2019
Children’s Legislative Briefing Book

A collaborative effort between:

Children’s Advocacy Alliance

Nevada Institute For Children’s Research & Policy

NICRP
This briefing book was prepared by the Children’s Advocacy Alliance (CAA) and the Nevada Institute for Children’s Research and Policy (NICRP). We would also like to thank the following organizations and individuals throughout Nevada who have made contributions to the briefing book.

Baby’s Bounty
Children’s Cabinet
Educate Nevada NOW
HOPE for Nevada
Immunize Nevada
Madison Sandoval-Lunn
Nevada Association for the Education of Young Children
Nevada Children’s Mental Health Consortia’s
Nevada Department of Education Office of Early Learning and Development
Nevada Early Childhood Obesity Steering Committee
Nevada Maternal and Child Health Coalition
Nevada Office of Suicide Prevention
Nevada Partnership for Homeless Youth
Nevada Primary Care Office
Partners for a Healthy Nevada
Southern Nevada Health District
University of Nevada Reno Cooperative Extension

Nevada Institute for Children’s Research and Policy
Home of Prevent Child Abuse Nevada | University of Nevada, Las Vegas
nic.unlv.edu
Table of Contents

Overview of the Nevada Children’s Report Card 4

Special Issue Brief – 2020 Census 5

**Education** 8
School Readiness 10
  Issue Brief – Child Care Subsidies 13
  Issue Brief – Small Child Care Establishments 15
Student Achievement 17
High School Completion 19
Funding 21
  Issue Brief – Pre-K Funding 24

**Health** 26
Access to Healthcare 28
  Issue Brief – Albuterol Inhalers 30
  Issue Brief – Hearing Aids 32
Prenatal, Infant, and Child Health 35
  Issue Brief – Diaper Assistance Programs 37
Immunizations 39
Childhood Obesity 41
  Issue Brief – Early Childhood Obesity Prevention 44
Dental Health 46
Mental Health 48
Sexual Health 52
Table of Contents

Safety 54
Child Maltreatment 56
  Issue Brief – Transition Age Foster Youth 59
  Issue Brief – Child Welfare Funding 62
Youth Homelessness 64
Juvenile Violence 68
Child Deaths and Injury 70
  Issue Brief – Bicycle Safety Helmets 72
Substance Abuse 74

Economic Well Being 77
Employment 80
Housing 82
Poverty 84
Income 87

Appendix: 2018 Children’s Report Card Data and Sources 90
2018 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 well-being indicators. 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 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. It is important to note that there are instances where Nevada’s indicator has improved, but our rank has gone down (due to other state’s improving more than Nevada). Because the grades are based on Nevada’s rank, this may result in a lower grade, despite improvements on the indicator.

2018 Summary of Grades

<table>
<thead>
<tr>
<th>HEALTH: D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Health Care F-</td>
</tr>
<tr>
<td>Prenatal/Infant Health D+</td>
</tr>
<tr>
<td>Immunizations C-</td>
</tr>
<tr>
<td>Childhood Obesity B-</td>
</tr>
<tr>
<td>Dental Health F+</td>
</tr>
<tr>
<td>Mental Health C-</td>
</tr>
<tr>
<td>Sexual Health D-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SAFETY: C-</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Maltreatment C</td>
</tr>
<tr>
<td>Youth Homelessness D</td>
</tr>
<tr>
<td>Juvenile Violence D+</td>
</tr>
<tr>
<td>Child Deaths &amp; Injuries C</td>
</tr>
<tr>
<td>Substance Abuse B</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EDUCATION: F</th>
</tr>
</thead>
<tbody>
<tr>
<td>School Readiness F-</td>
</tr>
<tr>
<td>Student Achievement F</td>
</tr>
<tr>
<td>High School Completion F-</td>
</tr>
<tr>
<td>Funding F</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ECONOMIC WELL-BEING: D</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment C+</td>
</tr>
<tr>
<td>Housing D-</td>
</tr>
<tr>
<td>Poverty D</td>
</tr>
<tr>
<td>Income D</td>
</tr>
</tbody>
</table>

How Grades are Determined: By State Ranking (Where Available)

<table>
<thead>
<tr>
<th>Grade</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>A+</td>
<td>1-3</td>
</tr>
<tr>
<td>A</td>
<td>4-7</td>
</tr>
<tr>
<td>A-</td>
<td>8-10</td>
</tr>
<tr>
<td>B+</td>
<td>11-13</td>
</tr>
<tr>
<td>B</td>
<td>14-17</td>
</tr>
<tr>
<td>B-</td>
<td>18-20</td>
</tr>
<tr>
<td>C+</td>
<td>21-23</td>
</tr>
<tr>
<td>C</td>
<td>24-27</td>
</tr>
<tr>
<td>C-</td>
<td>28-30</td>
</tr>
<tr>
<td>D+</td>
<td>31-33</td>
</tr>
<tr>
<td>D</td>
<td>34-37</td>
</tr>
<tr>
<td>D-</td>
<td>38-40</td>
</tr>
<tr>
<td>F+</td>
<td>41-43</td>
</tr>
<tr>
<td>F</td>
<td>44-47</td>
</tr>
<tr>
<td>F-</td>
<td>48-51</td>
</tr>
</tbody>
</table>
Special Issue Brief – THE 2020 CENSUS

The census affects our nation’s ability to ensure equal representation and access to government and private sector resources for all Americans. The results are used to ensure fair representation by allocating seats and drawing district lines for the U.S. House of Representatives, Nevada legislature, and local governing boards. Additionally, the census is used to determine how best to allocate federal funds and resources for more than 300 federal programs to citizens across the nation. From just the largest 16 programs alone, Nevada is estimated to receive over $4.6 billion in federal funding as a result of an accurate count. When individuals are undercounted (or missed) in the census, it impacts not only voting districts but also can result in the loss of millions of dollars for essential social safety net programs that are based on population.

In 2010, it was estimated that over 1 million children in the country under the age of 5 were missed in the counts, including a disproportionate number of minority children – Hispanic and Black – that were not counted. In the upcoming 2020 Census, it is estimated that 68,000 children in Nevada are at risk of being missed. Other hard to count (HTC) populations include racial and ethnic minorities, persons who do not speak fluent English, those living in poverty or who are homeless, undocumented immigrants, transient populations, and LGBTQ persons.

These groups may be underrepresented in the upcoming census due to changes in survey methodology, housing insecurity, language limitations, immigration status, distrust of the government, understanding of the process, or concerns about data confidentiality. Additionally, as the government moves to electronic surveys as opposed to the traditional mailed paper versions, access to computers and internet service may have an additional impact on the ability of low-income and rural populations to participate. Unfortunately, most individuals (particularly those in HTC populations) are not aware of the political and/or financial impacts of the undercount to the state, their communities and to themselves.

Hard to Count Populations
- Children under the age of 5
- Racial and ethnic minorities
- Persons who do not speak fluent English
- Poor and homeless
- Undocumented immigrants
- Transient populations
- LGBTQ persons
- Residents in rural counties
- Individuals who are angry at or distrustful of the government.

Nevada is currently one of a handful of states with a majority-minority population, with approximately 51% of all Nevadans reported as non-white or Hispanic. The following is Nevada’s current race and ethnic makeup based on the 2016 American Community Survey:  

- White – 1,933,057  
- Black or African American – 243,552  
- American Indian and Alaska Native – 31,927  
- Asian – 222,612  
- Native Hawaiian and Other Pacific Islander – 18,334  
- Other Race – 260,654  
- Hispanic or Latino (of any race) – 790,497  

Nevada also has a significant amount of children living in the state under the age of five, with 180,135 children under five living in our state in 2015. Projections from the Nevada State Demographer estimate that this population will increase by 5.2% by 2020. Additionally, approximately 21% of all children under the age of 18 in Nevada live in households below the poverty level and 54% live in a renter-occupied housing unit. In terms of homelessness, Nevada ranks 4th in the nation with the most vulnerable population of homeless youth, unaccompanied homeless youth, and 1st on unsheltered unaccompanied youth. Overall, approximately 32% of Nevada’s current population (40% in Clark County) live in HTC neighborhoods and in 2016 nearly 20% of Nevada households had limited or no internet access. This data, along with a growing fear of government contact, particularly among immigrant and undocumented populations, demonstrates a strong need for a culturally inclusive 2020 census outreach and education campaign.

In an effort to increase the census respondent rate to ensure a complete and accurate count of all Nevadans, thereby increasing representation and federal funding, the state should conduct a long-term strategic outreach campaign to communicate the importance of completing the upcoming 2020 census to all of its residents.

---

RECOMMENDATIONS FOR IMPROVEMENT:

- Develop at least three regional 2020 census coalitions (North, South, and Rural) including representatives from relevant government entities (state and local), organizations serving communities of color, early learning providers, low-income housing and homeless serving organizations, other advocacy organizations, and key community leaders, among others.
- Develop outreach and educational materials urging Nevadans to participate in the 2020 census.
- Establish the Nevada 2020 Census Commission during the 2019 Legislative Session, including an appropriation to support outreach and advocacy efforts targeted in HTC neighborhoods and among HTC populations.

For more information on this topic, please contact:
Children’s Advocacy Alliance
702-228-1869 | 775-440-1767 | www.caanv.org
EDUCATION 2019

“Education must not simply teach work – it must teach life.” - W.E.B. Du Bois

Education Overview

1. School Readiness
2. Student Achievement
3. High School Completion
4. Funding
EDUCATION OVERVIEW
Nevada Children’s Report Card Grade: F

Quality education provides a pathway of opportunity for children to realize their full potential. It is critical that children develop cognitive, social, and emotional skills to provide for themselves and for their future families. Education increases opportunities for employment, reduces the spread of communicable diseases, reduces mother and infant mortality, and improves overall health. Inequities in the education system deepen existing disparities within communities and contribute to the school to prison pipeline.8

In 2017, the Governor proposed and the Nevada State Legislature passed over 40 bills aimed at improving Nevada’s education system. These included increased funding for high quality early childhood education, provisions to increase student safety in schools, continuation of Victory and ZOOM schools, revisions to the funding formula for public schools and numerous other policies aimed at improving the infrastructure and quality of education in Nevada. Nevada continues to make investments and improvements in schools, however, the education system remains largely underfunded and thus struggles to prepare all students to be successful in their endeavors post high school. If Nevada wants to improve outcomes for its children, significant change is required.

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 2018 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. 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 ranked 48th in the nation for preschool enrollment with only 36.7% of 3- and 4-year-olds enrolled, a slight improvement since the last report card. Of the 36.7% of enrolled students, only 12% are enrolled in state preschool, special education or Head Start programs. Nevada ranks 41st for state spending per capita for states that offer preschool programs, currently investing $65.79, a slight improvement from 2015, but still significantly below the national average of $955.22.

Given the limited capacity of public preschool programs, efforts have also been made to increase access to high quality early learning programs. Between September 2015 and March 2018, Nevada increased monthly subsidy (child care assistance) caseload by 4,188 children, an increase of 77.86%. However, even with this increase, Nevada is only serving approximately 5.84% of children living below 200% of poverty.

Evidence overwhelmingly demonstrates that experiences from birth through the preschool years are critical to children’s development and that high-quality early learning opportunities support children’s school readiness and promote later life success. The ability for a child’s brain to develop is heavily influenced by the child’s environment and experiences. It is vital that they are exposed to high quality early learning experiences during the first few years of life.

In addition, by increasing access to quality early childhood programs, both children and parents are being supported. Quality programs can provide a network of professionals and parents that can support each other by providing networking opportunities, education on child

10 Ibid
11 Ibid
development, and model learning activities that can be replicated at home. Nevada is still 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 early learning opportunities will lead to less intervention and remediation in later grades—ultimately resulting in increased rates of high school graduation and overall success in adulthood.

“Access to early care and education means that parents, with reasonable effort and affordability, can enroll their child in an arrangement that supports the child’s development and meets the parents’ needs. This working definition takes the perspective of the family and their experiences finding ECE arrangements that meet their needs. A family-based perspective allows for consideration of the unique preferences, priorities, and needs of each household.”13

Research has identified the following as some of the primary barriers to accessing early care and education:

- Lack of high quality programs, especially in low income neighborhoods,
- Lack of caregiver knowledge of available programs,
- Lack of high reliable transportation,
- Programs for children do not align hours of program operation for parents with non-traditional work hours,
- Limited availability of programs that accept children with a physical, emotional, or developmental disability, and
- Limited availability of programs with bilingual staff.14

Nevada has many early childhood programs that have been shown by research to be effective such as Early Head Start, Head Start, home visiting, and full day kindergarten. However, these programs do not serve and support all children in need. In addition, children with disabilities, mental and behavioral health needs, and children of color are disproportionally impacted by the lack quality early learning environments that are affordable and located within their neighborhoods.

14 Ibid
RECOMMENDATIONS FOR IMPROVEMENT:

• Ensure that high quality early childhood education programs are accessible and affordable for all children - birth through kindergarten - in Nevada.
  o Increase state funding for child care subsidy programs. Currently, Nevada is serving less than 6% of the eligible population. The high cost of early childhood education programs is a barrier in the community. Increases in subsidy would increase access for Nevada's most vulnerable children.
  o In addition, current market rates should be used to determine subsidy reimbursements. The Child Care Development and Block Grant (CCDBG) has mandates that states develop strategies for increasing supply and quality of child care services in vulnerable populations. One barrier to accessing quality care is the cost of care and reimbursement rates for providers. Increasing quality requires an increased financial investment. While Nevada is required to conduct the market rate every three years to stay current, the reimbursement rate is not set at the current market rate. Nevada must legislatively mandate setting the reimbursement rate to the most recent market rate to ensure equal access to quality early childhood education programs in the most vulnerable populations.

• Continue to invest in programs that assess quality of care, such as the Silver State Stars Quality Rating Improvement System.

• Support infrastructure development, including the development of new classroom space and qualified early learning teachers, to enable Nevada to offer universal PreK in the near future. Currently, public preschool serves 11% of eligible 4-year-olds which is at capacity.

• Continue to raise reimbursement rates to enhance educator wages. Support a Wages program for early childhood educators. As the state raises qualifications for ECE educators, it should make investments that can support higher wages so that providers can recruit and retain educators with the specialized knowledge and skills they need to teach young children.
ISSUE BRIEF – Child Care Subsidies

In Nevada, over 65% 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 $11,137 for an infant to $8,835 for preschoolers (age 3-5). These high costs cause a huge financial burden to all working families, especially those living in poverty. Today, a single parent with an infant and preschooler making $1,702 a month (100% of poverty) would have to spend 97% of her income on center-based care for her children. Many families in this situation cannot afford to work.

To help reduce this financial burden, the Federal Child Care and Development Fund (CCDF) provides child care subsidies to families with children up to age 13 living in poverty (up to 75% of Nevada’s median income). 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.

Currently, parents who are enrolled in higher education programs, such as attending a Nevada System of Higher Education college/university or apprenticeship program, are not eligible for subsidy. The inability for parents to receive assistance paying for child care can discourage or prohibit them from pursuing additional educational and professional opportunities.

Unfortunately, the subsidy program lacks sufficient funding to reach those in need. Nevada’s subsidy program currently only serves 5.84% of eligible children. Access to quality care is also limited due to the State’s subsidy reimbursement rate currently being based on the 2004 market rates. To access care outside of what the state will reimburse, parents, including foster

---

16 This parent would be making an estimated pretax hourly wage of $9.80 compared to the state minimum wage of $8.25 an hour. A parent making minimum wage would spend more than their annual salary on child care for their two children.
17 Nevada is receiving a $26 million increase to the overall child care subsidy budget in the upcoming biennium as a result of the FY 2018 Omnibus Spending Bill.
18 Effective Monday, August 13th, 2018, and until further notice, individuals participating in the Nevada System of Higher Education and SNAP E&T Workforce Program with Western Nevada College or Truckee Meadows Community College will become eligible to access child care subsidy assistance as part of an education and training “pilot program,” under specified Reason for Care and Purpose of Care categories.
19 Nevada currently reimburses providers at a tiered reimbursement rate based on quality with providers rated 1-star being reimbursed at the 2004 market rate and five star rated providers being reimbursed at the 2015 market rate.
parents, must pay the overage between the State’s maximum reimbursement rate and providers’ actual market rate. For example, this would require a parent whose child is in pre-kindergarten care in Clark County and Washoe County to pay the difference of approximately $19.35 and $12 a day, respectively. This difference alone is 24% and 15% of the income for a single parent with a preschooler living at 100% of poverty, in Clark and Washoe Counties, respectively. Because higher quality child care is often more expensive than lower quality care, families on the subsidy program are often forced to utilize lower quality services for their children.

In addition to providing parents with the necessary resources to become productive members of the workforce, subsidies have the potential to help at-risk children to gain a strong start. Research shows that low-income children who attend high quality preschool programs are less likely to need special education, less likely to repeat a grade, less likely to be arrested and are more likely to graduate high school, attend college and be employed. Additionally, while children are in high-quality child care, parents can become better employees. Participation in child care has been shown to increase parent employment rates, reduce worker turnover, absenteeism and increase productivity.

RECOMMENDATIONS FOR IMPROVEMENT:

- Provide additional funding to increase the proportion of eligible children served by subsidies, including those children under 13 years of age who live at or below 75% of Nevada’s median income in both single and dual earner households to allow them to work, seek employment, or attend school/vocational training.
- Increase the reimbursement rate to meet current market rates.
- Increase the number of QRIS coaches for rating centers under the Silver State Stars program.
- Provide incentives to providers to serve children during nontraditional hours so parents have access to safe, high-quality child care while working in industries with a 24 hour schedule.
- Ensure that child care providers serving foster children are paid at 100% of the current market rate cost of care so foster parents are not required to pay the difference between what the subsidy will pay and what the center charges.

For more information on this topic, please contact:
Children’s Advocacy Alliance
702-228-1869 | 775-440-1767 | www.caanv.org
ISSUE BRIEF - Small Child Care Establishments

Nevada’s early childhood provider capacity meets only 23% of the need for child care for children ages 0-5. This lack of licensed providers has only gotten worse since the great recession with Nevada experiencing a 52% decline in licensed family child care programs and a 5% decline in licensed centers since 2008 – decreasing Nevada’s overall licensed capacity by 4,891 slots.20

Due to the severe lack of licensed providers in the state, many parents are relying on license-exempt or non-licensed child care, defined as individuals watching less than five non-related children in their home. These license-exempt providers (unless they receive child care subsidy funding) are not currently required to complete a personal history, background, and child abuse and neglect checks. Additionally, these providers do not have any minimum standards related to safety, curriculum or quality. Without these minimum standards, parents have a more difficult time knowing of the safety/quality standards of the providers who are watching their children. Parents then rely on word-of-mouth, the visual appearance of the center and potentially unreliable, for those who can afford it, 3rd party background check companies to determine safety and quality of care for young children.

In Nevada, 65.1% (approximately 130,000) of children ages 0-5 live in households where all parents work.21 To be able to attend work, many of these parents rely on child care providers to care for their children when they are away. Although many home-based, unlicensed providers are providing excellent care, without regulation or oversight, there are also many providers who are not providing consistent care. Having unreliable child care can cause increased absenteeism, reduce productivity and can cause some families to exit the workforce.

To help ensure parents have peace of mind when sending their child to an unlicensed/license exempt child care provider, the Nevada Legislature recently passed Assembly Bill 346 (AB 346) which created a new category of child care provider, small child care establishments – a provider that provides care to no more than four children unrelated to the operator for compensation, outside the home and the presence of the parent or guardian of any of the children and on a regular basis for at least 3 weeks. These providers are able to register with the Division of Welfare and Supportive Services of the Department of Health and Human Services and receive a full background check (at provider cost).

21 Ibid
While this was a great first step in addressing unlicensed/license exempt child care providers, it still allows many providers to operate without ensuring they are safe and quality environments for children. Additionally, it keeps these programs from being able to receive supports to help them improve their operational capacity and services. Ideally, as these providers begin to register as small child care establishments with the Division of Welfare and Supportive Services, the state will better understand the locations in which these providers are operating and can offer resources related to safety practices, curriculum and educational best practices, how to provide healthy meals and snacks, and age appropriate physical activities. The state should also utilize this opportunity to understand barriers faced by these providers and provide incentives and/or stipends to assist providers in improving quality and/or becoming licensed providers. This would help address the decline in licensed family child care program slots and provide parents with more quality options for care.

RECOMMENDATIONS FOR IMPROVEMENT:

- **Require providers who meet the small child care establishment definition to register with the state and receive a full background check.**
- **Appropriate funding to help incentivize small child care establishments to become licensed family care providers by providing one-time grants to offset any additional costs related to becoming licensed.**
- **Provide small child care establishments support and resources to help them offer high quality care.**

For more information on this topic, please contact:
Children’s Advocacy Alliance
702-228-1869 | 775-440-1767 | www.caanv.org
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. According to the NAEP, the percentage of 4th graders who are proficient at reading has slightly increased from 29% in 2015 to 31% in 2017.22 Similarly, 8th graders proficient in math increased from 26.1% to 27% in 2017.23 Despite these increases, Nevada remains near the bottom of both rankings, 43rd for reading and 41st for math. Nevada ranks 50th overall for postsecondary participation, with just 41% of young adults enrolled in postsecondary education or with a degree.24

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 a study conducted by the National Center for Education Statistics (2016), based on data received at the beginning of their study in the 2010-2011 school year, 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 emerged for math abilities as well.25

It is important that data are disaggregated by race/ethnicity as well as other risk factors such as income and disability status, to identify groups of students that need additional educational supports to increase their chances of success. Since 2005, the percentage of fourth grade students in Nevada scoring below the proficient reading level has decreased significantly. However, Black/African American and Hispanic/Latino children still have the highest rates of non-proficiency.

---

(80% and 78% respectively), while those of Asian/Pacific Islander descent have the lowest rate of non-proficiency at 55%. These results are similar when examining proficiency in fourth grade mathematics.

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. When our schools lack the resources to properly educate our students, the community at large will experience the related negative outcomes. Increasing school achievement is influenced by many factors. Increased teacher effectiveness is a complex issue as there are many factors that contribute to success such as a student attitudes, motivation, and external supports as well as teacher self-efficacy, continued professional development, school leadership, and school culture. Increased resources are needed to target all of these areas including teacher pay. Increases in pay have shown to increase attractiveness to the state and district. While pay is a factor, sustaining teachers includes working to address the factors listed above.

RECOMMENDATIONS FOR IMPROVEMENT:

- Increase funding for all schools in order to increase pay for teachers.
- Continue support for additional professional development for teachers at all grade levels to increase their ability to offer quality instruction to students.
- Provide resources to reduce classroom sizes when needed to increase teacher time to dedicate to individualized student improvement.
- Ensure that children receive supports early by providing high quality early education programs so that children enter school ready to learn.
- Continue programs that support at-risk youth with additional support in reading & math.
- Support family education and engagement programs to encourage regular school attendance and healthy academic practices in the home.

---

26 Kids Count, “Fourth graders who scored below proficient reading level by race.”
https://datacenter.kidscount.org/data/line/5126-fourth-graders-who-scored-below-proficient-reading-level-by-race?loc=30&loct=2#2/30/false/871,573,36,867,38,18,16/asc/10,168,9,12,185,107/11557


3. **HIGH SCHOOL COMPLETION**

*Nevada Children’s Report Card Grade: F-*

The high school completion grade is based upon high school dropouts (teens age 16 to 19 who are not in school and have not yet graduated), as well as high school graduation rates. Nevada’s dropout rate is 7% as of 2016, a slight increase from 6% in 2014. In order to grade Nevada by national rank, data for the high school graduation indicator is based upon the class of 2016 – which was 73.6%. Nevada still ranks low at 49th in the nation, and is below the national average of 84.1%. It is hopeful that continued investments in education will help to increase these rankings in the coming years.

The graduation rate for Nevada has improved over the past few years due to changes in graduation requirements. However, Nevada continues to have deep disparities in graduation rates. Students in Nevada who are Black or American Indian/Alaskan Native have a graduation rate of 67.73% and 73.91%, while the average graduation rate for all students in Nevada is 80.85%. In addition, those with an Individualized Education Program (IEP) (64.73%) and migrant students (71.43%) also have lower graduation rates comparatively. The changes in requirements however have reduced disparities for students who are Hispanic (79.71%), English Language Learners (ELL) (81.66%), and those on Free and Reduced Lunch (FRL) (76.84%).

<table>
<thead>
<tr>
<th>Nevada Graduation Data by Ethnicity</th>
<th>Am In/AK Native</th>
<th>Asian</th>
<th>Black</th>
<th>Hispanic</th>
<th>Two or More Races</th>
<th>Pacific Islander</th>
<th>White</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016-2017</td>
<td>73.91</td>
<td>93.09</td>
<td>67.73</td>
<td>79.71</td>
<td>81.25</td>
<td>82.34</td>
<td>84.18</td>
<td>80.85</td>
</tr>
<tr>
<td>2015-2016</td>
<td>64.71</td>
<td>87.92</td>
<td>56.53</td>
<td>69.74</td>
<td>76.84</td>
<td>75.92</td>
<td>79.88</td>
<td>73.55</td>
</tr>
<tr>
<td>2014-2015</td>
<td>58.4</td>
<td>84.73</td>
<td>55.46</td>
<td>66.7</td>
<td>75.63</td>
<td>71.04</td>
<td>78.04</td>
<td>70.77</td>
</tr>
</tbody>
</table>

*Note. Am In/AK Native = American Indian/Alaskan Native*

<table>
<thead>
<tr>
<th>Nevada Graduation Data by Special Populations</th>
<th>EVER FRL</th>
<th>EVER IEP</th>
<th>EVER ELL</th>
<th>EVER MIG</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016-2017</td>
<td>76.84</td>
<td>64.73</td>
<td>81.66</td>
<td>71.43</td>
<td>80.85</td>
</tr>
<tr>
<td>2015-2016</td>
<td>66.73</td>
<td>29.29</td>
<td>42.58</td>
<td>55.81</td>
<td>73.55</td>
</tr>
<tr>
<td>2014-2015</td>
<td>63.68</td>
<td>28.97</td>
<td>32.05</td>
<td>45.24</td>
<td>70.77</td>
</tr>
</tbody>
</table>

*Note. FRL= Free and reduced lunch; IEP= Individualized Education Plan; ELL=English Language Learner; MIG=Migration*

34 Ibid
The average dropout rate in Nevada for grades 6-12 is 3.2% with 11th and 12th grade having the highest percentage of dropouts at 3.7% and 4.0%. There are also disparities in dropout rates with Black students having the highest dropout rate in every grade with the highest being 7.0% in 12th grade. 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. Each of these factors represents a point of intervention that can be targeted to reduce risk associated with high school dropouts in Nevada. Interventions addressing these factors need to begin well before high school to have the best chance at reducing high school dropout.

Nevada needs to continue to make investments in education in order to reduce the dropout rate and increase graduation rates which will in turn reduce unemployment, reduce reliance on government cash assistance, food stamps, and housing assistance, and reduce incarceration rates. Educational success is not simply a concern for the school systems, but for the community overall.

RECOMMENDATIONS FOR IMPROVEMENT:

- Increase supports and interventions in preschool, elementary, and middle school years, specifically for the families of students most at risk for not completing high school.
- Increase support services for youth and families to address other factors associated with low graduation and dropout rates including youth homelessness, poverty, physical, mental and behavioral health needs, and participation in high risk behaviors.
- Increase funding to support additional professional development for teachers at all grade levels to increase their ability to offer quality instruction to students.
- Increase pay to keep qualified teachers in the classroom.
- Reduce classroom sizes in all grades so teachers have more time to dedicate to individualized student improvement.

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, as well as student-teacher ratios. Per pupil expenditures are calculated for public elementary and secondary education.\(^{39}\) In Nevada, actual per pupil expenditures for the 2015-2016 fiscal year were $8,960 compared to $11,762 nationally. Nevada’s ranking of 43\(^{rd}\) in this category is a slight increase from the previous report card rank of 46\(^{th}\).\(^{40}\) Nevada’s low per pupil expenditure continues to cause high student-teacher ratios, ranking the state 48\(^{th}\) in the nation with an average ratio of 20.6 compared to 16.0 nationally.\(^{41}\) In 2013, Nevada ranked 14\(^{th}\) overall in the nation for categorical funding, allocating over 200 million dollars. Nevada has since increased categorical funding amounts in the past two sessions (2015 and 2017), investing nearly 500 million more dollars.

Encouragingly, the State of Nevada has prioritized education over the last two biennium. In 2015, $2.85 billion was secured for the K-12 funding biennium, close to a 16 percent increase from the then-current budget. In 2017, there was a statewide increase in education funding of $179,025,112 from the previous biennium, which is an 8.2 percent increase.\(^{42}\)

Despite some investments in education funding during the 2015 and 2017 sessions, Nevada’s per pupil funding for the 2017 fiscal year was well below the states own estimates for meeting the needs of students.\(^{43}\) State per pupil funding to districts has continued to remain largely flat, when accounting for inflation, and this funding represents about 70 percent of the funds districts receive. Flat state per pupil funding is particularly problematic given that district costs continue to rise at rates that outpace inflation, mandates on students and schools often go un- or underfunded, and major changes in student demographics remain largely unaccounted for. And though new revenue sources dedicated to education should be available to help increase per pupil funding, they often are used to reduce the state’s General Fund contribution to the education budget. This explains why new revenue sources, such as the commerce, marijuana, and the 2009 room taxes have only managed to fund smaller, finite programs, and the state per pupil funding still has not reached pre-recession levels.

---

\(^{39}\) The per pupil amount used in this analysis takes into consideration categorical funds allocated to education and the funding from the Nevada funding formula.


The legislature’s most recent evaluation of the actual cost of educating students in Nevada found the State is still falling at least $2 billion short in funding. English Language Learners (ELL), Free and Reduced Lunch (FRL), and Gifted and Talented Education (GATE) students are still not accounted for in the formula, despite the State’s specified intention of transitioning to weighted funding. Additionally, special education funding is still well below the recommendation of the Legislature’s 2015 K-12 Task Force on Public Education Funding.\(^44\)

As a result, Nevada ranks 48\(^{\text{th}}\) in per pupil expenditures and suffers from the highest class sizes in the nation.\(^45\) Nevada still has a long journey to reach an equitable level of education funding for all students. Though many of the programs and initiatives from the last two sessions have led to promising results, more work needs to be done.

**RECOMMENDATIONS FOR IMPROVEMENT:**

- Nevada should have a new and improved education per pupil funding formula that:
  - Accounts for evolving demographic changes;
  - Allows for additional dollars to supplement education spending rather than substitute the state’s contribution;
  - Determines funding levels by evaluating the actual costs necessary to ensure our students have a chance to succeed; and
  - Ensures changes to the funding model not be detrimental to statewide equity.\(^46\)
- Increased funds need to come with accountability, stability and resources to ensure a return on investment regarding our students and their academic success.

---

\(^44\) Task Force on K-12 Public Education Funding, https://www.leg.state.nv.us/App/InterimCommittee/REL/Document/9061


- Nevada currently has the highest number of enrolled students per teacher in the country. We must concentrate efforts to accomplish successful Class Size Reduction, to retain our professional educators, and recruit the thousands that are needed to fill vacancies.47
- Nevada should continue to invest in public preschool programs (infrastructure and seats) to achieve universal PreK.

---

The impacts of high-quality early childhood education can span a lifetime. In fact, research shows that preschool is an effective early intervention method that creates lasting academic and social impacts. A high-quality early childhood education system can bring short and long-term benefits not only to Nevada’s families but to our state as well. Some of the benefits include:

- Less welfare dependency
- Lower rates of crime
- Better health outcomes
- Higher levels of verbal, mathematical, & intellectual achievement
- Lower unemployment and higher earnings
- Greater government revenues & lower government expenditures
- Greater success at school, including less need for special education, less grade retention, and higher graduation rates

For Nevada’s most at-risk students, high quality early childhood education can be the difference in entering kindergarten ready to learn or entering 18 months behind their affluent peers. The benefits of preschool go beyond the classroom and into adulthood. The positive impact of preschool for an individual translates to a large return on investment (ROI) for society. Children who attend preschool are less likely to need costly services, such as an extra year of schooling, welfare assistance, or a jail bed. Additionally, children who attend preschool are more likely to be employed and have a higher salary as adults - enabling them to contribute greater earnings to the community. Some communities have seen a ROI as high as $7 for every dollar invested in Pre-K.

Despite the proven benefits of investment into high quality early childhood education programs, Nevada has limited funds for the state preschool program. Even with the changes made to the funding formula in 2015, the Nevada Plan does not guarantee funding for early childhood education for non-special education students. The Nevada State Preschool Program is currently funded by external categorical dollars allowing it to be easily reduced or eliminated. The State has yet to increase funding for this external categorical program but has instead decreased funding. In 2001, the Nevada State Preschool Program was funded at $3.5million and today it is funded at $3.3million. Currently, Nevada ranks 42nd for state spending per capita for states that offer preschool programs, investing $46.35 per child compared to the national average of $773.63.

---


49 https://www.naeyc.org/resources/pubs/tyc/feb2014/the-word-gap

Fortunately, the Nevada State Preschool Program has had indirect funding to help increase access for young children. During the 2017 Legislative Session, the legislature continued funding for Zoom Schools and Victory Schools which allows some funds to be used for preschool classrooms. Additionally, in 2014, Nevada received a four-year federal grant to expand the number of children participating in high-quality preschool programs. The Nevada Ready! Preschool Development Grant required a match from the state which was approved by the legislature in June 2015. With these funds, Nevada has seen a 3,000 seat increase in quality care. Unfortunately, Nevada is in the last year of the Nevada Ready! Grant and will receive no more federal money for the 2019-2020 school year. To ensure we do not lose the seats we have gained, the legislature will need to increase funding for preschool by $14,077,008 annually.

This investment is critical to ensure Nevada does not go backwards on the progress we have made for early learning programs and to help us move toward a universal preschool program. While providing funds to address the Nevada Ready! Grant gap should be a critical priority, there are still more funds needed to build a strong robust preschool program for Nevada’s children. A critical first step is to support the infrastructure of the early learning community by allocating funds for buildings, the expansion of the Silver Stars Quality Rating Improvement System, and professional development for early learning educators. Nevada’s traditional public preschool program does not have the capacity to serve many more children and most rely on private child care facilities. To build a universal preschool program in Nevada, the state needs to increase supports aimed at improving the quality of local child care providers.

The Nevada State Preschool Program has had to rely almost entirely on indirect funding to help increase access to preschool programs for young children. These categorical investments are steps in the right direction, but Nevada needs to start looking at long-term, sustainable funding for its preschool programs and work to ensure every child in Nevada has access to a high-quality preschool program.

RECOMMENDATIONS FOR IMPROVEMENT:

- Provide necessary funds to keep the Nevada Ready! Preschool Development Grant seats.
- Provide funds to support building the infrastructure of the early learning community including, but not limited to, increasing classroom space, expanding the Silver State Stars Quality Rating Improvement System, and building a robust early learning teacher community.
- Gradually increase funding for preschool programs until Nevada has a universal preschool program.
- Increase funds for the child care subsidy program to help support private providers and increase quality.

For more information on this topic, please contact:
Children’s Advocacy Alliance
702-228-1869 | 775-440-1767 | www.caanv.org
“Good health is not something we can buy. However, it can be an extremely valuable savings account.” – Anne Wilson Schaef

Children’s Health Overview

1. Access to Healthcare
2. Prenatal and Infant Health
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 young adulthood.

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 behavioral health services.
- 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 regarding nutrition, physical activity, chronic disease prevention, avoidance of risky behaviors and overall well-being.

It is every child’s right to have access to the preventative care and treatments they need to thrive. Access includes both affordability and an adequate provider pool to obtain services in reasonable time. Too often, families forego preventative care and treatment due to lack of medical coverage and the high cost of care. Neglecting a child’s basic health care needs can contribute to health problems and higher costs as they grow.

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 2018 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 and 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**-

For the Nevada Children’s Report Card, the access to health care grade includes the percentage of children without health insurance (Nevada ranks 47th), those who have a quality medical home (Nevada ranks 51st), and patient to provider ratios, in which Nevada ranks 48th. While all of these indicators are critical to ensuring access to quality healthcare, those children with adequate health insurance are far more likely to receive the preventative care necessary for healthy development.

Since the passage of the Affordable Care Act, Nevada’s rates of uninsured children has significantly declined. Despite this success, Nevada continues to rank in the bottom states when it comes to providing health insurance coverage for children. There are also disparities in health insurance coverage, seen both in the nation and in our state. In Nevada, 10% of children who are Hispanic are uninsured which, despite continuous improvements from previous years, is still 3% higher than the national average for that ethnic group. In the 2017 legislative session, SB325 removed the 5 year wait period for lawfully residing children to access Medicaid and CHIP, taking a step in the right direction to increase coverage for all children.

<table>
<thead>
<tr>
<th>States with the Highest Uninsured Rates</th>
<th>2013</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>7.1%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Alaska</td>
<td>11.6%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Texas</td>
<td>12.6%</td>
<td>9.2%</td>
</tr>
<tr>
<td>Wyoming</td>
<td>5.7%</td>
<td>8.8%</td>
</tr>
<tr>
<td>North Dakota</td>
<td>7.9%</td>
<td>7.8%</td>
</tr>
<tr>
<td>Arizona</td>
<td>11.9%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>10.0%</td>
<td>7.3%</td>
</tr>
<tr>
<td><strong>Nevada</strong></td>
<td><strong>14.9%</strong></td>
<td><strong>6.8%</strong></td>
</tr>
</tbody>
</table>


Good health is key for academic achievement. Children with health 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. 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.\textsuperscript{57}

As we improve health insurance coverage rates, it is important to note that access to healthcare does not end with an insurance card. Having adequate medical providers is also key to ensuring access to appropriate medical care for children. Nevada currently ranks 49\textsuperscript{th} in active patient care physicians at a rate of 70.1 physicians per 100,000 population.\textsuperscript{58} Historically, Nevada has had difficulty retaining a sufficient number of quality physicians due to low reimbursement rates by insurance companies (including Medicaid) and rapid population growth. To compensate for the rising costs of providing care, physicians overbook their schedules to accommodate more patients in the same amount of time, sacrificing their ability to provide high quality extensive care.\textsuperscript{59}

A ranking of the best and worst states for healthcare was completed in 2018, finding Nevada to be 47\textsuperscript{th} in affordability, 50\textsuperscript{th} in availability, and 28\textsuperscript{th} in healthcare results.\textsuperscript{60}

**RECOMMENDATIONS FOR IMPROVEMENT:**

- Review reciprocity and/or waiver policies for various types of medical providers to encourage experienced providers to come to Nevada.
- Continue to expand 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.
- Revise Medicaid reimbursement rates to better support provider costs, enabling more providers to accept Medicaid patients.

\textsuperscript{57} 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


ISSUE BRIEF – Emergency Albuterol Inhalers

According to the National Heart, Lung, and Blood Institute, asthma affects people of all ages, but most often starts during childhood.\(^6\) Just over 1 out of 12 children in the United States have been diagnosed with asthma.\(^2\) The effect of asthma is compounded by Nevada’s dry climate, dust & quick temperature changes – resulting in high asthma rates. In Nevada, asthma is the most common medical condition for children entering kindergarten and 24% of high school students reported having asthma.\(^3\) While in school, children with asthma, whether diagnosed or undiagnosed, are at-risk of having an asthmatic attack. In 2010, 3 out of 5 children who have asthma had one or more asthma attacks in the previous 12 months.\(^4\) The symptoms include:\(^5\)

- Coughing
- Wheezing
- Chest Tightness
- Shortness of breath

These attacks can be mitigated by the use of an albuterol delivery devise. But without this treatment, depending on the severity of the attack, these children’s symptoms may worsen and become a life-threatening emergency. Unfortunately, children do not always have an inhaler available for use. This may be due to them being undiagnosed, not owning an inhaler, leaving it at home, or because it is broken, or empty. The lack of owning inhalers also disproportionately affects minority children and children living in poverty.

According to the Nevada State Asthma Control Plan:

“Minority children and children in poverty have a greater burden from asthma compared with white, more socioeconomically advantaged children, and the same children are less likely to receive adequate treatment and to have family or community support for their asthma management.”

---


---
To improve access to asthma medications in schools, the American Lung Association made the following recommendations:66

- State and local officials must educate all school personnel on existing laws and policies, and clarify expectations for their implementation.
- Schools, asthma advocates and healthcare providers must facilitate parent and caregiver engagement in the management of their child’s asthma at school.
- School districts must implement standardized protocols and instruments for the assessment of a student’s readiness to self-carry.
- Schools must provide access to back-up medication using standing orders for quick-relief medication.

Access to an emergency a back-up albuterol delivery device provides a safeguard for children who do not have access to an inhaler. This legislation would be similar to Senate Bill 453, passed in 2013, which: allowed for a physician to issue an order for auto-injectable epinephrine to a public or private school; required for public schools to obtain an order from a physician or osteopathic physician for auto-injectable epinephrine to maintain the drug at the school; allowed a school nurse or other designated employee of the public or private school, as applicable, who has received training in the storage and administration of auto-injectable epinephrine to possess and administer auto-injectable epinephrine to a pupil on the premises of the school during the school day who is reasonably believed to be experiencing anaphylaxis; and require training in the storage and administration of epinephrine to be provided to designated employees of a public or private school.67

RECOMMENDATIONS FOR IMPROVEMENT:

- Mandate schools to provide access to back-up albuterol delivery device using standing orders for quick-relief medication to be administered by a trained professional within the school. Training should include assessment for use of inhaler vs. epinephrine.
- Require school districts to implement standardized protocols and instruments for the assessment of student’s need for an emergency inhaler and/or nebulizer treatment.
- Work with pharmaceutical companies to reduce the fiscal burden on school districts purchasing the medication.
- Establish protections from liability for schools who administer and medical providers who write the prescriptions.

For more information on this topic, please contact:
Children’s Advocacy Alliance
702-228-1869 | 775-440-1767 | www.caanv.org

ISSUE BRIEF - Hearing Aids for Children

Hearing loss is the most common congenital condition present at birth in the United States.68 Approximately two to three of every 1,000 children in the United States are born deaf or with some degree of hearing loss and more lose their hearing later during childhood.69 As a child learns their first language it is not taught like a school subject; rather it is “caught” as children pick up on words through continuous exposure to spoken language through listening.70 If hearing loss is left undetected and untreated, a child’s spoken speech and language acquisition, academic achievement, and social and emotional development can be harmed.71 It is critical that a child with hearing loss receive appropriate hearing devices and access to early intervention services as early as possible.

According to the American Speech Language Hearing Association (ASHA), “hearing aids represent a relatively inexpensive intervention for the amount of benefit gained, especially when calculating the long-term benefits of early intervention to children and society.”72 When infants with hearing loss have access to hearing devices and start intervention by six months of age, they are often able to have the same language abilities as their peers when they enter kindergarten.73

Nevada Medicaid, which covers 61% of Nevada’s children, and Nevada Check Up cover hearing tests, hearing devices, batteries for hearing devices and speech therapy.74 However, many commercial insurance plans in Nevada do not fully cover hearing devices, leaving many families unable to afford and obtain these necessary and life changing devices. Families struggle to pay bills amounting to several thousands of dollars for hearing devices in addition to the cost of ear molds, batteries, hearing assistive technology (i.e. personal FM systems), other supplies, and additional necessary maintenance. Moreover, families often have copays associated with each visit to necessary appointments with ear nose and throat specialists, audiologists and services like speech therapy.

---

73 Ibid
74 Medicaid Brochure 2012. https://www.leg.state.nv.us/Session/77th2013/Exhibits/Assembly/HHS/AHHS205D.pdf
More than 90% of deaf children are born to hearing parents, making the financial burden of services and devices an unexpected reality. Additionally, about 50% of childhood hearing loss is genetic, so it is common for many families to have more than one child with hearing loss. Consider the story of Beth Jones from Las Vegas, who explained: “As a mom of two children unexpectedly diagnosed with hearing loss, I was both shocked and terrified at the cost of four hearing aids, how often I would need to replace both the devices and their necessary equipment like ear molds, and how little my insurance covered in both the monetary amount and frequency of reimbursement. My family even had to consider moving out of state, moving in with extended family, or selling our house and downsizing just to allow two of my children to hear. No family should have to make those hard choices to be able to afford what is medically necessary for their child to have access to sound.”

Families are put under enormous financial strain to make sure their kids have the necessary devices they need to access auditory information necessary for developing spoken speech and language skills. Many families are simply unable to afford it despite making many sacrifices.

To help ensure all children have access to these necessary medical devices, over twenty states have passed legislation requiring that health benefits plans in their state pay for hearing devices for children. Hearing device coverage not only provides a clear health benefit to the child, it also saves the state money in the future. If a child with hearing loss is left untreated, they are likely to lag academically, and states will spend thousands of dollars more on speech-language services and special education.

RECOMMENDATIONS FOR IMPROVEMENT:
- Require commercial insurance plans to provide coverage for medically necessary expenses such as ear molds, batteries, retention and FM services incurred in the purchase of a hearing device for covered children 21 years of age or younger.
- Coverage should include the purchase of a hearing device for each ear, when medically necessary and as prescribed or recommended by a licensed physician or audiologist.

---

75 “Quick Statistics About Hearing” National Institute of Deafness and Other Communication Disorders

76 “Genetic Hearing Loss” https://www.babyhearing.org/genetic-hearing-loss
• If a hearing device chosen by the covered person is priced higher than the benefit payable, they may pay the difference between the price of the hearing device and the benefit payable, without financial or contractual penalty to the provider of the hearing device.

• Require coverage of cochlear implants (surgical and non-surgical components), batteries, retention supplies, and personal hearing assistive technology. Coverage should also apply to medically necessary replacement parts when out of warranty.

• Local health plans should advise employers offering self-funded health plans of the cost-effectiveness and high consumer satisfaction of offering this type of benefit. State insurance law does not apply to a company’s self-insured benefit plan because the federal Employee Retirement Income Security Act (ERISA) pre-empts the state law for self-insured plans.

For more information on this topic, please contact:
Children’s Advocacy Alliance
702-228-1869 | 775-440-1767 | www.caanv.org
2. **PRENATAL and INFANT HEALTH**  
**Nevada Children’s Report Card Grade: D+**

The prenatal, infant, and child health grade is based upon the number of pregnant women receiving late or no prenatal care, infant mortality rates, and the percentage of low birth weight babies in Nevada. Nevada’s grade has dropped from a C- to a D+ over the past two years. Infant and child mortality rates increased from 5.1 per 1,000 to 5.7 per 1,000, changing Nevada’s rank from 13th in 2014 to 17th in 2016.  
77 Low birth weight babies also showed a slight increase from 8.0% to 8.5%, dropping the state ranking to 30th.  
78 The percentage of women receiving late or no prenatal care, dropped slightly from 9% in 2014 to 8.2% in 2016, however Nevada is still ranked at 46th.  
79

Prenatal care refers collectively to the health services a pregnant woman receives before a baby’s birth. Studies have shown that prenatal care is critical to identify any health issues that may endanger the mother or her baby during pregnancy and ensuring treatment for any of these health concerns before delivery. It is recommended that a woman begins prenatal care in her first trimester and continues her prenatal visits on a regular basis until delivery.  
80 Babies born to mothers who received no prenatal care are 3 times more likely to be born at a low birth weight and 5 times more likely to die than those whose mothers received prenatal care.  
81

According to the Centers for Disease Control and Prevention, preterm birth is the birth of an infant before 37

---


weeks of gestation. During the last weeks 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. In Nevada in 2016, 10.4% of infants were born preterm. Although this rate has declined since 2003 when the rate was 13.6%, Nevada still received a D grade as the national goal is to be 8.1% or under. In addition, there are racial and ethnic disparities in preterm birth rates, especially for African American women where the preterm birth rate is 46% higher compared to all other women.82

According to the March of Dimes, low birth weight is when a baby is born weighing less than 5 pounds, 8 ounces. While infants with a low birth weight may not experience any complications, it can cause serious, immediate health conditions 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 birth weight include prematurity, inadequate maternal nutrition, and smoking.83 In Nevada in 2017, 8.5% of infants were born at a low birth weight which is an increase from the previous reporting period in 2015 which was 8.0. The national average for 2017 was 8.1%.84

RECOMMENDATIONS FOR IMPROVEMENT:

- **Maternal and child health services for prenatal care through the postpartum period need to be expanded and made more accessible for all parents including parents with diverse backgrounds and/or those who are economically challenged.**
- **While efforts have been made to establish additional medical schools in Nevada, as well as reciprocity for licensure, Nevada needs to continue to support efforts to train and retain medical providers locally to increase access and availability, especially for specialty care providers.**
- **Increase outreach efforts and programs like home visiting programs that provide educational and referral services to families to increase participation in preventative care practices and other necessary services.**
- **Support efforts to improve education and outreach about family planning and interconception care as well as early identification of pregnancy and enrollment in early prenatal care.**

---

ISSUE BRIEF - Diaper Assistance Programs

The cost of diapers places a huge financial burden on Nevada’s most at-risk families. Infants, on average, use about 240 diapers per month which costs a family approximately – assuming they can purchase in bulk - $78 per month. A one parent family with an infant making $1,353 a month (100% of poverty) would spend 5.7% of their monthly income on diapers. For families receiving public assistance, this cost is compounded by the fact that diapers are labelled as a luxury item, resulting in them not being covered by most government assistance programs. A study by Yale University found that 30% of mothers reported that they were unable to afford to change their child’s diapers as often as they would like. To “stretch” the use of diapers many families reported reusing diapers – removing the diapers, dumping out the excrement and then placing the soiled diaper on the infant – or leaving the soiled diapers on longer than they should. This practice leads to negative health outcomes for the child – such as urinary tract infections (UTIs) – sometimes resulting in chronic UTIs – and severe diaper dermatitis (diaper rash). A lack of diapers also directly affects the mental health of mothers. The same Yale study found, “diaper need was more likely among mothers [identified as having] some form of mental health need”.

Families who can afford to purchase diapers suffer from price inequality – low income families pay upwards of two to three times the price of diapers compared to middle to high income families. This is largely due to their inability to purchase diapers in bulk at big-box stores or through the internet – due to a lack of transportation, cash flow or credit. These families are also burdened by the sales tax they pay on diapers. In Nevada, the lowest sales tax rate is 6.850%. This tax provides an additional burden on a necessity good for families, as they pay more than $60 a year in taxes for diapers alone.


Cloth Diapers

The use of cloth diapers is not an option for many families as:

- Child Care Facilities typically will not accept cloth diapers (due to health and sanitary reasons) and require parents to provide a supply of disposable diapers.
- Washing machines and dryers are a luxury that many low-income families cannot afford.
- Coin-laundromats do not allow cloth diapers (due to health and sanitary reasons)
RECOMMENDATIONS FOR IMPROVEMENT:

- Create a child diaper fund to provide diapers to parents with infants.
- Remove the state sales tax on diapers. This would provide all working families with a relief from paying taxes on a necessary good.86
- Encourage convenience stores and businesses in low-income neighborhoods to sell diapers in bulk.

For more information on this topic, please contact:
Children’s Advocacy Alliance
702-228-1869 | 775-440-1767 | www.caanv.org

---

86 There is an estimated 90,854 children ages 0-2 living in Nevada (2016 American Community Survey). Assuming all of these families spend $78 per month on diapers – $936 annually – the potential lost net tax revenue is $5.83 million a year.
3. **IMMUNIZATIONS**  
**Nevada Children’s Report Card Grade: C-**

The immunizations grade focuses on the percentage of children receiving recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, PCV vaccines by age 19 to 35 months, and new to this year’s report card, adolescents who are up to date on HPV vaccinations. 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, meningitis, and many more. Nevada’s grade and ranking has improved since 2015, with 71.9% of children in the state ages 19 to 35 months receiving the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and PCV vaccines (ranking Nevada 24th), compared to 67.7% and ranking 37th in 2015. However, Nevada’s children have lower immunization rates than their nationwide counterparts and Nevada parents have reported difficulties in ensuring their children receive all CDC recommended doses of vaccines. Nevada currently ranks 29th in the nation for adolescents who are up to date on their HPV vaccinations at 49%, slightly above the U.S. average of 48.6%.

Vaccines, such as HPV, are encouraged for adolescents to receive at the same time as their required Tdap and Meningococcal vaccinations needed to enter 7th grade and university. The HPV vaccine protects against virus types associated with certain types of cancers including cervical, oral, and penile. While overall adolescent immunization rates for HPV in Nevada are close to the national average, there are disparities when the data is disaggregated by gender. Males are vaccinated at a much lower rate than females.

As the number of recommended vaccines has increased along with costs to vaccinate, 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 Center (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. However, health districts and public health clinic sites are facing budget strains and personnel cuts at the same time their patient loads are increasing.

**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 July 2018, there are:

- 1,526 Providers
- 2,713 Clinics
- 16,914 Users
- 3,876,173 Patient Records
- 40,342,746 Vaccinations

However, there are still providers not using Nevada WebiZ to its fullest capacity. Accurate, timely, and complete widespread use of Nevada WebiZ would reduce unnecessary immunizations, support accountability of publicly-funded vaccines, provide better data to identify Nevada’s vaccination gaps, especially during periods of outbreak, provide access for patient reminder/recall, facilitate patient use of the Nevada WebiZ Public Access Portal, and help providers better manage immunization inventory and administration within their practice.

**RECOMMENDATIONS FOR IMPROVEMENT:**

- *Increase accurate and timely use of Nevada WebiZ statewide in order to reduce unnecessary immunizations and facilitate accurate coverage assessments.*
- *Increase availability and affordability of public and private vaccines for children in Nevada.*
4. **CHILDHOOD OBESITY**

Nevada Children’s Report Card Grade: B-

The childhood obesity grade is based on the percentage of children in grades 9 through 12 whose Body Mass Index (BMI) is at or above the 85th percentile for overweight (14.3% - NV ranked 8th)\(^90\) and for obesity (14.0% - NV ranked 19th)\(^91\), the percentage of 9th-12th grade students not physically active 5 days per week for 60+ minutes (53.6% - NV ranked 17th)\(^92\), and the percentage of children who do not consistently eat fruit (7.5% - NV ranked 20th)\(^93\). This last indicator has been changed from the last report card to focus on consumption of fruit rather than vegetables, with Nevada’s rate higher than the national average of 5.6%.

---

**ACTIVE KIDS DO BETTER IN LIFE**

**WHAT THE RESEARCH SHOWS ON THE COMPOUNDING BENEFITS**

---


---

Children who are overweight or obese are at a significantly higher risk for developing other serious health conditions including diabetes, heart disease, and hypertension. They are also predisposed to be obese in adulthood.\textsuperscript{94} Obesity results in nearly five percent of global deaths and $663 billion in impacts to the United States.\textsuperscript{95} Obesity has become a pandemic with the prevalence among youth aged 2-19 having epidemically risen to 18.5% in 2016 in the United States alone.\textsuperscript{96} In Nevada:

- 13.4% of Nevada high school students are obese and 15.5% are overweight.\textsuperscript{97}
- 21.2% of Nevada kindergarten students are obese and 10.1% are overweight.\textsuperscript{98}

Factors that contribute to obesity include genetics, behavior, and the environment.\textsuperscript{99} Obesity in children can be positively impacted by improving eating and physical activity behaviors in families and their surrounding environments so access to nutritious food and opportunities for physical activity is accessible, affordable, and encouraged. In many environmental conditions, nutrition, and physical activity are not prioritized. For instance, 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 or substitutions. Establishing nutrition and physical activity habits in early childhood that continue through early adulthood are key to improving health outcomes.

**RECOMMENDATIONS FOR IMPROVEMENT:**

- **Enforce state and local school wellness policies at the school level.**
- **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 and resources can be directed to areas of greatest need.**
- **Increase access to safe and affordable places for physical activity.**\textsuperscript{100}

\textsuperscript{100} For more information on early childhood obesity prevention, see the Nevada Early Childhood Obesity Prevention State Plan at dpbh.nv.gov/Programs/Obesity/Obesity_Prevention_and_Control_-_Home/
- 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 structured physical activity in after-school and child care settings.
- 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 Streets\textsuperscript{101} policies and the adoption of Complete Streets elements into local planning documents at the state, regional and local levels and support other comprehensive approaches to improve community design and access to public transportation that make the environment safer for active transport.

- Increase access to healthy food:
  - Increase the number of public places including worksites, parks, recreation and community centers with healthy food retail including healthy vending options.
  - Establish nutrition standards and increase opportunities for healthy eating in after-school and child care settings.
  - Increase availability of affordable healthy food options in communities, particularly communities within designated ‘food deserts’ and in low-income communities.
  - 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.

\textsuperscript{101} For more information on the Complete Streets policy, see: http://www.smartgrowthamerica.org/complete-streets
ISSUE BRIEF - Early Childhood Obesity Prevention

American obesity is becoming an epidemic with an estimated national cost of $190.2 billion each year with childhood obesity averaging $14 billion in direct medical costs. 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. In Nevada, the prevalence of obesity in children is especially high amongst our youngest children. According to the Nevada Institute for Children’s Research and Policy at UNLV, 2017 Kindergarten Health Survey, 21.2% of Nevada’s Kindergarteners are obese. These rates are disproportionately high for Native American/Alaska Native children (38.3%), African American/Black children (26.3%), Hispanic children (30.3%), and Asian/Pacific Islander children (23%) compared to their Caucasian counterparts (15.7%).

To combat this issue, Nevada has developed the State of Nevada’s Early Childhood Obesity Prevention Workgroup and corresponding State Plan for Early Childhood Obesity Prevention (State Plan). The State Plan includes strategic components aimed at conducting education and outreach, scaling effective intervention programs, building state infrastructure and implementing policies and procedures to allow greater access to healthy foods and physical activity for children ages 0 to 8 years old in Nevada. To date, these efforts have resulted in the passage of enhanced policies for nutrition and physical activity in licensed child care facilities (AB152, 2015 Nevada Legislative Session), development of online toolkits for parents and child care providers, as well the creation of a comprehensive website developed by the University of Nevada Cooperative Extension office which provides resources, tips and strategies for parents and providers.

Implementation of these strategies can often be difficult for child care providers. These providers need on-going training to learn effective techniques for implementing nutrition education and physical activity into their curriculums. The Child and Adult Care Food Program

---


103 Healthy Kids Resource Center - www.unce.unr.edu/HealthyKids/
Implementation of these strategies can often be difficult for child care providers. These providers need on-going training to learn effective techniques for implementing nutrition education and physical activity into their curriculums. The Child and Adult Care Food Program (CACFP) is also underutilized by child care providers due to application and reporting processes, as well as regulations which limit the types of foods that providers can prepare in their facilities. To continue to build upon current efforts, the state should provide technical assistance, training and stipends to assist early childhood providers’ ability to serve healthy meals and snacks, as well as implement appropriate physical activity components, including limiting sedentary activity.

RECOMMENDATIONS FOR IMPROVEMENT:

- **Continue trainings for early childhood providers on national standards and implementation strategies for healthy nutrition and physical activity in early childhood settings which must align with USDA Child and Adult Care Food Program (CACFP) guidelines and Caring for Our Children (CFOC) standards. Enhance trainings offered by incorporating cultural competency for the most at-risk populations and engaging trainers from diverse racial/ethnic communities.**

- **Provide direct technical assistance (in coordination with the Silver State Stars Quality Rating Improvement System – QRIS) to early childhood providers including, but not limited to, the following: development of wellness plans, proper food preparation techniques, enrollment assistance & reporting for CACFP, curriculum development, meal plan development, improving physical environments, creating a culture of health/wellness and integrating physical activity & nutrition standards into daily activities.**

- **Provide grants and/or stipends to early childhood providers to assist with implementation of physical activity and/or healthy nutrition (PAN) standards (i.e. purchasing necessary kitchen and/or playground equipment; starting a school garden; hiring substitute teachers to allow staff to attend trainings or participate in technical assistance; purchasing related curriculum and/or classroom materials; and other expenses as deemed directly related to implementation of PAN standards). Priority should be given to providers serving low-income children (child care subsidy), those with a high proportion of racial/ethnic minorities, and rural providers with limited access to resources.**

For more information on this topic, please contact:
Children’s Advocacy Alliance
702-228-1869 | 775-440-1767 | www.caanv.org
5. **DENTAL HEALTH**  
**Nevada Children’s Report Card Grade: F+**

The dental health grade is based upon preventative dental health care of children ages 0 to 18, including the percentage of children who have had no preventative dental care visits in the past year and whose teeth were described as being in fair or poor condition. Nevada ranks 42nd in the nation for both indicators, with 20.1% of children receiving no preventive dental care  and 6.1% of children having fair to poor teeth.\(^{105}\)

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. Evidence has shown infections in the mouth, such as gum disease, may increase the risk of heart disease, contribute to premature labor, and disrupt the ability of the body to regulate blood sugar for people living with diabetes.\(^{106}\) The far-reaching systemic effects of poor oral health, throughout life, demonstrate the enormous value of proper oral and preventive health care not only early in life, but throughout the lifespan.

Dental sealants are a proven to reduce decay in permanent molars, first appearing at ages six and twelve. Sealants are a cost-saving measure when compared to dental fillings. Per the American Dental Association, sealants can reduce the risk of decay by 80%; a benefit that can be realized well into adulthood. Nevada has only three small school-based sealant programs, and these programs are unable to meet the vast dental needs of Nevada’s school children. Nevada does not have a school-based, state-funded sealant program that could reach all counties.

In 2015, the American Dental Association (ADA) found that 35% of adult survey respondents in Nevada felt that the overall condition of their mouth and teeth was either fair or poor, with 22% stating that the appearance of the mouth and teeth affects the ability to interview for a job.\textsuperscript{107} Needing a dentist is compounded by the fact that most counties in Nevada are federally designated Dental Health Provider Shortage Areas, with some residents driving over 100 miles to the nearest dentist.\textsuperscript{108} Systemic effects of oral disease can thus be compounded by an absence of dental providers and a lack of medical emergency facilities for those who have a dental emergency. Safety net services (such as Medicaid, providing medical and dental services to over 630,000 Nevadans) offer comprehensive dental services for children, but adults over 21 years of age have only emergency and limited prosthetic (partial and complete denture) services.

Efforts toward good oral health must start early in life. It is therefore imperative that evidence-based preventive measures are offered along with oral health education to elementary through high school age children/young adults, in both Nevada’s metropolitan and rural areas, to reduce dental disease and its impact through childhood and through a lifetime.

RECOMMENDATIONS FOR IMPROVEMENT:

- Provide funding for a state-wide dental sealant program and other programs to enhance oral health and reduce dental and systemic costs associated with dental disease.
- Support programs that currently provide these services.
- Reimburse existing programs for the medically indigent children in Nevada schools.
- Ensure that reimbursement rates for federally mandated EPSDT dental services for children covered by Medicaid and Nevada Check-Up reflect provider costs.


\textsuperscript{108} Personal communication with the Nevada Primary Care Office, 2018.
6. **MENTAL HEALTH**  
**Nevada Children’s Report Card Grade: C-**

The mental health grade is based upon rates of mental health treatment, suicide attempts, and teen suicide rates. Nevada ranks 41st in the nation for overall rates of youth mental health treatment in which children received needed mental health treatment or counseling in the past 12 months.\(^{109}\) Nevada’s attempted suicide rank decreased from 30th in 2015 to 9th in 2017, with a significant decrease in attempts – 10.7% in 2015 compared to 7.4% in 2017.\(^{110}\) However, Nevada’s youth suicide rate has increased from 2.29 to 4.2 (per 100,000 children age 0-18), decreasing our rank for this indicator from 16th to 32nd.\(^{111}\)

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.\(^{112}\) In its 2018 report, Mental Health America ranked Nevada’s behavioral health services for children as 51st in the nation due to the state’s disproportionately high rates of youth mental illness coupled with below average access to health care coverage and needed treatment services.\(^{113}\)

This report shows that of youth in Nevada ages 12-17 who experienced a major depressive episode in the past year, 64.0% did not receive any mental health services at all. Though the overall prevalence of mental illness in Nevada ranks the state 49th for the population as a whole, a statewide shortage of available mental healthcare providers yields a ratio of 1 provider for every 580 individuals in the state. However, this number does not provide a complete picture of the mental health workforce. For instance, this is out of all mental health providers in

---

the state and not all providers have the expertise to treat youth ages 12-17 and even less that treat younger children. In addition, many rural and frontier counties within the state do not have mental health providers available for youth services. In spite of a growing nationwide need for age appropriate and evidence-based mental health interventions for children, there are still many families in Nevada facing significant barriers in accessing mental health care. 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.

- Half of lifetime mental health disorders start by age 14.
- Approximately 14% of Nevada’s youth had experienced a major depressive episode in 2015, a rate that is significantly higher than the national average.
- Approximately 1/3 of youth receive treatment.

In 2015 suicide was the leading cause of death for youth in Nevada ages 8 through 17, with a rate of 4.99 suicides for every 100,000 youth. The national average rate for the same age group was 3.69 per 100,000. For ages 15-24, suicide was the third leading cause of death for youth in Nevada, with a rate of 14.85 suicides for every 100,000 youth. The national average rate for the same age group was 13.15 per 100,000. The Nevada Youth Risk Behavior Survey (YRBS) for 2017 found that 16.6% of high school students had seriously considered attempting suicide, 14.4% of high school students made a suicide plan, and 7.4% of high school students actually attempted suicide. According to the Clark County Children’s Mental Health Consortium 2017 Service Priorities, all school children need access to screening and universal behavioral health promotion activities. Multi-tiered and interconnected systems of support are an effective and efficient strategy to help address academic, behavioral, and mental health needs of children and families in a way to avoid entrance into public service systems, such as child welfare,
By providing public education environments that support wellness through behavioral health promotion activities, many children could avoid deeper involvement in the public service systems. In addition, research shows that “the high rate of comorbidity between drug use disorders and other mental illnesses argues for a comprehensive approach to intervention that identifies and evaluates each disorder concurrently, providing treatment as needed.”

It is of great importance to appropriately address mental health issues in childhood and early adolescence as 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. 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 Nevada.

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 effort to improve mental and behavioral health issues.
  - Universal screening for suicide risk and substance abuse 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 at risk of suicide have been appropriately trained and possess requisite skills.
  - All persons identified as at risk of suicide by primary care practices and clinics, hospitals (especially 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.

- Continue to increase mental health promotion in schools, such as social and emotional learning along with suicide prevention strategies that need to be implemented for

---

http://docs.wixstatic.com/ugd/cd1b7b_3a7a3c0cdc5445adb94de013b96952a6.pdf
elementary, middle, and high school students. Strategies in the education system need to be tailored to target audiences by gender, race, disability, and sexual orientation.

- **Mobile crisis assessment needs expansion, especially in rural regions, to ensure crisis response, family stabilization, and continuity of care for youth who are identified as at-risk or who have previously attempted suicide.**

- **Build up the workforce in all parts of Nevada, especially in rural regions, so there is local ability to provide appropriate mental health resources.**
  - Address insurance network adequacy to ensure children with insurance have timely access to mental health treatment.
  - Support greater use of technology to enhance access to mental health services, especially in areas where transportation is problematic, such as the rural regions of our state.

- **Support youth to succeed as adults. Develop, fund and implement system-level policies coupled with successful strategies to help youth with mental health needs transition to postsecondary education, employment, and independent lives.**
7. SEXUAL HEALTH

Nevada Children’s Report Card Grade: D-

The sexual health grade encompasses many factors such as teen birth rate, sexual activity, condom use, any birth control use, and sexually transmitted infection (STI) rates. With 18.9% of Nevada’s high school students not using any type of birth control, Nevada ranks 31st out of the 37 states reporting this information. Nevada also ranks 18th out of 39 states reporting information for condom use. This directly affects the teen birth rate of 24 births per 1,000 females ages 15 to 19 and ranks Nevada 32nd in the nation. With regard to STI rates, Nevada ranks slightly above average for chlamydia (31st) and gonorrhea (30th), and has seen a decrease in syphilis from 25.1 (per 100,000 15 to 24-year-olds) in 2014 to 22.9 in 2017, but still is above the U.S. average of 14.8 per 100,000.

Every school district in Nevada is currently required to teach some sex education (NRS 389.065), but standards vary across the state. 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. Teens who received evidence-based, age-appropriate and medically accurate sexuality education were 50% less likely to experience pregnancy than those who received abstinence-only education.

Nevada has made some progress and the teen birth rate (ages 15-19) in Nevada declined 12% between 2015 and 2016, saving taxpayers $29 million in that year alone. Nevada’s HIV infection rate of youth and young adults ages 13 to 24 who were newly diagnosed in 2016 is 21.5 per 100,000. Sexually transmitted infections (STIs) place a significant economic strain on

---

131 "Abstinence-Only Education and Teen Pregnancy Rates: Why We Need Comprehensive Sex Education in the U.S.” http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3194801/
132 Ibid
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.\textsuperscript{134}

**RECOMMENDATIONS FOR IMPROVEMENT:**

Some level of sex education is currently required in Nevada schools, but the curriculum is not consistent across the state. This recommendation still maintains that parents would be able to make decisions about their children’s participation in this coursework, without penalty. 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.

CHILDREN’S SAFETY
2019

“Your own safety is at stake when your neighbor’s wall is ablaze.” – Horace

Children’s Safety Overview
1. Child Maltreatment
2. Youth Homelessness
3. Juvenile Violence
4. Child Injury and Death
5. Substance Abuse
CHILDREN’S SAFETY OVERVIEW
Nevada Children’s Report Card Grade: C-

In 2016, over 664,632 children under the age of 18 years old lived in Nevada. Each of these children deserve to be safe and secure, but often lack the skills to protect and care for themselves. For this reason, 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 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 C-, which the state received on the 2018 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 Injury and Death
5. Substance Abuse

---

135 “American Fact Finder” United States Census Bureau http://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml
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 15th in 2014 to 17th in the nation in 2016. For physical, sexual, and neglectful maltreatment, Nevada ranked 38th, 20th, and 32nd, respectively. Finally, Nevada’s 2018 ranking is 30th 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.

Nevada State Child Welfare Information for July 2017 - June 2018

<table>
<thead>
<tr>
<th></th>
<th>Clark County</th>
<th>Washoe County</th>
<th>Rural Counties</th>
<th>Total Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total New Referrals</td>
<td>28,185</td>
<td>5,621</td>
<td>4,144</td>
<td>37,950</td>
</tr>
<tr>
<td>Information Only</td>
<td>15,184</td>
<td>3,456</td>
<td>2,803</td>
<td>21,443</td>
</tr>
<tr>
<td>Differential Response or Investigation Initiated</td>
<td>322</td>
<td>210</td>
<td>460</td>
<td>992</td>
</tr>
<tr>
<td>Total Closed Investigations</td>
<td>12,679</td>
<td>1,955</td>
<td>912</td>
<td>15,207</td>
</tr>
<tr>
<td>% Substantiated</td>
<td>19.1%</td>
<td>19.6%</td>
<td>26.1%</td>
<td>19.5%</td>
</tr>
</tbody>
</table>

In Nevada in 2016, the majority of child maltreatment substantiations were neglect (approximately 80.0%) and physical abuse (approximately 26.2%), and a smaller percentage are due to sexual abuse (approximately 5.5%). 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, 87% never report their abuse.

Child abuse and neglect creates a tremendous burden on society, in both social and economic...

---

137 Ibid
139 Denby, R. W., & Haran, H., 2018. “Child Maltreatment in Nevada.” In The Social Health of Nevada: Leading Indicators and Quality of Life in the Silver State, edited by D. N. Shalin. Las Vegas, NV: UNLV Center for Democratic Culture, http://cdclv.unlv.edu. Please note the percent’s will total over 100% because a child may have more than one substantiation.
terms. Abused or neglected children suffer from much higher likelihoods of mental health problems, perpetuation of abuse, suicide, homelessness, teen pregnancy, addiction, and crime. In 2016, 4,869 youth in Nevada were confirmed to be victims of child maltreatment by child protective services. Of these, the top racial/ethnic groups affected were non-Hispanic White (29%), Hispanic or Latino (26%), and unknown race (20%), and non-Hispanic Black (18%). However, when compared to the racial breakdown of Nevada’s youth (49.1% White, 28.8% Hispanic or Latino, and 9.8% Black), these numbers indicate that non-Hispanic Black youth are disproportionately represented in the system. Research has not found a relationship between child maltreatment and race once poverty and other risk factors are considered. Child welfare systems need to examine policy and internal practices that may increase disproportionality.

To reduce instances of abuse and neglect, Nevada’s child welfare system works to protect children by providing support and services to them and their families, with the primary goal of family preservation. Unfortunately, sometimes staying in the care of their parents is not always in the best interest of the child. As a last resort the child is removed from the family and placed into foster care. In FY18, just over 3,000 children were in out-of-home placements which is consistent with the previous two years. As of June 2018, the average stay in foster care was 13 months for children in Clark County which was consistent with previous years, and 13 months in rural counties which is a reduction from previous reporting periods in which stays were as high as 21 months in June of 2016. In Washoe County, average length of stay increased from 14 to 16 months.

In addition, there are approximately 200 children in Nevada who do not return home and transition into young adulthood from the foster care system. These youth are at high risk for poor outcomes and need support and assistance through this difficult period in their life. Please

---

141 Zimmerman, F., Mercy, J. A Better Start: Child Maltreatment Prevention as a Public Health Priority. Zero to Three (J), v30 n5 p4-10 May 2010
142 Kids Count, “Children who are confirmed by child protective services as victims of maltreatment by race and Hispanic origin - 2016”
143 US Census Bureau Quick Facts Nevada 2017 Race and Hispanic Origin for Persons Under 18 Years

“Unless someone like you cares a whole awful lot, nothing is going to get better. It’s not.” — Dr. Seuss
read the Issue Brief on Transition Age Foster Youth for a more detailed discussion about these youth and the support they need from Nevada.

Nevada’s Child Welfare System needs to continue to work to identify mechanisms and policies that can be put in place to promote family preservation. Entering into the foster care system should not be the answer to permanently escaping abuse and neglect; rather, the root causes of abuse or neglect should be addressed and the child welfare system should be redesigned to focus more on family-centered intervention services and prevention. In early 2018, Congress signed the Family First Prevention Act into law. The primary purpose of this Act was to “reform the federal child welfare financing streams, Title IV-E and Title IV-B of the Social Security Act, to provide services to families who are at risk of entering the child welfare system. The Act aims to prevent children from entering foster care by allowing federal reimbursement for mental health services, substance use treatment, and in-home parenting skills training. It also seeks to improve the well-being of children already in foster care by incentivizing states to reduce placement of children into congregate care.”

This law provides Nevada an opportunity to increase resources to both prevent children from entering foster care and to support those children that are currently in care.

**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.
- Ensure that foster families are appropriately trained to be sensitive to diverse youth (including those of different races and sexual orientations) and develop appropriate screening practices and checkpoints to ensure the youth are residing in a healthy environment while in foster care.
- 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.
- Promote improved outcomes related to “well-being” for transition age youth – see the following Issue Brief Transition Age Foster Youth for details.

---

147 [Community We Will Brief](http://nic.unlv.edu/files/CommunityWeWillBusinessCase.pdf)
ISSUE BRIEF - Transition Age Foster Youth

Every year in the United States, over 17,000 children emancipate or age out of the foster care system. It is thoroughly documented that youth aging out of foster care have elevated risks of negative outcomes such as homelessness, incarceration, and substance abuse. These outcomes have an estimated social cost of $5 billion per year to taxpayers and the community.

In 1999, the Foster Care Independence Act established the John H. Chafee Foster Care Independence Program. This program increased funding for independent living (IL) services for youth in foster care, including, but not limited to, housing and employment assistance for youth aging out of care. In 2008, the Foster Connections Act provided states with the option to utilize federal funds to extend foster care until the age of 21. In 2018, the Family First Prevention Act provided states with the option to utilize Title IV-E funding to extend IL services to aged out youth until 23. This option to extend IL services is only applicable to states that have already extended foster care until age 21. Twenty-five states have taken the option to extend foster care up to age 21.

There is evidence that youth in states with extended foster care experience better outcomes. Remaining in care, after 18, significantly reduces the likelihood of economic hardship, homelessness, over-reliance on public assistance, and criminal convictions. Youth were far more likely to complete a high school education and pursue higher education.

Nevada, with few exceptions, does not provide youth with the option of extended foster care. There are two sources of support for youth transitioning out of foster care in Nevada at 18.

---

154 Ibid
1. **FAFFY**: In 2005, the Nevada legislature established the Financial Assistance for Former Foster Youth (FAFFY) program. This program provided aged out foster youth funding to cover the cost of housing and employment training until the 21 years of age.\(^{157}\) The funds are distributed on the youth’s behalf and not directly to the youth. In 2017, Nevada spent over $500,000 on FAFFY youth, without a federal match.\(^{158}\)

2. **Voluntary Court Jurisdiction**: In 2011, the Nevada Legislature passed Assembly Bill 350 (AB 350), also known as Voluntary Court Jurisdiction. This bill offered youth aging out of the foster care system the option to remain under juvenile court jurisdiction until 21 years of age.\(^{159}\) Unlike the FAFFY program, financial assistance under Voluntary Court Jurisdiction are paid directly to youth to use to fulfill their needs.\(^{160}\) In 2017, Nevada spent $4.6 million on Voluntary Jurisdiction youth, without a federal match.\(^{161}\)

Unfortunately, many transition age youth in foster care forego permanency, such as adoption or guardianship, at the chance to receive financial support after 18. Nearly 200 youth age out of the Nevada’s foster care system each year.\(^{162}\) Since 2011, the number of youth emancipating from care has increased from 75.2%\(^{163}\) to 81.7%.\(^ {164}\) Over a third of youth age 16 and 17 in foster care have emancipation as a primary permanency goal.\(^ {165}\) Compared to the national average, youth aging out of foster in Nevada experience higher rates of negative outcomes.\(^ {166}\)

To increase permanency among transition age youth, 44 states have expanded their adoption and guardianship subsidies after 18.\(^{167}\) Many of the states have expanded subsidies until 21 years of age. States with extended subsidies have twice the number of children achieving permanency compared to those without extensions.\(^{168}\) Federal funds can be utilized to extend assistance to 21 as long as the states have determined the “child has a mental or physical

---

\(^{157}\) “NRS 432.017” Nevada Legislature. N.d., Web. https://www.leg.state.nv.us/NRS/NRS-432.html#NRS432Sec017


handicap which warrants the continuation of assistance."\textsuperscript{169} Nevada does not have adoption or guardianship subsidy extensions after 18.\textsuperscript{170}

**RECOMMENDATIONS FOR IMPROVEMENT:**

- *To promote better well-being outcomes for transition age youth, Nevada should maximize federal financial support (Family First Act) by extending foster care for transition age youth until age 21.*
- *To promote permanency for transition age youth, Nevada should maximize federal financial support (Foster Connections Act) by extending the adoption and guardianship assistance program until age 21. Additionally, for youth who exited foster care to either adoption or legal guardianship after 16, Nevada should continue providing independent living services to youth until their 21st birthday. This is an option available to states who have an extended foster care program.*\textsuperscript{171}

For more information on this topic, please contact:
Children’s Advocacy Alliance
702-228-1869 | 775-440-1767 | www.caanv.org

 ISSUE BRIEF – Child Welfare Funding

Nevada’s child welfare program is tasked with ensuring the safety, permanency, and well-being of children who have been abused or neglected, as well as those deemed at risk of abuse or neglect.172 To best serve children and families throughout the state, Nevada uses a state-supervised, county-administered structure for the management of child welfare services with Clark County Department of Family Services (CCDFS) and Washoe County Human Services Agency (WCHSA) serving their respective counties and the Nevada Department of Family Services serving the other 15 rural counties.173

Historically, all three programs were provided categorical funding for their daily operations. However, in 2011, Nevada revised the child welfare funding structure for the two urban county child welfare agencies, CCDFS and WCHSA. Now each year, CCDFS and WCHSA are provided with a capped block grant to support child welfare services. The block grant is divided into two allocations:

- A base allocation for each biennium which is based on the total State General Fund appropriated for the previous biennium.
- A second allocation which would include the estimated cost attributable to projected caseload growth for the adoption assistance program.

Overall, Nevada’s child welfare programs are funded through Local, State, and Federal funding with an estimated 66% coming from local and state funds and the remaining 34% from federal funding.174 The federal funding is derived from a variety of sources including child welfare funding specific, Title IV-B and Title IV-E of the Social Security Act, and broader funding sources such as Medicaid, Social Services Block Grant (SSBG), and the Temporary Assistance for Needy Families (TANF) and is used for the following services:175

- In-home services to prevent child abuse or neglect and/or to prevent foster care placement or re-entry
- Child protective services
- Out-of-home placement costs

175 Ibid
• Adoption and legal guardianship costs
• Services and assistance for older youth in, or previously in, foster care

It is imperative for the state to ensure all child welfare program funding be used properly and that we are maximizing all federal sources, while also investing and distributing funds in a manner that best serves children. The recent passage of the federal Families First Act will also shift how the state can draw down federal funds, making it imperative to conduct a thorough review of our child welfare funding system. According to the book, *National Blueprint for Excellence in Child Welfare*, “funding should be linked to positive outcomes, and should be discontinued for programs, services and supports that do not work or result in unintended negative consequences.”\(^{176}\) Additionally, “each [Child Welfare] entity should collect meaningful data to support its ability to make decisions, improve proactively, and help children, youth, and families to achieve identified outcomes.”\(^{177}\) As such, Nevada’s child welfare data system, UNITY, should be reviewed for functionality, efficiencies, cross system applications, system performance and user friendliness. A highly functional database is critical to ensure not only that we are able to track data, but also to ensure timely and appropriate services and to ensure efficiencies across systems.

**RECOMMENDATIONS FOR IMPROVEMENT:**
The State of Nevada should allocate funds to contract with an outside consultant to conduct a comprehensive study, including recommendations to include a review of:

• **The current block grant structure to the local child welfare agencies.** Specifically, asking if this structure is appropriate/sufficient to support the needs of the child welfare agencies and if there are other structures that may be more appropriate.

• **Potential funding sources to support child welfare.** Determining what other sources of funding are available to support child welfare that NV is not currently receiving.

• **All funding sources (local, state, federal, and potentially private) that support the broad child welfare system.** Besides funding specifically directed toward child welfare agencies, the system itself is reliant upon many other social programs and systems including funding for medical care, mental health, substance abuse, education, juvenile justice, child care and other social service/welfare programs. The study should review how these systems are aligned to ensure appropriate support services for children and families.

• **The viability of replacing the UNITY Data System to improve system functionality and streamline services, as well as to ensure efficiency.**

For more information on this topic, please contact:
Children’s Advocacy Alliance
702-228-1869 | 775-440-1767 | www.caanv.org

\(^{176}\) National Blueprint for Excellence in Child Welfare p. 121

\(^{177}\) Ibid p. 85
2. **YOUTH HOMELESSNESS**

Nevada Children’s Report Card Grade: D

The youth homelessness grade is based upon accompanied youth (children under 18 with their families), unaccompanied youth (youth who are not part of a family with children during their episode of homelessness), and unsheltered youth (youth who stay in places not meant for human habitation, such as the streets, abandoned buildings, vehicles, or parks). In 2017, Nevada ranked 51st in the U.S. for child and youth homelessness, with 2,166 unaccompanied homeless children and youth (231.8 per 100,000)\(^{178}\) and had the highest rate of unsheltered unaccompanied children and youth under 25 during the 2017 Point-In-Time Count.\(^ {179}\) Nevada ranked 12th in the nation for the total share of homeless families.\(^ {180}\)

Youth homelessness is a devastating and growing problem in Nevada. In 2012-2013, which is the most recent data available for all children that experienced homelessness as defined by McKinny-Vento throughout Nevada was 23,790, a 15% increase over the prior year.\(^ {181}\) In 2014, the National Center on Family Homelessness ranked Nevada 44th in the United States for overall child homelessness based on a composite score reflecting Nevada’s extent of child homelessness, child well-being, risk for child homelessness, and state planning and policy efforts. Nevada’s state policy and planning efforts in particular were ranked 47th in the country, pointing to a serious need for focused policy work around youth homelessness in our state. Research shows that children who experience...

---


\(^{179}\) Ibid

\(^{180}\) Ibid

homelessness with their families are often hungry, sick, and scared, struggle to attend and succeed in school, and are likely to develop mental health problems as a result of being exposed to high levels of stress, violence, and uncertainty. The most recent data available from the Nevada Department of Education indicates that 17,184 homeless students were enrolled in public schools throughout the state during the 2014-2015 school year, with 65.4% of those students enrolled in a Clark County.

Unaccompanied homeless youth – youth who experience homelessness on their own without their families – find themselves in even more danger. In 2017, Las Vegas had the third highest number of unaccompanied homeless youth under age 25 (2,052 youth) of all major cities in the nation, with over 92% of those youth living unsheltered.\textsuperscript{182} Illustrating Nevada’s severe lack of age-appropriate beds and services for this population, in 2017, Nevada had the highest rate of unaccompanied homeless youth living unsheltered of any state in the country, with 89% of identified unaccompanied homeless youth under 25 living on our streets unsheltered at the time of the count.\textsuperscript{183} In fact, in 2017, though 2,052 unaccompanied youth experienced homelessness in Southern Nevada on an average night, only 319 beds within Clark County’s homeless services system were devoted to homeless youth (38 of which were dedicated to serving unaccompanied homeless minors).

Youth often become homeless due to inter-related factors of family breakdown, economic insecurity, and/or residential instability.\textsuperscript{184} Family breakdown is the most common contributing factor to youth becoming homeless on their own: many youth leave home after enduring years of sexual, physical, and/or emotional abuse, neglect, parental substance abuse, and rejection. Homeless youth find themselves in different situations and require distinct resources from homeless adults because young people enter into homelessness with little or no work experience or life skills and are often forced into dropping out of school as a result of their homelessness. They also experience higher levels of criminal victimization, including sexual exploitation and labor trafficking. Racial and ethnic minorities and LGBTQ youth are also overrepresented among the homeless youth population, pointing to a need for culturally competent and diverse services.

Youth homelessness has dangerous consequences for both the youth experiencing homelessness and their communities. 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.\textsuperscript{185} Every day homeless youth spend on the streets increases their likelihood of engaging in substance abuse, developing mental and physical health problems, contracting sexually transmitted infections, experiencing unwanted pregnancies, committing and becoming

\textsuperscript{183} Ibid
\textsuperscript{184} National Coalition for the Homeless, 2008 https://nationalhomeless.org/
\textsuperscript{185} National Alliance to End Homelessness, http://www.endhomelessness.org/
victims of crimes, getting involved in gangs, dropping out of school, and becoming homeless adults. Homeless youth are vulnerable to forming complicated relationships with our education, health, welfare, and criminal justice systems, creating costly and long-term problems for themselves and their communities.

Limited federal resources are not enough to provide housing and services to Nevada’s homeless youth and many local and state-level funders and policymakers are simply unaware of the extent and severity of youth homelessness in our state. Through building awareness, collaboration, and devoting concentrated resources to age-appropriate, evidence-based service offerings, we can not only turn individual lives around, but save significant long-term costs. Numerous studies have shown that providing unaccompanied homeless youth with appropriate housing interventions is significantly cheaper and more effective than serving youth through the child welfare or juvenile justice systems.\textsuperscript{186}

The community is currently undertaking efforts to create a wide-spread movement to address youth homelessness in Southern Nevada, for more information please visit: www.nphy.org/themovement.

**RECOMMENDATIONS FOR IMPROVEMENT:**

- *Create a statewide plan for responding to and ending youth homelessness.*
- *Build awareness and collaboration among systems that interact with high-risk and homeless youth, including homeless services, public education, juvenile justice, and child welfare.*
- *Develop a coordinated and comprehensive community response to prevent and address youth homelessness.*
- *Increase resources for the proactive prevention of youth homelessness, including family counseling.*
- *Devote larger portions of general funding and the creation of specific funding streams to support culturally competent youth-focused homeless service offerings, including drop-in centers, emergency shelter, transitional housing, rapid re-housing, and permanent supportive housing developed specifically to respond to youths’ unique needs and developmental stage.*
- *Increase targeted outreach and crisis intervention to at-risk and homeless youth.*
- *Devote resources to subject populations that intersect with youth homelessness, including commercial sex exploitation of children (CSEC), LGBTQ, immigration, foster care, child protective services, and juvenile justice.*
- *Require public school districts to create formal plans on addressing youth homelessness in schools, including establishing partnerships with community providers for 24/7 crisis response and services.*

\textsuperscript{186} National Partnership to End Youth Homelessness; National Network for Youth, https://www.nn4youth.org/
• Reduce barriers for unaccompanied homeless youth to successfully complete primary education, including issues regarding truancy and timing of enrollment, as well as improving access to high quality education, including higher education.

• Mitigate barriers around access to quality health care and Medicaid for unaccompanied homeless youth.

• Advance data collection, analysis, and research around youth homelessness.
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 2017, 9.0% of Nevada’s high school students felt unsafe attending school, ranking 26th in the nation.\(^{187}\) Furthermore, Nevada ranked 15\(^{th}\) out of 38 states for students reporting to have brought a weapon to school (4.7%),\(^ {188}\) and 5\(^{th}\) in the nation for the percentage of students who have been in a fight on campus (5.9%).\(^ {189}\) 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 2017, Nevada ranked 5\(^{th}\) out of 39 reporting states for physical dating violence\(^ {190}\) and 11\(^{th}\) out of 29 reporting states for sexual dating violence\(^ {191}\) with 6.7% of individuals experiencing physical violence and 10.3% experiencing sexual violence; both indicators showing improvement since 2015.\(^ {192}\) 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

---

**ECONOMICS OF INCARCERATION**

KIDS THAT MAKE MISTAKES NEED HELP, NOT JUST PUNISHMENT

Economists have shown that incarcerating youth will hurt their future earnings and ability to stay in the workforce.

\(~40\%\) of incarcerated youth have a learning disability and will struggle in school when they leave detention.

In 2015, 600 children lived in juvenile correction facilities.

---


\(^{191}\) Ibid

\(^{192}\) Ibid
The challenges faced by Nevada’s youth in regards to juvenile violence can be seen further in the number of individuals involved with the state’s juvenile justice system. In 2015, Nevada ranked 42nd in the nation in the number of youth residing in juvenile detention, correctional and/or residential facilities with 209 children per 100,000 residing in juvenile detention; well above the national average of 152 per 100,000. 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.

**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.*\(^{194}\)

- *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.*

---


4. **CHILD INJURY AND DEATH**

*Nevada Children’s Report Card Grade: C*

The child deaths and injury grade is based on the overall number of child deaths, road traffic injuries, and, new to this year’s report card, combined unintentional injuries, homicide, and suicide. Unintentional injuries include things that are often referred to as “accidents,” such as motor vehicle or traffic accidents, drowning, poisoning or overdose, suffocation, or fire. Unintentional injuries are the leading cause of hospitalization and death for children ages 1-18 years, both nationally and in Nevada. In 2016, Nevada ranked 34th in the nation for child deaths with 20 deaths per 100,000 children, a slight increase from 2014, and slightly above the national average of 17 deaths per 100,000. Nevada ranked 10th in the nation for transportation related deaths in 2016— a slight improvement from 13th in 2014—and 16th in the nation for combined unintentional injuries, homicide, and suicide rates at 16.9 per 100,000 deaths, similar to the national average of 16.5 per 100,000 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 2015 Child Death Review Report for Nevada, the leading cause of death for children is non-motor vehicle accidents which specifically includes suffocation, drowning, gunshot wounds, and poisoning/overdose which is consistent with the national data. Listed below are the counts and percentages of 2015 child deaths by manner and cause in Nevada (excluding natural and undetermined causes):

- **Non-motor vehicle accidents – 18.4% (n=50)**
  - Asphyxia (n=18)
  - Drowning (n=15)
  - Overdose (n=7)
  - Fall (n=4)
  - Fire (n=2)

---

• Heat (n=1)
  • Gunshot Wound (n=1)
  • Drug Exposed Infant (n=1)
  • Other (n=1)
• Motor vehicle accidents – 7.7% (n=21)
  • Pedestrian (n=11)
  • Passenger (n=5)
  • Driver (n=2)
  • Bicycle (n=2)
  • Unknown (n=1)
• Homicide – 6.3% (n=17)
• Suicide – 5.2% (n=14)

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 their 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 and strengthen discharge plans to ensure support for after they deliver the baby.
• Support efforts to restrict the sale of crib bumpers in the state of Nevada. These products have been associated with infant deaths due to asphyxiation in other states in the US. While Nevada has not had any reported fatalities directly a result of a crib bumper, this has happened in other states prompting legislation to ban crib bumpers. To prevent these deaths in Nevada, a statewide ban on the sale of crib bumpers is recommended and has been implemented in other states such as Maryland.200

ISSUE BRIEF - Bicycle Safety Helmets

Riding a bicycle remains a longstanding popular activity that provides children with much needed physical activity. However, bicycle accidents are one of the leading causes of injuries treated at emergency rooms across America. “In 2010 in the U.S., 800 bicyclists were killed and an estimated 515,000 sustained bicycle-related injuries that required emergency department care. Roughly half of these cyclists were children and adolescents under the age of 20.”201 In 2010, the estimated cost of non-fatal bicycle injuries was over half a billion dollars in medical costs alone for children ages 0-14 in the United States.202 According to the Center for Disease Control and Prevention, children not wearing bicycle helmets are at an even greater risk of receiving a head injury,203 which may result in traumatic brain injuries (TBI), the leading cause of death and acquired disability in children and adolescents.204 An estimated 26,000 of child and adolescent bicycle-related injuries are traumatic brain injuries treated in emergency departments. Sadly, the use of bicycle helmets, which are highly effective at reducing the risk for head injuries, including severe brain injuries and death, is relatively low among children. Less than 50% of children report that they always use a bicycle helmet,205 while 31% report never wearing a helmet while riding a bicycle.206

<table>
<thead>
<tr>
<th>State/Jurisdiction</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>Under 16</td>
</tr>
<tr>
<td>California</td>
<td>Under 18</td>
</tr>
<tr>
<td>Connecticut</td>
<td>Under 16</td>
</tr>
<tr>
<td>Delaware</td>
<td>Under 16</td>
</tr>
<tr>
<td>Florida</td>
<td>Under 16</td>
</tr>
<tr>
<td>Georgia</td>
<td>Under 16</td>
</tr>
<tr>
<td>Hawaii</td>
<td>Under 16</td>
</tr>
<tr>
<td>Louisiana</td>
<td>Under 12</td>
</tr>
<tr>
<td>Maine</td>
<td>Under 16</td>
</tr>
<tr>
<td>Maryland</td>
<td>Under 16</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Under 17*</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>Under 16</td>
</tr>
<tr>
<td>New Jersey</td>
<td>Under 17</td>
</tr>
<tr>
<td>New Mexico</td>
<td>Under 18</td>
</tr>
<tr>
<td>New York</td>
<td>Under 14*</td>
</tr>
<tr>
<td>North Carolina</td>
<td>Under 16</td>
</tr>
<tr>
<td>Oregon</td>
<td>Under 16</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>Under 12</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>Under 16</td>
</tr>
<tr>
<td>Tennessee</td>
<td>Under 16</td>
</tr>
<tr>
<td>West Virginia</td>
<td>Under 15</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>Under 16</td>
</tr>
</tbody>
</table>

* Laws in Massachusetts and New York prohibit bicyclists from transporting passengers younger than age 1.

Sources: AAA and NCSL, 2012.

---

206 Ibid
To promote and encourage the use of bicycle helmets, 22 states, plus Washington D.C., have passed legislation requiring children to wear bicycle helmets. This legislation has positively affected helmet use amongst children. A recent evaluation of these laws found that “of the children who lived in states with a child helmet law, 51% of respondents reported that their child always wears a bicycle helmet, as compared with 40% of those living in states without a law. Conversely, 35% of children living in states without a state law were reported to never wear a helmet compared with 21% of children in states with a state law. In addition, children were no more likely to ride a bicycle within states that had state helmet laws as compared to those with no state helmet laws.”

Additionally, several studies in Canadian provinces and local U.S. jurisdictions that adopted bicycle helmet legislation for children have also reported declines in child head injury rates, although the amount of decline varied widely across studies, from 2% to 45%.207 For example, a study reviewing the bicycle safety law passed in California in 1994, which used 44,069 patient discharge cases from all public hospitals in California, from 1991 through 2000, found that the legislation was associated with a reduction of 18.2% in the proportion of traumatic brain injuries (Head-TBI) among youth bicyclists.208

**RECOMMENDATIONS FOR IMPROVEMENT:**
- Implement a law requiring children under the age of 18 years old wear a helmet while riding a non-motorized vehicle.

**For more information on this topic, please contact:**
Children’s Advocacy Alliance  
702-228-1869 | 775-440-1767 | www.caanv.org

---

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5189688/  
208 Ibid
5. **SUBSTANCE ABUSE**  
Nevada Children’s Report Card Grade: B

In 2017, Nevada and other state high school students were surveyed and reported their drug and substance abuse. Compared to the other states, Nevada fares very well in the percentage of high school students who smoke cigarettes (6.7%)\(^{209}\) or use smokeless tobacco (3.0%)\(^{210}\), ranking 9\(^{th}\) and 2\(^{nd}\) respectively. Additionally, the percentage of youth who use any type of tobacco has significantly decreased from 30.4% in 2015 to 11.5% in 2017, improving the state’s ranking to 6\(^{th}\).\(^{211}\) Newly measured in this year’s report card are students currently using electronic vapor products. Nevada ranks 22\(^{nd}\) out of 32 reporting states for the number of high school students who have ever used this type of product (42.1%).\(^{212}\) 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.\(^{213}\)

With regards to alcohol consumption, Nevada ranked 11\(^{th}\) in the nation with 25.8% of Nevada high school aged youth reported currently drinking alcohol on a regular basis.\(^{214}\) While 60.2% reported having had at least one drink in their life, which is consistent nationally, 17.2% of youth having had their first drink before the age of 13 which is above the national average of 15.5.\(^{215}\) Among persons aged 12 to 17, approximately 6,000 children needed but did not receive treatment at a specialized facility for alcohol use.\(^{216}\)

---


216 SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015 and 2016.
Although Nevada has recently legalized the use of recreational marijuana for those of legal age, the rate of youth currently using marijuana is actually lower than the national average (17.9% in Nevada vs. 19.8% nationally) ranking Nevada 14th out of 42 states.\textsuperscript{217} The current rate of use in Nevada is also lower than the state rate in 2015, decreasing from 19.3%. Another growing source of substance abuse are opioids, identified as prescription pain medicine that is taken without a doctor’s prescription or used differently than how a doctor instructed. The 2017 Youth Behavior Risk Survey added this question, and found that 14.7% of Nevada’s youth reported ever having participated in this behavior, slightly higher than the national average of 14.0%.\textsuperscript{218} Nevada continues to rank low for ecstasy use, which comes in at 24th out of 31 states\textsuperscript{219} and has slightly improved for prescription drug use at 26th out of 39 states.\textsuperscript{220} For inhalants and heroin use, Nevada ranks 20th out of 30\textsuperscript{221} and 18th out of 36,\textsuperscript{222} respectively. Promoting safe storage of medication in the home and parent education regarding the distribution of prescription medication to children can help to prevent injury and misuse among youth that could lead to long-term negative health outcomes.

Among persons aged 12 to 17, approximately 12,000 children had a substance use disorder and only approximately 2,000 received treatment.\textsuperscript{223} 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.\textsuperscript{224} It is important to appropriately address substance abuse issues in adolescents with age-appropriate prevention, intervention, and treatment measures. In addition, research shows that “the high rate of comorbidity between drug use disorders and other mental illnesses argues for a comprehensive approach to intervention that identifies and evaluates each disorder concurrently, providing treatment as needed.”\textsuperscript{225}

\begin{itemize}
\item \textsuperscript{217} Center for Disease Control and Prevention- \textit{Current Marijuana Use Data Tables-Nevada, High School Youth Risk Behavior Survey, 2017}\n\item \textsuperscript{218} Ibid
\item \textsuperscript{219} Center for Disease Control and Prevention- \textit{Ecstasy Use Data Tables-Nevada, High School Youth Risk Behavior Survey, 2017}\n\item \textsuperscript{220} Center for Disease Control and Prevention- \textit{Prescription Drug Use Data Tables-Nevada, High School Youth Risk Behavior Survey, 2017}\n\item \textsuperscript{221} Center for Disease Control and Prevention- \textit{Inhalant Use Data Tables-Nevada, High School Youth Risk Behavior Survey, 2017}\n\item \textsuperscript{222} Center for Disease Control and Prevention- \textit{Heroin Use Data Tables-Nevada, High School Youth Risk Behavior Survey, 2017}\n\item \textsuperscript{223} SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2015 and 2016.
\item \textsuperscript{225} National Institute of Drug Abuse Research Report Series. Comorbidity: Addiction and Other Mental Illnesses. NIH Publication Number 10-5771 Revised September 2010
\end{itemize}
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 and increase substance abuse treatment options for youth, especially ages 14-17.
- Accelerate efforts to promote awareness and help-seeking behaviors among youth, as well as screening and early intervention in schools to identify both substance abuse and mental and behavioral health disorders before there is a crisis.
  - Identification and treatment of mental and behavioral health must be included in any effort to improve substance use or abuse.
  - Universal screening for substance abuse and 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.
- 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.
ECONOMIC WELLBEING 2019

“Our workforce and our entire economy are strongest when we embrace diversity to its fullest, and that means opening doors of opportunity to everyone and recognizing that the American Dream excludes no one.” - Thomas Perez

Economic Well-Being Overview
1. Employment
2. Housing
3. Poverty
4. Income
CHILDREN’S ECONOMIC WELL-BEING OVERVIEW

Nevada Children’s Report Card Grade: D

A family’s economic well-being impacts the ability for a child to achieve his or her full potential from the beginning of life. Parents with low income jobs are often employed in stressful, inflexible positions with few benefits. As hospitality is one of the largest industries in the state, parents may be required to work irregular shifts, without many choices for adequate child care. This provides parents little opportunity to devote the time and resources necessary to be positive role models for their children. Family stress due to economic hardship, which disproportionately affects minority families and those who live in poor neighborhoods, has been shown to negatively affect parenting behaviors which may decrease a child’s overall physical and mental well-being. Instability of the home life experienced during childhood has been shown to have long-term negative effects, including academic difficulties, behavioral issues, and an increased risk for chronic disease. Addressing the need of economic well-being for Nevada’s children will help to ensure a better future for the state as a whole.

In 2012, the state released “Moving Nevada Forward: A Plan for Excellence in Economic Development.” This 3-year plan looked to bring Nevada out of the recession from 2008 and diversify the workforce through 5 primary goals:

1) Establish a cohesive economic development operating system.
2) Advance targeted sectors and opportunities in healthcare services, manufacturing, and back-office operations in all areas of the state along with other economic initiatives.
3) Expanding global engagement.
4) Catalyzing innovation in core and emerging industries.
5) Increase opportunity through education and workforce development.

Six years later, Nevada continues to work towards these goals through economic, legislative, and educational means.

For this briefing book, economic well-being is defined as consisting of the following four areas that need improvement and contribute to the Overall Children’s Economic Well-being Grade of D, which the state received on the 2018 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. Employment
2. Housing
3. Poverty
4. Income
1. **EMPLOYMENT**  
   *Nevada Children's Report Card Grade: C+*

The Employment grade is comprised of the percentage of children whose parents lack secure employment and the unemployment rate of parents. Improvement has been seen in the overall unemployment rate (seasonally adjusted) of the state, declining from 6.8% in 2015 to 5.7% in 2016,\(^{232}\) coming close to the current national unemployment rate last measured in December, 2017 (Nevada – 5%; U.S. – 4.1%). This positive trend may be a direct result of efforts made to achieve the state’s fifth primary goal for enhancing the economy; increasing opportunity through education and workforce development. In recent years, the Governor’s Office of Economic Development has invested in multiple projects to help forge connections between the education and business communities, including funding the Workforce Investment for the New Nevada (WINN) and overseeing legislative initiatives to support small businesses owned by women, minorities, and the disadvantaged (AB126) and to help revitalize downtown areas throughout the state (AB417).\(^{233}\)

This improvement is mirrored in the rates of unemployed parents in Nevada, dropping from 6% in 2014 to 4% in 2016, and decreasing again to 3% in 2017.\(^{234}\) This rate is determined by dividing the number of parents unemployed by the total number of parents in the workforce. Parents’ employment helps to contribute to the overall household production, and the ability of the family’s budget to support healthy child development. However, maternal employment during the first year of a child’s life has been shown to negatively affect cognitive development, as an infant’s trajectory for healthy development is positively impacted by the amount of quality time spent with the mother.\(^{235}\) As unemployment rates decrease and parents are spending more time at work, it is more important than ever to provide high quality, accessible, and affordable child care and early childhood educational opportunities to help mitigate parents’ time spent away from home.\(^{236}\) Previous research has shown that longer periods of

---


employment by fathers during their child’s preschool years yielded a reduction in the child’s risk of unemployment and psychological distress as a young adult.\textsuperscript{237}

The rate of parents who lack secure employment has also declined since 2015, from 32% to 30% in 2016, ranking Nevada 33\textsuperscript{rd} in the nation.\textsuperscript{238} This rate refers to the percentage of all children living in families where no parent has regular, full-time employment (at least 35 hours per week, 50 weeks per year). Secure employment for parents is an important indicator for the stability of a child’s home life and ability to succeed academically. Fluctuations in parents’ employment status do have a direct effect on the emotional wellbeing of parents and have been found to affect math and reading comprehension skills among children.\textsuperscript{239} Children in households with a lack of secure parental employment are deemed to be more economically vulnerable, and at risk of experiencing the negative health, academic, and behavioral outcomes associated with poverty.

RECOMMENDATIONS FOR IMPROVEMENT:

- \textit{Increase workforce training opportunities for parents especially in areas where there might be a demand for specific skills in the region.}
- \textit{Increase jobs that pay a livable wage which would allow individuals to reduce the number of jobs needed to provide the essentials for living, and increase parent’s available time to dedicate toward family needs.}
- \textit{Increase jobs that provide paternity and maternity leave with pay allowing job security along with family development.}


2. **HOUSING**

Nevada Children’s Report Card Grade: D-

The Housing grade is comprised of the percentage of children living in households with a high housing cost burden, and the percentage of children living in low-income households with a high housing cost burden. In 2016, 34% of children in Nevada lived in a household with a high housing cost burden where Nevada ranks 44th in the county.\(^{240}\) In these households more than 30% of the monthly income was spent on rent, mortgage payments, taxes, insurance, and/or related expenses.\(^{241}\)

Rising housing costs throughout the state make it challenging for families to find safe, affordable housing in metropolitan areas, pushing families further away from the economic, educational, and employment opportunities located within bigger cities. These areas must find ways to address the lack of local capacity and wage gap when working to provide affordable housing for its population.\(^{242}\)

For children in low-income households (less than 200% of the federal poverty level) with a high housing cost burden, Nevada averages the same as the national average at 61% and ranks 28th in the nation overall.\(^{243}\) Low-income housing carries additional risks for children’s health, including increased exposure to environmental toxins and neighborhood violence, and limited access to safe

---


\(^{241}\) Ibid


outdoor spaces and healthy foods.\textsuperscript{244} These environmental conditions also impact children’s behavior, with youth that live in disadvantaged neighborhoods having 1.9 times higher odds of parent-reported severe behavioral problems.\textsuperscript{245} The 2016 Nevada Housing Cost Burden by Income Group graphic provides detailed information compiled by the National Low Income Housing Coalition showing the percentage of Nevada’s population living with an extremely low income and the availability of affordable housing options in the state.

### HOUSING IN NEVADA IS NOT AFFORDABLE FOR FAMILIES

| 233,000 children in Nevada lived in households with a high housing cost burden | 30% of children in Nevada have parents who lack secure employment |

Home ownership is another significant indicator of economic well-being for families, as it allows them to accumulate equity and claim sizable tax savings. However, research shows unequal opportunities for racial minorities, exacerbating the wealth and achievement gap. A 2017 report from the Stanford Center on Poverty & Inequality found that less than half of African American (41%) and Hispanic (45%) families in the U.S., versus 71% of Caucasian families, owned their homes in 2014. This report also found that 16.7% (1 in 6) African American and Hispanic families spend more than 50% of their income on housing, meaning these families have less resources to devote to children’s health, education, and other essential needs.\textsuperscript{246}

**RECOMMENDATIONS FOR IMPROVEMENT:**

- Develop areas of communities that provide affordable safe housing for families.
- Implement policies that encourage businesses to provide a livable wage for their employees which will assist them in affording safe housing.
- Enforce regulations which require non-discriminatory home ownership policies and support programs that provide additional education and resources for first time home buyers.

---


3. **POVERTY**  
_Nevada Children’s Report Card Grade: D_

The poverty grade is based upon the percentage of children in poverty (100 percent poverty), children in extreme poverty (50 percent poverty), and new to this report card, children who live in households that were food insecure at some point during the year. Nevada ranked 31st for children in poverty at 19% in 2017, which is the same as the national average, but a decrease from the 21% reported in 2015.\(^{247}\) The percentage of children in extreme poverty has dropped slightly from 9% in 2015 to 7% in 2017 where Nevada ranks 29th in the nation.\(^{248}\) In 2016, 20.5% of children in Nevada were food insecure at some point during the year, ranking 39th in the nation.\(^{249}\) It is encouraging to see that current actions are helping to improve poverty outcomes in Nevada and it is important to continue that momentum by expanding policies that will move the needle closer to an A grade.

To further understand the implications of poverty, it is necessary to review how it is defined and measured. The U.S. Census has measures of poverty based on pre-tax cash resources against a threshold measured at three times the cost of a 1963 minimum food diet.\(^{250}\) However this measure does not fully tell the story about the type of poverty people may experience.\(^{251}\)

There is a distinction between generational, also known as chronic poverty, which persists over many years and is typically passed down between generations, and situational, also known as transitory poverty, which passes with the process of systemic growth.  

There are many factors that lead to generational poverty. Children who grow up in poverty experience higher rates of teen pregnancy, lowered levels of college attendance, lower earnings, negative health and behavioral outcomes, and increased criminal justice interventions. All of these experiences equate to needing additional assistance as adults. Situational poverty occurs when an unexpected event may suddenly deplete or require additional resources that impacts one’s ability to obtain necessary resources. Many times, situational poverty is temporary and requires assistance with basic necessities on an interim basis. Each type of poverty requires diverse strategies for assisting in supporting and developing assets to establish upward mobility.

Children experience poverty at much higher rates than adults and the impact is especially consequential in a developing mind and body. Childhood sets the stage for having the skills necessary to get out of or stay out of poverty making children an important target for the future economic success of Nevada. Chronically poor children are more likely to become byproducts of generational poverty as children who grow up poor are not as equipped to succeed economically as adults.

---


outcomes related to social and emotional development, cognition, health, and education— all factors that contribute to a child’s economic well-being later in life.

Because children’s future incomes are connected to their parents’ current incomes, focusing on families is imperative to helping people out of poverty. Research has shown that addressing poverty between children and parents simultaneously through access to early childhood education, job training, and other methods to achieve financial stability equips parents and children will the skills needed to thrive rather than just survive.256

RECOMMENDATIONS FOR IMPROVEMENT:

- **Create a statewide plan for ending poverty that focuses on families using multigenerational strategies.**
- **Create opportunities to build capacity and collaboration among safety net providers who service those experiencing poverty.**
- **Build awareness among poverty-stricken individuals to improve education of and access to available resources.**
- **Increase resources and funding available for subsidies and benefits in kind to increase access to free education, healthcare, early childhood education and childcare, jobs training, financial literacy and asset building, housing, and nutritious foods.**
  - Support programs that promote successful transitions into adulthood for children who grow up in poverty.
  - Reduce barriers for people coming out of the criminal justice system and develop policies that support successful re-entry to support adequate employment and training.
  - Expand eligibility and loosen requirements of social service programs to increase access and encourage sustainability.
  - Provide subsidies for companies to establish businesses in depressed areas to support access to livable wage jobs and revitalization efforts.
  - Reduce barriers to gainful and steady employment by increasing minimum wages and enacting policies that provide flexible schedules that work, paid parental leave, and paid sick leave.
  - Increase access to transportation and improve the walkability and safety of communities to support active transport.

4. **INCOME**  
**Nevada Children’s Report Card Grade: D**

The income grade is determined by the share of low-income working families with children and the number of teens ages 16-19 not attending school and not working. In 2016, Nevada ranked 38th in the nation for low-income working families with children at 24%, a slight decrease from 25% in 2015. These numbers reflect the percentage of families that meet the following criteria: 1) family income is less than 200% of the federal poverty level, 2) at least one parent worked 50 weeks or more during the previous year, and 3) there is at least one child under the age of 18 in the family (not including foster children).

Income is another important component in determining a child’s developmental well-being. Studies have shown that low family income adds to chronic family stress and chaotic home lives, which have been linked to long-term negative effects on parent-child relationships, social-emotional outcomes, and lower functioning immune systems. As the conversation continues about increasing minimum wage and reducing gender wage gaps, it is important to consider the impact of increasing family income on improving childhood well-being.

---

Although the median income has increased in Nevada in recent years, the vast majority of that growth has benefitted only the top 1% of income earners – capturing 81% of the state’s overall income growth between 2009 and 2015. This earned Nevada the rank of 4th most unequal income distribution in the nation in 2015 with the top 1% making an average of 32.7 times the income amount of the bottom 99%, according to the Economic Policy Institute. This disparity affects more than just economic resources available to families, but can potentially have long term effects on children’s health. Even in highly developed countries, like the United States, longitudinal research studies have shown that an increase in the income gap of a population directly correlates with an increase in disparities in life expectancy. Simply speaking, this means those with higher income will live longer than those of low-income status, and when life expectancy increases for a given population, higher income individuals will see more years of life gained than others.

Nevada is currently 30th in the nation for teens ages 16-19 not attending school and not working at 6%, a decrease from 9% in 2015. In academic literature, these teens are often referred to as “disconnected youth.” Previous research has shown that these youth are more likely to be poor, have children, live apart from parents, and have fewer years of education than their connected peers. Disconnection from both work and school denies individuals the ability to accumulate social capital and learn skills needed for success in the labor market. The prevalence of disconnected youth also impacts society as a whole through lost productivity, higher crime rates, and increased use of public assistance programs. Effective approaches to engaging this population employ multi-faceted, system-level strategies that can coordinate education, healthcare, and other youth-related policies. Programs found to be successful often

---

incorporate opportunities for paid work or financial incentives, strong connections between schools and job training, and comprehensive support services.\textsuperscript{265}

RECOMMENDATIONS FOR IMPROVEMENT:

- Support legislation to raise the minimum wage for all working Nevadans.
- Provide funding to subsidize vocational and trade schools, as well as higher education.
- Support programs designed to encourage high school graduation, vocational training, and higher education for disconnected youth.
- Assist employers with providing comprehensive health insurance and subsidized child-care for workers.
- Encourage businesses to follow best practice strategies to ensure diverse hiring practices.

APPENDIX

2018 Nevada Children’s Report Card

Data & Sources

“Things get done only if the data we gather can inform and inspire those in a position to make a difference.” – Mike Schmoker
## APPENDIX: 2018 NEVADA CHILDREN’S REPORT CARD DATA AND SOURCES

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Grade</th>
<th>Rank</th>
<th>Stat</th>
<th>Stat year</th>
<th>Change*</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>4th Grade Reading- Percent of 4th Grader’s Reading Scores Proficient and above</td>
<td>F+</td>
<td>43</td>
<td>31%</td>
<td>2017</td>
<td>↑ (+2%)</td>
<td>Kids Count Data Center- Fourth Grade Reading Achievement Levels.” Kids Count Data Center. N.p.,n.d. Web. 6 Sept. 2018.</td>
</tr>
<tr>
<td>8th Grade Math- Percent of 8th Grader’s Math Scores Proficient and Above</td>
<td>F+</td>
<td>41</td>
<td>27%</td>
<td>2017</td>
<td>↔ (+0.9%)</td>
<td>Kids Count Data Center- Eight Grade Math Achievement Levels.” Kids Count Data Center. N.p.,n.d. Web. 6 Sept. 2018.</td>
</tr>
<tr>
<td>Postsecondary Participation- Percent of young adults enrolled in postsecondary education or with a degree</td>
<td>F-</td>
<td>50</td>
<td>41%</td>
<td>2017</td>
<td>↔ (+0.9%)</td>
<td>Grading Summary - Education Week. (n.d.). Retrieved September 6, 2018, from <a href="https://www.edweek.org/media/quality-counts-2018-grading-summary-copyright-education-week.pdf">https://www.edweek.org/media/quality-counts-2018-grading-summary-copyright-education-week.pdf</a></td>
</tr>
<tr>
<td>High School Dropout Rate- Percent of youth of high school age who are not attending</td>
<td>F-</td>
<td>49</td>
<td>7%</td>
<td>2016</td>
<td>↓ (−1.1%)</td>
<td>Kids Count Data Center- Teens Ages 16 to 19 Not in School and Not High School Graduates” Kids Count Data Center. N.p.,n.d. Web. 6 Sept. 2018.</td>
</tr>
<tr>
<td>Patient Provider Ratios- Active Primary Care Physicians per 100,000 Population by Degree Type</td>
<td>F-</td>
<td>48</td>
<td>70.1</td>
<td>2016</td>
<td>↔ (+0.3)</td>
<td>Association of American Medical Colleges- 2017 State Physician Workforce Data Book Center for Work Studies November 2017” Association of American Medical Colleges. N.p.,n.d. Web. 5 Sept. 2018.</td>
</tr>
<tr>
<td>Prenatal Care- Births to Women Receiving Late or No Prenatal Care</td>
<td>F</td>
<td>46</td>
<td>8.2%</td>
<td>2016</td>
<td>↔ (−0.8%)</td>
<td>Births: Provisional data for 2017 - cdc.gov. May 2018. Web. 5 Sept. 2018.</td>
</tr>
<tr>
<td>Infant/Child Mortality- # per 1,000 (infant deaths &lt; 1 year per # live births)</td>
<td>B</td>
<td>17</td>
<td>5.7</td>
<td>2016</td>
<td>↔ (+0.6)</td>
<td>Center for Disease Control and Prevention- National Center for Health Statistics” Center for Disease Control and Prevention. N.p.,n.d. Web. 5 Sept. 2018.</td>
</tr>
<tr>
<td>Low Birth Weight- Percentage of infants weighing less than 2500 grams (5 pounds, 8 ounces) at birth.</td>
<td>C-</td>
<td>30</td>
<td>8.5%</td>
<td>2016</td>
<td>↔ (+0.5%)</td>
<td>Kids Count Data Center-Low Birth Weight Babies” Kids Count Data Center. N.p.,n.d. Web. 5 Sept. 2018.</td>
</tr>
<tr>
<td>Indicator</td>
<td>Grade</td>
<td>Rank</td>
<td>Stat</td>
<td>Stat year</td>
<td>Change*</td>
<td>Source</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>-------</td>
<td>------</td>
<td>------</td>
<td>-----------</td>
<td>------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Immunizations- Percentage of children aged 19 to 35 months receiving recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and PCV vaccines.</td>
<td>C</td>
<td>24</td>
<td>71.9%</td>
<td>2016</td>
<td>↑ (+4.2%)</td>
<td>America’s Health Rankings United Health Foundation-Immunizations Nevada*</td>
</tr>
<tr>
<td>HPV Up-to-Date (UTD)- Adolescents who are UTD on their HPV vaccinations</td>
<td>C-</td>
<td>29</td>
<td>49.0%</td>
<td>2017</td>
<td>↑ (+9.1%)</td>
<td>National Center for Health Statistics (U.S.), National Immunization Program (Centers for Disease Control and Prevention), &amp; Abt Associates. (2018). National Immunization Survey. Hyattsville, Md: U.S. Dept. of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics.</td>
</tr>
<tr>
<td>Physical Fitness- 9-12 grade students not physically active 5 days per week, 60+ minutes</td>
<td>B-</td>
<td>17</td>
<td>53.6%</td>
<td>2017</td>
<td>↑ (+4.6%)</td>
<td>Center for Disease Control and Prevention- Physical Fitness Data Tables Nevada, High School Youth Risk Behavior Survey, 2017” Center for Disease Control and Prevention. N.p.,n.d. Web. 5 Sept. 2018.</td>
</tr>
<tr>
<td>Overweight- Percentage of HS students &gt;= 85th percentile but &lt;95th percentile for body mass index, based on sex- and age-specific reference data from the 2000 CDC growth charts</td>
<td>B+</td>
<td>8</td>
<td>14.3%</td>
<td>2017</td>
<td>↔ (−0.7%)</td>
<td>Center for Disease Control and Prevention- Overweight Data Tables-Nevada, High School Youth Risk Behavior Survey, 2017” Center for Disease Control and Prevention. N.p.,n.d. Web. 5 Sept. 2018.</td>
</tr>
<tr>
<td>Nutrition- Percentage of HS students who did not eat fruit during the 7 days before the survey</td>
<td>B-</td>
<td>20</td>
<td>7.5%</td>
<td>2017</td>
<td>↑ (+2.3%)</td>
<td>Center for Disease Control and Prevention- No Fruit Eating Data Tables-Nevada, High School Youth Risk Behavior Survey, 2017” Center for Disease Control and Prevention. N.p.,n.d. Web. 5 Sept. 2018.</td>
</tr>
<tr>
<td>Mental Health Treatment- Percentage of children who received needed mental health treatment or counseling in the past 12 months</td>
<td>F+</td>
<td>41</td>
<td>2.8%</td>
<td>2016</td>
<td>↔ (0.0%)</td>
<td>National Survey of Children’s Health. NSCH 2016. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved 09/5/18 from <a href="http://www.childhealthdata.org">www.childhealthdata.org</a></td>
</tr>
<tr>
<td>Sexual Activity- Percentage of HS students who are currently sexually active</td>
<td>C+</td>
<td>16</td>
<td>25.9%</td>
<td>2017</td>
<td>↓ (−1.1%)</td>
<td>Center for Disease Control and Prevention- Sexual Activity Data Tables-Nevada, High School Youth Risk Behavior Survey, 2017” Center for Disease Control and Prevention. N.p.,n.d. Web. 5 Sept. 2018.</td>
</tr>
<tr>
<td>Condom Use- Percentage of HS students who used a condom during last sexual intercourse</td>
<td>C</td>
<td>18</td>
<td>45.6%</td>
<td>2017</td>
<td>↔ (−0.7%)</td>
<td>Center for Disease Control and Prevention- Condom Use Data Tables-Nevada, High School Youth Risk Behavior Survey, 2017” Center for Disease Control and Prevention. N.p.,n.d. Web. 5 Sept. 2018.</td>
</tr>
<tr>
<td>Indicator</td>
<td>Grade</td>
<td>Rank</td>
<td>Stat</td>
<td>Stat year</td>
<td>Change</td>
<td>Source</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-------</td>
<td>------</td>
<td>------</td>
<td>-----------</td>
<td>--------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>No birth control use:</strong> Percentage of HS students who did not use any method to prevent pregnancy during last sexual intercourse</td>
<td>D-</td>
<td>31</td>
<td>18.9%</td>
<td>2017</td>
<td>↑ (+6.5%)</td>
<td>Center for Disease Control and Prevention- No Birth Control Use” Data Tables- Nevada, High School Youth Risk Behavior Survey, 2017” Center for Disease Control and Prevention. N.p.,n.d. Web. 5 Sept. 2018.</td>
</tr>
<tr>
<td>Syphilis (STD Rate)- rate 15-24 year olds per 100,000</td>
<td>F-</td>
<td>49</td>
<td>22.9</td>
<td>2016</td>
<td>↓ (−2.2%)</td>
<td>Center for Disease Control and Prevention- Syphilis (STD Rate) NCHHSTP Atlas” Center for Disease Control and Prevention. N.p.,n.d. Web. 5 Sept. 2018.</td>
</tr>
<tr>
<td>Foster Care Placement- # of children removed &amp; placed in foster care, per 1,000 children under age 18 in population</td>
<td>C-</td>
<td>30</td>
<td>5</td>
<td>2016</td>
<td>↑ (+2)</td>
<td>Kids Count Data Center- Children Foster Care Placement” Kids Count Data Center. N.p.,n.d. Web. 5 Sept. 2018.</td>
</tr>
<tr>
<td>Maltreatment- Total child maltreatment victims rate per 1,000 of the population under age 18</td>
<td>B</td>
<td>17</td>
<td>7</td>
<td>2016</td>
<td>↔ (+0.5)</td>
<td>Kids Count Data Center- Children who are confirmed by child protective services as victims of maltreatment” Kids Count Data Center. N.p.,n.d. Web. 5 Sept. 2018.</td>
</tr>
<tr>
<td>Physical Maltreatment- Percentage of child victims</td>
<td>D-</td>
<td>38</td>
<td>26%</td>
<td>2016</td>
<td>↓ (−10.4%)</td>
<td>Kids Count Data Center- Children who are confirmed by child protective services as victims of maltreatment by type” Kids Count Data Center. N.p.,n.d. Web. 5 Sept.2018.</td>
</tr>
<tr>
<td>Sexual Maltreatment- Percentage of child victims</td>
<td>B-</td>
<td>20</td>
<td>6%</td>
<td>2016</td>
<td>↔ (+0.7%)</td>
<td>Kids Count Data Center- Children who are confirmed by child protective services as victims of maltreatment by type&quot; Kids Count Data Center. N.p.,n.d. Web. 5 Sept.2018.</td>
</tr>
<tr>
<td>Neglect- Percentage of child victims</td>
<td>D+</td>
<td>32</td>
<td>80%</td>
<td>2016</td>
<td>↑ (+4.4%)</td>
<td>Kids Count Data Center- Children who are confirmed by child protective services as victims of maltreatment by type” Kids Count Data Center. N.p.,n.d. Web. 5 Sept.2018.</td>
</tr>
<tr>
<td>Unsheltered Youth- % of Unaccompanied Children and Youth who were Unsheltered</td>
<td>F-</td>
<td>51</td>
<td>89.2%</td>
<td>2017</td>
<td>↑ (+1.7%)</td>
<td>The U.S. Department of Housing and Urban Development Office of Community Planning and Development- The 2017 Annual Homeless Assessment Report (AHAR) to Congress” The U.S. Department of Housing and Urban Development Office of Community Planning and Development. N.p.,n.d. Web. 5 Sept. 2018.</td>
</tr>
<tr>
<td>High School Violence- Percentage of NV HS students who reported involvement in fighting on school property</td>
<td>B+</td>
<td>5</td>
<td>5.9%</td>
<td>2017</td>
<td>↔ (−0.9%)</td>
<td>Center for Disease Control and Prevention- Physical Fighting at School Data Tables- Nevada, High School Youth Risk Behavior Survey, 2017” Center for Disease Control and Prevention. N.p.,n.d. Web. 5 Sept. 2018.</td>
</tr>
<tr>
<td>Weapons on school property- Percentage of NV HS students who reported to have carried a weapon on school property</td>
<td>C+</td>
<td>15/38</td>
<td>4.7%</td>
<td>2017</td>
<td>↔ (+0.6%)</td>
<td>Center for Disease Control and Prevention- Weapon Carrying at School Data Tables- Nevada, High School Youth Risk Behavior Survey, 2017” Center for Disease Control and Prevention. N.p.,n.d. Web. 5 Sept. 2018.</td>
</tr>
<tr>
<td>Indicator</td>
<td>Grade</td>
<td>Rank</td>
<td>Stat</td>
<td>Stat year</td>
<td>Change*</td>
<td>Source</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-------</td>
<td>------</td>
<td>------</td>
<td>-----------</td>
<td>---------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Indicator</td>
<td>Grade</td>
<td>Rank</td>
<td>Stat</td>
<td>Stat year</td>
<td>Change*</td>
<td>Source</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-------</td>
<td>------</td>
<td>------</td>
<td>-----------</td>
<td>---------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Drugs - Percentage of Nevada HS students that have used</strong></td>
<td>C-</td>
<td>22</td>
<td>3.2%</td>
<td>2017</td>
<td>⇔ (-0.6%)</td>
<td>Center for Disease Control and Prevention - Methamphetamine Use Data Tables - Nevada, High School Youth Risk Behavior Survey, 2017* Center for Disease Control and Prevention. N.p.,n.d. Web. 5 Sept. 2018.</td>
</tr>
<tr>
<td><strong>Drugs - Percentage of Nevada HS students who have used any form of</strong></td>
<td>C-</td>
<td>23</td>
<td>5.4%</td>
<td>2017</td>
<td>↓ (-1.2%)</td>
<td>Center for Disease Control and Prevention - Cocaine Use Data Tables - Nevada, High School Youth Risk Behavior Survey, 2017* Center for Disease Control and Prevention. N.p.,n.d. Web. 6 Sept. 2018.</td>
</tr>
<tr>
<td><strong>Drugs - Percentage of NV HS students who reported current marijuana</strong></td>
<td>B-</td>
<td>14/42</td>
<td>17.9%</td>
<td>2017</td>
<td>↓ (-1.4%)</td>
<td>Center for Disease Control and Prevention - Current Marijuana Use Data Tables - Nevada, High School Youth Risk Behavior Survey, 2017* Center for Disease Control and Prevention. N.p.,n.d. Web. 6 Sept. 2018.</td>
</tr>
<tr>
<td><strong>Drugs - Percentage of NV HS students who reported ever using</strong></td>
<td>C</td>
<td>20/30</td>
<td>7.1%</td>
<td>2017</td>
<td>⇔ (-0.6%)</td>
<td>Center for Disease Control and Prevention - Inhalant Use Data Tables - Nevada, High School Youth Risk Behavior Survey, 2017* Center for Disease Control and Prevention. N.p.,n.d. Web. 5 Sept. 2018.</td>
</tr>
<tr>
<td><strong>Drugs - Percentage of NV HS students who reported ever using</strong></td>
<td>C</td>
<td>18/36</td>
<td>2.4%</td>
<td>2017</td>
<td>⇔ (-0.3%)</td>
<td>Center for Disease Control and Prevention - Heroin Use Data Tables - Nevada, High School Youth Risk Behavior Survey, 2017* Center for Disease Control and Prevention. N.p.,n.d. Web. 5 Sept. 2018.</td>
</tr>
<tr>
<td><strong>Food Insecurity – Percentage of children who live in households that are food insecure</strong></td>
<td>D-</td>
<td>39</td>
<td>20.5%</td>
<td>2016</td>
<td>⇔ (-0.5)</td>
<td>Feeding America - Map the Meal Gap. (n.d.). Retrieved September 6, 2018, from <a href="http://map.feedingamerica.org/">http://map.feedingamerica.org/</a></td>
</tr>
</tbody>
</table>

*Note. Green arrows = positive change, red arrows = negative change, and yellow arrows = no change (< +5%).
Children’s Advocacy Alliance

The Children’s Advocacy Alliance (CAA) is a community-based nonprofit organization that serves as an independent voice for Nevada’s children and families by advocating for improved policies, practices and laws related to children’s health, safety and school readiness.

Staff:
Denise Tanata - Executive Director
Jared Busker- Associate Director
Emma Rodriguez - Health Policy Manager
Shelby Henderson- School Readiness Policy Manager
Christopher Croft- Safety Policy Manager
Maggie Salas-Crespo- Communications Coordinator
Aaliyah Goodie- Data Analyst
Berdie Woodhouse - Administrative Assistant
Shema Dannatt - Southern Nevada Storybanking Coordinator
Michelle Baker - Northern Nevada Storybanking Coordinator
Mika Alvarez - Northern Nevada Storybanking Coordinator

Children’s Advocacy Alliance
5258 S. Eastern Ave. #151
Las Vegas, NV 89119
(702) 228-1869
3500 Lakeside Ct, Suite 214
Reno, NV 89509
(775) 440-1767
www.caanv.org

Nevada Institute for Children's Research and Policy

The Nevada Institute for Children's Research and Policy (NICRP), located within the School of Community Health Sciences at the University of Nevada Las Vegas, is a not-for-profit, non-partisan organization dedicated to improving the lives of children through research, advocacy and other specialized services.

Staff:
Tara Phebus - Executive Director
Amanda Haboush-Deloye –Associate Director
Dawn Davidson - Chief Research Associate
Erika Marquez - Research Associate
M. Amaris Knight - Assistant Research Analyst
Mayra Pacheco - Project Coordinator
Jay Cafferata - Trainer
Saily Gomez-Batista - Nevada Outreach Coordinator
Natascha Kotte – Research Assistant
Amber Osterholt – Research Assistant
Camille Layseca – Research Assistant
Elizabeth Holka – Research Assistant

Nevada Institute for Children’s Research and Policy
Home of Prevent Child Abuse Nevada
School of Community Health Sciences
University of Nevada, Las Vegas
4505 Maryland Pkwy
Las Vegas, NV 89154-3030
(702) 895-1040 Fax (702) 895-2657
nic.unlv.edu
A collaborative effort between:

Children’s Advocacy Alliance

Nevada Institute For Children’s Research & Policy