Children's Advocacy ALLIANCE

Nevada Children's Report Card

2026 Call to Action

Metrics By Design

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About the 2026 Children's Report Card

The Children's Advocacy Alliance (CAA) is Nevada's independent voice for children, advancing policy solutions in children's health, child welfare, and early education. Through research, advocacy, and cross-sector collaboration, CAA works to ensure every Nevada child has the opportunity to grow up safe, healthy, and supported.

CAA proudly serves as Nevada's KIDS COUNT® grantee through the Annie E. Casey Foundation. Each year, CAA publishes a Nevada Data Book, providing policymakers, community leaders, advocates, and families with reliable, accessible data to better understand the status of child well-being in Nevada. CAA also contributes Nevada's data to the national KIDS COUNT Data Center, ensuring state trends are reflected in one of the nation's leading child well-being resources.

The *2026 Nevada Children's Report Card: A Call to Action* presents data across three core pillars: Early Education, Children's Health, and Child Welfare. It provides a data-driven snapshot of the current Nevada landscape, highlighting statewide trends, disparities, and opportunities for action while examining the policies, systems, and community conditions that influence child well-being.

The report draws upon the most current publicly available federal, state, and local data for each indicator. Sources include administrative records, population surveys, vital statistics, legislative audits, program reports, and geographic information system (GIS) mapping. Because publication schedules differ across agencies, reporting years may vary by indicator and are identified throughout the report. All indicators use the most currently available estimates and previous estimates, within 1-3 years. Statewide trend results are purely directional (indicating positive or negative movement over time) rather than causal or statistically significant.

Whenever possible, indicator values are presented alongside historical trends, national comparisons, demographic breakdowns, and regional analyses to provide additional context. Geographic mapping is used to examine how location– including environmental exposures, service availability, and community conditions– may influence child and family well-being. To improve readability and accommodate the breadth of data contained in this report, citations are consolidated in the reference section rather than repeated throughout individual pages. Complete source documentation for each figure, table, and indicator is available upon request.

The findings presented in this report should be interpreted in light of several common data limitations. Differences in reporting systems, sample sizes, confidence intervals, missing demographic information, and data suppression may affect the completeness or comparability of results. Administrative datasets generally reflect only the populations served or captured by the reporting agency and may not represent the full statewide system. For example, the Division of Child and Family Services behavioral health waitlist data do not include services provided through Nevada Medicaid or commercial insurance.

The Opportunities for Action presented throughout the report are informed by observed trends, disparities, system performance, research evidence, and identified data gaps. They are not intended to serve as definitive recommendations or conclusions, but rather to support discussion, guide future research, strengthen data infrastructure, and inform policies and investments that improve outcomes for Nevada's children and families.

Use of Generative AI and AI-Assisted Technologies

This report includes content that was generated or edited with the assistance of generative AI technologies. These tools were used to support literature review, drafting and refining text, editing, and formatting. All AI-assisted content was reviewed, verified, and revised by the report authors to ensure accuracy and appropriateness. All data collection, data analysis, interpretation of findings, figures, tables, and conclusions were developed and validated by the report authors.

A Word from the Executive Director

CAA has a track record: identify the gaps in children's data, then move forward with innovative, cross-cutting solutions. This year's report card follows the same pattern, and we're excited to work with you to find and build the solutions we need.

Past Progress

There's real progress to build on. In early childhood, we used the childcare gap to build the case for dedicated pre-k funding. In children's health, maternal mortality data inspired us to push for Medicaid coverage for doulas, and the CMHAC identified a universal need for early intervention workforce, work that became SB165. In child welfare, we surfaced the kinship care shift and pushed to get relative caregivers the same financial and navigation support as licensed foster homes.

Where The Gaps Remain

In childcare, licensed capacity is still just 25 seats per 100 children under five. We're using that number to build the case for dedicated state investment in early childhood.

In maternal health, Black women in Nevada die from pregnancy complications at three times the state average. Next session, we want to build on the doula work with more prevention: lactation consultants, home visits, the supports that catch problems early.

In children's mental health, Nevada's female teens die by suicide at a rate 58% higher than the national average, and Nevada estimates were unavailable for 4 of 7 race and ethnicity groups. As a result, 57% of demographic group data is essentially invisible when it comes to targeting prevention dollars. We're missing vital connections.

In child welfare, we need to invest more in prevention so kids can safely stay home, and keep improving the transition to independent living for youth aging out of foster care.

Our 2026 Call to Action

- ★ Early childhood investments in affordability, capacity, and workforce, with collaborative governance across agencies.
- ★ Coordinated children's mental health efforts across state agencies so no child falls through the cracks.
- ★ Expanded race and ethnicity data collection so prevention resources go where they're actually needed.
- ★ Stronger child welfare outcomes for kids and families in the system.

None of this is partisan. It helps every Nevada kid, in every county, no matter their background.

Together, we can act.

Elisa Cafferata

Elisa Cafferata
Executive Director
Children's Advocacy Alliance of Nevada
August 2026

Acknowledgements

The Children's Advocacy Alliance extends our sincere gratitude to the many individuals and organizations whose support made the *2026 Nevada Children's Report Card: Call for Action* possible.

This research was funded by the Annie E. Casey Foundation. We thank the Foundation for its generous support; however, the findings and conclusions presented in this report are those of the author(s) alone and do not necessarily reflect the opinions of the Foundation.

This report was researched, analyzed, written, and designed by Metrics By Design, in partnership with the Children's Advocacy Alliance, who guided the development of this publication. We are deeply grateful for Metrics by Design's expertise, collaboration, and commitment throughout the research and production process.

We also thank the Children's Advocacy Alliance Board of Directors for their leadership and unwavering commitment to improving the lives of Nevada's children and families.

2026 Board of Directors

Acknowledgements

Finally, we extend our appreciation to the Children's Advocacy Alliance team for their dedication to advancing policies that improve the health, education, and well-being of Nevada's children and families.

Children's Advocacy Alliance Team

Elisa Cafferata, Executive Director

Annette Dawson-Owens, Child Welfare Policy Director

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Report Credits

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Anruo Wang

About the Team

Cecelia Di Mino is a Nevada native and founder of Metrics By Design, partnering with public agencies and nonprofit organizations to strengthen programs through evaluation, performance improvement, and data-informed policy. She has advanced training in humanitarian response, evaluation science, and social impact through the Harvard T.H. Chan School of Public Health and the Blum Center for Developing Economies at the University of California, Berkeley. Cecelia holds a Master of Education in Human Development and Education from Harvard University and a B.A. in Linguistics from the University of California, Berkeley. She is committed to advancing equitable, data-informed solutions that improve opportunities and outcomes for children, families, and communities.

Anruo Wang is a GIS specialist and policy analyst with experience in geospatial analysis, and mix-methods policy research. Her professional experience includes geospatial research with the Massachusetts Institute of Technology, geospatial and data analysis for the City of Las Vegas, and policy research with Year Up United, United Nations Secretariat and UNESCO-ICHEI. She holds a Master of Education in Education Policy and Analysis from Harvard University and a BSc in Social Policy from the London School of Economics and Political Science. Anruo is passionate about using data to make complex policy challenges visible and accessible, believing that when the right people can see the right information clearly, it has the power to drive meaningful change for families and communities.

Elisa Cafferata is a fourth-generation Nevadan, an unrepentant #nightowl, champion of change, and an experienced advocate. She brings decades of advocacy to her position as the Executive Director of the Children's Advocacy Alliance. She has been recognized for her policy wins for public health, women's equity, workforce development, and earned paid sick leave.

Annette Dawson Owens is a lifelong Nevadan, working in Community Engagement and as a Policy Director for the past six years with Children's Advocacy Alliance, advancing education, child welfare, health, and workforce policy and practices. She holds master's degrees from the University of Nevada, Las Vegas and Sierra Nevada University, was appointed by the Governor to serve on the Nevada State Board of Education and is dedicated to improving outcomes for Nevada's children and families.

Jamelle Nance currently serves as the Early Childhood Policy Director at the Children's Advocacy Alliance, bringing over a decade of experience supporting children and families through direct service, program leadership, and equity-centered community initiatives. Jamelle began her career working in the juvenile justice system – an experience that deepened her understanding of how early childhood experiences shape lifelong outcomes. Motivated to address challenges at their root, she transitioned into working within the early childhood sector with a holistic, family-centered approach. Grounded in public service, Jamelle is committed to empowering families through education, advocacy, and community partnership.

Alexis Marin, M.A., serves as the Health Policy & Advocacy Manager at the Children's Advocacy Alliance. With a master's degree in Social Policy from the University of Chicago and experience advancing policy initiatives through the Illinois Justice Project, she brings a research-driven approach to improving systems and outcomes for Nevada's children and families.

Sophie Ralston leads the Children's Advocacy Alliance's communications and social media efforts. A Reno native, she is an artist, designer, and arts educator with experience in marketing and administration. Sophie earned a bachelor's degree in Cultural Anthropology with a minor in Digital Media from the University of Nevada, Reno and is passionate about using her creative talents to advance the Alliance's mission.

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Nevada • 2026

CHILDREN'S REPORT CARD

A synthesis of evidence from children's systems across three policy pillars: Children's Health, Early Education, and Child Welfare.

Checkmarks categorize the findings most relevant to each section.

SECTION	EVIDENCE OF PROGRESS	AREAS REQUIRING ATTENTION	MIXED / CONTEXTUAL FINDINGS	EVIDENCE GAPS
BEHAVIORAL HEALTH	✓	✓	✓	✓
MATERNAL & INFANT HEALTH		✓		✓
EARLY LEARNING		✓	✓	✓
SAFETY & PREVENTION		✓		✓
OUT-OF-HOME CARE	✓	✓	✓	✓

Evidence of Progress
Findings show measurable improvements or positive movement.

Areas Requiring Attention
Findings suggest concerns or challenging trends that warrant further evaluation.

Mixed / Contextual
Evidence reflects meaningful tradeoffs, with strengths and challenges occurring simultaneously.

Evidence Gaps
Data are insufficient or missing to draw conclusions about current performance.

Early Education

Investing early creates opportunities that last a lifetime.

Early learning begins years before children enter kindergarten and is shaped by the availability, affordability, and quality of early childhood opportunities. This section examines key indicators across these areas to identify trends, disparities, and opportunities to strengthen school readiness, support working families, and improve lifelong outcomes.

Topics Include:

- Early Learning Access
- Childcare Capacity
- Affordability & Family Support

2026 Call To Action

PILLAR 1: EARLY EDUCATION

Early Learning and Access

Do Nevada's youngest children have access to early learning opportunities?

Methodology: Data reflect the most current available estimates and the most recent available estimates, from 1–3 years prior. State trend results are directional only.

NEVADA EARLY LEARNING INDICATORS (CHILDREN UNDER 6)	STATE Previous	STATE Recent	STATE Trend	NATIONAL Recent
Preschool Enrollment Percentage of children ages 3–4 enrolled in preschool (2024)	34.3 Per 100	38.9 Per 100	↑ Increasing	49.3 Per 100
Public Preschool Enrollment Percentage of children ages 3–4 enrolled in public preschool (2024)	23.3 Per 100	23.0 Per 100	↓ Decreasing	28.8 Per 100
Private Preschool Enrollment Percentage of children ages 3–4 enrolled in private preschool (2024)	11.0 Per 100	15.9 Per 100	↑ Increasing	20.5 Per 100
Childcare Cost Burden Percentage of a single-parent family's median income needed for annual center-based toddler care (2025)	29.0 Per 100	33.0 Per 100	↑ Increasing	33.0 Per 100
Licensed Childcare Capacity Licensed childcare seats per 100 children under age 5 (2025)	26.1 Per 100	25.1 Per 100	↓ Decreasing	57.2 Per 100
Children Living Below 200% of the Federal Poverty Level Percentage of children under age 6 living below 200% of the federal poverty level (2024)	43.4 Per 100	38.5 Per 100	↓ Decreasing	36.3 Per 100
Single-Parent Households with at least One Child Under 6 Percentage of households headed by a single parent with at least one child under age 6 (2024)	37.9 Per 100	37.4 Per 100	↓ Decreasing	36.5 Per 100
Parents in Labor Force with Children Under 6 Percentage of children under age 6 with all available parents in the labor force (2024)	65.0 Per 100	71.2 Per 100	↑ Increasing	69.6 Per 100
Kindergarten Readiness Percentage of children meeting kindergarten readiness expectations	N/A	N/A	Unknown	N/A

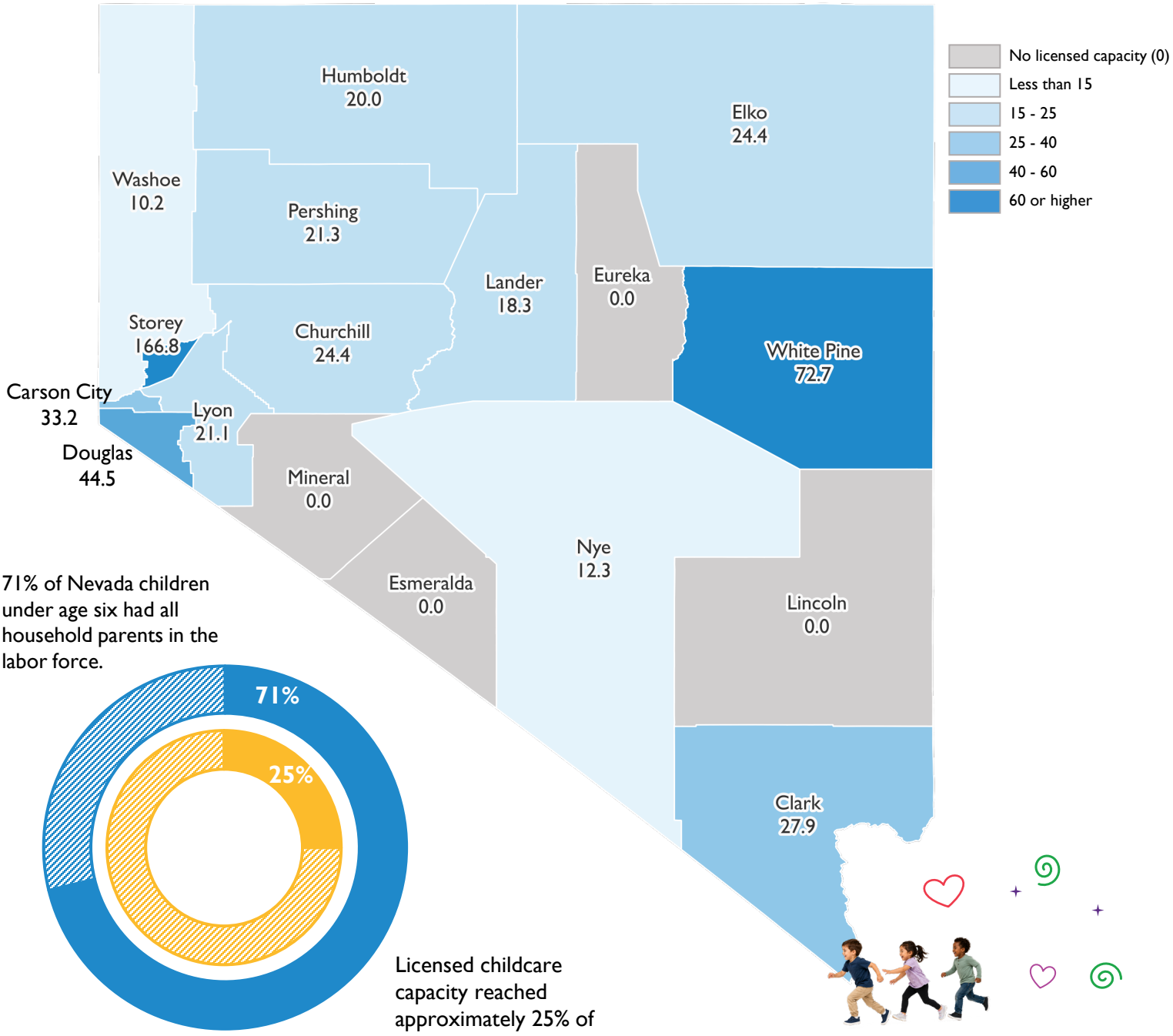
Approximately 29 states and the District of Columbia require statewide kindergarten entry assessments for incoming kindergarten students, an increase of four states since 2020. This growth reflects the expanding use of kindergarten readiness assessments to monitor school readiness and inform early childhood system performance.

DATA INSIGHTS · EXPANDING EARLY LEARNING ACCESS

Where Are Early Learning Opportunities Available in Nevada?

Licensed provider capacity varies substantially across Nevada. In 2025, a total of 99 childcare facilities across the state closed. Among these, childcare centers and family childcare homes experienced the greatest provider turnover: 77% of all facility closures.

Childcare Capacity: Licensed Seats per 100 Children Under Age 5



71% of Nevada children under age six had all household parents in the labor force.

Licensed childcare capacity reached approximately 25% of children under age 5.

Opportunity for Action:
Prioritize early childhood investments in communities with limited licensed childcare capacity and examine communities with higher licensed capacity to identify scalable strategies and promising practices (e.g., Storey County).

Affordability | Provider Availability | Workforce Capacity | Geographic Access

DATA INSIGHTS · EXPANDING EARLY LEARNING ACCESS

Nevada is Expanding Preschool Enrollment— But Remains Below the National Average

1 PRESCHOOL PARTICIPATION (AGES 3-4)

Nevada	United States
38.9%	49.3%

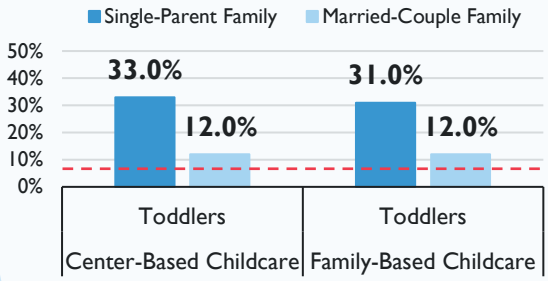
+4.6 percentage-point increase from 2023-2024.

Approximately 6 in 10 Nevada children ages 3–4 are not enrolled in preschool.

2 ACCESS BARRIER: CHILDCARE AFFORDABILITY

Nearly 4 in 10 Nevada households with children under age 6 are single-parent households.

2025 Childcare Cost as a Percentage of Median Family Income



Dashed Line Represents Federal Affordability Benchmark at 7% Median Family Income

3 CAPACITY BARRIER: DECLINING SEATS

Approximately one licensed childcare seat is available for every four preschool-aged children in Nevada.

Licensed Childcare Capacity
(Seats per 100 Children)

26.1
2024

25.1
2025

Opportunity for Action:

Address barriers to preschool participation to ensure Nevada families access the opportunities they need to thrive, including support for licensed operators.

Affordability | Provider Availability | Workforce Capacity | Geographic Access | Family Awareness

Policy and System Implications

Nevada's early childhood system appears to be evolving. Several indicators suggest conditions are moving in a positive direction: preschool participation has increased by nearly five percentage points, driven largely by growth in private preschool enrollment; more parents of young children are participating in the workforce; and fewer young children are living in low-income households. Family and economic conditions associated with participation in early learning have improved.

At the same time, the state's early childhood infrastructure has not expanded at the same pace. Preschool participation is influenced by both family circumstances and the availability of affordable, licensed childcare. In Nevada, licensed childcare capacity has declined, childcare costs continue to exceed the federal affordability benchmark, and there are just 25 licensed childcare seats for every 100 children under age five– less than half the national average (57). Although preschool participation has increased, nearly six in ten Nevada children ages three and four remain unenrolled. Continued attention to provider capacity, affordability, workforce availability, and geographic distribution through business assistance, startup and expansion support, workforce development, and provider retention initiatives can help the early childhood system meet growing family demand.

Nevada's opportunity extends beyond increasing the availability of childcare and preschool. A strong early childhood system requires more than expanded access alone. The National Academies of Sciences, Engineering, and Medicine (2018) recommend a financing framework that supports high-quality services, a well-supported childcare workforce, equitable access, and *accountability for outcomes*. Measuring both system indicators (e.g., participation, affordability, and capacity) and child outcomes (e.g., kindergarten readiness) can provide a more complete picture of whether Nevada is moving beyond expanding participation to preparing children for a successful transition to formal education. However, because Nevada does not currently administer a statewide kindergarten readiness assessment, the state's ability to evaluate whether improvements in preschool participation and access are translating into successful outcomes is limited. As Nevada's early childhood system continues to evolve, kindergarten readiness data would complement existing measures of participation, affordability, and capacity by informing whether expanded access to early learning is achieving its intended educational outcomes. This would identify opportunities for continuous improvement and inform targeted investments in the early childhood system.

Children's Health

Children thrive when interconnected ecosystems are strong, healthy, and equitable.

Children's health begins before birth and is shaped by the quality of maternal care, behavioral health, and physical environments where children live, learn, and grow. This section examines key indicators across these interconnected areas to identify trends, disparities, and opportunities to improve healthy development.

Topics Include:

- Behavioral & Mental Health
- Maternal and Infant Health
- Environmental Health & Safety

2026 Call To Action

PILLAR 2: CHILDREN'S HEALTH

Children's Behavioral & Mental Health

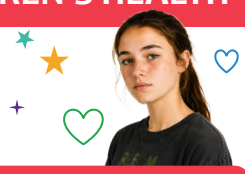
Mental Health Status— How Are Nevada Children Doing?

Methodology:

Data reflect the most current available estimates and the most recent available estimates, from 1–3 years prior. State trend results are directional only.

***Note**: Because confidence intervals were provided, it was possible to assess statistical significance. Based on the reported confidence intervals, differences between Nevada and the national average were not statistically significant and may reflect normal sampling variation.*

Nevada Children Behavioral and Mental Health Indicators	STATE Previous	STATE Recent	STATE Trend	NATIONAL Recent
Children with Mental, Emotional, Developmental, or Behavioral Problems Annual rate of children ages 3–17 with MEDB Concerns (2024)	**21.0** Per 100	**22.0** Per 100	⬆ **Increasing**	**27.0** Per 100
Division of Child and Family Services Early Childhood Services Waitlist Monthly rate of children (ages 0-8) waiting for early childhood mental health services through the DCFS (SFY2026)	**10.4** Per 100	**9.6** Per 100	⬇ **Decreasing**	**N/A**
Division of Child and Family Services Children's Clinical Services Waitlist Monthly rate of children (ages 6-17) waiting for outpatient mental health services through the DCFS (SFY2026)	**9.6** Per 100	**5.8** Per 100	⬇ **Decreasing**	**N/A**
Teen Depression Annual rate of high school students who felt sad/hopeless daily for 2+ weeks (2023)	**45.6** Per 100	**44.1** Per 100	⬇ **Decreasing**	**39.7** Per 100
Teen Suicide Annual rate of teen deaths due to intentional self-harm per 100,000, ages 15-19 (2023)	**15.0** Per 100,000	**13.9** Per 100,000	⬇ **Decreasing**	**13.4** Per 100,000
Substance Use in the Past Month Monthly rate of children (ages 12-17) who used drugs or alcohol (2024)	**8.5** Per 100	**8.2** Per 100	⬇ **Decreasing**	**7.1** Per 100
Nicotine Vaping Use in the Past Month Monthly rate of children (ages 12-17) who used vaping (2024)	**7.6** Per 100	**6.6** Per 100	⬇ **Decreasing**	**6.4** Per 100
Tobacco Product Use in the Past Month Monthly rate of children (ages 12-17) who used tobacco products, excludes vaping (2024)	**2.1** Per 100	**1.8** Per 100	⬇ **Decreasing**	**1.9** Per 100

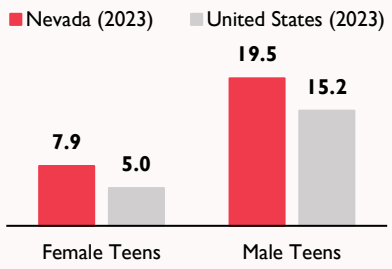


DATA INSIGHTS · SUICIDE BREAKDOWN

Statewide Averages May Mask Disparities in Youth Suicide

1 SUICIDE RATE: WHO IS AT GREATEST RISK?

Deaths by Suicide per 100,000 (Ages 15-19)



58% higher than national average for female teens

28% higher than national average for male teens

2 SUICIDE RATE: WHAT DISPARITIES EXIST?

Nevada exceeds the national rate for Black, Hispanic, and White adolescents. Other data is not available.

Race / Ethnicity	Nevada	U.S.	Nevada vs U.S.
AI/AN	N/A	33.5	N/A
Asian	N/A	8.4	N/A
Black	**20.3**	10.4	95.2% ▲
Hawaiian/ Pacific Islander	N/A	16.5	N/A
Hispanic	**10.5**	7.6	38.2% ▲
Multiracial	N/A	8.0	N/A
White	**16.8**	11.4	47.4% ▲

3 SUICIDE RATE: WHAT LIMITS ACTION?

57% of Nevada's race/ethnicity data for teen suicide were unavailable.

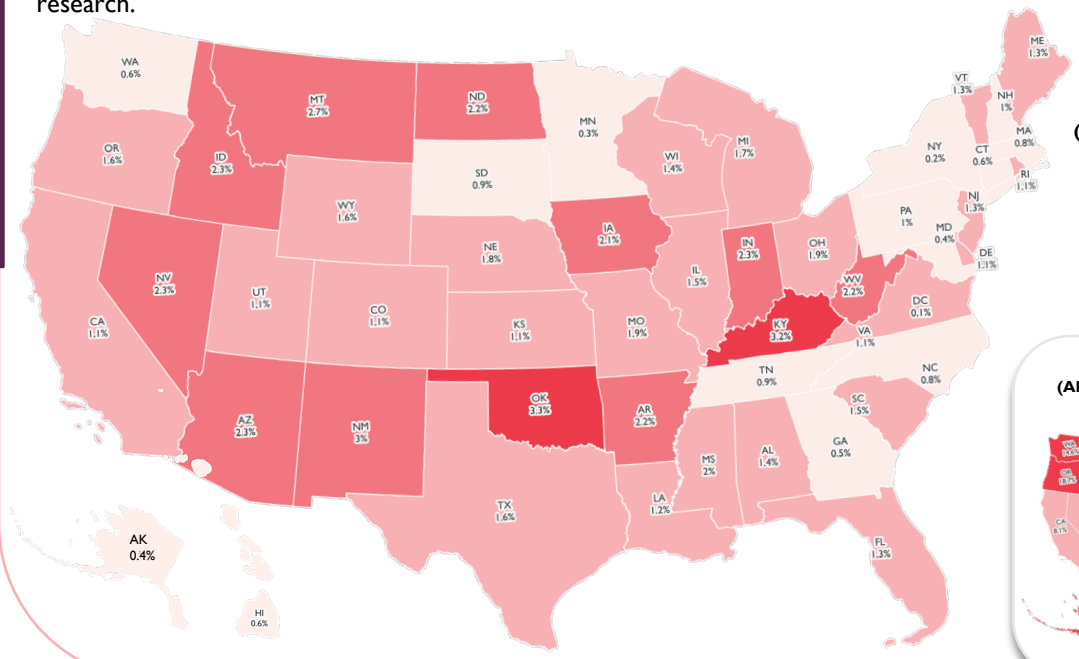
Reportable Nevada 2021–2023 estimates were unavailable for 4 of 7 race and ethnicity groups. The CDC will suppress estimates because of small numbers and also cautions that race and ethnicity recorded on death certificates may be subject to misclassification, particularly for American Indian/Alaska Native (AI/AN), Asian, and Native Hawaiian/Other Pacific Islander populations.

DATA INSIGHTS BULLYING BREAKDOWN

Statewide Averages May Mask Disparities in Bullying

4 BULLYING RATE: AVAILABLE DATA SUGGEST SIMILAR DEMOGRAPHIC PATTERNS ACROSS FREQUENT BULLYING AND SUICIDE

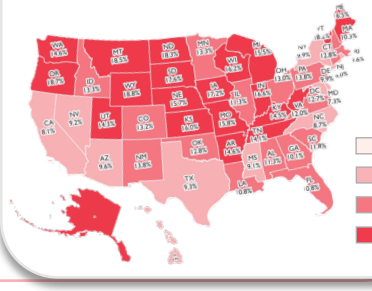
Nationally, Nevada has comparatively lower rates of reported regular bullying. However, higher rates of Nevada female children reported being bullied "nearly every day" (2.3%). Because bullying occurring "nearly every day" is an extreme event, a small percentage is expected. Nonetheless, this estimate is based on eight respondents (n = 8) and should only be interpreted as a guide for further research.



National Girls Experiencing Extreme Bullying
(Females Bullied "Nearly Every Day," 2021-2022)

- 0.0% - 1.0%
- 1.0% - 2.0%
- 2.0% - 3.0%
- >3.0%

National Children Bullied "Regularly"
(All Children Bullied At Least Twice Monthly, 2021-2022)



- 0.0% - 6.0%
- 6.0% - 10.0%
- 10.0% - 14.0%
- 14.0% - 18.8%

Opportunity for Action:
Strengthen community-based research and surveillance to better understand bullying experiences and suicide risk among Nevada's various teen populations, including whether bullying may contribute to elevated suicide risk.

DATA INSIGHTS · DISAGGREGATED SUBSTANCE USE METRICS

Substance Use Prevalence Increases Markedly between Adolescence and Young Adulthood

KEY NEVADA YOUTH SUBSTANCE USE INDICATORS (2024)

YOUTH SUBSTANCE USE (Ages 12-17)		YOUTH DISORDERS (Ages 12-17)	YOUNG ADULT SUBSTANCE USE (Ages 18-25)
8.9% Illicit Drug Use (Past Month)	**1.1%** Prescription Opioid Misuse (Past Year)	**8.2%** Drug Use Disorder (Past Year)	**33.6%** Illicit Drug Use (Past Month)
13.2% Marijuana Use (Past Year)	**0.3%** Cocaine Use (Past Year)	**4.2%** Alcohol Use Disorder (Past Year)	**40.2%** Marijuana Use (Past Year)
6.7% Marijuana Use (Past Month)	**0.2%** Methamphetamine Use (Past Year)	**10.2%** Any Substance Use Disorder (Past Year)	**49.1%** Alcohol Use (Past Month)
8.1% Alcohol Use (Past Month)	**4.3%** Binge Alcohol Use (Past Month)	*Most recent past-year and past-month rates for Nevada youth (12-17) and young adults (18-25)*	

DATA INSIGHTS · REGIONAL WAITLIST COMPARISON

Division of Child and Family Services Waitlists: Northern vs Southern Nevada DCFS SFY

1 DCFS NORTHERN NEVADA (Ages 0 to 17 Combined)

Reno / Washoe County

Approx. **84** kids served per month, **12** waiting.

Waitlist Rate
~ 1 in 8 Kids

12.4%

Per 1,000 kids **0.82** served

2 DCFS SOUTHERN NEVADA (Ages 0 to 17 Combined)

Las Vegas / Clark County

Approx. **151** kids served per month, **7** waiting.

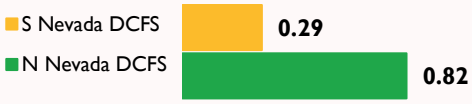
Waitlist Rate
~ 1 in 22 Kids

4.6%

Per 1,000 kids **0.29** served

3 REGIONAL COMPARISON: Northern vs. Southern

Northern Nevada DCFS serves nearly 3× more children per capita than Southern Nevada.



SFY2024 Statewide DCFS Waitlist Rates

Early Childhood Services	Children's Clinical Services
1 in 4 kids waiting	**1 in 6** kids waiting

Contextual Note

Division of Child and Family Services waitlist data reflect only children seeking services through DCFS Early Childhood Mental Health Services and Children's Clinical Services. These programs provide specialized behavioral health services ranging from early childhood developmental and family supports to outpatient therapy, psychological assessment, psychiatric care, medication management, care coordination, and crisis services. The data do not include services provided through Medicaid, private insurance, or other community-based providers, which may contribute to regional differences in service utilization rates. Accordingly, these findings should not be interpreted as representative of statewide behavioral health service capacity or unmet need.

Policy and System Implications

Data from the Nevada Division of Child and Family Services (DCFS) waitlists indicate substantial improvement in access metrics. Waitlist rates have declined significantly since 2024, when approximately 1 in 4 children waited for Early Childhood Services and 1 in 6 children waited for Children's Clinical Services. However, because these data do not capture services provided through Nevada Medicaid or commercial insurance, DCFS waitlist data are not a comprehensive measure of statewide access to behavioral health care. Within the DCFS system, however, recent trends indicate substantial improvements in access-related performance: the Children's Clinical Services waitlist rate peaked at 17.7% in SFY2024 before declining to 5.8% in SFY2026 (1 in 17 children waiting). This represents a 67% reduction from the SFY2024 peak and a nearly 40% decrease from SFY2025, demonstrating that meaningful improvements in access-related program metrics can occur over a relatively short period of time.

Additional data is needed to better understand the factors contributing to declining waitlist rates. Nevada should examine Medicaid and other statewide data sources to assess: (1) the number of children receiving behavioral health and developmental services by year and region; (2) the number of participating providers by year and region; and (3) average wait times from referral to first appointment. Information on referrals, provider denials, intake volumes, and family experiences would provide a more complete understanding of access to care and help determine whether improvements in DCFS metrics are translating into broader gains in access to care for Nevada children and families. Importantly, the substantial decline in DCFS waitlist rates does suggest meaningful progress in access-related program metrics. This progress provides an opportunity to identify and replicate throughout the youth behavioral health system the successful practices, investments, and operational changes contributing to improved performance.

Regional waitlists should be monitored for stabilization as capacity adjusts to demand. In Northern Nevada, the waitlist increased from 8 to 15 children between SFY2025 and SFY2026, but this occurred alongside substantial growth in service utilization, with the North Region serving 64 more children monthly on average in SFY2026 than in SFY2022. If provider shortages are contributing to higher waitlist rates in Northern Nevada, examination of existing telehealth capacity, provider network arrangements, and workforce resources may help identify opportunities to improve access across regions. Northern Nevada serves fewer children overall because the population is smaller, but proportionally more children there are seeking services through DCFS– the North Region serves nearly three times as many children per capita through DCFS as Southern Nevada. Capacity has not kept pace with demand, resulting in their larger waitlist. If Southern Nevada has more Medicaid, private, nonprofit, or hospital-based behavioral health providers, some children who would otherwise appear on a DCFS waitlist may instead receive services elsewhere. Consequently, children entering DCFS services in Northern Nevada remain more likely to be placed on a waitlist than those in Southern Nevada.

Nevada's recent progress positions the state to move from meeting national benchmarks to exceeding them. Current estimates indicate Nevada's children are generally comparable to children nationally across many key behavioral health indicators. Combined with improvements in DCFS waitlist rates, findings suggest recent investments may be strengthening the state's behavioral health system. By building on recent gains and continuing to invest in system improvements, Nevada can position itself as a national leader in children's behavioral health, workforce readiness, and long-term economic well-being.

Female youth emerge as a potentially high-risk group across available suicide and bullying indicators, but the state's data limitations prevent a complete understanding of risk. In Nevada, both female and male adolescents experience suicide rates above the national average, with the largest relative disparity observed among female teens, whose suicide rate is estimated to be 58% higher than the U.S. rate. National bullying data further indicate that Nevada female children may experience higher rates of extreme bullying than males; across all other bullying frequency categories, both Nevada females and males were generally comparable to national estimates with the exception of more female children reporting bullying "nearly every day" (2.3%). These findings suggest a similar demographic group may be experiencing elevated rates of both suicide and frequent bullying. If future research identifies a meaningful relationship between severe bullying and the severe outcome of suicide among Nevada youth, **suicide prevention efforts may need to extend beyond traditional mental health approaches to include violence prevention, trauma-informed supports, and restorative practices that address interpersonal victimization.**

Youth suicide data gaps for race and ethnicity information prevent meaningful assessment of suicide risk among American Indian/Alaska Native, Asian, Hawaiian/Pacific Islander, and Multiracial youth. These data limitations constrain Nevada's ability to identify disparities, monitor trends, and target prevention resources effectively. Expanding statewide suicide and bullying survey efforts, and conducting qualitative, ethnographic, and community-based research could help identify the social, cultural, family, school, and environmental factors to better inform targeted prevention strategies.

2026 Call To Action

PILLAR 2: CHILDREN'S HEALTH

Maternal and Infant Health

A Snapshot of Health and Well-Being among Nevada Moms and Babies

Methodology:

Data reflect the most current available estimates and the most recent available estimates, from 1–3 years prior. State trend results are directional only.

Nevada Maternal and Infant Indicators	STATE Previous	STATE Recent	STATE Trend	NATIONAL Recent
Severe Maternal Morbidity Rate Annual rate of serious, unexpected complications during labor and delivery that result in significant short- or long-term health consequences for the mother. Examples include severe hemorrhage, eclampsia, sepsis, organ failure, or other life-threatening conditions (2023)	**190.4** Per 10,000	**201.1** Per 10,000	↑ **Increasing**	**93.1** Per 10,000
Maternal Mortality Rate Annual rate of death from complications of pregnancy or childbirth that occur during the pregnancy or within six weeks after the pregnancy ends (2023)	**20.4** Per 100,000	**22.7** Per 100,000	↑ **Increasing**	**18.6** Per 100,000
First Trimester Prenatal Care Initiation Annual rate of the entry into prenatal care within the first 3 months of pregnancy (2023)	**76.5** Per 100	**76.8** Per 100	↑ **Increasing**	**75.5** Per 100
Inadequate Prenatal Care Annual rate of pregnancy-related medical care that either begins in the fifth month of pregnancy (or later) or includes less than 50% of the appropriate number of visits for the infant's gestational age (2024)	**16.3** Per 100	**16.5** Per 100	↑ **Increasing**	**16.1** Per 100
Pre-term Birthrate Annual rate of babies born too early (before 37 weeks of pregnancy completed) (2024)	**11.1** Per 100	**11.0** Per 100	↓ **Decreasing**	**10.4** Per 100
Infant Mortality Rate Annual number of deaths of infants under one year of age per 1,000 live births (2023)	**4.5** Per 1,000	**5.9** Per 1,000	↑ **Increasing**	**5.6** Per 1,000
Sudden Unexpected Infant Death Rate Annual rate of the sudden and unexpected death of an infant less than 1 year old, where the cause is not immediately obvious prior to investigation (2023)	**22.5** Per 100	**23.9** Per 100	↑ **Increasing**	**17.9** Per 100
Neonatal Abstinence Syndrome Rate Rate per 1,000 births for a group of conditions that can occur when newborns withdraw from certain substances they were exposed to before birth (2023)	**10.7** Per 1,000	**9.0** Per 1,000	↓ **Decreasing**	**5.3** Per 1,000

DATA INSIGHTS · 2024 MATERNAL MORTALITY REVIEW COMMITTEE FINDINGS

Nevada's Maternal Mortality: Understanding Disparities for Prevention

The Maternal Mortality Rate is limited to deaths resulting from pregnancy complications that occur during pregnancy or within six weeks after the end of pregnancy. To develop recommendations for preventing future maternal deaths, the Nevada Maternal Mortality Review Committee reviewed a broader category of pregnancy-associated deaths, encompassing all deaths of Nevada residents that occurred during pregnancy or within one year after the end of pregnancy, regardless of cause.

1 2024 CASE REVIEW SUMMARY

94% of reviewed maternal deaths were **PREVENTABLE**

(86% nationally)

36 maternal deaths reviewed

2022-2023 timeline reviewed

2 CONTRIBUTING CIRCUMSTANCES

Unemployment	56%
Child Protective Services Involvement	53%
Injury, Violence, or Self-Harm	49%
Substance Use Disorder	47%
Domestic Violence	44%
Mental Health Conditions	42%

3 LEADING CAUSE OF PREGNANCY-ASSOCIATED DEATHS BY RACE/ETHNCITY

Percent of Deaths within Each Reviewed Racial/Ethnic Group

BLACK, NON-HISPANIC (n = 17)		HISPANIC (n = 13)		WHITE, NON-HISPANIC (n =21)	
Cardiovascular Disease	29.4%	Pregnancy-Related Causes	30.8%	Overdose (Non-Transport)	38.1%
Overdose (Non-Transport)	17.6%	Transport Injury	23.1%	Pregnancy-Related Causes	23.8%
Transport Injury	5.9%	Homicide	15.4%	Suicide	14.3%

Opportunity for Action:

Maternal mortality risks vary across Nevada's population. **1 out of 4 reviewed deaths were linked to discrimination.** Developing culturally responsive, population-specific strategies can better address differences in health risks, quality of care, behavioral health, chronic disease, and the broader factors contributing to maternal mortality across Nevada.

Quality of Care | Culturally Responsive Care | Health Equity

Contextual Note

Substance use is the leading cause of maternal death in Nevada. In 2022, the rate of Neonatal Abstinence Syndrome (NAS) reached 10.7 per 1,000 live births statewide and 8.9 per 1,000 births in Clark County, with the highest county rate observed among White newborn infants (13.0 per 1,000 births). This pattern aligns with the Nevada Maternal Mortality Review Committee's finding that non-transport overdose was the leading cause of pregnancy-associated death among White, non-Hispanic women. After declining from 9.2 per 1,000 live births in 2017 to just 5.9 in 2019–2020, Nevada's NAS rate then nearly doubled by 2022. This trend mirrors national shifts in the opioid epidemic, including reductions in prescription opioid exposure during the late 2010s, followed by increasing deaths involving illegally manufactured fentanyls beginning in the early 2020s. Substance-exposed infant data published by CPS reflects a similar pattern. Given these large fluctuations in rates, the absence of timely NAS surveillance data can limit Nevada's ability to identify emerging trends and target resources.

DATA INSIGHTS · MATERNAL & INFANT HEALTH

Strong Starts Require Equitable Maternal and Infant Care

Statewide data highlights persistent disparities across pregnancy and infant outcomes.

1 HEALTH DISPARITIES

Black women in Nevada have a

3x

higher pregnancy-associated death rate than the state average at **13.9 per 100,000.**

The state average is 4.6 per 100,000.

Black women in Washoe County have nearly

8x

higher pregnancy-associated death rates than the state average (4.6) at **35.1 per 100,000**.

Black women aged 35+ experienced the highest pregnancy-associated death ratio at **323 women per 100,000 live births**.

Among women under age 25, White, non-Hispanic women experienced the highest pregnancy-associated death ratio at **179 women per 100,000 live births**.

2 MATERNAL HEALTH OUTCOMES

Severe Maternal Morbidity in Nevada is more than twice the national rate.

(per 100,000 delivery hospitalizations)

Nevada	United States
201	93

Nearly **1 in 4 women delay prenatal care** (initiating in the 2nd or 3rd trimester).

Delayed or absent prenatal care **more than doubles the risk** of neonatal near-miss or death.

Groups with Higher Inadequate Prenatal Care:

(per 100,000 delivery hospitalizations)

American Indian / Alaska Native Mothers **1.9x** state average

Pacific Islander Mothers **1.6x** state average

3 INFANT HEALTH OUTCOMES

Black infants in Nevada experience

9.9 deaths

per 1,000 live births.

Nevada: 5.9
United States: 5.6

Black mothers in Nevada experience

15%

preterm birth rate

Nevada: 11%
United States: 10.4%

Sudden Unexpected Infant Death accounted for

24%

of infant deaths in Nevada (United States: 18%)

National SUID rates are highest among Black, American Indian/Alaska Native, and Native Hawaiian/Pacific Islander infants.

Contextual Note

Air pollution exposure is associated with increased risks of adverse pregnancy outcomes and these associations are observed more frequently among Black and Hispanic mothers. Black women in Nevada experience disproportionately high rates of pregnancy-associated mortality, with pregnancy-associated death ratios approximately three times the statewide average. Hispanic mothers accounted for the highest proportion of Severe Maternal Morbidity cases. Nevada overall experiences elevated rates of severe maternal morbidity, preterm birth, and infant mortality, with persistent racial and ethnic disparities across several maternal and infant health indicators. These outcomes parallel a growing body of research that highlights environmental exposure as an important consideration within broader maternal health equity efforts. The following regional pollutant transport pathway maps illustrate how Nevada's two largest population centers may experience environmental exposures originating both within Nevada and neighboring California.

DATA INSIGHTS · REGIONAL ENVIRONMENTAL EXPOSURE PATHWAYS

Integrating Environmental Exposures into Maternal Health Planning

The Maternal Vulnerability Index developed by Surgo Health identifies communities at greatest risk for poor pregnancy outcomes using 43 indicators across six domains: reproductive health care, physical health, mental health and substance use, general health care, socioeconomic conditions, and the physical environment. Surgo Health emphasizes that **reducing maternal mortality requires a better understanding of why mothers– particularly mothers of color– are dying at higher rates.**

For Nevada, the Physical Environment indicator is the highest contributor to an overall high maternal vulnerability index score:

Physical Environment Maternity Risk Score

Clark County 76/100
Washoe County 69/100

One of the top three leading indicators for Severe Maternal Morbidity in Nevada is Adult Respiratory Distress Syndrome (16.3 per 10,000 deliveries).

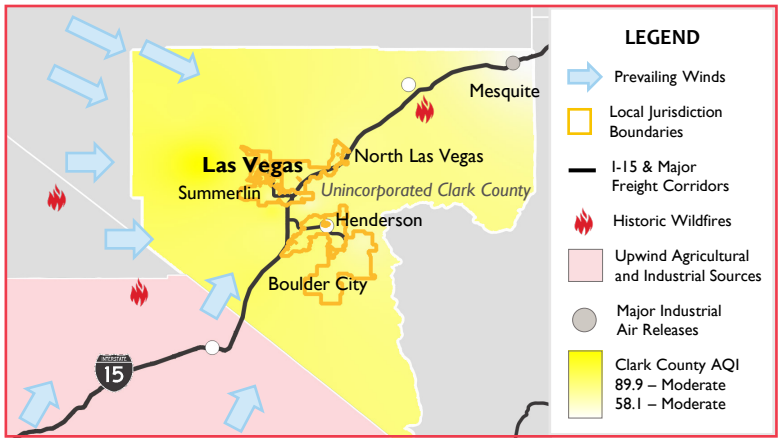
According to PlainAirData, Clark and Washoe Counties are among the most polluted in the nation. Below we provide the following maps to visualize the routes by which pollutants travel through the atmosphere to where people are ultimately exposed.

Environmental Protection Agency Air Quality Index (AQI)

- **Good** (0 –50)
- **Moderate** (51-100)
- **Unhealthy for Sensitive Groups** (101-150)
- **Unhealthy** (151-200)
- **Very Unhealthy** (201-300)
- **Hazardous** (301+)

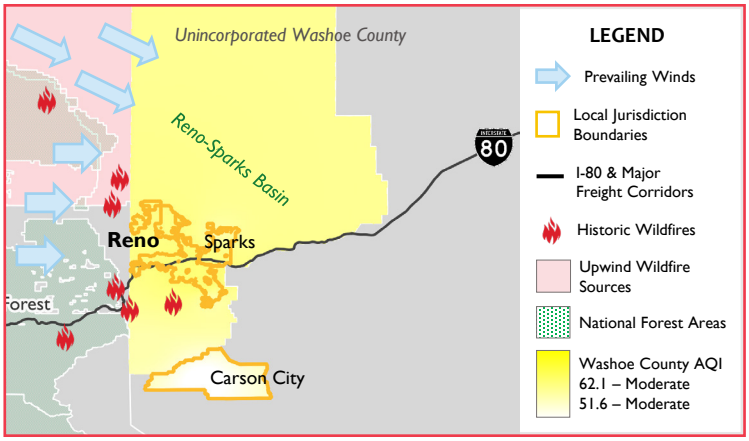
Clark County

Regional Air Quality and Industrial Emission Pathways in Clark County



Washoe County

Regional Airshed: Wildfire Smoke and Particulate Matter Pathways in Washoe County



Contextual Note

In 2025, Clark County had a recorded median AQI of 64 (Moderate). Of 274 monitored days, 26% were Good, 65% Moderate, and 9% Unhealthy for Sensitive Groups. The highest daily AQI reached 138. In 2025, Washoe County recorded a median AQI of 51 (Moderate). Half of monitored days were Good, 49% were Moderate, and 1% reached Unhealthy for Sensitive Groups (maximum AQI: 112). **Chronic air pollution exposure is associated with increased risks of preterm birth, low birth weight, fetal growth restriction, stillbirth, and hypertensive disorders of pregnancy– outcomes that mirror several of the maternal and infant health indicators observed in Nevada.**

Opportunity for Action:

The U.S. Environmental Protection Agency works with coalitions to help develop tools, reports, workshops, meeting communications and other initiatives that help protect public health from environmental threats.

Implications for Policy and Practice

Preventable infant deaths remain an important area for intervention. Sudden Unexpected Infant Death accounted for nearly one-quarter of infant deaths in Nevada, with national rates highest among Black, American Indian/Alaska Native, and Native Hawaiian/Pacific Islander infants. This suggests opportunities to strengthen safe sleep education and infant injury prevention efforts.

Nearly all reviewed maternal deaths in Nevada were deemed preventable. Nevada's Maternal Mortality Review Committee determined that 94% of reviewed maternal deaths from 2022-2023 could have been prevented. Roughly 1/3 of the reviewed pregnancies had been unwanted. The Committee's July 2024 report published by the Nevada Department of Health and Human Services offers an extensive list of Giant, Extra Large, Large, Medium, and Small impact recommendations for prevention efforts.

The leading cause of maternal death in Nevada is substance-abuse related. The CDC estimates 70% of overdose deaths involve illegal fentanyls. The parallel timing of Neonatal Abstinence Syndrome (NAS) rates decreasing then increasing alongside declining prescription opioid exposure and increasing fentanyl-related harms suggests an opportunity to evaluate whether Nevada women with opioid dependence had adequate access to evidence-based pain management, treatment, and recovery services during this transition. Understanding how women navigated changes in opioid availability may help identify gaps in treatment access and inform strategies to reduce pregnancy-associated overdose and NAS. Partnering with healthcare providers and community organizations to deliver culturally responsive education, stigma-reducing outreach, and evidence-based treatment for substance use during pregnancy, especially for communities with the highest rates of NAS, could improve access to care.

Timely prenatal care plays an important role in reducing severe maternal and infant complications. Absent or delayed prenatal care was associated with high rates of severe maternal morbidity. Given Nevada's high burden of substance use-related maternal deaths and Neonatal Abstinence Syndrome, further research is warranted to better understand barriers to prenatal care that may include whether concerns related to substance use screening or other factors contribute to delayed engagement in care. Findings could inform policies and programs that encourage early prenatal care while fostering a supportive, non-punitive environment for Nevada's expectant mothers who may be struggling with substance use.

Nevada's maternal health challenges do not appear to be driven solely by access to prenatal care. While prenatal care utilization is similar to or slightly better than national levels, maternal mortality, severe maternal morbidity, and preterm birth rates remain elevated. Racial and ethnic differences suggest that addressing maternal health requires targeted policies addressing quality of care, behavioral health, chronic disease, and broader social and environmental determinants of health for varying community needs. Significant inequities persist, with Black women experiencing pregnancy-associated death ratios approximately three times the statewide average, Black infants experiencing infant mortality rates nearly twice the statewide average, and American Indian/Alaska Native and Pacific Islander mothers experiencing the highest rates of inadequate prenatal care. While Black women were more likely to die during or after pregnancy, among reviewed deaths, Hispanic mothers were more likely to die directly related to pregnancy (30.6%). Beyond traditional maternity care, the data highlights the importance of coordination across healthcare, behavioral health, child welfare, workforce development, and community-based systems in improving outcomes for Nevada mothers and their families.

Transport-related injuries signal an important consideration for maternal and child health in Nevada. Among Hispanic mothers, 23% of maternal deaths were transport-related, and Hispanic children experienced 28% more traffic fatalities than children in the rest of the population. These disparities highlight a need for culturally responsive injury prevention strategies and improved transportation safety initiatives.

Environmental injustice is a critical component of maternal health equity. Air pollution exposure has been associated with increased risks of preterm birth, low birth weight, fetal growth restriction, stillbirth, and hypertensive disorders of pregnancy, with stronger associations observed among Black and Hispanic mothers. In Nevada, The Maternal Vulnerability Index developed by Surgo Health identifies Nevada's physical environment– including transportation access, housing conditions, violent crime, and environmental pollution– as a major contributor to its maternal vulnerability. Our discussion here focuses on environmental pollution, particularly air quality, as an important and overlooked component of this domain. Consistent with the index's finding, Nevadans live with an overall "Moderate" air quality, with most experiencing "Healthy" conditions less than half the year (for Clark County, it is one-quarter). Multiple local and upwind sources contribute to Nevada's pollution burdens: according to the U.S. Environmental Protection Agency, the San Joaquin Valley has some of the nation's worst air quality, failing to meet federal health standards for both ozone and particulate pollution; in 2025, a prospective study of pregnant women in the western U.S. found that greater exposure to wildfire-related $PM_{2.5}$ was associated with increased odds of preterm birth; similarly, the Union of Concerned Scientists found that communities near concentrated freight facilities, including major corridors such as I-15 and I-80, experience higher pollution burdens. The scientists also found that **state and local policymakers have effective tools to reduce emissions and better protect nearby residents.** Alleviating environmental harms could in turn alleviate health system burdens for maternal and child health.

Child Welfare

Children are safest when families are supported and systems respond early, consistently, and effectively.

Child welfare reflects how well communities prevent harm, strengthen families, and support children when they cannot safely remain at home. This section examines key indicators across these areas to identify trends, disparities, and opportunities to improve safety, stability, and permanency for Nevada children.

Topic Include:

- Safety & Prevention
- Out-of-Home Care & Permanency
- Kinship & System Quality

2026 Call To Action

PILLAR 3: CHILD WELFARE

Safety and Prevention

How safe are Nevada's children?

Children's Advocacy ALLIANCE

Methodology: All data use the most currently available estimates. Child welfare indicators are presented relative to Nevada's 2018 baseline to highlight changes in statewide trends over time. State trend results are directional only.

Nevada's Child Protection System Indicators	STATE Previous	STATE Recent	STATE Trend	STATE 2018 Value
CPS Referrals Received Number of referrals alleging incidents of suspected child abuse and neglect reported to child welfare agencies (SFY2026)	43,285	46,339	↑ Increasing	41,928
CPS Reports Dispositioned Number of Child Protective Services reports reviewed and assigned a screening decision and disposition (SFY2025)	42,123	45,106	↑ Increasing	40,713
Median Days to Initiation of Services Median number of days from the CPS report to the initiation of child welfare services (2024)	58	58	— No Change	36
Screened-In Substance-Exposed Infants Number of infants with prenatal substance exposure whose reports met Nevada's CPS screening criteria and were accepted for investigation or assessment (SFY2024)	536	469	↓ Decreasing	12
Child Fatalities Number of child fatalities resulting from abuse or neglect per 100,000 children (SFY2024)	3.0 Per 100,000	2.8 Per 100,000	↓ Decreasing	2.8 Per 100,000
Substantiated Child Maltreatment Rate of children determined to be victims of abuse or neglect (SFY2025)	25.2 Per 100	25.6 Per 100	↑ Increasing	22.1 Per 100
Children Without Recurring Maltreatment Percentage of children without a subsequent substantiated report within six months (SFY2025)	94.9 Per 100	95.9 Per 100	↑ Increasing	94.9 Per 100

Contextual Note

Since SFY 2018, annual reports of CPS referrals and reports dispositioned have remained relatively unchanged, with no sustained upward or downward trend. Similarly, the percentage of reported children without recurring maltreatment within six months has remained consistent, nearing 100%, despite approximately one-quarter of investigated cases resulting in a substantiated finding of child maltreatment.

A 2025 Legislative Auditor's review identified concerns with child welfare agencies' handling of child abuse- and neglect-related fatalities and near-fatalities. In 7 of 43 cases reviewed, the auditor identified instances in which agency practice did not fully comply with state policy. **Areas of concern** were: **(1)** present or impending danger assessments not adequately performed or documented; **(2)** reports of abuse or neglect not properly screened at intake; **(3)** other safety threats not mitigated; **(4)** allegation decision did not adequately reflect significant evidence discovered; **(5)** insufficient information gathered to assess allegations; **(6)** home environment not observed; **(7)** monthly face-to-face child contact not adequately performed or documented; **(8)** all children in home not properly assessed; **(9)** caregiver follow-through with services not adequately monitored; and **(10)** all caregiver protective capacities not adequately assessed. Please see page 25 for a suggested Opportunity for Action.

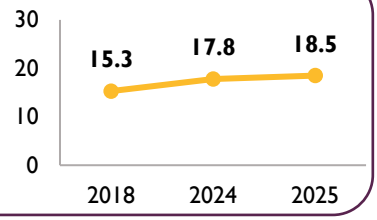
DATA INSIGHTS · SAFETY AND PREVENTION

Child Welfare Trends in Nevada

Key Safety and Risk Factors for Nevada Children and Families

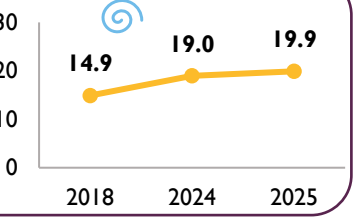
MENTAL HEALTH ISSUES

Percentage of CPS reports involving mental health issues as a reported tracking characteristic (per 100)



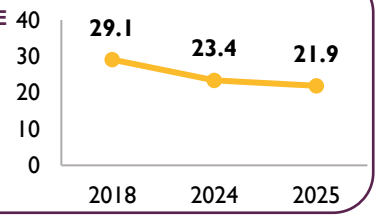
DOMESTIC VIOLENCE REPORTS

Percentage of CPS reports involving domestic violence as a reported tracking characteristic (per 100)



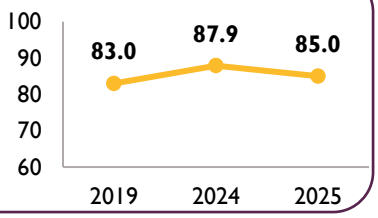
PARENTAL SUBSTANCE ABUSE

Percentage of CPS reports involving caregiver substance use as a reported tracking characteristic (per 100)



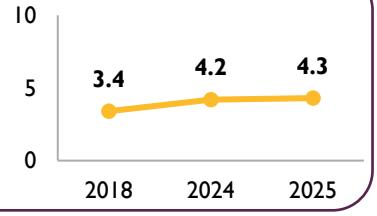
NEGLECT ALLEGATIONS

Percentage of screened-in maltreatment allegations involving neglect (per 100)



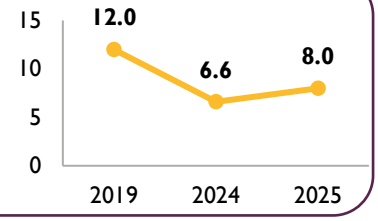
PARENT IN JAIL

Percentage of CPS reports involving parental incarceration as a reported tracking characteristic (per 100)



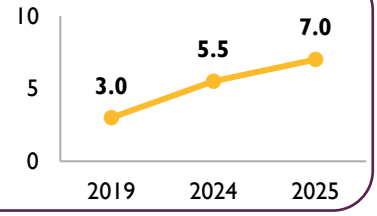
PHYSICAL ABUSE

Percentage of CPS Reports involving physical abuse (per 100)



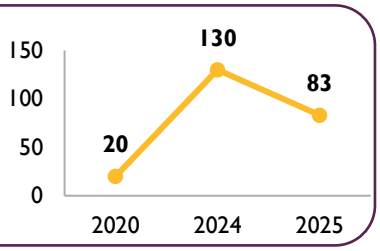
SEXUAL ABUSE

Percentage of CPS Reports involving sexual abuse (per 100)



YOUTH VICTIMS OF HUMAN TRAFFICKING

Number of reported victims of human trafficking involving commercial sex acts and involuntary servitude among persons ages 10–19 (SFY2026)



Data Gap To Address

41,243 Nevada children lacked specific CPS tracking information in SFY 2026.

In SFY 2026

3,391

UNIQUE CHILDREN were classified under "Other"

37,852

UNIQUE CHILDREN had "No Reported Tracking Characteristics"

Note: Children may have multiple reports or ongoing involvement with the child welfare system but are counted only once for that fiscal year.

Opportunities for Action:

Report the primary reasons reports are accepted for investigation or assessment. In 2026, ~46,000 referrals were received and ~45,000 reports were dispositioned– a relatively consistent pattern spanning eight years. Greater transparency into whether reports are accepted based on statutory requirements, agency policy, or professional discretion can help evaluate whether screening practices and child welfare resources are appropriately aligned.

Over 40,000 unique children lacked specific CPS tracking information in 2026. Strengthen the collection and reporting of CPS tracking characteristics to reduce "Other" and "No Reported Tracking Characteristics" categories. More complete and specific characteristic and demographic data would improve the state's ability to identify risk factors, monitor emerging trends, target prevention efforts, and allocate child welfare resources effectively.

When feasible, collect and report geographic information at the ZIP code level. This can support place-based analysis, identify communities with elevated risk, and guide targeted prevention and resource allocation.

Target Investments in Clark County. Clark County accounts for nearly three-quarters of statewide CPS reports. Investments here may have the greatest statewide impact.

Opportunity for Action:

Continue strengthening quality assurance and workforce training to improve consistent implementation of statewide child welfare policies, with particular emphasis on danger and safety assessments, investigation documentation, caregiver protective capacity assessments, and ongoing case monitoring. Regular monitoring of recurring audit findings can help determine whether corrective actions result in sustained improvements over time.

Policy and System Implications

Protecting children requires continued attention to the circumstances documented during child welfare involvement. Trends in Nevada's reported CPS tracking characteristics indicate upticks in domestic violence, mental health concerns, and parental incarceration, while reports involving parental substance use have declined over time. Physical abuse and sexual abuse allegations have increased as a proportion of screened-in maltreatment allegations. These trends suggest the needs of families involved with Child Protective Services are changing over time, and highlights the importance of ensuring prevention, intervention, and family support services remain responsive to evolving circumstances. Meanwhile large numbers of children continue to be classified under "Other" or "No Reported Tracking Characteristics," limiting the state's ability to fully understand emerging risks and target prevention resources. Continued attention to data quality, consistent reporting practices, and geographic analyses can improve Nevada's ability to identify communities with elevated need and allocate resources effectively.

Children under age 11 accounted for nearly 70% of CPS reports associated with domestic violence, while 17-year-olds accounted for 3.6%. This age distribution may be consistent with a child protection framework in which traditional CPS pathways primarily serve younger children while school-based intervention systems provide complementary supports for older children. However, the relatively few CPS reports involving adolescents raises important questions about how the needs of older children are identified, monitored, and addressed outside the child welfare system. In 2019, Nevada legislation created Handle with Care (HWC). HWC requires law enforcement to submit notifications when school-age children have been exposed to a potentially traumatic event which could interfere with their ability to succeed in school. All law enforcement, except those in Washoe County, report their notifications to the SafeVoice platform. Between FY2022–23 and FY2023–24, Handle with Care notifications increased by 29%. However, there is no information around demographics, such as age. Publicly available reporting does not currently provide a unified view of child safety across Child Protective Services, SafeVoice, and Handle with Care, limiting the ability to understand how these systems collectively identify, monitor, and support older Nevada children and youth.

Nevada's opportunity extends beyond responding to child maltreatment after it occurs. Physical abuse allegations remain below their 2019 level though they have increased since 2024, indicating an opportunity to build on long-term progress and help prevent future increases. A strong child welfare system requires high-quality investigations, consistent implementation of statewide policies, coordinated prevention efforts, and timeliness of services. In 2024, the median time from a CPS report to the initiation of services was 58 days in Nevada, compared with 28 days nationally. In 2025 a Legislative Auditor's review identified recurring concerns related to danger and safety assessments, investigation practices, documentation, caregiver protective capacity assessments, and ongoing case monitoring. Continued attention to prevention, policy implementation, child welfare workforce development, and timely service delivery can strengthen Nevada's capacity to protect children and support families before crises escalate.

Human trafficking continues to affect children within Nevada's own communities. The data indicate at least 80 children in Nevada were victims of modern slavery during the reporting year. Although the number of identified child victims of human trafficking declined by 50 between 2024-2025, changes in identified victims cannot be interpreted as changes in the underlying prevalence of human trafficking. Trafficking is widely recognized as an under identified crime, therefore reported counts may reflect both victimization and the capacity of public systems to identify, investigate, and document victims. A 2019 Southern Nevada Human Trafficking Task Force report found that nearly 60% of identified minor victims were local children. These children are subjected to commercial sexual exploitation or involuntary servitude (involuntary servitude includes forced labor, domestic servitude, forced criminal activity, or other forms of labor obtained through force, fraud, or coercion). Because these figures only represent identified victims, continued investments in prevention, early identification, multidisciplinary intervention, and survivor services remain essential.

2026 Call To Action

PILLAR 3: CHILD WELFARE

Out-of-Home Care

How well does Nevada support children in foster care?

Methodology: Data reflect the most current available estimates and the most recent available estimates, from 1–3 years prior. State trend results are directional only.

Nevada's Out-of-Home Care Indicators	STATE Previous	STATE Recent	STATE Trend	NATIONAL Recent
Children Entering Foster Care Rate of children entering foster care per 1,000 children (FFY2025)	3.8 Per 1,000	3.8 Per 1,000	— No Change	2.4 Per 1,000
Children Currently in Foster Care Rate of children currently in foster care on September 30 per 1,000 children (FFY2025)	5.6 Per 1,000	5.9 Per 1,000	↑ Increasing	4.5 Per 1,000
Children Exiting Foster Care Rate of children exiting foster care per 1,000 children (FFY2025)	3.6 Per 1,000	3.5 Per 1,000	↓ Decreasing	2.3 Per 1,000
Total Children Served Overall rate of children served in foster care during the federal fiscal year per 1,000 children (FFY2025)	9.2 Per 1,000	9.4 Per 1,000	↑ Increasing	6.9 Per 1,000
Exits to Adoption Percentage of foster care exits resulting in adoption (FFY2025)	30.0 Per 100	24.0 Per 100	↓ Decreasing	25.6 Per 100
Youth Living with Relatives Percentage of foster youth placed with relatives (2023)	39.3 Per 100	44.8 Per 100	↑ Increasing	31.6 Per 100

Foster Care Placement Types	2019	2023	2025
All Licensed Foster Homes	1,818	1,099	1,209
Non-Relative Foster Homes	1,281	823	862
Congregate Care Providers	21	19	24
Relatives with Active Placements	414	176	967

DATA INSIGHTS · FFY 2025 OUT-OF-HOME CARE TRENDS

Nevada's Foster Care System Is Evolving Toward Family-Based Care

1 SYSTEM DEMAND

In FFY2025, Nevada's foster care entry rate was **60%** higher than the national average, with **30%** more children in foster care, compared nationally.

Nevada	United States
3.8 Per 1,000 children **Entering Foster Care**	**2.4** Per 1,000 children **Entering Foster Care**
5.9 Per 1,000 children **In Foster Care**	**4.5** Per 1,000 children **In Foster Care**

2 PERMANENCY

Approximately **1 in 4** foster care exits resulted in adoption, **decreased from approximately 1 in 3** the year prior.

24%
of FFY2025 foster care exits resulted in adoption

Down from 30% in FFY2024

3 PLACEMENT INFRASTRUCTURE

Since 2019 to 2025, the foster care system's resources have shifted:

Licensed Foster Homes ↓ **34%**

Relative Placements ↑ **134%**

The increase in relatives with active placements (+553) was similar in magnitude to the decline in licensed foster homes (-609).

Contextual Note

As of June 30, 2025, seventeen (17) licensed foster care agencies inspected by the Legislative Auditor were caring for 504 children within a combined licensed capacity of 719 placements, i.e., 70% occupancy. This data reflects inspected foster care agencies only and does not reflect statewide placement capacity.

DATA INSIGHTS · QUALITY OF FOSTER CARE

Legislative Inspections Identified Recurring Quality and Safety Concerns

QUALITY ASSURANCE FINDINGS FROM LEGISLATIVE INSPECTIONS OF NEVADA CHILDREN'S FACILITIES (SFY2025)

Finding	Percentage of Facilities
Facilities with Significant Concerns	36%
Fire Safety Deficiencies	60%
When Children's Rights Were Denied, Proper Reporting Occurred	50%
Consent Documentation Deficiencies	52%
Background Check Deficiencies	44%

According to the Nevada Legislative Auditor (2026), recent inspections identified health, safety, welfare, or children's rights concerns in 9 of 25 inspected facilities (36%). Recurring findings included deficiencies in medication management, fire safety, mandatory reporting, and personnel documentation. Inspectors also identified recurring children's rights concerns, including incomplete documentation of complaint procedures, missing complaint logs, incomplete denial-of-rights reporting, and failures to post or communicate children's rights as required. These findings highlight opportunities to strengthen quality assurance, oversight, and compliance with standards protecting children's health, safety, and civil rights.

Opportunity for Action:
Move beyond compliance toward continuous quality improvement to ensure every child receives safe, consistent, and rights-centered care.

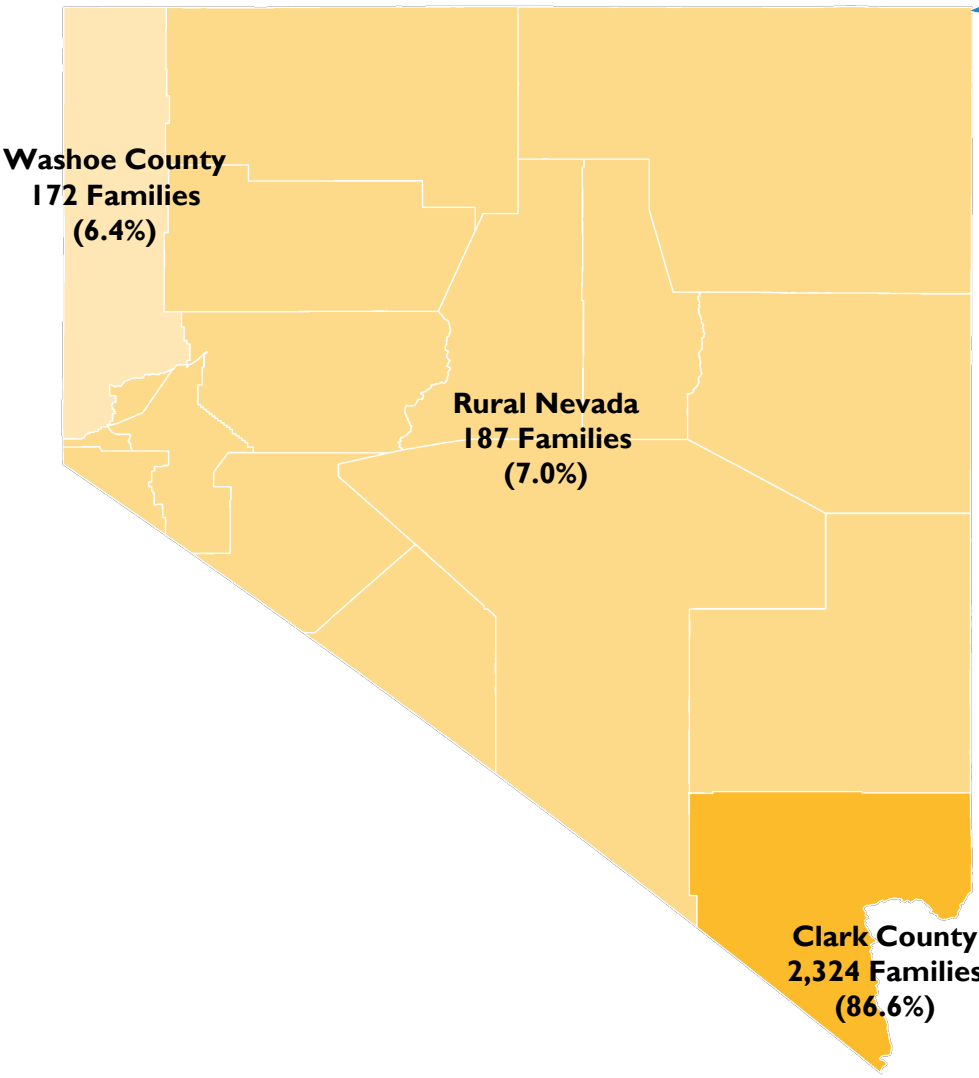
Licensing and Oversight · Quality Assurance · Workforce Training · Children's Rights · Continuous Improvement

DATA INSIGHTS · SHARE OF KINSHIP NAVIGATOR PROGRAM FAMILIES

Kinship Navigation Improves Access to Resources and Placement Stability

Nevada's growing reliance on kinship care is supported by a statewide service infrastructure that reaches both formal and informal caregivers. The Foster Kinship Navigator Program is designed to serve kinship caregivers (both relatives and non-relative kin) who are raising children in nonparental care. In FY2024, the Kinship Navigator Program served 2,683 unique families.

Share of Kinship Navigator Family Program by Region (FY2024)



EVALUATION RESULTS IN CLARK COUNTY: FOSTER KINSHIP NAVIGATOR PROGRAM

3.4x more likely to become licensed (and access services)

1.7x more likely to receive child-only TANF financial assistance

~3X more likely to maintain a stable placement without disruption

Opportunity for Action:

Build on Nevada's federally rated "Promising" Kinship Navigator model by expanding access in counties with limited participation, connecting more kinship families to coordinated legal, financial, and community supports that strengthen placement stability.

Expand · Evaluate · Improve

Policy and System Implications

Nevada's placement system appears to be shifting toward greater reliance on kinship care. As this transition continues, ensuring relatives have access to financial assistance, navigation services, training, and behavioral health supports may become increasingly important for sustaining stable family-based placements.

Licensed care availability may vary by placement type, level of care, or geographic location rather than reflecting a uniform statewide shortage. Available capacity within inspected foster care agencies, alongside the continued use of out-of-state facilities for children with complex cases, suggests an opportunity to better understand placement utilization and unmet placement requests. Many children in foster care have specific requirements, such as emergency placement, complex health support, rural placement, placement close to family and community, or advanced foster care. Reporting foster care demand, placement resources, and quality-of-care indicators at the regional level could help identify where capacity constraints exist and what types of placements are most needed. This would support more targeted resource allocation.

Although Nevada's foster care entry rate declined 42% (from 6.6 to 3.8 children per 1,000 between FFY2018 and FFY2025), Nevada continues to rely on foster care at rates above the national average. This higher utilization underscores the need to distinguish between factors influencing initial entry into foster care and processes that impact children's progression toward permanency once they are in foster care. Continued investment in family preservation, prevention, behavioral health, and early intervention services may help reduce the circumstances that lead to children's removal from their homes. At the same time, expanding public reporting for the length of time to permanency, permanency pathways, and children's legal status would help determine whether barriers in case progression also contribute to Nevada's comparatively higher foster care population. For example, compared with the national average, Nevada has a higher proportion of children whose permanency goal is adoption, yet a lower proportion of children who are legally free for adoption. This pattern suggests children in Nevada may progress from adoption planning to legal eligibility differently from children nationally, requiring closer examination to better understand these differences. Such measures could help clarify whether future policy efforts should prioritize preventing foster care entry, accelerating permanency, or both.

A complete understanding of permanency requires measuring reunification, guardianship, and adoption— not adoption alone. The decline in the proportion of exits resulting in adoption coincides with increased reliance on relative/kinship placements. Expanding public reporting on permanency outcomes– e.g., reunification, guardianship, and adoption– would provide a more complete understanding of how children achieve permanent family connections. This could inform policies that support the full continuum of permanency outcomes.

Opportunities for improvement may lie less in expanding the quantity of placement facilities and more in strengthening the quality, consistency, and oversight of services provided to children in existing out-of-home care sites. The number of children served through Nevada's foster care system has declined over time (-11%), while kinship care has increased, and at least some licensed facilities are now operating below capacity. Meanwhile, independent inspections continue to identify recurring concerns affecting the quality of care provided within existing children's facilities: thirty-six percent (36%) of facilities inspected exhibited concerning deficiencies related to health, safety, welfare, or children's rights. Common concerns included fire safety, medication management, documentation of mandatory reporting, background check compliance, informed consent, and protection of children's rights. These recurring findings suggest opportunities to strengthen statewide quality assurance, licensing oversight, staff training, and technical assistance to promote consistent standards of care across children's facilities.

Looking Ahead

2027 Children's Advocacy Alliance Priorities

Focused priorities to strengthen systems, expand opportunity, and improve outcomes for Nevada children.

Early Childhood

- Establish the Nevada Child Care Investment Fund
- Grow Child Care Supply
- Build the Early Childhood Workforce
- Support Early Childhood System Alignment

Children's Health

- Protect and Expand Medicaid Access and Capacity
- Strengthen the Behavioral Health Workforce
- Coordinate Children's Mental Health at the State Level
- Establish the Nevada Perinatal Quality Collaborative

Child Welfare

- Ensure Continuity of Services for Youth in Care
- Strengthen Transition-Age Youth Stability
- Support Neurodivergent Youth to Prevent System Involvement
- Improve Intervention Tracking for Child Abuse Cases

Crosscutting Opportunities

- Home Visiting
- Social Media Lawsuit Revenue for Children's Mental Health
- Housing Stability as a Foundation for Child Well-Being

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Children's Advocacy ALLIANCE

NEVADA

The Children's Advocacy Alliance is an independent voice for Nevada children, advancing systemic change in the areas of early childhood education, children's health, and child welfare. We achieve public policy wins through collaboration and collective impact within the community to ensure every child in Nevada thrives.

Scan to learn more about how you can support our advocacy.

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THANK YOU