEVEMENT

Nevada Children's Report Card Grade: F

The student achievement grade is based upon 4th grade reading scores, 8th grade math scores, and postsecondary participation. In 2013-2014, only 68.5% of Nevada 4th graders were proficient in reading and only 36.7% of Nevada 8th graders were proficient in math. Compared to the previous year there was a slight decline in reading scores (70.8%) and math scores (38.8%). Moreover, compared to the United States, Nevada remains near the bottom of both rankings, 45th for reading and 39th for math. With regards to post-secondary education, 40.6% of young adults in Nevada are enrolled in postsecondary education or have a degree which is below the national average of 55.8%, and leave Nevada ranking 50th.¹⁹

As discussed in the previous section, student achievement is dependent on the quality of care prior to primary school enrollment as well as within primary school. According to the U.S. Department of Education (2011), first-time kindergartners' fall reading skills differed based on their primary care arrangements in the year prior to entering kindergarten. Specifically, children who had not received any non-parental care on a regular basis and those whose primary care arrangement was home-based with a relative had lower fall reading scores than children who attended home-based nonrelative care, attended center-based care, or had multiple care arrangements. These patterns also emerged for math abilities as well.

Learning to read and write are essential skills to be successful in school and in life. It is imperative that students are provided an opportunity to achieve their full potential during their early and primary years in order to ensure the likelihood they graduate from high school.

RECOMMENDATIONS FOR IMPROVEMENT:

- Increase funding to support additional professional development for teachers at all grade levels to increase their ability to offer quality instruction to students.
- Reduce classroom sizes in all grades so teachers have more time to dedicate to individualized student improvement.
- Increase funding for all schools in order to increase pay for quality teachers. It is important to keep qualified teachers in the classroom.

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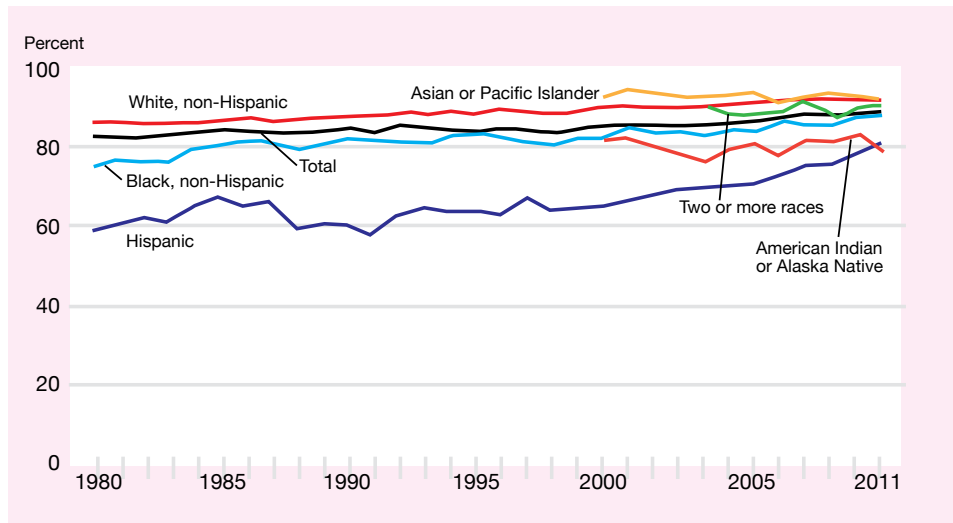
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3. HIGH SCHOOL COMPLETION

Nevada Children’s Report Card Grade: F

The high school completion grade is based upon attainment of a high school diploma or its equivalent. This is an indicator that a person has acquired the basic reading, writing, and mathematics skills needed to function in modern society. The percentage of young adults ages 18–24 with a high school diploma or an equivalent credential is a measure of the extent to which young adults have completed a basic prerequisite for many entry-level jobs and for higher education. The graph below shows high school diploma attainment by race across the country.

Percentage of young adults ages 18–24 who have completed high school by race and Hispanic origin, 1980–2011²⁰



In Nevada, the 2014 high school completion rate was 70.65%. Much like the graph above, Nevada has deep disparities in graduation rates. Students who are Black or Hispanic have a graduation rate of 40.75% and 51.92% in Nevada respectively, thus showing that Nevada’s trend mirrors that which is occurring across the US. In addition, there are other groups who have disparate graduation rates including those eligible for free or reduced price lunch (51.09%), English Language Learners (18.79%), and those with an Individualized Education Program (20.00%).²¹

According to a report by the National Dropout Prevention Center, there are many factors that influence the dropout rate which include: chronic or mental illness, early marriage, low occupational aspirations, need for autonomy, sexual involvement, pressures to seek employment, change in educational services or placement, school dissatisfaction, having siblings that dropped out, and substance

abuse.²² Each of these factors represents a point of intervention that can be targeted to reduce risk associated with high school dropouts in Nevada.

Identifying and addressing the reasons Nevada’s students drop out will help improve overall graduation rates. Reducing the dropout rate is also advantageous for the State. Individuals lacking a high school diploma are more likely to face unemployment, rely on government cash assistance, food stamps, and housing assistance, and to cycle in and out of the prison system.²³ Research conducted by Dr. Tiffany G. Tyler and Dr. Sandra Owens from the University of Nevada, Las Vegas suggests that increasing the 2010 graduation rate by half would result in Nevada seeing gains of \$64,844,808 in earnings, \$155,366,635 in vehicle and home purchases, 405 new jobs supported, and \$53,317,331 in lost revenue.²⁴ This evidence shows that high school completion is not simply a concern for the school systems, but for the community overall.

RECOMMENDATIONS FOR IMPROVEMENT:

- Increase funding to support additional professional development for teachers at all grade levels to increase their ability to offer quality instruction to students.
- Reduce classroom sizes in all grades so teachers have more time to dedicate to individualized student improvement.
- Increase funding for all schools in order to increase pay for quality teachers. It is important to keep qualified teachers in the classroom.

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²⁰ “High School Completion,” <http://www.childstats.gov/americaschildren13/edu4.asp> (2011)

²¹ Nevada Department of Education “Nevada Annual Reports of Accountability,” <http://www.nevadareportcard.com/di/>

²² Hammond, C., Linton, D., Smink, J., & Drew, S., “Dropout Risk Factors and Exemplary Programs. Clemson, SC: National Dropout Prevention Center, Communities in Schools, Inc” (2007)

²³ Tyler, T. G. and Owens, S., edited by Dmitri N. Shalin., “High School Graduation and Dropout Rates,” http://cdclv.unlv.edu/healthnv_2012/index (2012)

²⁴ Tyler, T. G. and Owens, S., edited by Dmitri N. Shalin., “High School Graduation and Dropout Rates,” http://cdclv.unlv.edu/healthnv_2012/index (2012)

4. FUNDING

Nevada Children's Report Card Grade: F

The funding grade is based on the amount of money allocated per pupil in the state. Per pupil expenditures are calculated for grades pre-kindergarten through 12th grade for public elementary and secondary education.²⁵ In Nevada, actual per pupil expenditures for the 2011-2012 fiscal year were \$8,223 compared to \$10,608 nationally.²⁶ Nevada's ranking of 45th in this category remains unchanged since the last report card. Nevada's low per pupil expenditure causes high student-teacher ratios. Nevada ranks 47th in the nation for per pupil funding with an average ratio of 20.8 compared to 16.0 nationally.²⁷

The Nevada Plan – the Nevada funding formula – was created in 1967 and is still the basis of school funding used today. The current funding plan “sets a guaranteed amount of money per pupil for educating elementary and secondary pupils, determines the amount of money per pupil the district can raise from local revenue sources, and then pays the difference between local revenue raised and the state guarantee.”²⁸ As shown above, the Nevada state guarantee per pupil is very low when compared nationally. Also, Nevada's landscape and population has changed drastically since 1967. For example, there are more students in Nevada's K-12 system today than there were people in the state in 1967, but the state funding formula has not been revised to best support the Nevada schools of today.

Besides the low per pupil expenditure, additional concerns with the Nevada Plan include:

- The Nevada Plan's current funding rates are based on cost data that has not been updated which can create overfunding or underfunding for districts. Currently, the Nevada Plan “uses incrementally adjusted expenditure data based on a benchmark.”²⁹
- The Nevada Plan only provides additional funding for special education pupils (in terms of an antiquated unit funding), but does not take into consideration that certain student groups, such as at-risk, ELL, and gifted and talented, are also more costly to educate and need greater per pupil spending.³⁰
- The Nevada Plan funds kindergarten pupils at lesser rates than pupils in grades 1-12. In the funding formula, pupils in grades 1-12 are weighted 1.0 (a full person) and kindergarteners are weighted .6 (only 3/5 a person).³¹

²⁵ The per pupil amount used in this analysis takes into consideration categorical funds allocated to education and the funding from the Nevada funding formula.

²⁶ Dixon, M., “Public Education Finances: 2012,” <http://www2.census.gov/govs/school/12f33pub.pdf>

²⁷ <http://nces.ed.gov/pubs2012/2012325rev.pdf> (May 2014)

²⁸ American Institute for Research, “Study of a New Method of Funding for Public Schools in Nevada,” http://leg.state.nv.us/Interim/76th2011/Committee/Studies/FundingSchools/Other/NV_Funding_Study_Report_FINAL_2012_09_25.pdf (September 25, 2012)

²⁹ Ibid.

³⁰ Ibid.

³¹ “Chapter 387 – Financial Support of School System,” <http://www.leg.state.nv.us/NRS/NRS-387.html>

- The Nevada Plan does not guarantee funding for educational programs critical for student success, such as the class-size reduction program, early childhood education for non-special education students, and student counseling services. Instead, these programs are funded by external categorical dollars allowing them to be easily reduced or eliminated.³²
- The Nevada Plan does not provide “capital outlay funding through the state except for capital expenditure for transportation” forcing capital expenditure for building schools to be raised locally by bonds or pay-as-you-go programs.³³

While a large concern for Nevada should be its low per pupil expenditure, it is important to understand that appropriate funding in the state has greater nuances than amount spent per student. If Nevada was to “ensure each Nevada child [receives] a reasonably equal educational opportunity”³⁴, the state must address additional concerns with the current funding formula.

RECOMMENDATIONS FOR IMPROVEMENT:

- Nevada should make a larger contribution to the education of our children by increasing the per pupil expenditure.
- Nevada should revise the current funding formula to make sure that every child has access to quality education.

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The following section includes a special focus on Funding for Kindergarten. This “Special Issue” provides additional information and recommendations for the expansion of full-day kindergarten in Nevada, which is a critical component to ensuring that children have the skills and foundations necessary to be successful in later grades, and ultimately, in life.

³² American Institute for Research, “Study of a New Method of Funding for Public Schools in Nevada,” http://leg.state.nv.us/Interim/76th2011/Committee/Studies/FundingSchools/Other/NV_Funding_Study_Report_FINAL_2012_09_25.pdf (September 25, 2012)

³³ “Chapter 387 – Financial Support of School System,” <http://www.leg.state.nv.us/NRS/NRS-387.html>

³⁴ Ibid

FUNDING - SPECIAL ISSUE

Full Day Kindergarten

As we continue to bridge the achievement gap by investing in early childhood education, it is crucial that all children have an opportunity to attend full-day kindergarten to build upon the academic and social gains made in early learning programs. According to a study by the Clark County School District, “Children who attend full-day kindergarten end up with slightly more than one month of extra literacy learning and slightly less than one month of extra math learning compared with children who attend half-day programs.”³⁵

The extra instruction time promotes “more independent learning, classroom involvement, productivity in work with peers and reflectiveness”³⁶ causing full-day attendees to “outperform half-day students on various end of the year achievement tests.”³⁷ These benefits continue through the third grade, in which full-day participants had “better attendance records, higher grade point averages and were more likely to be on grade level.”³⁸

Full-Day vs. Half-Day

- ♥ Full-day kindergarteners exhibit more independent learning, classroom involvement, productivity in work with peers and reflectiveness than their half-day counterparts.
- ♥ Full-day attendees outperform half-day students on various end of the year achievement tests.
- ♥ Researchers found that students who attended full-day kindergarten had better attendance records, higher grade point averages and were more likely to be on grade level by third grade.

Since 2005, the State has funded full-day kindergarten programs at 128 at-risk schools throughout Nevada. While there are 337 elementary schools in the state, the current funding levels can only support a handful of spots for full-day programs; only those students considered most at-risk (minority, poverty, ELL) are selected. Families that do not fall into the “most at-risk” category may choose to have their children attend a half-day program available at all public schools, or they may send their child to full-day kindergarten programs at a cost of \$3,100 per school year.³⁹ Half-day programs do not provide the same educational nor experiential benefits that full-day programs provide, which contributes to the

achievement gap. Also of note, state-funded full-day kindergarten provides an opportunity for working parents to maintain full-time employment while saving on the cost of child care and after school programs.

“School districts enrolling large numbers of children from low income families would be advised to provide access to full-day kindergarten programs that are designed to reduce –or eliminate –wide, socially stratified achievement gaps in literacy and in other curricular by the time children enter first grade. If these gaps are not closed by the end of first grade, these districts not only will find it increasingly difficult to close the gaps in later grades but also will face increasingly higher costs in attempting to do so.”

♥ *Report from the Clark County School District entitled, Full/Extended-Day Kindergarten Study (FEDS)*

RECOMMENDATIONS FOR IMPROVEMENT:

- Develop and expand full-day kindergarten programs by establishing public-private partnerships between the school district and private kindergarten programs. This will allow the state to enhance capacity and increase slots without a substantial investment in infrastructure.
- Emphasize funding to schools with large at-risk population; low-income, minority, and English Language Learner students.
- Require districts to have full alignment of preschool and kindergarten standards, curricula and services.
- Fund full-day kindergarten programs at the same rate as first through twelfth grade by revising Nevada Revised Statute 38.1233. Currently, kindergarten is funded at Six-tenths the count of pupils.⁴⁰ This causes school districts to have a disincentive to provide full-day programs as they are funded the same as half-day.

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³⁵ Pitch, L. and Edwards, O., “Kindergarten Study: Full-Day versus Half-Day Kindergarten,” <http://www.ccsd.net/resources/assessment-accountability-research-school-improvement-division/full-day-kindergarten-review-of-literature.pdf>

³⁶ “Tuition-Based Extended Day Kindergarten Program,” <http://static.ccsd.net/ccsd/content/ccsd-press/pdf/tuition-based-kindergarten-2013-2014.pdf>

³⁷ Center for Public Education, “Starting out right: pre-k and kindergarten: full report,” <http://www.centerforpubliceducation.org/Main-Menu/Organizing-a-school/Starting-Out-Right-Pre-K-and-Kindergarten/Starting-Out-Right-Pre-K-and-Kindergarten-full-report.htm> (November 2011)

³⁸ Pitch, L. and Edwards, O., “Kindergarten Study: Full-Day versus Half-Day Kindergarten,” <http://www.ccsd.net/resources/assessment-accountability-research-school-improvement-division/full-day-kindergarten-review-of-literature.pdf>

³⁹ “Tuition-Based Extended Day Kindergarten Program,” <http://static.ccsd.net/ccsd/content/ccsd-press/pdf/tuition-based-kindergarten-2013-2014.pdf>

⁴⁰ “Chapter 387 – Financial Support of School System,” <http://www.leg.state.nv.us/NRS/NRS-387.html#NRS387Sec1233>

Children's Health 2015

“He who has health has hope; and he who has hope, has everything”
♥ Arabic Proverb

Children's Health Overview

1. Access to Healthcare
2. Prenatal, Infant, and Child
3. Immunizations
4. Childhood Obesity
5. Dental Health
6. Mental Health
7. Sexual Health

CHILDREN'S HEALTH OVERVIEW

Nevada Children's Report Card Grade: D

Every child in Nevada should have the opportunity to grow up healthy, from the prenatal period through their teen years.

To be healthy, children and families need:

- High quality, and on-time, prenatal care.
- Access to high quality, affordable health care, including oral health and mental health.
- On-time, recommended childhood immunizations.
- Access to food that supports good nutrition, including an adequate supply of fruits and vegetables.
- Communities that provide a safe place to run and play, offering ample opportunities for physical activity.
- Access to information to make healthy decisions about their health, including sexual health, to become healthy adults.

Every child deserves a healthy start in life and access to quality health care. Neglecting a child's basic health care needs can contribute to health problems and higher costs as they grow. It is also important that children receive necessary on-time, affordable care. Too often, families forego preventative care and treatments due to lack of medical coverage and the high cost of care.

There are several areas of children's health which need improvement and contribute to the Overall Children's Health Grade of D, which the state received on the 2014 Children's Report Card. Details in each of these areas are provided in the sections below in addition to recommendations for improvement in the state. These include:

1. **Access to Health Care**
2. **Prenatal/Infant Health**
3. **Immunizations**
4. **Childhood Obesity**
5. **Dental Health**
6. **Mental Health**
7. **Sexual Health**

1. ACCESS TO HEALTHCARE

Nevada Children's Report Card Grade: F

In this section, the access to health care grade considers access to health insurance (Nevada ranks 51st)⁴¹, access to a quality medical home (Nevada ranks 50th)⁴², and patient provider ratios, in which Nevada ranks 46th.⁴³

The rates of uninsured children in the nation continue to decline, even in Nevada. However, despite this decline, Nevada continues to rank last in the nation when it comes to providing healthcare insurance coverage for children. Approximately 15% of Nevada's children have no healthcare insurance coverage, which is more than double the national rate of 7.1%.⁴⁴ There are also disparities in healthcare insurance coverage, seen both in the nation and in our state. Hispanic children are the most likely group in the nation to be uninsured with an average of 11.3%. In Nevada, 20% of children who are Hispanic are uninsured which is the highest percentage in the country.⁴⁵

States with Highest Uninsured Rates ⁴⁶		
	2012	2013
National	7.2%	7.1%
Nevada	16.2%	14.9%
Texas	13.2%	12.6%
Arizona	12.9%	11.9%
Alaska	11.8%	11.6%
Florida	11.9%	11.1%

Good health is key for academic achievement. Children with healthcare insurance, who have greater access to regular medical care, have an easier time focusing during class, participate more in activities and are not absent from school as often. Access to healthcare insurance will save the lives of many children. In 2008, one of the leading causes of natural child deaths in the nation was a treatable chronic illness. Of the children who die every year, it is estimated that roughly 37.8% of them could have been saved if they had health insurance.⁴⁷ In addition, children

who are born underweight because of various causes such as lack of prenatal care and pre-birth stress, have an 80% chance of being in a special needs program in school.⁴⁸

When children are hospitalized, those without health insurance are 60% more likely to die than those who are insured.
 ♥ *Center on Budget and Policy Priorities, Improving Children's Health, 2007*

Significant progress has been made across the nation in reducing the rate of uninsured children, yet Nevada continues to lag behind, partly driven by the failure to fund outreach and enrollment for Medicaid and the Nevada Check Up program, the state-provided health insurance for children of low-income families, despite the fact that the Federal Government pays for 70% of the program's costs.

With the expansion of the Nevada Medicaid program to low-income, uninsured adults and the ongoing implementation of the Affordable Care Act, an unprecedented opportunity exists to dramatically improve healthcare insurance coverage for Nevada's children at a limited cost.

RECOMMENDATIONS FOR IMPROVEMENT:

Develop and fund outreach programs to increase enrollment among eligible children and families in Medicaid and Nevada Check Up programs. Continue to implement the Affordable Care Act in full, while developing outreach to the community to educate the public on its provisions and effects.

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⁴¹ <http://ccf.georgetown.edu/all/american-community-survey-reveals-another-decline-in-uninsured-rate-for-kids/>
⁴² <http://childhealthdata.org/browse/snapshots/nsch-profiles?geo=30&rpt=16>
⁴³ <https://www.aamc.org/download/362168/data/2013statephysicianworkforcedatabook.pdf>,
<https://www.aamc.org/download/263512/data/statedata2011.pdf>
⁴⁴ Alker, J. and Cheter, A., Georgetown University Health Policy Institute, Center for Children and Families. "Children's Coverage at a Crossroads: Progress Slows," <http://ccf.georgetown.edu/wp-content/uploads/2014/10/Childrens-Coverage-at-a-Crossroads.pdf> (2014)
⁴⁵ Schwartz, S., Chester, A., Lopez, S., et al, "Hispanic Children's Coverage: Steady Progress, But Disparities Remain," <http://ccf.georgetown.edu/wp-content/uploads/2014/11/HispanicChildrensCoverage.pdf>
⁴⁶ Alker, J. and Cheter, A., Georgetown University Health Policy Institute, Center for Children and Families. "Children's Coverage at a Crossroads: Progress Slows," <http://ccf.georgetown.edu/wp-content/uploads/2014/10/Childrens-Coverage-at-a-Crossroads.pdf> (2014)
⁴⁷ Abdullah, Zhang, Lardaro, Black, Colombani, Chrouser, Pronovost, & Chang (2010). Analysis of 23 million US hospitalizations: uninsured children have higher all-cause in-hospital mortality. *Journal of Public Health*, 32(2), 236-244.

⁴⁸ Nevada Business Summit on Early Childhood Investments. Nevada Institute for Children's Research and Policy; nic.unlv.edu/files/NBS%20on%20Early%20Childhood%20Investment.pdf

2. PRENATAL, INFANT, AND CHILD

Nevada Children's Report Card Grade: C+

The prenatal, infant, and child grade is based upon the number of pregnant women receiving late or no prenatal care, infant and child mortality rates, and low birth weight.

Prenatal care refers collectively to the health services a pregnant woman receives before a baby's birth. As numerous studies have shown, prenatal care is important in that as potential problems that may endanger the mother or her baby are more likely to be discovered and treated before birth. It is recommended that a woman begins prenatal care in her first trimester and continues her prenatal visits on a regular basis until delivery.⁴⁹ Babies born to mothers who received no prenatal care are 3 times more likely to be born at low birth weight and 5 times more likely to die than those whose mothers received prenatal care.⁵⁰ With regard to the number of women receiving late or no prenatal care, the percentage of women in Nevada in 2012 was 11% which is consistent with the data from 2011, and well above the national percentage of 6%.⁵¹

According to the Centers for Disease Control and Prevention, preterm birth is the birth of an infant before 37 weeks of gestation. Preterm births cost the U.S. health care system more than \$26 billion in 2005.⁵² In Nevada in 2012, 13% of infants were born preterm and this rate has not changed since 2002.⁵³ During the final stages of pregnancy, infants are going through the final stages of organ development which includes the development of the brain, lungs, and liver. If delivered early, the infant could experience complications including organ failure, breathing problems, developmental delays, and are at a higher risk for infant mortality. While Nevada has improved in its infant and child mortality rates, going from 5.6% in 2005 to 5.5% in 2010, ranking 16th in the Nation (including Puerto Rico, Virgin Islands, and Guam),⁵⁴ infant mortality rates due to inadequate care remains a problem.

According to the March of Dimes, low birthweight is when a baby is born weighing less than 5 pounds, 8 ounces. While infants with a low birthweight may not experience any complications, it can cause serious health conditions which are immediate such as respiratory distress, bleeding in the brain, patent ductus arteriosus (a congenital heart defect), as well as long term health conditions such as diabetes, heart disease, high blood pressure, metabolic syndrome, and obesity.

Major risk factors for low birthweight include prematurity, inadequate maternal nutrition and smoking.⁵⁵ In Nevada in 2012, 8.0% of infants were born at a low birthweight which has increased from 7.2% in 2003.⁵⁶

RECOMMENDATIONS FOR IMPROVEMENT:

- Maternal and child health services, prenatal through the postpartum period, need to be expanded and more accessible for all parents including parents with diverse backgrounds and/or those who are economically challenged.

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⁴⁹ "Prenatal Care and Infant Mortality in Nevada," <http://cdclv.unlv.edu/healthnv/prenatalcare.html> (November 5, 2004)

⁵⁰ Office on Women's Health, U.S. Department of Health and Human Services, "Prenatal care fact sheet," <http://www.womenshealth.gov/publications/our-publications/fact-sheet/prenatal-care.html?from=AtoZ>

⁵¹ Kids Count, "Births to Women Receiving Late or No Prenatal Care," <http://datacenter.kidscount.org/data/tables/11-births-to-women-receiving-late-or-no-prenatal-care?loc=1&loct=2#detailed/1/any/false/868,867,133,38,35/any/265,266> (May 2014)

⁵² Center for Disease Control and Prevention, "Preterm Birth," <http://www.cdc.gov/reproductivehealth/MaternalInfantHealth/PretermBirth.htm> (October 30, 2014)

⁵³ March of Dimes, "Peristats," http://www.marchofdimes.org/Peristats/pdflib/999/pds_32_3.pdf (May 30, 2014)

⁵⁴ Matthews, T.J and Macdorman, F., Center for Disease Control and Prevention, "Infant Mortality Statistics from the 2010 Period Linked Birth/infant Death Data Set," http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_08.pdf (December 18, 2013)

⁵⁵ March of Dimes, "Your premature baby," <http://www.marchofdimes.org/baby/low-birthweight.aspx#> (October 2014)

⁵⁶ America's Health Rankings, United Health Foundation, "Low Birthweight," <http://www.americashealthrankings.org/Measures/Mesure/NV/birthweight> (2014)

3. IMMUNIZATIONS

Nevada Children's Report Card Grade: D+

The immunizations grade focuses on the percentage of children receiving recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and PCV vaccines by age 19 to 35 months. Considered by many to be our society's greatest healthcare achievement, childhood immunizations provide a preventative measure against a variety of once common diseases such as polio, measles, pertussis, measles, and many more. Nevada children have lower immunization rates than their nationwide counterparts and Nevada parents have reported difficulties in ensuring their children receive their recommended doses of vaccines. In 2014 60.6% of Nevada children age 19 to 35 months received the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and PCV vaccines compared to 68.4% nationwide. Nevada ranks 49th in the percentage of children who receive their recommended immunizations by age 19 to 35 months.⁵⁷

Nevada WebIZ

Nevada's Immunization Information System (IIS), Nevada WebIZ, continues to see positive results from the implementation of Nevada Revised Statute (NRS) 439.265. As of October 2014, there are:

- 1,469 Providers
- 2,480 Clinics
- 13,650 Users
- 3,000,330 Patient Records
- 30,260,111 Vaccinations

However, there are still providers not using Nevada WebIZ to its fullest capacity. Complete and widespread use of Nevada WebIZ would reduce unnecessary immunizations; provide better data to identify Nevada's vaccination gaps, especially during periods of outbreak; provide access for patient reminder/recall; and help providers better manage immunizations within their practice.

Challenges with Implementation of ACA

The changing health care marketplace continues to create challenges for immunization delivery in Nevada and across the country. Physicians in private practice continue to experience great economic pressure as vaccine costs rise and reimbursement rates shrink. Also, as the number of recommended vaccines has increased, some providers simply cannot afford to stock the increased inventory. As a result, more private offices are no longer administering all vaccines and end up referring their patients to local public health and Federally Qualified Health Clinic (FQHC) sites. Privately insured Nevadans also utilize these clinics for convenience, because access to a primary care physician can be limited due to the inability to quickly get appointments. Ranking at 49th, Nevada has one of the lowest per capita public health funding expenditures in the U.S. at \$7.85, while

the median per-capita expenditure is \$27.49.⁵⁸ Unfortunately, due to this and other factors, health districts and public health clinic sites are facing budget strains and personnel cuts at the same time their patient loads are increasing.

Medicaid Expansion

Nevada's Medicaid expansion was immensely successful; however, Nevada is already functioning within a physician shortage environment. Ranked as 47th in terms of physician to population ratio, Nevada needs more than 2,800 new doctors to catch up with the national rate of physicians per capita.⁵⁹ Many existing physicians are reluctant to see patients covered by Medicaid (or to accept new patients covered by Medicaid) due to low reimbursement rates, which is also taxing the public health and FQHC sites previously mentioned. Medicaid-covered vaccines are supplied to children through the Vaccines for Children (VFC) Program and only the administration fees are reimbursable. The Centers for Medicaid and Medicare Services' (CMS) cap for Nevada's administration fee is \$7.80/dose⁶⁰ and \$22.57/dose is the allowable VFC admin fee for non-Medicaid covered children.⁶¹ Nevada's immunization leadership and stakeholders continue to express concern about this new fragmentation of the vaccine delivery system if these problems are not resolved.

Recommendations for Improvement:

- Mandate statewide use of Nevada WebIZ to reduce unnecessary immunizations.
- Increase availability and affordability of vaccines for children in Nevada.
- Increase incentives for doctors to accept children covered by Medicaid to increase the availability of providers for these children.

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⁵⁸ <http://healthyamericans.org/assets/files/TFAH2014-InvestInAmericaRpt06.pdf>

⁵⁹ http://medicine.nevada.edu/Documents/unsom/statewide/reports/Physician_Workforce_in_Nevada-July_2014.pdf

⁶⁰ https://www.medicaid.nv.gov/Downloads/provider/NV_Pharmacy_Manual.pdf

⁶¹ http://www.snohd.org/Portals/0/Snohd/Provider/files/USE-2014%20VFC%20Operations%20Guide_Version%201.pdf

4. CHILDHOOD OBESITY

Nevada Children's Report Card Grade: C

The childhood obesity grade is based on the percentage of children between the ages 10 and 17 whose Body Mass Index (BMI) is at or above the 85th percentile, the percentage of 9th-12th grade students not physically active 5 days per week for 60+ minutes, and the percentage of children who do not consistently eat vegetables. The rate of unhealthy bodyweight among children and adolescents in the US has tripled since the 1980s. For the first time in more than 100 years, children's life expectancy is declining due to an increase in obesity. Children who are overweight or obese are at a significantly higher risk for developing other serious health conditions including diabetes, heart disease, and hypertension.

American obesity is becoming an epidemic that cost more than \$147 billion in medical expenses in 2008. In Nevada, the prevalence of obesity in children has increased by 29% since 2003. Children who are obese are more likely to have a shortened lifespan and develop a variety of health problems, including hypertension, high cholesterol, liver disease, orthopedic problems, sleep apnea, asthma and more often, type 2 diabetes. They are also predisposed to be obese in adulthood. Research indicates that physically active and fit children tend to have better academic achievement, better school attendance, and fewer disciplinary problems. Children who get regular exercise may have improved concentration and cognitive functioning.⁶²

- 11.5% of Nevada High School students are obese and 14.9% are overweight.⁶³
- 30.0% of kindergarten students in Nevada were found to be overweight or obese.⁶⁴
- 18% of 4th, 7th and 10th graders in Nevada are overweight and 20% are obese.⁶⁵
- In Nevada, Physical Education is not required in elementary schools, and even though it is a requirement for high school graduation, many children seek and are granted waivers and substitutions are allowed for others, including online courses where there is no way to know if physical activity is actually being incorporated.

Recommendations for Improvement:

- Recently state and local school wellness policies have been strengthened to increase access to healthy foods and increase opportunities for physical activity at schools. However, it is important that now that the policies have been improved, it is imperative that the new policies are implemented and enforced at the school level.

- Increase the number of Physical Education minutes in schools. The consensus recommendation is 150 minutes per week in elementary schools and 250 minutes per week in middle schools.
- Reduce the number of Physical Education waivers and substitutions.
- Increase opportunities for physical activity and healthy eating in after-school and child care settings.
- Increase the number of public places including worksites, parks, recreation and community centers that offer healthy vending options.
- Increase availability of affordable healthy food options in communities, particularly communities within designated 'food deserts' and in low-income communities.
- Ensure development of a sustainable, well connected regional trail systems for physical activity, recreation and active transport.
- Increase the number of schools that are participating in Safe Routes to Schools programs, which will encourage more active transport for children to and from school.
- Support the adoption of Complete Streets⁶⁶ policies and the adoption of Complete Streets elements into local planning documents at the state, regional and local levels in order to make the environment safer for active transport.
- Support adoption of nutrition standards and/or menu labeling efforts in restaurants, movie theaters and other locations that serve meals and snacks so that parents can make informed and healthy choices about what to feed their children when out.
- Dedicate sustainable funding to support evidence-based obesity prevention efforts both in schools and in communities.
- Continue BMI Surveillance in schools so that childhood obesity rates can be monitored. Nevada requires height and weight measurements to be taken in schools, but the requirement expires after the 2015 school year.

⁶² Trost S., "Active Education: Physical Education, Physical Activity and Academic Performance. A Research Brief," Princeton, NJ: Active Living Research, a National Program of the Robert Wood Johnson Foundation. (Summer 2009), Available from www.activelivingresearch.org

⁶³ "2013 Nevada Youth Risk Behavior Survey," (October 14, 2014)

⁶⁴ Nevada Institute for Children's Research and Policy, "Summary of Findings: Health Status of Children Entering Kindergarten: Results of 2013-2014 (Year Six) Nevada Kindergarten Health Survey," (2014)

⁶⁵ "BMI Summary Report and Recommendations; Nevada State Health Division," (2010)

⁶⁶ For more information on the Complete Streets policy, see: <http://www.smartgrowthamerica.org/complete-streets>

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The following Special Issue provides additional information and recommendations for provisions to early childhood education regulations, specifically NAC 432A, to help combat obesity among Nevada's children.

CHILDHOOD OBESITY - SPECIAL ISSUE**Physical Fitness & Nutrition Standards for ECE Settings**

According to the CDC, in Nevada 36.3% of adults are overweight and 26.2% of adults are obese.⁶⁷ This movement is not just occurring amongst adults, but children as well. As early as kindergarten, 30% of students are either overweight or obese.⁶⁸ Most children will carry this weight concern into adulthood where the health risks associated with obesity greatly increase. Obese adults are more likely to have chronic diseases including diabetes, coronary heart disease, stroke and some cancers. The health costs for combating these preventative issues are large. In 2006, the estimated cost associated with treating overweight and obesity in Nevada was 337 million dollars annually.⁶⁹ Strategies to combat obesity will help the state create a healthy population and save money. Since weight issues are occurring as early as kindergarten, prevention methods encouraging physical activity and proper nutrition among young children and their families are key to reversing this trend.

The Nevada Division of Public and Behavioral Health (DPBH), the Nevada Early Childhood Policy Workgroup (Workgroup), the Children's Advocacy Alliance and other partners are working collaboratively to identify, research, and implement effective systems level strategies to prevent childhood obesity for our youngest children. This collaborative effort has led to several recommendations aimed at improving physical fitness and nutrition standards in early childhood education settings through proposed changes to Nevada Administrative Code section 432A, Services and Facilities for the Care of Children.

**Nevada only meets
3 of 47
standards published by CFOC
in "Preventing Childhood
Obesity in Early Care and
Education Programs."**

These changes were formed by reviewing the nationally recognized "Caring for Our Children" (CFOC) reports and recommendations as a basis for best practices. In 2010, CFOC published the second edition of "Preventing Childhood Obesity in Early Care and Education Programs" which outlines specific policy recommendations aimed at improving nutrition, physical activity, and screen time standards in early childhood education settings. An analysis of these recommendations was conducted in comparison to the Nevada Administrative Code (NAC) and the Workgroup found that Nevada met only 3 of the 47 standards. As such, the Workgroup drafted proposed changes to the NAC which incorporate many of the recommended policy standards developed by CFOC. The proposed code changes have been vetted among the providers throughout the State of

⁶⁷ Centers for Disease Control and Prevention, "Nutrition, Physical Activity and Obesity: Date, Trends, and Maps – Nevada Location Summary," http://nccd.cdc.gov/npao_dtm/LocationSummary.aspx?state=Nevada

⁶⁸ Nevada Institute for Children's Research and Policy, "Kindergarten Health Survey 2012-2013," http://nic.unlv.edu/files/KHS%20Year%205%20Report_514.13_FinalRevised.pdf (May 2013)

⁶⁹ Nevada State Health Division Bureau of Community Health "Strategic Plan for the Prevention of Obesity in Nevada". <http://www.health.nv.gov/PDFs/obeseplan.pdf>

Nevada and changes were incorporated to reflect their feedback. If all proposed changes are adopted into NAC 432A, Nevada will meet 34 of the 47 standards set by CFOC.

Proposed Changes Include:

- Improving practices for feeding infants (ie: feeding on cue, holding the bottle instead of propping the bottle);
- Establishing standards and guidelines for age-appropriate portion sizes, with specific limits and standards for milk, milk products, and juice that is served by a licensed facility;
- Requiring licensed facilities that provide meals and/or snacks to follow meal patterns issued by the Child and Adult Care Food Program;
- Adults modeling healthy eating habits during meal time with the children;
- Including definitions for words and terms related to physical and sedentary activity (ie: moderate and vigorous physical activity, muscular and bone strengthening activities);
- Limiting sedentary activity and screen/media time for all children;
- Establishing standards and guidelines for age-appropriate physical activities.

Recommendations for Improvement:

- Nevada Administrative Code section 432A, Services and Facilities for the Care of Children, does not properly address nutrition, physical activity, or screen time in a way that helps promote healthy lifestyles. All of the recommended provisions should be made to NAC 432A to help combat obesity among Nevada's children.
- To assist early child care providers with implementation of the proposed regulations, training, and technical assistance should be provided. This will ensure that all providers have the tools, resources and knowledge to implement the proposed changes in the most effect and cost efficient manner. The Department of Public and Behavioral Health has a grant from the Centers for Disease Control and Prevention to provide this support for two years starting in October 2014.

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5. DENTAL HEALTH

Nevada Children's Report Card Grade: F

The dental health grade is based on children who have had no preventive dental care visits in the past year and children whose teeth were described as being in fair or poor condition. Nevada ranks 50th and 51st in the nation, respectively, for these two categories with 32.6% of children receiving no preventive dental care and 12.3% having fair to poor teeth. Oral health plays a significant role in overall health and wellbeing. It is intimately related to the health of the entire body and plays a vital role in overall physiology. Mounting evidence has shown infections in the mouth such as periodontal gum disease to increase the risk of heart disease, increase the risk of premature labor, and disrupt the ability of the body to regulate blood sugar for people living with diabetes⁷⁰. The far-reaching effects of oral health demonstrate the enormous importance of proper oral and preventative health care for people of all ages.

According to the 2012 Burden of Oral Disease in Nevada report, Nevadans experience many oral diseases in greater number than their national counterparts. The 2008 Third-Grade "Healthy Smile, Happy Child" report found that more than 65% of Nevada's third-grade students have tooth decay in comparison to just 53% nationwide⁷¹. Further, significantly more adolescents in Nevada suffer with untreated tooth decay than their national counterparts (28% vs. 18%). These effects are compounded by the fact that many Nevadans report experiencing barriers in accessing proper preventative dental care. As many oral diseases are progressive and become more difficult to manage over time, there exists a great need to improve access to preventative and regular dental care for children across all of Nevada.

- 22.2% of Nevada children have one or more oral health problems compared to 18.7% of children nationwide.
- 67.4% of Nevada children had one or more preventive dental care visit(s) in a 2011/2012 12 month survey compared to 77.2% nationwide.⁷²
- 68% of Nevada children reported receiving any type of dental care at all in a 2011/2012 12 month survey compared to 77.5% of children nationwide.⁷³

⁷⁰ "The Burden of Oral Disease in Nevada," <http://nsla.nevadaculture.org/statepubs/epubs/31428002984595-2012.pdf> (April 2012)

⁷¹ Oral Health Publication – Nevada State Health Division, "Happy Smile, Healthy Child" (2008)

⁷² 2011/12 National Survey of Children's Health. Child and Adolescent Health Measurement Initiative (CAHMI), "2011-2012 NSCH: Child Health Indicator and Subgroups SAS Codebook, Version 1.0" 2013, Data Resource Center for Child and Adolescent Health, sponsored by the Maternal and Child Health Bureau.

⁷³ Ibid

Recommendations for Improvement:

- In order to improve the overall health of Nevada's children, access to preventative dental care and treatment of dental issues needs to be improved.

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nic.unlv.edu**6. MENTAL HEALTH****Nevada Children's Report Card Grade: D+**

The Mental Health grade is based upon mental health treatment, suicide attempts, and teen suicide rates. Nevada ranks 49th in the nation for mental health treatment in which children receive needed mental health treatment or counseling in the past 12 months. Without the needed treatment, Nevada ranks 16th out of 40 states for the number of students who attempted suicide but ranks 36th in the nation for actual suicide rates.

The World Health Organization lists mental illness as the single most common cause of disability in young people worldwide. Despite this fact, Nevada has cut its mental health funding budget by 28.1% since 2009 and has one of the lowest per capita rates of mental health funding in the nation.⁷⁴ Mental health is an essential part of children's overall health, with extensive influence on children's physical health and their ability to succeed in school, work, and society.⁷⁵ In spite of a growing nationwide need for age appropriate and evidence-based mental health interventions for children, funding for children's mental health continues to decline.

It is of great importance to appropriately address mental health issues in childhood and early adolescence as many disorders have life-long effects. These include not only psychological effects, but great economic costs for families, schools, communities, and the state. While this economic burden is great, the life-long effects of undiagnosed mental health disorders are far-reaching and forever affect the ability of young people to establish healthy interpersonal relationships, succeed in school, and become a part of the work force. An estimated 15 million children nationwide currently have an undiagnosed mental health disorder.

- Approximately 28,000 children in Nevada live with serious mental illness.
- It is estimated that only 7% of those youth who need services receive appropriate help from mental health professionals.⁷⁶
- During the 2006-2007 school year, approximately 65% of Nevada students aged 14 and older living with serious mental health conditions who receive special education services dropped out of high school.⁷⁷
- Twenty-one percent of U.S. children aged 9 to 17 have a diagnosable mental or addictive disorder that causes at least minimal impairment.⁷⁸

⁷⁴ National Alliance on Mental Illness State Advocacy, "State Statistics: Nevada" (2010)

⁷⁵ The State of America's Children, "http://www.childrensdefense.org/child-research-data-publications/data/2014-soac.pdf (2014)

⁷⁶ American Psychological Association, "Children's Mental Health," <http://www.apa.org/pi/families/children-mental-health.aspx>

⁷⁷ National Alliance on Mental Illness State Advocacy, State Statistics: Nevada (2010)

⁷⁸ U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 1999.

- In any given year, only 20% of children with mental disorders in the United States are identified and receive mental health services.⁷⁹
- Half of lifetime mental health disorders start by age 14.⁸⁰
- As many as 2 in 3 depressed youth are not identified by their primary care clinicians and do not receive any kind of care.⁸¹

Nevada consistently has one of the highest youth suicide rates in the country.⁸² In 2012, suicide was the second leading cause of death for 15 to 24 year old Nevadans, with a rate of 10.13 suicides for every 100,000 youth. The national average rate for the same age group was 11.09 per 100,000.⁸³ Comparing youth ages 10-24, Nevada ranks just below the national average of 8.02 with a Nevada rate of 7.12. The Nevada Youth Risk Behavior Survey (YRBS) for 2013 found that 19.3% of high school students had seriously considered attempting suicide, 16.6% of high school students made a suicide plan, and 12.2% of high school students actually attempted suicide.⁸⁴ According to the Clark County Children's Mental Health Consortium Annual Plan, all school children need access to screening and universal behavioral health promotion activities. The findings from the assessments in each system point to the need to develop a system that supports children and families in a way to avoid entrance into public service systems, such as child welfare, juvenile justice and special education.⁸⁵ By providing public education environments that support wellness through behavioral health promotion activities, many children could avoid deeper involvement in the public service systems.

All children have the right to live healthy lives and deserve access to appropriate and effective mental health care. It is important to address the tremendous amount of unmet need and improve the state of children's mental health care in the state of Nevada. Mental health promotion within communities and schools as well as screening for early detection of youth who are at risk for suicide are working and are imperative to preventing youth from attempting and taking their own lives.

Recommendations for Improvement:

- Accelerate efforts to promote awareness and help-seeking behaviors among youth in the education system, as well as screening and early intervention to identify behavioral health disorders before there is a crisis.
 - Identification and treatment of substance abuse must be included in any suicide prevention effort.

- Universal screening for suicide risk should also be routine in all Primary Care, Hospital Care (especially emergency department care), Behavioral Health Care, and Crisis Response settings (e.g., help lines, mobile teams, first responders, crisis chat services). Any person who screens positive for possible suicide risk should be formally assessed for suicidal ideation, plans, availability of means, presence of acute risk factors (including history of suicide attempts), and level of risk.
- Public health and behavioral health organizations should assure staff working with persons with suicide risk have been appropriately trained and possess requisite skills.
 - All persons identified as at risk of suicide by primary care practices and clinics, hospitals (esp. emergency departments), behavioral health organizations and crisis services should have a collaboratively designed safety plan prior to release from care. Persons with suicidal risk leaving intervention and care settings should receive follow-up contact from the provider or caregiver.
- In schools, mental health promotion, such as social and emotional learning along with suicide prevention strategies need to be implemented for elementary and middle school students as well as high school students. Strategies in the education system need to be tailored to reach females as well as males.
- In school, suicide prevention strategies need to match the diversity of the student population, with specific emphasis on Hispanic and Latino youth.
- Gatekeeper and professional training is needed in the foster care system, juvenile justice and child welfare systems to address the large numbers of youth with depression and suicidal ideation.
- Mobile crisis assessment needs expansion to ensure crisis response, family stabilization, system re-entry safety plans and continuity of care for youth identified at risk or who have previously attempted suicide.

⁷⁹ U.S. Public Health Service, Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington, DC: Department of Health and Human Services, 2000.

⁸⁰ National Institute of Mental Health Release of landmark and collaborative study conducted by Harvard University, the University of Michigan and the NIMH Intramural Research Program (release dated June 6, 2005 and accessed at www.nimh.nih.gov).

⁸¹ Simonian SJ. Screening and identification in pediatric primary care. Behavior Modification. 2006;30(1):114-131.

⁸² Nevada Office of Suicide Prevention

⁸³ "Web-based Injury Statistics Query and Reporting System, 2014 Data," <http://www.cdc.gov/injury/wisqars/> (2014)

⁸⁴ 2013 Nevada YRBS

⁸⁵ Clark County Children's Mental Health Consortium, "10 Year Strategic Plan." (2010)

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The sexual health grade encompasses many factors such as teen birth rate, sexual activity, condom use, any birth control use, and STD rates. With 16% of Nevada's high school students not using any type of birth control, Nevada ranks 29th out of the 34 states reporting this information. This directly affects the teen birth rate of 33 births per 1,000 females ages 15 to 19 and ranks Nevada 32nd in the nation – an average of four births higher than the national average. Nevada ranks 16th out of 36 states reporting information for condom use. With regard to STD rates, Nevada ranks in toward the middle for Chlamydia (20th), Syphilis (22nd), and has a higher ranking for Gonorrhea (38th).⁸⁶

Nevada consistently has one of the highest teen pregnancy rates in the country.⁸⁷ Research has shown that teens who received evidence-based sex education were 50 percent less likely to experience pregnancy than those who received education only focused on refraining from sex.⁸⁸

Every school district in Nevada is currently required to teach some sex education (NRS 389.065), but standards vary across the state.⁸⁹ As of January 2012, national standards exist for sexuality education, as they do for math and reading. Including sex education standards in our health standards and curriculum ensures our youth receive consistent, medically-accurate, factual information to make informed decisions.

- Nevada has one of the highest teen birth rates with a rate of 33.4 births per 1,000 young women ages 15-19 compared to the national rate of 27 births per 1,000.⁹⁰
- When including all pregnancies, rather than just those that resulted in a birth, Nevada has even higher pregnancy rates among young women ages 15-19: 68 pregnancies per 1,000 young women as compared to the national rate of 57 pregnancies per 1,000.⁹¹
- Teen childbearing cost Nevada taxpayers at least \$68 million in federal, state, and local dollars in 2010. Between 1991 and 2010 there have been 73,470 teen births in Nevada, costing taxpayers a total of \$1.5 billion over that period.⁹²

⁸⁶ Please see Appendix: Report Card Sources

⁸⁷ Martin, J.A., Hamilton, B.E., Osterman, M.J.K., et al, "Births: Final Data for 2012". National Vital Statistics Reports, http://www.cdc.gov/nchs/data/nvsr/nvsr62/nvsr62_0chlamy9.pdf. 62(9) (2012)

⁸⁸ Stanger-Hall, K. F. and Hall, D.W., "Abstinence-Only Education and Teen Pregnancy Rates: Why We Need Comprehensive Sex Education in the U.S.," National Center for Biotechnology Information 10 (October 14, 2011)

⁸⁹ Clark County School District "Sex Education Curriculum Information," <http://www.ccsd.net/students/sex-ed-info.php> (November 2014)

⁹⁰ <http://thenationalcampaign.org/data/state/nevada>

⁹¹ Ibid

⁹² Ibid

- Nevada has made some progress and the teen birth rate in Nevada declined 48% between 1991 and 2010 saving taxpayers an estimated \$84 million.⁹³
- Young people (ages 15-24) are particularly affected, accounting for half (50 percent) of all new STIs.⁹⁴
- Nevada's HIV infection rate ranks 10th in the United States, with a rate of 18.9 cases per 100,000 individuals compared to the national rate of 19.5 cases per 100,000.⁹⁵ STIs place a significant economic strain on the U.S. healthcare system. CDC conservatively estimates that the lifetime cost of treating eight of the most common STIs contracted in just one year is \$15.6 billion.⁹⁶
- In 2013, the percent of sexually active high school students in Nevada that reported using any method of contraception the last time they had sex was 84%. The percent of all high school students in Nevada that have ever had sex was 43.8%.⁹⁷
- In a 2008 study, young people who received evidence-based, age-appropriate and medically accurate sexuality education used significantly fewer acts of violence toward a dating partner by the end of Grade 11.⁹⁸ Among sexually active boys, those who received evidence-based, age-appropriate and medically accurate sexuality education were more likely to practice safe sex 2.5 years later (i.e., always use a condom).⁹⁹
- Teens who received evidence-based, age-appropriate and medically accurate sexuality education were 50 percent less likely to experience pregnancy than those who received abstinence-only education.¹⁰⁰

Widespread support exists for balanced, evidence-based sex education in Nevada. A January 2013 poll conducted in the state showed that 67% of Nevadans agree with the policy of "teaching sex education in schools, including age-appropriate discussions of birth control options."¹⁰¹

Recommendations for Improvement:

- Some level of sex education is currently required in Nevada schools, but the curriculum is not consistent across the state. Policies should be implemented so that all school districts offer* consistent evidence-based, age-appropriate and medically accurate sexuality education curriculum that will include:

- Reproductive and sexual anatomy and physiology, including biological, psychosocial and emotional changes that naturally occur.
- Accurate information on AIDS/HIV and STI prevention, testing and treatment as well as contraception, with an emphasis on refraining from sex as the most effective way to prevent pregnancy and sexually transmitted infections.
- Development of interpersonal and life skills to help students develop healthy relationships and make responsible decisions about sexuality and sexual behavior.
- Inclusion and acceptance of individuals regardless of race, gender, gender identity, religion, sexual orientation, ethnic or cultural background or disability.
- Identification and prevention of domestic and dating violence, sexual abuse and legal, medical and counseling resources available.
- Awareness and understanding to prevent participation or exploitation of sexually explicit material over the Internet and other media platforms.

**This recommendation still maintains that parents would be able to make decisions about their children's participation in this coursework, without penalty.*

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⁹³ <http://thenationalcampaign.org/data/state/nevada>

⁹⁴ <http://www.cdc.gov/std/stats/sti-estimates-fact-sheet-feb-2013.pdf>

⁹⁵ <http://www.cdc.gov/hiv/surveillance/resources/reports/2008report/pdf/2008SurveillanceReport.pdf>

⁹⁶ <http://www.cdc.gov/std/stats/sti-estimates-fact-sheet-feb-2013.pdf>

⁹⁷ <http://thenationalcampaign.org/data/state/nevada>

⁹⁸ CAMH Centre for Prevention Science. The Fourth R: Relationship Based Violence Prevention. 2008. <http://youthrelationships.org>

⁹⁹ Ibid

¹⁰⁰ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3194801/>

¹⁰¹ Third Eye Strategies (2012). Nevada Voter Opinions July through December 2012. Produced and distributed by the State Capacity & Innovation Foundation.

Children's Safety 2015

Children's Safety Overview

1. Child Maltreatment
2. Youth Homelessness
3. Juvenile Violence
4. Child Deaths and Injury
5. Substance Abuse

Children's Safety Overview:

Nevada Children's Report Card Grade: D+

According to the United States Census Bureau, in 2013 23.7% of Nevada's population was under the age of 18 years old.¹⁰² Children often lack the skills to protect themselves so it is the responsibility of the parents, guardians, and the community to ensure the safety of all our children and youth. Factors such as poverty, low educational attainment, substance abuse and domestic violence can all have an impact on children's safety – resulting in abuse and neglect, homelessness, juvenile violence, preventable injuries and sometimes fatalities. Ensuring that children, and their families, have appropriate access to key resources and services is essential to improving the safety of children and youth in Nevada. Children's safety can mean a variety of things, but for the purpose of this briefing book, the areas of child safety are narrowed to the following five areas that need improvement and contribute to the Overall Children's Safety Grade of D+, which the state received on the 2014 Children's Report Card. Details in each of these areas are provided in the sections below in addition to recommendations for improvement in the state. These factors include:

- 1. Child Maltreatment**
- 2. Youth Homelessness**
- 3. Juvenile Violence**
- 4. Child Deaths and Injury**
- 5. Substance Abuse**

¹⁰² United States Census Bureau, "State & Country QuickFacts, Nevada," <http://quickfacts.census.gov/qfd/states/32000.html> (2014)

1. CHILD MALTREATMENT

Nevada Children's Report Card Grade: C-

The child maltreatment grade is based on the number of children who had substantiated experiences of maltreatment which include physical abuse, sexual abuse, and neglectful maltreatment.

Nevada remained relatively stable in overall maltreatment, going from 18th in 2011 to 19th in 2012.¹⁰³ For physical, sexual, and neglectful maltreatment, Nevada ranked 45th, 12th, and 28th, respectively.¹⁰⁴ This contributed to Nevada's 2012 ranking of 32nd in the nation for Foster Care Placement, in which an average of 5 children were removed from their homes and placed in foster care per 1,000 children.¹⁰⁵

Nevada State Child Welfare Information for 2013				
SFY2013	Clark County	Washoe County	Rural Counties	Total Statewide
Child Protective Services				
Total New Referrals	14,293	5,803	3,484	23,580
Information Only	5,000	3,348	1,724	10,072
Differential Response	642	267	441	1,350
Investigation	8,651	2,188	1,319	12,158
Total Closed Investigations	8,544	2,209	1,271	12,024
Substantiated	2,606	650	239	3,495
Un-Substantiated	5,938	1,559	1,032	8,529
Out of Home Care				
Year-End Foster Care Counts	3,855	813	439	5,107

Data provided by the Nevada Division of Child and Family Services

In Nevada, the majority of child maltreatment cases are due to neglect (approximately 77.6%) and physical abuse (approximately 36.4%), and a smaller percentage are due to sexual abuse (approximately 5.3%).¹⁰⁶ However, instances of sexual abuse are more likely to go unreported therefore the prevalence is likely much larger. For instance, it is estimated that one in four girls and one in six boys will be the victim of child sexual abuse by the time they are 18 years old, however, only 1 out of every 10 victims disclose their abuse.¹⁰⁷ During the last legislative

session, the Task Force on the Prevention of Sexual Abuse of Children was created through the passage of Senate Bill 258, now codified into NRS 432.B.700-730, to study and identify strategies, goals and recommendations for preventing child sexual abuse.

Child abuse and neglect creates tremendous burden on society, in both social and economic terms. Abused or neglected children suffer from much higher likelihoods of mental health problems, perpetuation of abuse, suicide, homelessness, teen pregnancy, addiction, and crime. The child welfare system thus grew around the attempt to solve or at least mitigate these problems, protecting the children in the community and ensuring their chance to thrive as healthy, hopeful children. Nevada's child welfare system is, like others in the country, comprised of many agencies and community groups, and a primary tool to protect the children from adult abuse and neglect is to remove them from their families into foster care. However, if our community had a stronger array of critical family support services, and a community ethic of investing in children and families before crisis hits, many children could remain safely with their parents, instead of entering foster care or ending up on the streets.

Nevada's child welfare system is not adequately organized or resourced to prioritize prevention and reduce the rate of entry into the foster care system. However, although foster care has no doubt saved many children from dangerous environments, and removal of at-risk, abused, or neglected children into foster care may seem like a logical first choice, the long term effect is not always the best. In Nevada in 2013, children that were removed from their home had an average stay in foster care of 5.5 months and 71.3% were reunified with their families in less than 12 months.¹⁰⁸ With these statistics, clearly entering into the foster care system is not always a permanent escape; rather, the root causes of abuse or neglect should be addressed and the child welfare system redesigned to focus more on family-centered child welfare service and prevention.¹⁰⁹

Recommendations for Improvement:

- Ensure that adequate resources are in place to provide children and families with the services needed to safely prevent removals and ensure timely reunifications.
- Establish new and expand existing in-home prevention and intervention services for families at risk, including but not limited to parent-child interaction therapy, nurse-family partnerships, and counseling services.
- Include parent representatives in the decision making process by requiring inclusion on state-level advisory and oversight groups, as appropriate.
- Revise NRS 432.B.700-730 to include the continuation of the Task Force on the Prevention of Sexual Abuse of Children and ensure that the task force is comprised of a multi-disciplinary team of experts, parents, survivors, and policy makers.

¹⁰³ "Child Maltreatment 2012," <http://www.acf.hhs.gov/sites/default/files/cb/cm2012.pdf#page=31> (2013)

¹⁰⁴ "The State of America's Children," <http://www.childrendefense.org/child-research-data-publications/data/2014-soac.pdf> (2014)

¹⁰⁵ Kids Count, "Children 0 to 17 Entering Foster Care," <http://datacenter.kidscount.org/data/tables/6268-children-0-to-17-entering-foster-care#ranking/2/any/true/868/any/1562> (July 2014)

¹⁰⁶ Division of Child & Family Services Nevada, "Nevada Context Data," dcfs.nv.gov/uploadedFiles/dcfsnv.gov/content/Tips/Reports/Nevada%20Context%20Data%20through%202013.pdf

¹⁰⁷ Division of Child & Family Services Nevada, "Task Force on the Prevention of Sexual Abuse of Children," <http://dcfs.nv.gov/uploadedFiles/dcfsnv.gov/content/Tips/Reports/SB258%20Report.pdf> (2014)

¹⁰⁸ Division of Child & Family Services Nevada, "Nevada Context Data," dcfs.nv.gov/uploadedFiles/dcfsnv.gov/content/Tips/Reports/SummaryNVperformanceFederalMeasuresFY10-13.pdf

¹⁰⁹ See the Community We Will brief for further information.

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The following sections include a special focus on several specific elements of child maltreatment; (1) Improving Data Systems, (2) Medical Consent, (3) Prudent Parent Standards, and (4) Child Welfare Funding.

CHILD MALTREATMENT - SPECIAL ISSUE

Integrated Data System Feasibility Study

Entities and communities should endeavor to provide a holistic, comprehensive, and integrated experience for children, youth, and families seeking support and receiving services. ♥ *Child Welfare League of America*¹¹⁰

Research shows that children who enter the child welfare system often cross over into other systems of care: a child who is abused/neglected is 55% more likely to be arrested as a juvenile¹¹¹; more than 20% of children who leave foster care experienced housing problems within two years of leaving¹¹²; and children in foster care are more than twice as likely to drop out of high school.¹¹³ Unfortunately, Nevada lacks the infrastructure to track and record a child's movement through these services.

In Clark County, a child who enters the child welfare system would have their information entered into the Unified Nevada Information Technology for Youth (UNITY) data system and the National Youth in Transition Database (NYTD). If he/she then receives welfare services, they would be entered into the CACTUS System and the Nevada Operations of Multi-Automated Data System (NOMADS). If the individual goes through the court system, they would be entered into Odyssey, and through the juvenile justice system into the Family Tracking, Reporting and Automated Case Support (FamilyTracs) system. If that child becomes homeless or receives homelessness services, they would be entered into the Homeless Management Information System (HMIS) and if they receive workforce aid they would be entered into the Southern Nevada Workforce Connections data reporting system (NVTrac). Additionally, they would be tracked by school district and health care services systems.



The lack of one integrated data system limits providers in their ability to tailor services for children based on what services they have already or are currently receiving from other providers in the community. It also places a burden on children

¹¹⁰ Child Welfare League of America, *National Blueprint for Excelling in Child Welfare* p. 70

¹¹¹ Bilchik, S. and Nash, M., "Child Welfare and Juvenile Justice: Two Sides of the Same Coin," <http://cjjr.georgetown.edu/pdfs/Fall%2008%20NCJFCJ%20Today%20feature.pdf> (2008)

¹¹² Fowler, P.J., Toro, P.A., and Miles, B.W., "Pathways to and From Homelessness and Associated Psychosocial Outcomes Among Adolescents Leaving Foster Care System," *American Journal for Public Health* 99, p.1453-1459 (August 2009)

¹¹³ Lips, D., The Heritage Foundation, "Foster Care Children Need Better Educational Opportunities," http://www.heritage.org/research/reports/2007/06/foster-care-children-need-better-educational-opportunities#_ftn10 (June 5, 2007)

and families by having them retell their history to each agency prior to accessing services.

Integrated data systems are data systems that “integrate individual-level data from multiple administrative agencies on an ongoing basis. These systems may exist for jurisdictions at various levels, including states, counties, and cities. Records in these systems may include those from human services (such as child welfare, income supports, and child care subsidies), health, employment, vital statistics, justice system, and education.”¹¹⁴ They could be accessed by participating entities and would include securely exchanged information that protects privacy and confidentiality. This would allow the organizations to quickly look up their client, see their personal information, which would be automatically populated, and see what services their clients have/are currently using. Having an integrated data system would lead to “an increased knowledge and communication among agencies, resource sharing and reduction of duplicated efforts, greater specialization, and an improved image with clients and the community.”¹¹⁵ Using an integrated data system would provide substantial benefits to the clients by offering “referrals to more and a wider range of services, improved access, and improved case management.”¹¹⁶

Recommendations for Improvement:

- Conduct a feasibility study to look at the viability of an integrated data system, including the following key design elements:
 1. Collect information from multiple service providers, which will provide greater coordination.
 2. Back-end systems should support robust, bidirectional information exchange, and automatically populate appropriate information into a record that follows the child through a continuum of care and over time.
 3. Information must be exchanged securely, in a manner that protects privacy and confidentiality, and the tools must support the specific designation of individuals authorized to see specific portions of the record (i.e. granular data segmentation and role-based access), among other protections.
 4. Electronic records generated must be able to extract and summarize important information, to include historical information to provide an accurate and complete client record.

5. Electronic records should be designed with consumer-facing features, such as patient portals and pre-visit questionnaires, as well as links to available tools that can feed critical information into the record, such as remote monitoring devices.¹¹⁷

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 702-228-1869
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¹¹⁴ Hendey, L., Coulton, C., and Kinsley, G.T., “Connecting People and Place: Improving Communities through Integrated Data Systems,” http://neighborhoodindicators.org/sites/default/files/publications/final_concept_paper_nnip_ids.pdf (June 2013)
¹¹⁵ Pindus, N., Koralek, R., Martinson, K., et al, “Coordination and Integration of Welfare and Workforce Development Systems,” http://www.urban.org/UploadedPDF/coordination_FR.pdf (March 20, 2000)

¹¹⁶ Ibid

¹¹⁷ State Policy Advocacy and Reform Center, “Electronic Information Exchange: Elements that Matter for Children in Foster Care,” <http://childwelfareparc.org/wp-content/uploads/2014/07/15-Electronic-Information-Exchange-Elements-that-Matter-for-Children-in-Foster-Care.pdf> (January 2013)

CHILD MALTREATMENT - SPECIAL ISSUE

Medical Consent

Children and youth in foster care are at a “higher risk for persistent and chronic physical, emotional, and developmental conditions because of the multiple and cumulative adverse events in their lives”.¹¹⁸ This causes them to frequently need medical care and procedures that require consent from their biological parents. These may include but are not limited to diagnostic, therapeutic, surgical, and anesthesia care (except in times of medical emergencies¹¹⁹), and the prescription of certain medications. For some children and youth in foster care, receiving medical consent for medical treatment can become a timely process especially in instances when the biological parent cannot be located or refuses to give consent.

Although the Nevada Foster Child Bill of Rights states that children in foster care receive “treatment as soon as practicable after the need for such services has been identified”¹²⁰, Nevada’s child welfare service agencies lack policies and procedures to ensure that when medical consent cannot be obtained, children still receive the care that they need. Each child care service agency has their own practices and timeframes they use to ensure a child receives care if they cannot readily receive the biological parent’s consent. These practices can sometimes lead to a child waiting days, weeks, or even months before receiving care, or in a few instances only being treated after it was determined to be a medical emergency.

When a child becomes a ward of the state, it is imperative that Nevada acts in the best interest of the child and takes into consideration their rights as written in the Nevada Foster Child Bill of Rights, before ensuring the biological parent’s parental rights are not violated. The following are different types of policies and procedures that states have legislatively established to protect the medical rights of a foster child¹²¹:

- **Caregiver’s Authorization Affidavit** – Caregivers can fill out a form that states that the parents of the child have been advised that the caregiver will have the power to authorize medical care of the child and have not objected.
- **Voluntary v. Non-voluntary placement, Routine v. Non-routine** – Some jurisdictions also categorize medical consent based on whether or not a child was placed voluntarily or involuntarily into foster care and whether the treatment is routine or non-routine. For example, when a minor is voluntarily placed into care, the parent/guardian must give prior written consent before the minor can receive routine examinations and treatment and the parent/guardian must also give prior written consent in each instance of non-routine treatment for the minor. If the parent/guardian does not consent or cannot be located, a court

order must be obtained by the foster care agency. In involuntarily placements, the county child and youth agency caseworker can authorize routine medical care and the parent or guardian must authorize non-routine treatment. If consent from the parent is not obtained, then a court order must be obtained.

- **Caseworker consent** – A court can designate the caseworker to provide medical consent for children in foster care. Often these consenters have to complete training. In some jurisdictions, the child and youth agency can also delegate their authority to foster parents.
- **Court Order** – Some states only allow courts to make medical decisions regarding the child.
- **Established Reasonable Effort Timeline** – Some states have established a time window within which welfare agencies would be required to have made a reasonable effort to receive consent from a parent. If the parent has not been located, or has not acted on the request to give consent, the state would then have the power of authority to give consent.

Recommendations for Improvement:

- **Establish a Reasonable Effort Timeline** – If a parent cannot be located and/or has not acted on the request to give consent within 72 hours, the child welfare agency should have the authority to give consent on behalf of the foster child.
- **Allow for the use of Affidavits** – A parent should be informed that if they so choose, they can allow a third party, such as the state or a relative, to give medical consent on behalf of the child. This affidavit could include exclusions to certain procedures based on religious beliefs and/or desires of the parent.
- **Remove a parent’s right to give medical consent if they are the reason the child needs the treatment and/or procedure** – If a parent caused physical harm to a child that requires medical treatment, the parent should not be able to decide when/if the child receives such treatment.
- **Give children over the age of 16 the ability to consent to some forms of treatment** – Assuming the child is competent, they should be given the ability to consent to some forms of medical treatment.

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¹¹⁸ American Academy of Pediatrics, “Fostering Health,” <http://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Pages/Fostering-Health.aspx>

¹¹⁹ “Chapter 129 – Minors’ Disabilities; Judicial Emancipation of Minors,” <https://www.leg.state.nv.us/NRS/NRS-129.html#NRS129Sec040>

¹²⁰ “Assembly Bill No. 393,” http://www.leg.state.nv.us/Session/77th2013/Bills/AB/AB393_EN.pdf

¹²¹ Research and information provided to the Children’s Advocacy Alliance from State Policy and Reform Center (SPARC)

CHILD MALTREATMENT - SPECIAL ISSUE

Prudent Parent Standard

The House of Representatives recently passed the “Prevent Sex Trafficking and Strengthening Families” Act, H.R. 4980. This potential bill would establish prudent parent rights throughout the United States. According to the Act, a ‘reasonable and prudent parent’ is “characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child while at the same time encouraging the emotional and developmental growth of the child.”¹²²

The law would allow foster parents or ‘caregivers’ to use prudent decisions in the determination to allow their child to participate in age or developmentally-appropriate, “activities or items that are generally accepted as suitable for children of the same chronological age or level of maturity based upon cognitive, emotional, physical and behavioral capacities”¹²³, extracurricular, enrichment, cultural, and social activities.

The act would allow caregivers to make decisions such as:

- Whether to allow the child to engage in social, extracurricular, enrichment, cultural, and social activities, including sports, field trips, and overnight activities lasting 1 or more days.
- Signing permission slips and arranging transportation for the child to and from extracurricular, enrichment, and social activities. Note: A caregiver can make these decisions as long as they do not go against previous judgments/rulings i.e. a child cannot go on a weekend trip if it violates a scheduled visitation time etc.

The law also further establishes rights of children in foster care who are 14 years or older to:

- Have a document that describes the rights of the child with respect to education, health, visitation, and court participation.

Purpose:

The reasonable and prudent parent standards allow caregivers to give their foster children permission to do daily, age appropriate, activities that promote cognitive, emotional, physical and behavioral growth. These standards, in accordance with the Federal John H. Chafee Foster Care Independence Program, help foster children make the transition to adulthood by providing necessary life skills and developmental growth.¹²⁴

Implementation:

Once this law is passed, it would require the states to amend their foster parent training/preparation to include:

¹²² “H.R. 4980 – Preventing Sex Trafficking and Strengthening Families Act,” <https://beta.congress.gov/bill/113th-congress/house-bill/4980/text>

¹²³ Ibid.

¹²⁴ Children’s Bureau, “John H. Chafee Foster Care Independence Program,” <http://www.acf.hhs.gov/programs/cb/resource/chafee-foster-care-program> (June 28, 2012)

“Knowledge and skills relating to the reasonable and prudent parent standard for the participation of the child in age or developmentally-appropriate activities, including knowledge and skills relating to the developmental stages of the cognitive, emotional, physical, and behavioral capacities of a child. “ Although, “The Secretary of Health and Human services shall provide assistance to the States on best practices for devising strategies to assist foster parents in applying reasonable and prudent parent standards in a manner to that protects child safety.”¹²⁵

The states would also have to create a “document that describes the rights of the child with respect to education, health, visitation, and court participation, and the right to stay safe and avoid exploitation to the case plan for every child in foster care over the age of 14.”

Recommendations for Improvement:

Adopt standards to include:

- A definition of “reasonable and prudent parent” in accordance with HR4980.
- A requirement for child welfare agencies to provide training to foster parents and caseworkers on the prudent parent standards.
- A requirement that the NV Department of Health and Human Services, Division of Child and Family Services adopt regulations to support Nevada’s Prudent Parent Standards, including information on what types of decisions/activities are to be included in the standards.
- A requirement that caregivers are provided with the appropriate information and background on the foster child necessary to make reasonable and prudent decisions.
- Provisions which provide that caregivers (foster parents) are a partner in decision making, and as such, should be included and/or consulted regarding decisions affecting children in their care.
- A requirement that decisions made under this standard cannot trump existing court orders and/or rulings related to visitation, therapy or other related matters unless otherwise approved by the child welfare agency and/or court.

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¹²⁵ “H.R. 4980 – Preventing Sex Trafficking and Strengthening Families Act,” <https://beta.congress.gov/bill/113th-congress/house-bill/4980/text>

CHILD MALTREATMENT - SPECIAL ISSUE

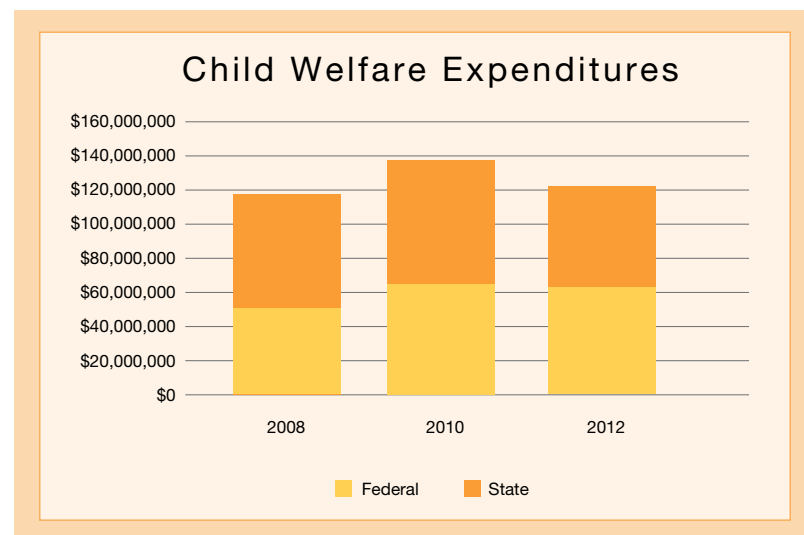
Study on Child Welfare Funding Structure

Funding decisions in the private sector and at federal, state, local and tribal levels are informed by the certainty that the well-being of children, families, and communities are interconnected and that sufficient and equitable funding is essential to the well-being of all of them.

♥ *Child Welfare League of America*

“Funding to support the well-being of children, families, and communities comes from tax revenues levied at all levels of government [local, state and federal] and, to a lesser extent from private philanthropy.”¹²⁶ From state and federal expenditures alone¹²⁷, Nevada spent \$122,837,546 in Fiscal Year 2012 on child welfare programs such as: “assessment and comprehensive case management services, emergency shelter care, foster family care, group home care, therapeutic foster care, respite care, residential treatment care both in and out-of state, and independent living services.”¹²⁸

Since state fiscal year 2010, Nevada's Child Welfare services providers, Nevada Department of Child and Family Services (DCFS), Washoe County Department of Social Services (WCDSS), and the Clark County Department of Family Services (CCDFS), have seen their state and federal funding decrease over 12%; between the fiscal years of 2010 and 2012, the federal expenditures decreased from \$63,993,270 to \$61,885,043 – a 7% decrease, and the state expenditures decreased from \$74,445,006 to \$60,952,503 – a decrease of over 21%.¹²⁹ The need remains relatively consistent despite the decrease in funding. For example,



¹²⁶ Child Welfare League of America, *National Blueprint for Excellence in Child Welfare*. p. 120

¹²⁷ Nevada did not report local expenditures in recent survey by Child Trends and the Annie E. Casey Foundation, <http://www.childtrends.org/wp-content/uploads/2014/09/2014-61ChildWelfareSpending20122.pdf>, <http://www.childtrends.org/wp-content/uploads/2013/03/2012-53FedStateLocalSpendingChildAbuseNeglect.pdf>

¹²⁸ http://www.dcf.state.nv.us/DCFS_ChildWelfareSvcs.htm

¹²⁹ Survey by Child Trends and the Annie E. Casey Foundation, <http://www.childtrends.org/wp-content/uploads/2014/09/2014-61ChildWelfareSpending20122.pdf>, <http://www.childtrends.org/wp-content/uploads/2013/03/2012-53FedStateLocalSpendingChildAbuseNeglect.pdf>

the number of children reported abused or neglected in Nevada increased from 4,654 in FY 2010 to 5,436 in FY 2012 and the number of children in foster care showed only a slight decrease from 4,806 to 4,746 in fiscal years 2010 and 2012, respectively.^{130, 131}

This has placed the burden on Nevada's welfare services to provide the same level of resource support with significantly less funding to meet the need. Barring a substantial increase in overall welfare funding in the near future, it is imperative that “funding be linked to positive outcomes, and should be discontinued for programs, services, and supports that do not work or result in unintended negative consequences.”¹³²

To best align funding with positive outcomes, the State of Nevada should conduct an interim study on Child Welfare Funding in Nevada to review the sources of funding and how and to whom it is dispersed. Evaluating benchmarks and outcomes will ensure that financial resources are being directed toward programs and services that are most successful. This will foster transparency in operations in order to allow legislators, funders and the general public to see what services are working and where money needs to be directed and/or redirected. Once the comprehensive study is complete, Nevada will then be able to reassess and realign resources to best meet the needs of the community.

“Understanding the ways in which state child welfare agencies fund services can help children's advocacy organizations and other nongovernmental stakeholders deepen their knowledge of the child welfare system.”¹³³ With a deepened knowledge, these stakeholders would be able to work closely with Child Welfare Services Providers to promote positive lasting change in Nevada's child welfare arena. Stakeholders have already begun working to promote change through the Building Connections in Child Welfare Community Forums. Forum participants include those involved with the child welfare system, such as social workers, educators, medical personnel, lawyers, biological parents, foster parents, and youth. The purpose of these forums is to solicit feedback, insight, and recommendations around three core issues in child welfare:

1. Identification of the most pressing issues facing our community, including strengths and weaknesses;
2. Identification of the most significant organizational challenges to serving the child welfare population, including insights on capacity building approaches;
3. Discussion of strategies to strengthen collaboration and partnerships to improve our children and families.

¹³⁰ “Children In the States, Nevada,” <http://www.childrendefense.org/child-research-data-publications/data/state-data-repository/cits/2014/2014-nevada-children-in-the-states.pdf> (May 6, 2014)

¹³¹ “The State of America's Children Handbook,” <http://www.childrendefense.org/child-research-data-publications/data/soac-2012-handbook.pdf> (2012)

¹³² Child Welfare League of America, *National Blueprint for Excellence in Child Welfare*. p. 121

¹³³ State Policy Advocacy and Reform Center, “Knowing the Numbers: Accessing and Using Child Welfare Data,” <http://childwelfareparc.org/wp-content/uploads/2014/09/Knowing-the-Numbers.pdf> (September 2014)

To date, there have been two Building Connections in Child Welfare Community Forums; one held in 2011 and the other in 2013. During both forums, stakeholders reported that “it would be important to understand the varying (funding) sources to have a true knowledge of what the system really costs to support children and families,” and that “funds are not used effectively”. The need for transparency and understanding of operations is vital in order to ensure the success of these child welfare programs.

Recommendations for Improvement:

Conduct an interim study on child welfare funding in Nevada.

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CHILD MALTREATMENT - SPECIAL ISSUE

Child Sexual Abuse: Improving Interviewing Standards

“Traditional law enforcement interviewing methods used in typical adult cases are counterproductive when it comes to child victims or witnesses to crimes. Sometimes you see unsuccessful outcomes in cases because of poor interview techniques. In many cases of child abuse, for example, where the victim is the only witness, the interview may be a critical element of the investigation.”

♥ *Stephanie Knapp, Federal Bureau of Investigation Child Forensic Interviewer*¹³⁴

According to the National Children's Advocacy Center, “A forensic interview is a structured conversation with a child that is designed to elicit accurate accounts of events. The goals of the interviews are to collect information that will either corroborate or refute allegations or suspicions of maltreatment, and to determine the identities and behaviors of all persons involved.”¹³⁵ Forensic interviews allow children to share their stories in a safe and comfortable setting with an interviewer who is trained to conduct an objective, developmentally sensitive, and legally defensible interview (many interviews conducted by untrained individuals are not considered valid and do not hold up in court). It also reduces the number of times the child has to tell their story, as it is recorded during the original interview.¹³⁶ This dramatically diminishes the amount of distress, trauma, and adverse outcomes on a child.

There are currently two agencies in Nevada that conduct child forensic interviews: the Southern Nevada Children's Assessment Center (SNCAC) and the Washoe County Child Advocacy Center (WCCAC). These centers have staff that are “highly skilled professionals who comprise a multidisciplinary team including child protection workers, law enforcement officers, medical providers, prosecutors, family/victim advocates, forensic interviewers, and mental health professionals.”¹³⁷ They work collaboratively to “Reduce the amount of trauma children experience; enhance response to child maltreatment; and support the needs of child victims and their families.”¹³⁸

However, many child victims of sexual and physical abuse are still being interviewed by individuals who lack specialized training and are not educated on the topic of sex crimes and child abuse. This is mostly due to a lack of access and availability to the SNCAC and WCCAC.

Additionally, Nevada Revised Statutes 432B.270 does not require children be forensically interviewed:

¹³⁴ Federal Bureau of Investigation, “Child Forensic Interviewers,” http://www.fbi.gov/news/stories/2012/april/forensic-interviewers_042012 (April 20, 2012)

¹³⁵ National Children's Advocacy Center, “Forensic Interview Structure,” http://www.unc.edu/uploadedFiles/UMCedu/Content/Administration/Health_Equities/Childrens_Justice_Center/NCAC_forensic_interview_model.pdf

¹³⁶ “Changing the Child Abuse System,” <http://www.clarkcountynv.gov/Depts/sncac/Documents/Robin.pdf>

¹³⁷ “SN Children's Assessment Center,” <http://www.clarkcountynv.gov/depts/sncac/Pages/default.aspx>

¹³⁸ Ibid.

The child and any sibling of the child may be interviewed, if an interview is deemed appropriate by the designee, at any place where the child or any sibling of the child is found. A designee who conducts an interview pursuant to this subsection must be trained adequately to interview children. The designee shall, immediately after the conclusion of the interview, if reasonably possible, notify a person responsible for the child's welfare that the child or sibling was interviewed, unless the designee determines that such notification would endanger the child or sibling.

Currently, interviewing standards require an individual “complete a program of training for the detection and investigation of and response to cases of sexual abuse or sexual exploitation of children under the age of 18 years.”(NRS 432B.610)¹³⁹ The purpose of the training is to “provide the information needed to identify child abuse and to understand the officer’s responsibility in responding to this crime.”¹⁴⁰ After completing the training, the student must “pass a written exam at or above 70% on the following: Define “child” (NRS 432B.010); Define “abused child” (NRS 200.508.4a); Define “neglected child” (NRS 200.508); Identify the elements of Child Abuse; Identify the elements of Child Neglect; Identify the elements of contributing to the delinquency of a minor; Define duties of agencies which provide child welfare services (NRS 432B.030); Define “sexual abuse” (NRS 432.100); Identify the term “sexual penetration” (NRS 200.364); Identify the time period when an investigation of child abuse or neglect must be initiated; Identify when an abused child must be removed from a home; Identify the responsibility of the officer upon placing a child into protective custody and; Identify the proper considerations for interviewing a child victim.”¹⁴¹

The class, Child Abuse and Sexual Abuse of a Child, does not provide Peace Officers with all of the resources and training needed to forensically interview children. It focuses on ways they can conduct an interview to identify abuse and neglect, which then allows them the flexibility to determine whether child welfare services should be called. While Peace Officers may determine that child welfare services should be called, they should also be trained to identify when the need for a Forensic Interviewer is necessary.

Recommendations for Improvement:

- Invest in Child Assessment Centers to ensure all children have access to these specialized services.
- Establish a process of oversight to ensure all interviews are conducted properly to protect children from further trauma.

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¹³⁹ “Chapter 432B – Protection of Children from Abuse and Neglect,” <http://www.leg.state.nv.us/nrs/nrs-432B.html>

¹⁴⁰ “Peace Officers’ Standards and Training,” <http://post.nv.gov/uploadedFiles/postnvgov/content/Training/NAC289.140%20CAT%20I.pdf> (May 2013)

¹⁴¹ Ibid

2. YOUTH HOMELESSNESS

Nevada Children’s Report Card Grade: D

Child and youth homelessness is quickly becoming a crisis in the United States and in Nevada. According to the National Center on Family Homelessness, over 2.5 million children experienced homelessness in the United States during 2013 – that’s one in every 30 children in the nation, a “historic high in the number of homeless children in the U.S.”¹⁴² In the State of Nevada, 23,790 children were homeless in 2012. In 2013, the National Center on Family Homelessness ranked Nevada 44th in terms of child homelessness, a composite rank that includes the state’s extent of child homelessness, child well-being scores, risk factors for child homelessness, and state policy and planning efforts.¹⁴³ Research shows that children who experience homelessness together with their families are hungry and sick more often than their peers, struggle in school, and are more likely to experience mental health problems requiring clinical evaluation.¹⁴⁴

Unaccompanied homeless youth – youth who experience homelessness on their own – find themselves in an even more dangerous situation. In 2013, Nevada had the 5th highest incidence of unaccompanied children and youth experiencing homelessness in the nation, with 1,922 unaccompanied homeless children and youth (up to age 24) reported in the U.S. Department of Housing and Urban Development’s 2013 Annual Homeless Assessment Report to Congress. Though 5th in overall prevalence of youth homelessness, Nevada had the highest rate of unsheltered unaccompanied children and youth in the United States, with 88% of unaccompanied homeless children and youth under 25 found living on the streets—rather than in shelters—during the 2013 Point-In-Time count. These statistics point to a severe lack of adequate shelter for unaccompanied homeless youth in Nevada.¹⁴⁵

Most unaccompanied homeless youth become homeless after being forced to leave their homes due to severe family breakdown, including parental substance abuse, physical, emotional, and/or sexual abuse, and neglect. Life on the streets is dangerous for unaccompanied youth. According to the National Alliance to End Homelessness, one out of every three teens on the streets will be lured into prostitution within 48 hours of leaving home, and according to the National Network for Youth, more than one third of homeless youth engage in survival sex. Unaccompanied homeless youth are more likely than their peers to engage in substance abuse, suffer from mental and chronic physical health problems, contract sexually transmitted diseases, become pregnant, commit crimes, get involved in gangs, drop out of high school, and become homeless adults.¹⁴⁶

¹⁴² The National Center on Family Homelessness at American Institutes for Research, “America’s Youngest Outcasts Fact Sheet,” <http://new.homelesschildrenamerica.org/mediadocs/275.pdf>

¹⁴³ The National Center on Family Homelessness at American Institutes for Research, “America’s Youngest Outcasts: A Report Card on Child Homelessness,” <http://new.homelesschildrenamerica.org/mediadocs/280.pdf> (November 2014)

¹⁴⁴ The National Center on Family Homelessness at American Institutes for Research, “America’s Youngest Outcasts Factsheet,” <http://new.homelesschildrenamerica.org/mediadocs/275.pdf>

¹⁴⁵ “The 2013 Annual Homeless Assessment Report (AHAR) to Congress,” <https://www.hudexchange.info/resources/documents/ahar-2013-part1.pdf>

¹⁴⁶ The National Network for Youth, “Unaccompanied Youth Overview,” http://www.nn4youth.org/system/files/IssueBrief_Unaccompanied_youth.pdf

There exists an unprecedented need to increase the amount of federal funding for evidence-based services for homeless youth. Nevada is severely lacking in evidence-based programs for these homeless youth and there is a great need for increased research and policy reform targeting homeless youth populations. With costs for providing services being less than half the costs of incarceration, Nevada should make greater investments in the following key policy priorities.¹⁴⁷

Recommendations for Improvement:

- Nevada needs to develop more effective response to child homelessness which should include: ¹⁴⁸
 - Safe, affordable housing.
 - Comprehensive needs assessments of all family members.
 - Family-oriented services that incorporate trauma-informed care.
 - Identification, prevention, and treatment of major depression in mothers.
 - Parenting supports for mothers.
 - Education and employment opportunities for parents.
 - Further research to identify evidence-based programs and services for children and families.
- Nevada also needs to make greater investments in the following areas:^{149, 150}
 - A statewide system to gather better data.
 - Expanding the safety net for homeless and human trafficked youth and ensure that youth-appropriate interventions are available and accessible.
 - Increasing education and employment supports for youth.
 - Make services easier to access for youth.
 - Increase support for homeless young families including safe housing and access to quality child care and early childhood education.
 - Increase LGBTQ-specific support (up to 40% of homeless youth nationally identify as LGBTQ).¹⁵¹

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¹⁴⁷ With costs for providing services being less than half the costs of incarceration, greater investments in the following key policy priorities are required:

¹⁴⁸ The National Center on Family Homelessness at American Institutes for Research, "America's Youngest Outcasts Factsheet," <http://new.homelesschildrenamerica.org/mediadocs/275.pdf>

¹⁴⁹ The National Network for Youth, "Youth Homelessness in America: The Current Status and the Way Forward," <http://www.nn4youth.org/system/files/FINAL%20Summit%20Fact%20Sheet.pdf>

¹⁵⁰ The National Network for Youth, "Youth Homelessness in America: The Current Status and the Way Forward Policy Brief," <http://www.nn4youth.org/system/files/NN4Y%20-%20Youth%20Homelessness%20in%20America%20-%202014.pdf> (March 17, 2014)

¹⁵¹ <http://nationalhomeless.org/issues/lgbt/>

3. JUVENILE VIOLENCE

Nevada Children's Report Card Grade: D+

The juvenile violence grade is based upon high school violence, weapons on school property, dating violence, fear of violence, and juvenile justice. In 2013, 11.1% of Nevada's high school students felt unsafe attending school, ranking 38th in the Nation. Furthermore, Nevada ranked 4th out of 34 states with data for students reporting to have brought a weapon to school (3.3%), and 10th in the nation for the percentage of students who have been in a fight on campus (6.8%).¹⁵² The threat of violence at school directly disrupts the ability of students to achieve success in school and increases the need for medical care. The effects of violence at school are far reaching however, and affect not only fellow students, but also the school and community as a whole. To ensure children receive the education they need, schools must be both safe learning and teaching environments.

In addition to violence at school, many of Nevada's youth experience both physical and sexual dating violence. In 2013, Nevada ranked 29th out of 38 reporting states for physical dating violence and 29th out of 31 reporting states for sexual dating violence with 10.9% of individuals experiencing physical violence and 12.2% experiencing sexual violence. Youth often experience violence in dating and relationships when one person tries to maintain power and control over the other through verbal, physical, emotional, or sexual abuse. Teenagers may tend to accept and conform to sexual stereotypes in greater numbers than adults, and mistake controlling behavior as signs of caring or love. For these reasons, youth are a population particularly susceptible to intimidation and control through violence.¹⁵³

The challenges faced by Nevada's youth in juvenile violence can be seen further in the number of juveniles with involvement in the state's juvenile justice system. In 2013, Nevada ranked 36th in the nation in the number of youth in the juvenile justice system with 7,804 juveniles arrested per 100,000 children; well above the national average of 4,889.¹⁵⁴ The economic burden of juvenile justice involvement is great and has long lasting effects on the social services of the community.

Juvenile violence is widespread in the United States, and violence against youth is the second leading cause of death for young people between the ages of 15 and 24 nationwide. It affects not only youth, but the overall health of the community. It can increase health care costs, decrease property values, and disrupt social services, in addition to the economic burdens of juvenile justice detention. There exists a great need to adequately address and prevent all aspects of juvenile violence in order to improve the overall health of our children and our community as a whole.

¹⁵² "Nevada High School Youth Risk Behavior Survey 2013," nccd.cdc.gov/youthonline/App/Results.aspx?LID=NV (2013)

¹⁵³ See Appendix: Report Card Sources.

¹⁵⁴ "The State of America's Children," <http://www.childrendefense.org/child-research-data-publications/data/2014-soac.pdf> (2014)

Recommendations for Improvement:

- School districts in the state of Nevada should create school wide prevention and intervention strategies to increase school safety that include ongoing staff development and training, fostering school-law enforcement partnerships, instituting school-based links with mental health and social service agencies, and fostering school, family, and community involvement.¹⁵⁵
- Increase prevention efforts related to reducing teen dating violence which may include increasing access to evidence-based programs about healthy relationships offered in schools and other youth serving organizations. In addition, more information is needed to educate children on the harms of recruitment into prostitution by pimps as sex trafficking is a serious problem in Nevada.
- Youth that become involved in the juvenile justice system, during incarceration and while on probation, need access to adequate resources and treatment to assist in rehabilitation and to prevent recidivism.
- Courts need to use structured decision making processes and tools in order to reduce racial and ethnic disparities in juvenile justice processing.
- All juvenile justice data should be generated by gender, race and ethnicity in order to monitor the implementation of effective decision making processes and to track the reduction of disparities in the system.

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The following Special Issue provides additional information and recommendations for revisions to the Adam Walsh Child Protection and Safety Act.

JUVENILE VIOLENCE - SPECIAL ISSUE

Adam Walsh Child Protection and Safety Act

Congress approved the Adam Walsh Child Protection and Safety Act, H.R. 4472 (109th), in 2006 as a guideline for state laws on sex crimes. The law created a comprehensive national system for the registration of sex offenders and offenders against children, as well as creating a three-tier classification system for sex offenders based upon specified criteria, including the seriousness of the underlying offense and the age of any child involved.¹⁵⁶

1. Tier I Sex Offender – a sex offender other than a Tier II or Tier III Sex Offender.
2. Tier II Sex Offender – a sex offender other than a Tier III Sex Offender whose offense is punishable by imprisonment for more than 1 year and—
 - Is comparable to or more severe than the following offense, when committed against a minor, or an attempt or conspiracy to commit such an offense against a minor: sex trafficking; coercion and enticement; transportation with intent to engage in criminal activity; abusive sexual contact;
 - Involves use of a minor in a sexual performance; solicitation of a minor to practice prostitution; or
 - Occurs after the offender becomes a Tier I Sex Offender.
3. Tier III Sex Offender – a sex offender whose offense is punishable by imprisonment for more than 1 year and—
 - Is comparable to or more severe than the following offenses, or an attempt or conspiracy to commit such an offense: aggravated sexual abuse or sexual abuse; or abusive sexual contact against a minor who has not attained the age of 13 years;
 - Involves kidnapping of a minor (unless committed by a parent or guardian); or
 - Occurs after the offender becomes a Tier II Sex Offender.¹⁵⁷

A part of the creation of the national sex offender registry included the requirement that all convicted criminals, including those as young as 14 years old, be placed on the national registry.

¹⁵⁵ National Criminal Justice Reference Service, "School Policies and Legal Issues Supporting Safe Schools," <https://www.ncjrs.gov/pdffiles1/ojdp/book2.pdf> (September 2002)

¹⁵⁶ "H.R. 4472 (109th): Adam Walsh Child Protection and Safety Act of 2006," <https://www.govtrack.us/congress/bills/109/hr4472#summary>

¹⁵⁷ "Text of the Adam Walsh Child Protection and Safety Act of 2006," <https://www.govtrack.us/congress/bills/109/hr4472/text>

CONVICTED AS INCLUDING CERTAIN JUVENILE ADJUDICATIONS – The term `convicted' or a variant thereof, used with respect to a sex offense, includes adjudicated delinquent as a juvenile for that offense, but only if the offender is 14 years of age or older at the time of the offense and the offense adjudicated was comparable to or more severe than aggravated sexual abuse (as described in section 2241 of title 18, United States Code), or was an attempt or conspiracy to commit such an offense. Sec. 111(8)¹⁵⁸

This requirement, though, may cause more harm than good as “70% of the approximately 15,000 juveniles arrested for sexual offenses annually would qualify for lifetime registration under the tier III” guideline¹⁵⁹ many of whom have frequently been abused themselves; “approximately 40% to 80 % of juvenile sex offenders have been sexually abused as children and 25% to 50% have been physically abused.”¹⁶⁰ Additionally, placement on the registry can be detrimental to a young person’s development, making it difficult to progress through school and to participate in appropriate adolescent activities. Young people are still developing physically and emotionally and are thus highly amenable to change.¹⁶¹

Despite these concerns, Nevada is currently in full compliance with the Adam Walsh Child Protection and Safety Act, including the mandate requiring juveniles as young as 14 years old to register on the public sex offender registry. Every state that does not substantially implement the law will receive 10% less funding than would otherwise be allocated through the Omnibus Crime Control and Safe Street Act of 1968, specifically the Byrne Justice Assistance Grant. Sec 125¹⁶² It should be noted, however, that Nevada might be able to implement a reasonable alternative procedure or accommodation, such as allowing judicial discretion instead of having a registry mandate, that is consistent with the purposes of the Act and still receive full funding.

Alternative Procedures- If the jurisdiction is unable to substantially implement this title because of a limitation imposed by the jurisdiction’s constitution, the Attorney General may determine that the jurisdiction is in compliance with this Act if the jurisdiction has made, or is in the process of implementing reasonable alternative procedures or accommodations, which are consistent with the purposes of this Act. Sec. 125 (3)¹⁶³

Recommendations for Improvement:

Allow judicial discretion rather than mandating juveniles to register under a blanket classification. This would permit individual judges to review the individual cases and determine whether or not it is appropriate that the juvenile be placed on the sex offender registry.

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¹⁵⁸ “Text of the Adam Walsh Child Protection and Safety Act of 2006,” <https://www.govtrack.us/congress/bills/109/hr4472/text>”

¹⁵⁹ National Council of Juvenile and Family Court Judges, “An Examination of the Sex Offender Registration and Notification Act as Applied to Juveniles,” <http://www.ncjfcj.org/sites/default/files/examinationofthesexoffender.pdf> (2008)

¹⁶⁰ National Juvenile Justice Network, “Fact Sheet on Youth who Commit Sex Offenses,” <http://www.acacamps.org/sites/default/files/images/knowledge/Fact%20Sheet--Youth%20Offenders.pdf>

¹⁶¹ National Council of Juvenile and Family Court Judges, “National Association of Criminal Defense Lawyers,” http://www.ncjfcj.org/sites/default/files/nacd1.mag_0.pdf

¹⁶² “Text of the Adam Walsh Child Protection and Safety Act of 2006,” <https://www.govtrack.us/congress/bills/109/hr4472/text>

¹⁶³ Ibid.

4. CHILD DEATHS AND INJURY

Nevada Children's Report Card Grade: D+

For the purpose of the Report Card, the child deaths and injury grade is based upon the rate of all deaths per 100,000 children (35th), transportation related deaths (7th) and child drownings (23rd) in 2011. Updated information from 2012 shows that, the number of deaths due to injury for children ages 0-17 years was 11.90 per 100,000, which is slightly over the national average of 11.75 deaths per 100,000.¹⁶⁴

Unintentional injuries include things that are often referred to as "accidents". These include motor vehicle or traffic accidents, drowning, poisoning or overdose, suffocation, fire, etc. Unintentional injuries are the leading cause of hospitalization and death for children ages 1-18 years, both nationally and in Nevada.¹⁶⁵

In thinking about prevention of child deaths it is important to note that the leading causes of death for children are different depending on the age group. For example, younger children are more likely to be injured in non-motor vehicle related accidents, while older children are more likely to be injured in motor vehicle accidents. In fact, infants under one year of age most frequently die from injuries related to unsafe sleep positioning that causes asphyxia, while children ages 1-4 years are the group most at risk for drowning. Older children – those between 5 and 17 – are most commonly the victims in motor vehicle accidents.

According to the 2012 Statewide Child Death Report¹⁶⁶ created from data compiled by the local child death review teams statewide, the leading cause of death for children is non-motor vehicle accidents which specifically include suffocation, drowning, and poisoning/overdose which is consistent with the national data. Listed below are the counts and percentages of 2012 child deaths by manner and cause in Nevada (excluding natural and undetermined causes):

- Non-motor vehicle accidents – 57.8% (n=59)
 - Asphyxia (n=25)
 - Drug Exposed Infant (n=12)
 - Drowning (n=11)
 - Overdose (n=4)
 - Fire (n=3)
 - Animal Bite or Attack (n=1)
 - Other (n=3)

- Motor vehicle accidents – 19.6% (n=23)
 - Driver (n=3)
 - Passenger (n=15)
 - Pedestrian (n=5)
- Homicide – 12.7% (n=13)
- Suicide – 6.9% (n=7)

The common theme with all of these deaths is that they are preventable. Many of these deaths may have been prevented by providing education about risk factors and improving supervision for the children and youth at the time of the incident that led to the death. Recommendations to improve prevention efforts are listed in the section below.

Recommendations for Improvement:

- Continue to support the activities of child death review teams and increase funding designated for prevention activities.
- Support efforts related to improving firearm safety and restricting access to firearms from children and youth.
- Support and promote existing efforts to eliminate child drowning incidents by supporting consistent policy regarding barriers to residential swimming pools and supporting education about drowning prevention.
- Support programs that provide training for parents and caregivers of infants on safe sleep practices as well as those that ensure families have safe sleep spaces for infants by providing low or no cost cribs.
- Support efforts to provide substance abuse treatment to pregnant women.

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¹⁶⁴ Center for Disease Control and Prevention, "Fatal Injury Data," <http://www.cdc.gov/injury/wisqars/fatal.html> (August 29, 2014)

¹⁶⁵ Children's Safety Network. "2013 Nevada State Fact Sheet," <http://www.childrensafetynetwork.org/sites/childrensafetynetwork.org/files/Nevada%202013%20State%20Fact%20Sheet.pdf>

¹⁶⁶ Nevada Division of Child and Family Services, "2012 Child Death Review Report for Nevada", [http://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Tips/Reports/2012%20Statewide%20Child%20Death%20Report%20\(final\).pdf](http://dcfs.nv.gov/uploadedFiles/dcfsnvgov/content/Tips/Reports/2012%20Statewide%20Child%20Death%20Report%20(final).pdf)

SUBSTANCE ABUSE

Nevada Children's Report Card Grade: C-

In 2013, Nevada and other state high school students were surveyed and reported their drug and substance abuse. For tobacco use, Nevada ranked 4th for students who currently smoke, 3rd for smokeless tobacco use, and 2nd for any type of tobacco use. Results from the 2012 National Youth Tobacco Survey (NYTS) indicate that more than 1.78 million middle and high school students nationwide tried e-cigarettes. E-cigarettes do not just emit "harmless water vapor." Secondhand e-cigarette aerosol (incorrectly called vapor by the industry) contains nicotine, ultrafine particles and low levels of toxins that are known to cause cancer. Exposure to fine and ultrafine particles may exacerbate respiratory ailments like asthma and constrict arteries.¹⁶⁷ According to the CDC, more than half (51.1 percent) of the calls to poison centers due to e-cigarettes involved young children 5 years and under.¹⁶⁸ The 2012 NYTS found that 76.3% of middle and high school students who used e-cigarettes within the past 30 days also smoked conventional cigarettes.^{169, 170} This raises concerns that e-cigarettes may be an entry point to conventional tobacco products.

With regards to alcohol consumption, Nevada ranked 26th in the nation with 34% of Nevada high school aged youth reported currently drinking alcohol on a regular basis. In addition, 68.5% reported having had at least one drink in their life.¹⁷¹

With regard to drug use, Nevada ranks among the worst states for most drug use except heroin and marijuana (where Nevada ranks 15th of 29 and 15th of 42 reporting states) ranking 29th of 29 states for ecstasy use, 32nd of 35 states for methamphetamines use, 32nd of 34 states for prescription drug use, and 25th out of 36 for inhalant use.¹⁷²

Nevada's rate of treatment for alcohol use among persons aged 12 or older with alcohol dependence was lower than the national rate in 2008-2012. Among persons aged 12 or older with alcohol dependence, approximately 9,000 individuals received treatment in 2008-2012, representing only 4.2% of the populations reporting alcohol dependence. Evidence suggests that the younger the age of a person's onset of drug use, the higher the likelihood of the person's later development of addiction will be.¹⁷³ For these reasons, it is important to

appropriately address substance abuse issues in adolescent age youth with age-appropriate prevention, intervention, and treatment measures.

Recommendations for Improvement:

- Given the rise in the use of E-Cigarettes by youth, Nevada needs stronger policies that prohibit minors from possessing and using E-Cigarettes.
- Improve/enhance substance abuse treatment options for youth, especially ages 14-17.
- Require pharmacies to include information with prescriptions about the dangers of using prescription drugs for recreational purposes. In addition, require pharmacies to include importance of securing and tracking prescription drugs as well as information about options for proper disposal of unused prescriptions drugs.

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¹⁶⁷ Americans for Nonsmokers' Rights, "Electronic Smoking Devices and Secondhand Aerosol," <http://no-smoke.org/pdf/ecigarette-secondhand-aerosol.pdf> (2014)

¹⁶⁸ Centers for Disease Control and Prevention, "Notes from the Field. Calls to Poison Centers for Exposures to Electronic Cigarettes — United States, September 2010–February 2014," (April 4, 2014)

¹⁶⁹ Centers for Disease Control and Prevention, "Electronic Cigarette Use Among Middle and High School Students — United States, 2011–2012," (September 6, 2013)

¹⁷⁰ Legacy, "Tobacco Fact Sheet, Electronic Cigarettes," <http://www.legacyforhealth.org/content/download/582/6926/file/LEG-FactSheet-eCigarettes-JUNE2013.pdf> (May 2014)

¹⁷¹ "Nevada High School Youth Risk Behavior Survey 2013," nccd.cdc.gov/youthonline/App/Results.aspx?LID=Nv (2013)

¹⁷² Center for Disease Control and Prevention, "Youth Risk Behavior Surveillance — United States, 2013," <http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf> (June 13, 2014)

¹⁷³ National Institute on Drug Abuse, "Preventing Drug Abuse: The best Strategy," <http://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/preventing-drug-abuse-best-strategy> (July 2014)

INNOVATIVE FUNDING IN NEVADA

Pay for Success Model: Social Impact Bonds

In Nevada’s current fiscal environment, the government needs to ensure that tax payer dollars are spent on efficient and effective programs. Determining which programs will become or are effective is difficult without being able to measure the end results which causes legislators to take a leap of faith when deciding which or how a program should be funded. Pay for Success (PFS) models help alleviate this problem by allowing state and local governments to pay for positive results.

Pay for Success (PFS) models are financing arrangements where the government agrees to pay for successful outcomes from varying service providers. An exciting, new and innovative PFS model is Social Impact Bonds (SIBs) that allows the government to finance successful service programs. In this PFS model, the government defines the success outcome and contracts with an organization that they believe can meet that outcome, but only pays for their services if they reach the pre-determined threshold of success. Commonly with SIBs, private investors provide the initial capital to help fund the designated program that targets the government’s area of concern. The government pays back these investors their capital with a pre-determined amount of interest if the program is able to reach the agreed upon outcomes. If the program is unable to reach the agreed upon outcomes, the government does not pay back the investors for their initial investment.

Often, SIBs not only improve public outcomes, but also generate fiscal savings for the government. For example, in Salt Lake City, an SIB was created to decrease the number of low income students being placed in special education by providing preschool. The SIB in this example funded the Utah High Quality Preschool Program which, through improving school readiness and academic achievement, empowers students to enter kindergarten less likely to use special education services. This in turn results in cost savings for the school districts, the state of Utah, and other government entities.¹⁷⁴ This intervention creates enough savings for Utah to pay back the initial investors and to continue to fund preschool services in Salt Lake City.

How does it work?

While there are several ways to structure a social impact bond, the information below provides a general framework that is often used.

Phase I: Determining an Investment

The government determines an area that could lead to public savings and positive public impact if a certain intervention were funded for a target population.

Phase II: Creating a Contract

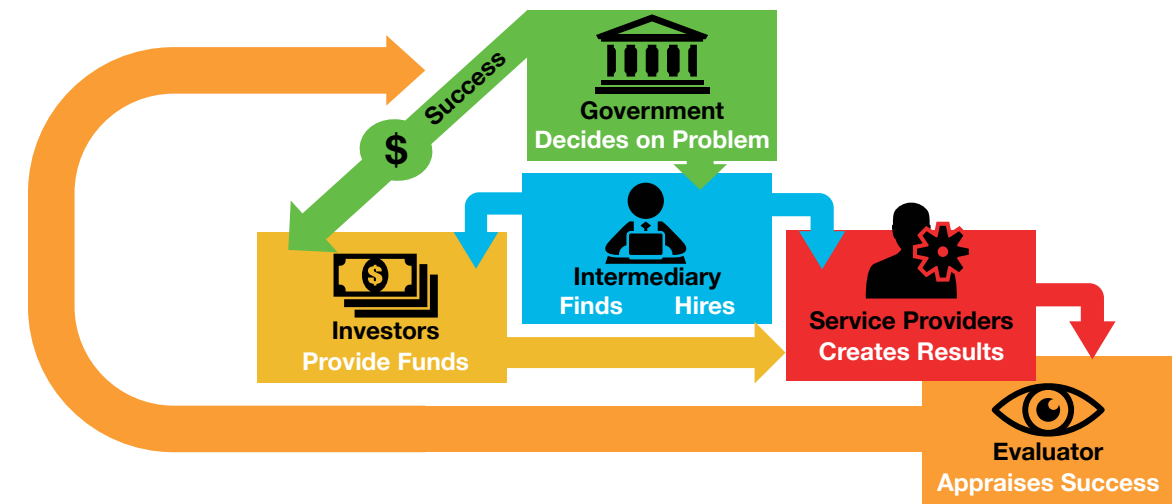
The government enters into a contract with an intermediary organization. During this phase, the intermediary finds investors, helps determine success metrics and finds a service provider.

Phase III: Implementing Services

While being overseen by the intermediary, service providers provide services for a targeted population. An independent evaluator measures the impact of the services and determines if the agreed upon success metric was met by the provider.

Phase IV: Making Payments

If success outcomes were met, the government repays investors their initial investment and (usually) a negotiated return through the intermediary organization.



What does this mean for the state of Nevada?

While Nevada has seen financial improvements since the Great Recession of 2008, many public programs are still not being funded at necessary amounts. For example, the state preschool program, which serves only 1.6% of the estimated 3 and 4 year old population¹⁷⁵, has seen decreases in its funding since inception despite reports showing success and research explaining the positive economic and social benefits of early childhood education. Even with the increase in revenue in the last couple years, Nevada still struggles to provide the needed public systems and structures to create a robust economy.

Social Impact Bonds are the perfect tool for Nevada to invest in proven and effective public programs for its citizens. The possibilities for SIBs are endless and are being used across the globe for different public services. Currently there are SIBs supporting services focused on reducing recidivism, improving early childhood education opportunities, developing employment skills, addressing homelessness, and assisting families through the adoption process. Some regions are exploring the possibilities of utilizing SIBs for programs serving the elderly population, addiction services, and nurse family partnerships among others.

¹⁷⁴ “Fact Sheet: The Utah High Quality Preschool Program,” <http://www.goldmansachs.com/what-we-do/investing-and-lending/urban-investments/case-studies/impact-bond-slc-multimedia/fact-sheet-pdf.pdf>

¹⁷⁵ Nevada Department of Education, “State PreK Program,” http://www.doe.nv.gov/Early_Childhood/

Recommendations for Improvement:

SIBs are most effective when the state is invested in the contract to help pay back investors from the captured savings. The State legislature should approve legislation to allow SIBs in Nevada and create a mechanism to capture state savings to assist in paying back investors and sustaining those proven programs.

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Appendix

2015

Appendix A:

2014 Children's Report Card Data & Sources

Appendix B:

Legislative Committee & Contact Information

Nevada Children's Report Card - 2014 Data and Sources

HEALTH	2014 Grade	2014 Rank	2014 NV Stat	2014 US Stat	stat year	2012 Grade	2012 Rank	2012 Stat	2012 US Stat	stat year	Description of Data
Access to Health Care	F					D					
Health Insurance	F-	51	6.60%	7.20%	2012	F	51	16.20%	7.50%	2011	Children without health insurance Source: http://ccf.georgetown.edu/all/american-community-survey-reveals-another-decline-in-unsured-rate-for-kids/
Medical Home	F-	50	44.60%	54.40%	2011-2012			45.40%	57.50%	2007	Children who have a medical home that is accessible, continuous, comprehensive, family centered, coordinated and compassionate Source: http://childhealthdata.org/browse/snapshots/nsch-profiles?geo=30&mp=16
Patient Provider Ratios	F-	46	69.4	90.1	2012	F	46	71.2	90.5	2010	Active Primary Care Physicians per 100,000 Population by Degree Type Source: https://www.aamc.org/download/362168/data/2013statephysicianworkforcedatabase.pdf , https://www.aamc.org/download/263512/data/statedata2011.pdf
Prenatal/Infant Health	C+										
Prenatal Care	D	38	11.00%	6%	2012	F		11.00%		2011	Births to Women Receiving Late or No Prenatal Care Source: http://datacenter.kidscount.org/data/tables/11-births-to-women-receiving-late-or-no-prenatal-care?c=1&loc=2&detail=22-52/false/868,867,133,38,35/any/265,266
Infant/Child Mortality	B+	18	5.72	6.27	2013	IB	17	5.85	6.39	2009	# per 1,000 (infant deaths < 1 year per # live births) Source: http://www.americashealthrankings.org/ALL/IMR
Low Birth Weight	C+	27	8.20%	8.10%	2013	C	22	8.30%	8.10%	2010	Percentage of infants weighing less than 2500 grams (5 pounds, 8 ounces) at birth. Source: http://www.americashealthrankings.org/Measures/Measure/NV/birthweight
Immunizations	D+										
Immunizations	D+	38	88%	90%	2012	F	49	85%	90%	2011	19-35 month old children Source: http://www.americashealthrankings.org/measures/Measure/ALL/immunize
Childhood Obesity	C										
Physical Fitness	C	25	55%	52.70%	2013						9-12 grade students not physically active 5 days per week, 60+ minutes) Source: http://www.cdc.gov/healthyyouth/ybs/factsheets/index.htm#compare
Childhood Obesity	D	36	33.2%	31.3%	2011-2012	C	26.20%	28.20%	2011		children age 10 to 17 with BMI at or above 85th percentile Source: http://www.childhealthdata.org/browse/rankings/maps?s=84
Nutrition	B	18	6.4%	6.6%	2013						9-12 grade students who did not eat vegetables during the 7 days before the survey Source: http://www.cdc.gov/healthyyouth/ybs/factsheets/index.htm#compare
Mental Health	D+										
Mental Health Treatment	F	49	49.30%	61.00%	2011						Receipt of needed mental health treatment or counseling in the past 12 months Source: http://www.nschdata.org/browse/allstates?q=2504
Attempted Suicide	B	16	6.80%	8.8%	2013	D	19	9.40%	8%	2011	# NV HS students who attempted suicide Source: http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf Notes: 16 out of 40
Suicide Rate	D	36	3.88	2.00	2011		10	1.57	1.85	2010	Suicide Rate Ages 0-18 Source: http://webappa.cdc.gov/sasweb/ncipc/dataRestriction_inj.html
Dental Health	F										
Child's Teeth	F	51	12.30%	7.60%	2011						Child's Teeth described as fair/poor condition Source: http://www.nschdata.org/browse/allstates?q=2458
Preventive Care	F	50	32.60%	22.80%	2011						No preventive dental care visits in the past year Source: http://www.nschdata.org/browse/allstates?q=2500
Sexual Health	C-										
Teen Birth Rate	D	32	33.00	29.00	2012	D	35	39.00%	34.00%	2010	# of births for teens age 15 to 19 per 1000 females Source: http://datacenter.kidscount.org/data/tables/6053-total-teen-births#detailed/1/any/false/868,867,133,38,35/any/12721,12722
Sexual Activity	B	15	29.20%	31.00%	2013						currently sexually active Source: http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf Notes: 15 out of 36
Condom Use	C	16	59.00%	57.75%	2013						Condom use during last sexual intercourse Source: http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf Notes: 16 out of 36
No birth control use	F	29	16.00%	13.10%	2013						HS students who did not use any method to prevent pregnancy during last sexual intercourse Source: http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf Notes: 29 out of 34
STD Rate	B	20	1,966.10	2,254.14	2011						Chlamydia rate 15-24 year olds per 100,000 Source: http://www.cdc.gov/std/stats/by-age/15-24-all-STDs/default.htm
	C	22	304.60	410.84	2011						Syphilis rate 15-24 year olds per 100,000 Source: http://www.cdc.gov/std/stats/by-age/15-24-all-STDs/default.htm
	D	38	9.70	7.17	2011						Gonorrhea rate 15-24 year olds per 100,000 Source: http://www.cdc.gov/std/stats/by-age/15-24-all-STDs/default.htm

Nevada Children's Report Card - 2014 Data and Sources

SAFETY & SECURITY	2014 Grade	2014 Rank	2014 NV Stat	2014 US Stat	stat year	2012 Grade	2012 Rank	2012 Stat	2012 US Stat	stat year	Description of Data
Child Maltreatment	C-										
Foster Care Placement	D	32	5.0	3.0	2012	D	24	4.00	3.00	2011	# of children removed & placed in foster care, per 1,000 children under age 18 in population Source: http://datacenter.kidscount.org/data/tables/6266-children-0-to-17-entering-foster-care#ranking/2/any/true/868,867,15620
Maltreatment	B	19	8.2	9.2	2012	B	18	7.3	10	2010	Total child maltreatment victims rate per 1,000 of the population under age 18 Source: http://www.acl.hhs.gov/sites/default/files/cb/cm2012.pdf#page=31
Physical	F	45	34.7	18.3	2012						Source: http://www.childrendefense.org/child-research-data-publications/data/2014-soac.pdf
Sexual	B	12	4.9	9.3	2012						Source: http://www.childrendefense.org/child-research-data-publications/data/2014-soac.pdf
Neglect	C	28	75.7	78.3	2012						Source: http://www.childrendefense.org/child-research-data-publications/data/2014-soac.pdf
Youth Homelessness	D										
Accompanied Youth	B	14	0.4%		2012						Source: https://www.hudexchange.info/resources/documents/2012-AHAR-Volume-2-Section-3.pdf Notes: Share of Homeless Families in the US
Unaccompanied Youth	F	45	1,922.0	2013							Source: https://www.hudexchange.info/resources/documents/ahar-2013-part1.pdf Notes: Estimates of Unaccompanied Homeless Children and Youth
	F	50	88.1	2013							Source: https://www.hudexchange.info/resources/documents/ahar-2013-part1.pdf Notes: % of Unaccompanied Children and Youth who were Unsheltered
Juvenile Violence	D+										
High School Violence	B	10	6.8%	8.4%	2013	C	22	9.30%	12%	2011	NV HS students reported involvement in fighting on school property Source: http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf Notes: 10 out of 35
Weapons on school property	A	4	3.3%	5.6%	2013	D+	33	4.10%	5.40%	2011	NV HS students reported to have carried a weapon on school property Source: http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf Notes: 3 out of 34
Dating Violence	D	29	10.9%	9.9%	2013	C	28	10.70%	9.40%	2011	Physical Violence Source: http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf Notes: 29 out of 38
	F	29	12.2%	10.6%	2013						Sexual Violence Source: http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf Notes: 29 out of 31
Fear of Violence	D	38	11.1%	7.1%	2013	B	14	5.80%	6%	2011	NV HS students who felt unsafe attending school in the past 30 days Source: http://nccd.cdc.gov/YouthOnline/App/Default.aspx
Juvenile Justice	D	36	7,804	4,889	2010						Arrests per 100,000 children 10-17 Source: http://www.childrendefense.org/child-research-data-publications/data/2014-soac.pdf
Child Deaths	D+										
Child Deaths	D	35	17.69	14.07	2011	C+	21	17	18	2010	All Deaths per 100,000 Source: http://webappa.cdc.gov/sasweb/ncipc/dataRestriction_inj.html
Road Traffic Injuries and Death	A	7	3.31	4.56	2011						Transport Deaths Source: http://webappa.cdc.gov/sasweb/ncipc/dataRestriction_inj.html
Drownings	D	23	1.58	1.22	2011						Drowning Deaths Source: http://webappa.cdc.gov/sasweb/ncipc/dataRestriction_inj.html Notes: 23 out of 33
Substance Abuse	C-										
Alcohol, Tobacco	D	26	34.00%	32%	2013	D+	6	71.80%	71%	2011	NV Students who currently drank alcohol Source: http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf Notes: 26 out of 41
	C	17	40.40%	39%	2013	C+	25	45.30%	45%	2011	NV HS students who have ever smoked any of a cigarette Source: http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf Notes: 17 out of 34
	A	4	10.30%	14%	2013						NV HS students who currently use cigarettes Source: http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf Notes: 4 out of 41
	A	3	5.00%	9%	2013						Current smokeless tobacco use Source: http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf Notes: 3 out of 38
	A	2	14.80%	26%	2013						use any form of tobacco Source: http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf Notes: 2 out of 35

Nevada Children's Report Card - 2014 Data and Sources

2014 Grade	2014 Rank	2014 NV Stat	2014 US Stat	stat year	2012 Grade	2012 Rank	2012 US Stat	stat year	Description of Data
F	32	34.00%	31.64%	2013	F+	18	5.40%	2011	NV HS students that have used methamphetamines at least once in their lives Source: http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf Notes: 32 out of 35
F	31	7.70%	5.79%	2013	F+	9	7.50%	2011	NV HS students have used any form of cocaine Source: http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf Notes: 31 out of 37
B	15	18.70%	19.84%	2013					use marijuana Source: http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf Notes: 15 out of 42
B	25	10.30%	9.38%	2013					Inhalants Source: http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf Notes: 25 out of 36
F	29	11.20%	6.92%	2013					ecstasy Source: http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf Notes: 29 out of 29
C	15	3.30%	3.43%	2013					heroin Source: http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf Notes: 15 out of 29
F	32	5.20%	3.99%	2013					prescription drugs Source: http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf Notes: 32 out of 34

EDUCATION	2014 Grade	2014 Rank	2014 NV Stat	2014 US Stat	stat year	2012 Grade	2012 Rank	2012 US Stat	stat year	Description of Data
School Readiness	F	F								
Pre-K Enrollment	F-	51	31.7%	47.7%	2012	F	51	31.40%	2011	Percentage of 3 and 4 year olds enrolled in preschool Source: http://www.edweek.org/media/ew/qc/2014/sshr/16shr.nv.h33.pdf
Pre-K Availability	F	49	10.9%	27.4%	2012-2013	F	48	11.00%	2011-2012	Enrollment of 3- and 4-year-olds in State Pre-K. Preschool Special Education and Federal and State Head Start Source: http://nieer.org/sites/nierr/files/yearbook2013.pdf
Pre-K Spending per Capita	F-	41	\$44.59	\$666.25	2012-2013	F	40	\$45.50	2011-2012	State spending on pre-K programs per capita (out of 41 states) Source: http://nieer.org/sites/nierr/files/yearbook2013.pdf
Student Achievement	F	F								
4th Grade Reading	F+	45	34.0%	41.3%	2013	F	46	25.50%	2011	Percent of 4th Grader's Reading Scores Proficient and above Source: http://www.edweek.org/media/ew/qc/2014/sshr/16shr.nv.h33.pdf
8th Grade Math	D+	39	30.3%	34.3%	2013	D	40	28.60%	2011	Percent of 8th Grader's Math Scores Proficient and Above Source: http://www.edweek.org/media/ew/qc/2014/sshr/16shr.nv.h33.pdf
Postsecondary Participation	F-	50	40.6%	55.8%	2012	F	50	43.10%	2011	Young adults enrolled in postsecondary education or with a degree Source: http://www.edweek.org/media/ew/qc/2014/sshr/16shr.nv.h33.pdf
High School Completion	F	F								
High School Dropout Rate	F+	47	7.0%	4.0%	2012	F	50	9.00%	2010	Youth of high school age who are not attending Source: http://datacenter.kidscount.org/data/tables/73-teens-ages-16-to-19-not-in-school-and#ranking/2/any/true/868/any/381
High School Graduation Rate	F+	48	62.7%	74.7%	Class of 2010	F	50	59.20%	Class of 2009	Graduation Rates Source: http://www.edweek.org/media/ew/qc/2014/sshr/16shr.nv.h33.pdf
Funding	F	F								
Money per Pupil	F-	45	\$8,223	\$10,608	2012	F	45	\$8,363	2009	PreK to 12th public actual expenditures Source: http://www2.census.gov/govs/school/1203pub.pdf
Pupil to Teacher Ratio	F-	47	20.8	16.0	2011-2012	F	48	20.1	2010-2011	PreK and 12th public student-teacher ratio - students per teacher Source: http://nces.ed.gov/pubdocs2013/2013441.pdf and http://nces.ed.gov/pubdocs2012/2012325rev.pdf

Legislative Committee & Contact Information

Assembly Standing Committees

Commerce and Labor	Kirner (C), Seaman (VC), P. Anderson, Bustamante Adams, Carlton, Diaz, Ellison, Fiore, Hansen, Kirkpatrick, Neal, Nelson, O'Neill, Ohrenschall, Silberkraus
Education	Woodbury (C), Stewart (VC), E. Anderson, Armstrong, Diaz, Dooling, Edwards, Flores, Gardner, Hickey, Joiner, Munford, Shelton, Swank
Legislative Operations and Elections	Stewart (C), Shelton (VC), E. Anderson, Moore, Munford, Ohrenschall, Seaman, Thompson, Trowbridge
Government Affairs	Ellison (C), Moore (VC), Carrillo, Dooling, Flores, Joiner, Munford, Neal, Silberkraus, Spiegel, Stewart, Trowbridge, Woodbury
Health & Human Services	Oscarson (C), Titus (VC), Araujo, Benitez-Thompson, Dickman, Gardner, Hambrick, Jones, Moore, Munford, Spiegel, Sprinkle, Thompson, Trowbridge
Judiciary	Hansen (C), Nelson (VC), E. Anderson, Araujo, Diaz, Fiore, Gardner, Jones, O'Neill, Ohrenschall, Seaman, Thompson, Wheeler
Natural Resources Agriculture, & Mining	Titus (C), Wheeler(VC), Araujo, Carlton, Carrillo, Dooling, Edwards, Ellison, Gardner, Hansen, Joiner, Oscarson, Swank
Taxation	Armstrong (C), Kirner (VC), Benitez-Thompson, Bustamante Adams, Diaz, Dickman, Hambrick, Hickey, Kirkpatrick, Neal, Nelson, Trowbridge
Transportation	Wheeler (C), Dickman (VC), Araujo, Carrillo, Dooling, Fiore, Flores, Jones, Kirkpatrick, O'Neill, Silberkraus, Spiegel, Sprinkle, Woodbury
Ways and Means	P. Anderson (C), Hambrick (VC) Armstrong, Benitez-Thompson, Bustamante Adams, Carlton, Dickman, Edwards, Hickey, Kirkpatrick, Kirner, Oscarson, Sprinkle, Swank, Titus

Senate Standing Committees

Commerce and Labor	Settelmeyer (C), Farley (VC), Atkinson, Hardy, Harris, Manendo, Spearman
Finance	Kieckhefer (C), Roberson (VC), Goicoechea, Lipparelli, Parks, Smith, Woodhouse
Government Affairs	Goicoechea (C), Hardy (VC), Atkinson, Lipparelli, Parks
Education	Harris (C), Hammond (VC), Denis, Gustavson, Lipparelli, Segerblom, Woodhouse
Judiciary	Brower (C), Harris (VC), Ford, Hammond, Kihuen, Roberson, Segerblom
Legislative Operations, etc	Farley (C), Settelmeyer (VC), Atkinson, Brower, Segerblom
Natural Resources	Gustavson (C), Goicoechea (VC), Manendo, Settelmeyer, Smith
Health & Human Services	Hardy (C), Kieckhefer (VC), Lipparelli, Smith, Woodhouse
Transportation	Hammond (C), Gustavson (VC), Denis, Farley, Manendo
Revenue & Economic Development	Roberson (C), Brower (VC), Ford, Hardy, Kieckhefer, Kihuen, Spearman

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A complete list of phone numbers, email addresses, and fax numbers can be found at www.leg.state.nv.us/lcb/research/leginfo.cfm. Assembly and Senate Standing Committee assignments as of January 6, 2015.

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