Substance Abuse Prevention and Treatment Agency 2019 Epidemiologic Profile

***Southern Nevada Region**:*

Esmeralda, Lincoln, Mineral and Nye Counties

January 2020

Office of Analytics on Behalf of

Nevada Department of Health and Human Services

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

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Data Sources/Limitations

Age-Adjusted Rates

A rate is a measure of the frequency of a specific event over a given period, divided by the total number of people within the population over the same period. An age-adjusted rate is a rate that has been adjusted, or weighted, to the same age distribution as a "standard" population. Throughout this report, rates are adjusted to the 11 standard age groups of the U.S. population in the year 2000 (Census table P25-1130). Rates are age-adjusted in order to eliminate any potential confounding effects, or biases, that may be a result of health factors that are associated with specific ages.

Behavioral Risk Factor Surveillance System (BRFSS)

BRFSS is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, chronic health conditions, and use of preventive services. More than 350,000 adults are interviewed each year, making the BRFSS the largest telephone health survey in the world. For many states, the BRFSS is the only available source of timely and accurate data on health-related behaviors. The survey consists of a set of federally grant funded core questions and states may include and pay for their own questions in the survey. While the survey's focus is chronic disease and injury, topics covered by the survey include car safety, obesity, and exercise among many others. Since state-added questions are not asked nationwide, these questions are not comparable.

Crude Rates

The crude rate is the frequency with which an event or circumstance occurs per unit of population.

Hospital Billing Data (Emergency Department Encounter and Inpatient Admissions)

The hospital billing data provides health billing data for emergency department encounters and inpatient admissions for Nevada's non-federal hospitals. NRS 449.485 mandates all hospitals in Nevada report information as prescribed by the director of the Department of Health and Human Services. The data are collected using a standard universal billing form. The data includes demographics such as age, gender, race/ethnicity, and uses International Classification of Diseases-9-Clinical Modification (ICD-9-CM) diagnoses codes and International Classification of Diseases-10-Clinical Modification (ICD-10-CM) diagnoses. ICD-10-CM diagnoses codes replaced ICD-9-CM diagnoses codes in the last quarter of 2015. Therefore, data prior to last quarter in 2015 may not be directly comparable to data thereafter. In addition, the data includes billed hospital charges, procedure codes, discharge status, and external cause of injury codes. The billing information is for billed charges and not the actual payment received by the hospital.

Nevada Report Card

The Nevada Report Card is the accountability reporting website of the Nevada Department of Education. In compliance with federal and state law, it assists community members (parents, educators, researchers, lawmakers, etc.) in locating a wealth of detailed information pertaining to K-12 public education in Nevada. The web site has three categories: "school and district information," "assessment and accountability" and "fiscal and technology."

Nevada State Demographer
The Nevada State Demographer's office is funded by the Nevada Department of Taxation and is part of the Nevada Small Business Development Center. It is responsible for conducting annual population estimates for Nevada's counties, cities, and towns.

State-Funded Mental Health Services (Avatar)
Avatar is a database containing demographic, treatment, billing, and financial information for Nevada mental health facilities throughout the state of Nevada. These data are representative of Nevada state-operated mental health facilities and are not generalizable to the rest of the population.

Substance Abuse and Mental Health Data
The National Survey of Drug Use and Health (NSDUH) is a survey on the use of illicit drugs, alcohol, tobacco, and mental health issues in the United States. The study includes those who are 12 years of age or older at the time of the survey. For more information on the survey: SAMHSA.

United States Census Bureau
The United States Census Bureau is responsible for the United States Census, the official decennial (10-year period) count of people living in the United States of America. Collected data are disseminated through web browser-based tools like the American Community Survey, which provides quick facts on frequently requested data collected from population estimates, census counts, and surveys of population and housing for the nation, states, counties, and large cities. The Bureau also offers the American Fact Finder, which profiles the American population and economy every five years.

Web-Enabled Vital Records Registry Systems (WEVRRS)
Statewide births and deaths are collected by the Office of Vital Records, in the Division of Public and Behavioral Health. WEVRRS is a software utilized by physicians, registered nurses, midwives, informants or funeral directors, and other individuals to collect and consolidate birth and death-related information.

Youth Risk Behavior Survey (YRBS)
The purpose of the YRBS is to provide Nevada data to assess trends in priority health-risk behaviors among high school students, measure progress toward achieving national health objectives for Healthy People 2020 and other program and policy indicators and evaluate the impact of broad school and community interventions at the national, state, and local level. The YRBS is a biennial, anonymous, and voluntary survey of students in 9th through 12th grade in traditional, public high schools that monitors the prevalence of health risk behaviors among youth. The survey asks students to self-report their behaviors in six major areas of health that directly lead to morbidity and mortality; these include: (1) Behaviors that contribute to unintentional injuries and violence; (2) Sexual behaviors that contribute to human immunodeficiency virus (HIV) infection, other sexually transmitted diseases, and unintended pregnancy; (3) Tobacco use; (4) Alcohol and other drug use; (5) Unhealthy dietary behaviors; and (6) Physical inactivity. For more information on YRBS: UNR YRBS.

Executive Summary

Purpose

This report is intended to provide an overview of behavioral health in Nevada for the prevention coalitions, public health authorities, Nevada legislators, behavioral health boards and the public. The analysis can be used to identify issues of concern and areas that may need to be addressed.

Key Findings

- The population of Southern Nevada has increased by approximately 5 percent since 2010.
- Mental health-related disorders were the underlying cause of 1,730 emergency room visits and 1,655 inpatient admissions, among Southern Nevada residents in 2018.
- Anxiety was the primary reason for emergency room visits followed by depression. From 2017, suicidal ideation has increased to become the third most common reason for emergency room visits. Anxiety, followed by depression, was also the primary reason for inpatient admissions.
- In 2018, 393 females utilized state mental health services as compared to 229 males. From 2017 to 2018, utilization for females has slightly decreased while utilization for males has slightly increased.
- In 2018, the utilization rate has increased significantly for Asians/Pacific Islanders to 983.8 per 100,000. In 2017, the utilization rate was 648.1 per 100,00.
- The age-adjusted suicide rate for 2018 was 33.0 per 100,000 population. In 2018, the age group with the highest prevalence was the 65-74-year-old age group.
- Out of Southern Nevada high school students, 58.5% have drank alcohol before, 24.8% currently drink alcohol and 16.6% have had alcohol before the age of 13 with is slightly higher than Nevada at 18.2%.
- In Southern Nevada, marijuana use has increased since 2011 at 12.1% to 13.1% in 2018. Marijuana use has increased consistently since 2014 and is expected to increase as marijuana was legalized in Nevada in 2017.
- Emergency department and inpatient visits for marijuana and methamphetamine use (not overdoses) were more prevalent in 2018 than in 2010.
- In 2018, 62 deaths were related to alcohol and/or drugs use, of which approximately 71% of these deaths were drug-related.
- Among Southern Nevada high school students for 2018 in Nevada, 30.3% have reported that they are currently having sex, which higher than Nevada at 25.8%.
- Self-report marijuana/cannabis use in pregnant women has increased significantly from 10.3 per 1,000 live births in 2017, to 22.4 per 1,000 live births in 2018.

Demographic Snapshot

Figure 1. Selected Demographics for Southern Nevada.

Population, 2018 estimate*	57,558
Population, 2010 estimate*	54,902
Population, percentage change*	4.8%
Male persons, 2018 estimate*	29,247 (50.8%)
Female Persons, 2018 estimate*	28,311 (49.2%)
Median household income (in 2017), 2013-2017**	$43,994
Per capita income in the past 12 months (in 2017), 2013-2017**	$24,376
Persons in poverty, percent (2017) **	15.4%
With a disability, under the age 65 years, percent, 2013-2017**	13.9%
Land area (square miles), 2017**	36,150

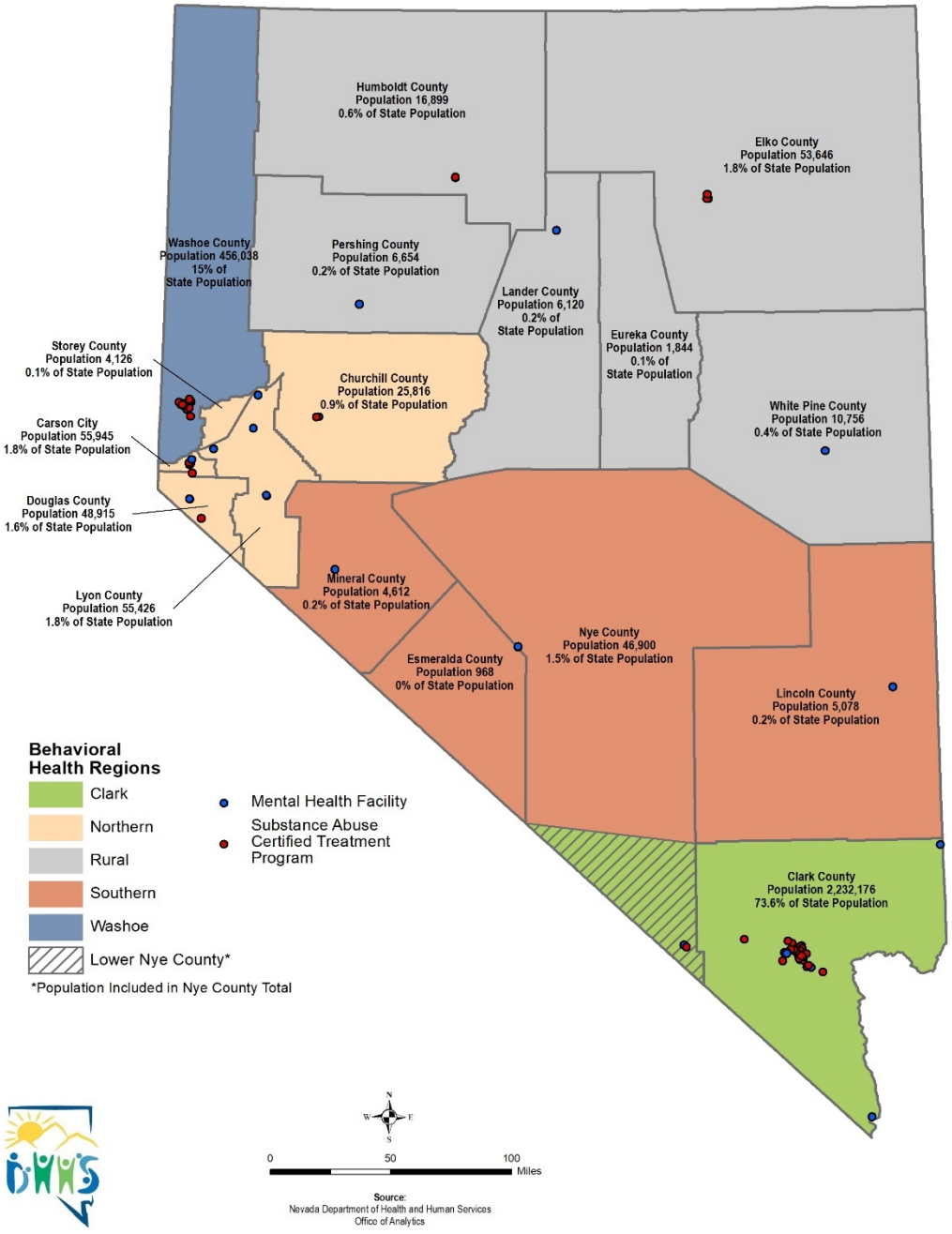
*Source: *Nevada State Demographer, Vintage 2018 and **US Census Bureau.*

In 2018, the estimated population for Southern Nevada was 57,558, a 4.8% increase from the 2010 estimated population. The population is made up of approximately equal percentages of females and males. The median household income is $43,994. Southern Nevada's land area is approximately 36,150 square miles.

During the 2017 session, regional behavioral health boards were formed to address behavioral health in Nevada. The regions were redrawn during the 2019 session and Nye county was split into regions. The northern half of Nye county is part of the southern region and the south half is part of the Clark County region. For data purposes, Nye county data is included in the southern region.

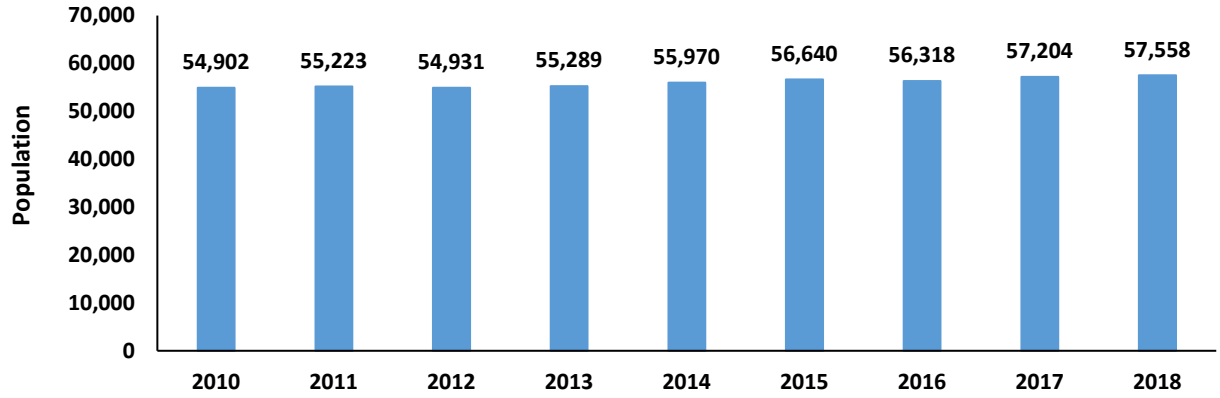
Esmeralda County is the least populated with 0.4% of Nevada's population with an estimated 968 persons. The Southern Nevada Behavioral Health region makes up 1.9% of Nevada's population.

Figure 2. Nevada Population Distribution by County, 2018.



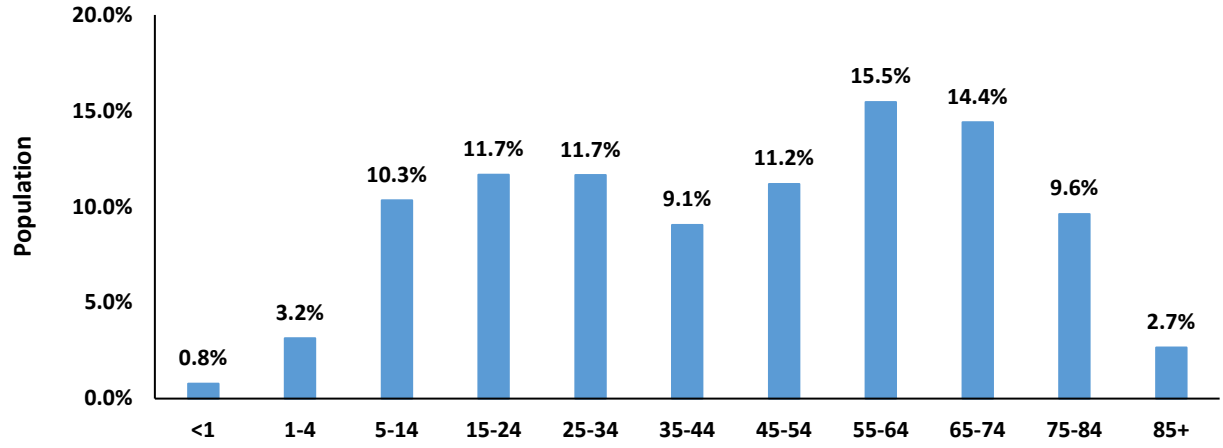
Source: Nevada State Demographer, Vintage 2018.
***Clark Region**: Clark County and southern Nye County.*
***Northern Nevada Region:** Carson City, Churchill, Douglas, Lyon, and Storey Counties.*
***Rural Nevada Region:** Elko, Eureka, Humboldt, Pershing, and White Pine Counties.*
***Southern Nevada Region:** Esmeralda, Lincoln, and northern Nye County.*
***Washoe Region**: Washoe County.*
**Nye County: North Nye County is included in Southern Region and southern Nye County is in part of Clark County Region. For data purposes, Nye County data is included in Southern Nevada Region Report and not in the Clark County Region report.*

Figure 3. Southern Nevada Behavioral Health Population, 2010-2018.



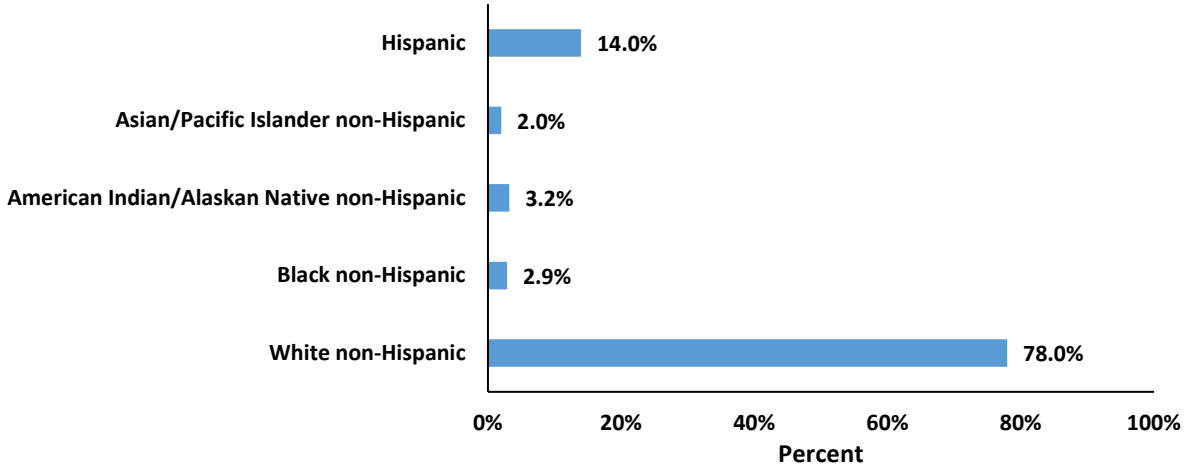
Source: Nevada State Demographer, Vintage 2018.

Figure 4. Southern Nevada Behavioral Health Population by Age Group, 2018.



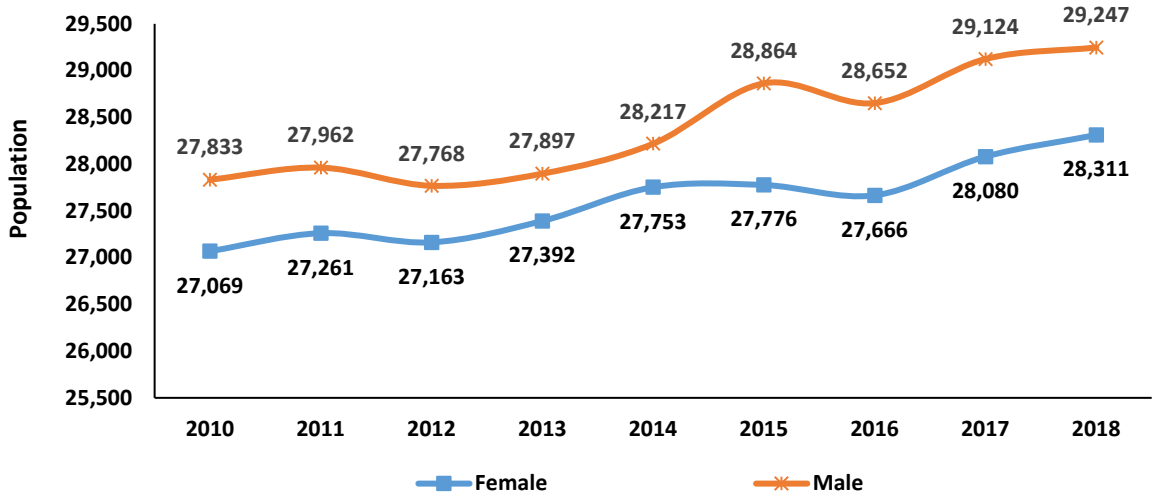
Source: Nevada State Demographer, Vintage 2018.
Chart scaled to 20% to display differences among groups.

Figure 5. Southern Nevada Behavioral Health Population by Race/Ethnicity, 2018.



Source: Nevada State Demographer, Vintage 2018.
Chart scaled to 90% to display differences among groups.

Figure 6. Southern Nevada Behavioral Health Population Distribution by Sex, 2010-2018.



Source: Nevada State Demographer, Vintage 2018.
Chart scaled to display differences among years.

In 2018, the estimated population for Southern Nevada was 57,558, a 4.8% increase from the 2010 estimated population. The population is made up of approximately 28,311 females (50.8%) and 29,247 males (50.8%).

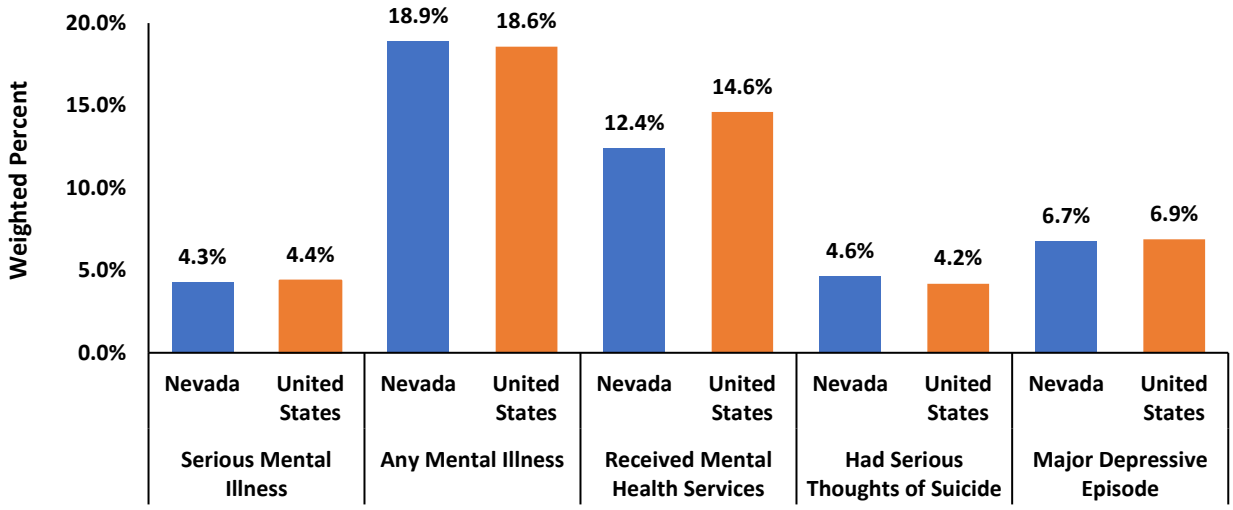
Mental Health

Mental health data are collected by numerous data sources in Nevada, including YRBS, BRFSS, hospital billing, state-funded mental health facilities, and vital records.

National Survey of Drug Use and Health

The Substance Abuse and Mental Health Services Administration (SAMHSA) sponsors the National Survey on Drug Use and Health (NSDUH). The survey tracks trends of illicit drug, alcohol, and tobacco use, as well as mental health issues throughout the United States.

Figure 7. Prevalence of Mental Health Measures, Nevada and United States, 2016-2017.



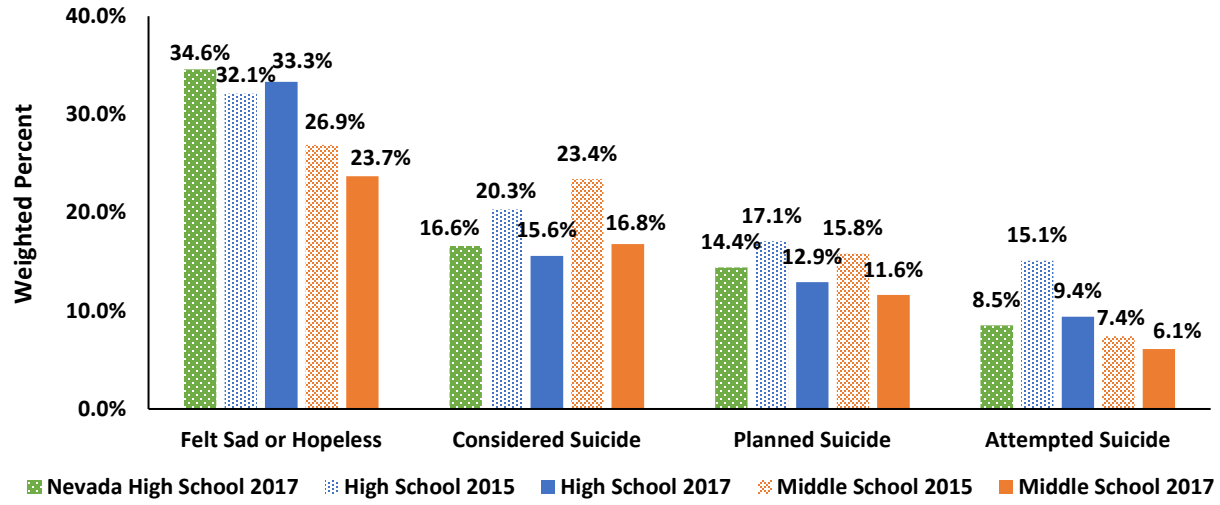
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2016-2017.
Chart scaled to 20% to display differences among groups.

Nevada has remained within a percent of the nation for most mental health issues. Nevada was slightly higher than the national measure with “any mental illness” and “having had serious thoughts of suicide.”

Youth Risk Behavior Survey (YRBS)

The YRBS monitors six categories of health-related behaviors that contribute to leading causes of death and disabilities among youth and adults. Nevada high school and middle school students are surveyed during the odd years. In 2017, 445 high school and 458 middle school students participated in the YRBS. The University of Nevada, Reno maintains the YRBS data and publishes data on each survey. For more information on the YRBS survey, please go to the following site: UNR YRBS.

Figure 8. Mental Health Behaviors, Southern Nevada Middle and High School Students, 2015 and 2017, and Nevada Statewide High School Students, 2017.



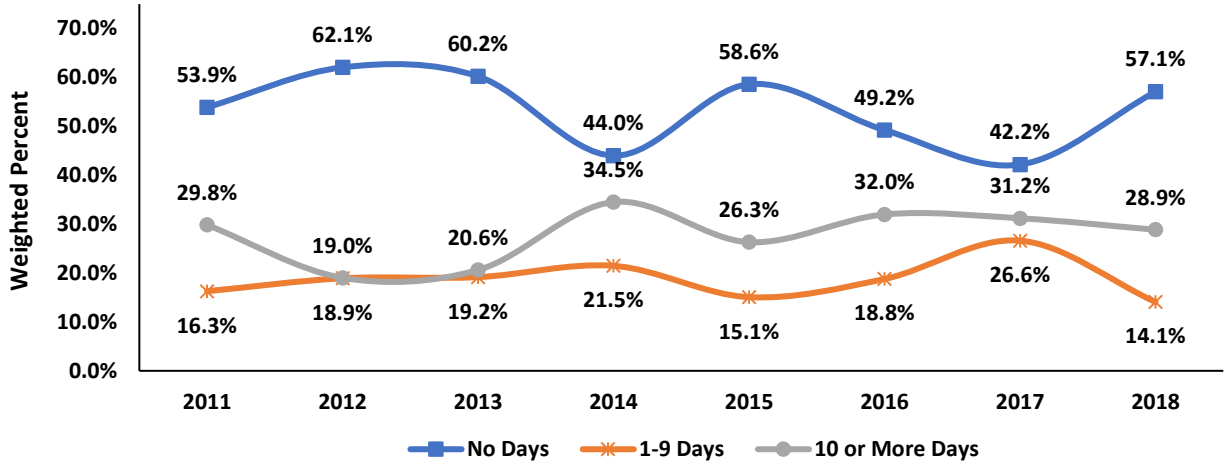
Source: Nevada Youth Risk Behavior Survey (YRBS).
Chart scaled to 35% to display differences among groups.

Among middle and high school students, mental health behaviors in Southern Nevada were not significantly different from those across Nevada statewide. More than a third of Southern Nevada high school students report feeling sad or hopeless. From 2015 to 2017, mental health behaviors in Southern Nevada did not significantly change among middle or high school students.

Behavioral Risk Factor Surveillance System (BRFSS)

BRFSS collects information on adult health-related risk behaviors. According to the Centers for Disease Control and Prevention, BRFSS is a powerful tool for targeting and building health promotion activities.

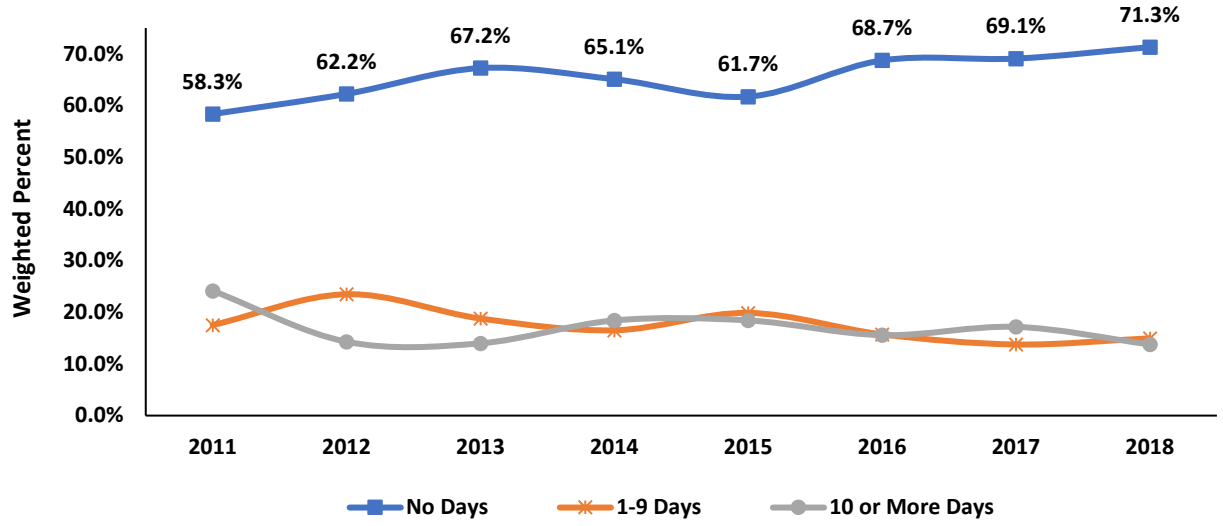
Figure 9. Percentages of Adults Who Experienced Poor Mental or Physical Health that Prevented Them from Doing Usual Activities by Days Affected, Southern Nevada, 2011-2018.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 70% to display differences among groups.

In 2018, 57.1% of Southern Nevada adult residents reported experiencing no days of poor mental or physical health that kept them from doing usual activities. However, 14.1% reported experiencing one to nine such days, while 28.9% reported experiencing 10 or more such days. These trends have remained constant since 2011 and have not significantly differed to those across Nevada statewide.

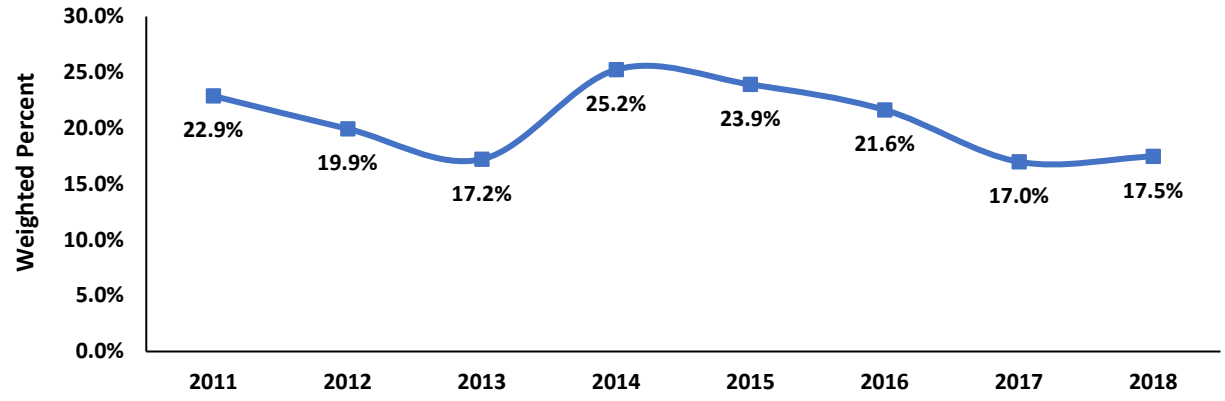
Figure 10. Percentages of Adults in Which Their Mental Health Was Not Good by Number of Days Experienced, Southern Nevada Residents, 2011-2018.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 80% to display differences among groups.

In 2018, 71.3% of Southern Nevada adult residents reported experiencing no days of unfavorable mental health in the past month, while 14.9% reported experiencing one to nine such days and 13.8% reported experiencing 10 or more such days. These trends have not significantly changed since 2011 and have remained comparable to those across Nevada statewide.

Figure 11. Percentages of Adults Who Have Ever Been Told They Have a Depressive Disorder, Including Depression, Major or Minor Depression, or Dysthymia, Southern Nevada Residents, 2011-2018.



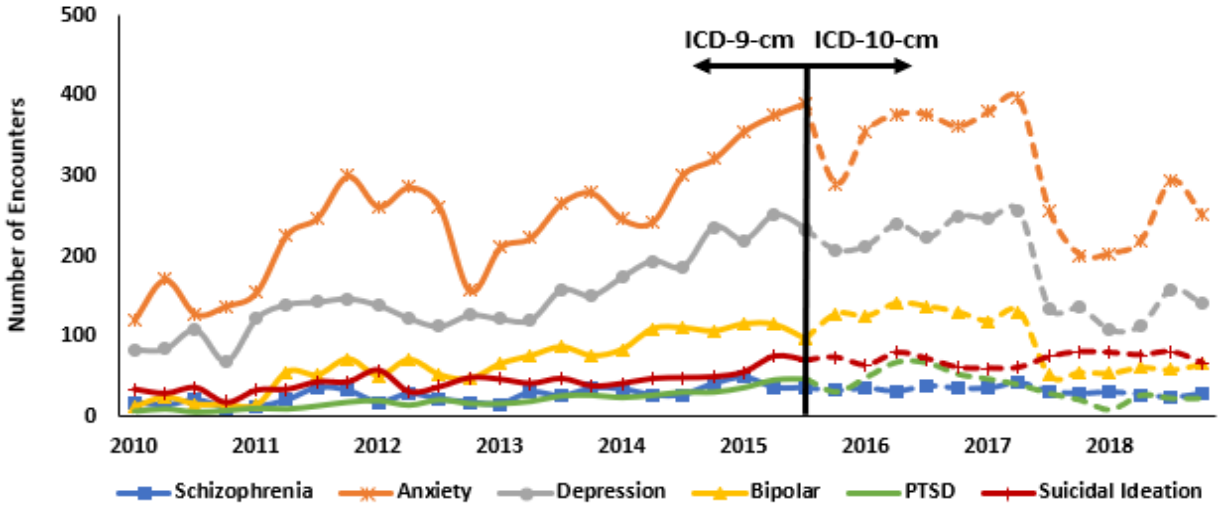
Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 20% to display differences among groups.

In 2018, 17.5% of Southern Nevada adult residents reported ever having a depressive disorder. This trend has remained constant since 2011 and has not significantly differed from those across Nevada statewide.

Hospital Emergency Department Encounters

The hospital emergency department billing data includes data for emergency room patients for Nevada's non-federal hospitals. There were 1,730 visits related to mental health disorders among Southern Nevada residents in 2018. Since an individual can have more than one diagnosis during a single emergency department visit, the following numbers reflect the number of times a diagnosis in each of these categories was given, and therefore the following numbers are not mutually exclusive.

Figure 12. Mental Health-Related Emergency Department Encounters, by Quarter and Year, Southern Nevada, 2010-2018.



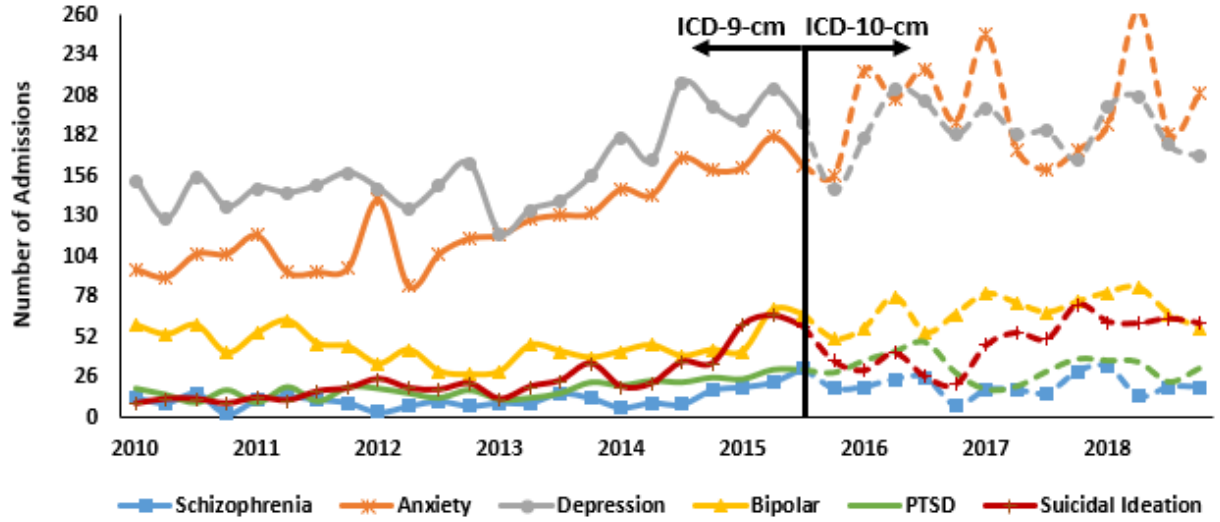
Source: Hospital Emergency Department Billing.
Categories are not mutually exclusive.
ICD-9 codes were replaced by ICD-10 codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Since 2010, anxiety has been the leading mental health-related diagnosis in emergency department encounters in Southern Nevada. Encounters related to anxiety and depression increased significantly from 2010 to 2018 in both counts and rates. In 2018, there were twice as many females (1,243.3 cases per 100,000) seen in emergency departments in Southern Nevada for depression compared to males (581.3 cases per 100,000). In 2018, Black non-Hispanics had the highest rate of emergency department encounters related to schizophrenia (789.7 cases per 100,000), anxiety (1,943.9 cases per 100,000), bipolar disorder (1,093.4 cases per 100,000), PTSD (182.2 cases per 100,000), and suicidal ideation (1,154.2 cases per 100,000).

Hospital Inpatient Admissions

The hospital inpatient billing data includes data for patients discharged from Nevada's non-federal hospitals. There were 1,655 inpatient admissions related to mental health disorders among Nevada residents in 2018. Since an individual can have more than one diagnosis during a single inpatient admission, the following numbers reflect the number of times a diagnosis was given and therefore the following numbers are not mutually exclusive.

Figure 13. Mental Health-Related Inpatient Admissions, by Quarter and Year, Southern Nevada, 2010-2018.



Source: Hospital Inpatient Billing.
Categories are not mutually exclusive.
ICD-9 codes were replaced by ICD-10 codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

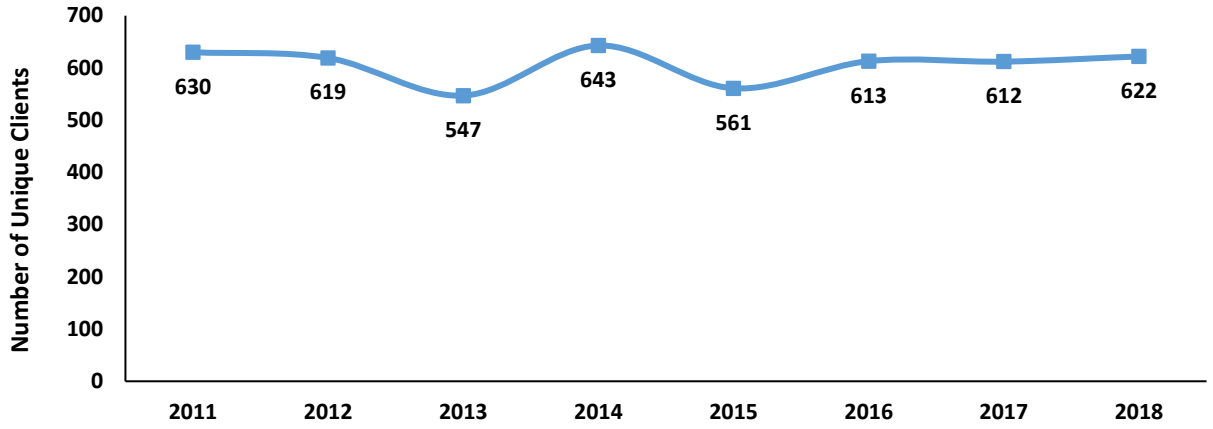
Unlike emergency department encounters, depression was the leading diagnosis for mental health-related inpatient admissions in Southern Nevada from 2010 to 2015. Since 2010, admissions related depression, anxiety, and suicidal ideation have increased in Southern Nevada. In 2018, there were twice as many Southern Nevada females seen for depression compared to males. In 2018, Black non-Hispanics in Southern Nevada had the highest rate of inpatient admissions for bipolar disorder (607.5 cases per 100,000) and suicidal ideation (546.7 cases per 100,000).

Suicidal ideation increased from 2010 to 2018, but it should be noted that in 2016, inpatient admissions in Southern Nevada dropped and then continued to increase in 2017. This may be due to ICD-9-CM conversion to ICD-10-CM or another change in medical billing.

State-Funded Mental Health Services (Avatar)

State-funded mental health facilities are divided into Northern Nevada Adult Mental Health Services (NNAMHS), Southern Nevada Adult Mental Health Services (SNAMHS), and Rural Clinic and Community Health Services. Different services that mental health facilities provide include inpatient acute psychiatric, mobile crisis, outpatient counseling, service coordination, and case management.

Figure 14. Unique Clients* Served at State-Funded Mental Health Clinics, Southern Nevada, 2011-2018.



Source: Avatar.
**A client is counted only once per year. Clients may be counted more than once across years.*

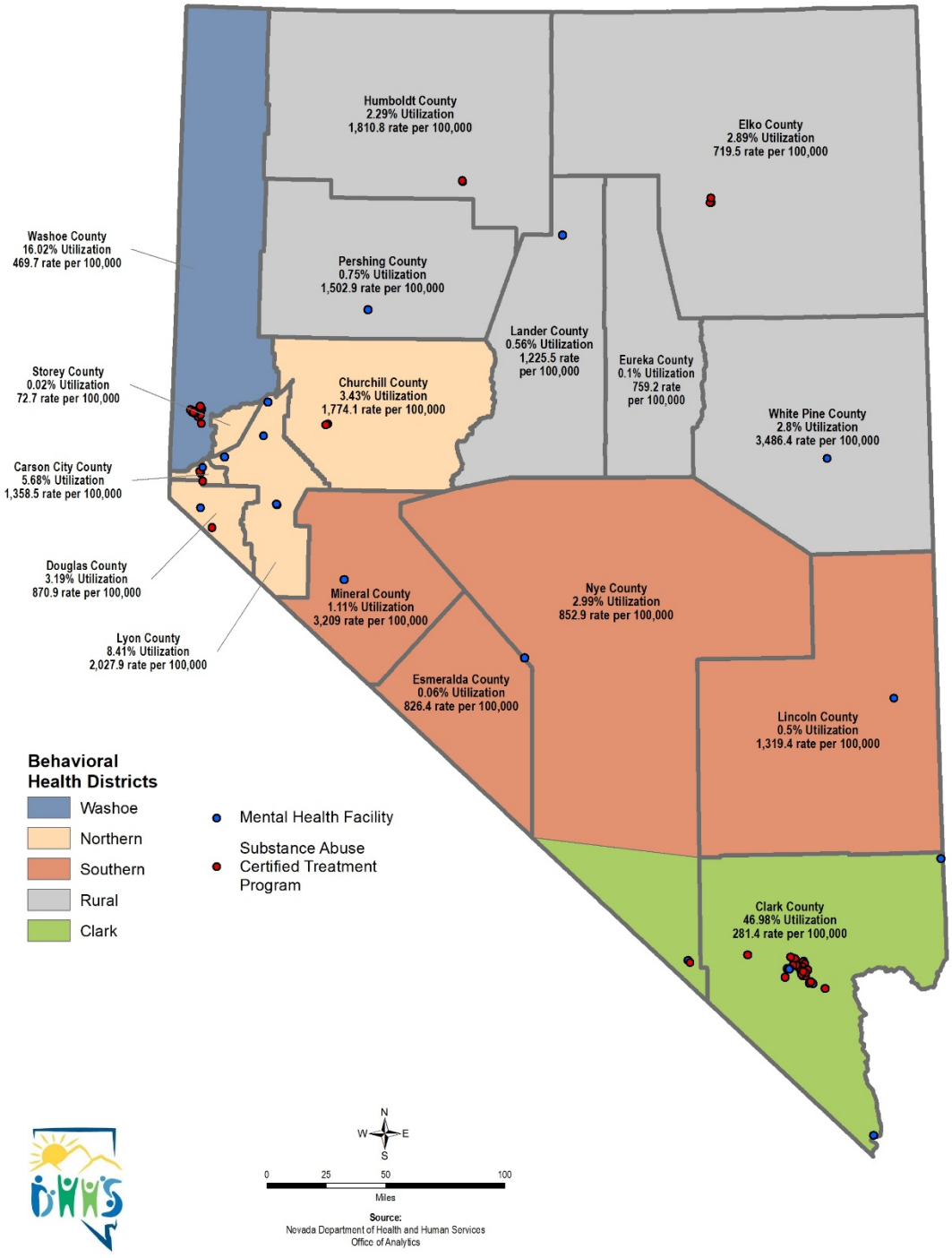
The number of unique clients served* by state-funded mental health facilities in Southern Nevada has remained constant from 2011 (630 clients) to 2018 (622 clients). The Affordable Care Act (ACA) went into effect in 2014. Therefore, many Nevada residents are now able to access non-state-funded facliites through the expansion of Medicaid.

Figure 15. Top Mental Health Clinic Services by Number of Patients Served*, Southern Nevada, 2012-2018.

Program	2011	2012	2013	2014	2015	2016	2017	2018
Pahrump Medication Clinic	207	218	202	240	199	250	248	233
Pahrump Outpatient Counseling	272	266	173	137	117	143	148	122
Pahrump Outpatient Screening	9	3	58	179	144	184	155	112
Pahrump RMH	91	80	125	54	27	13	9	25
Hawthorne Outpatient Counseling	61	55	51	42	34	31	64	83
Hawthorne Medication Clinic	45	41	41	32	37	56	58	90
Pahrump Service Coordination	79	92	48	47	30	28	27	16
SNAMHS Adult Medication Clinic	50	45	42	45	32	28	15	14

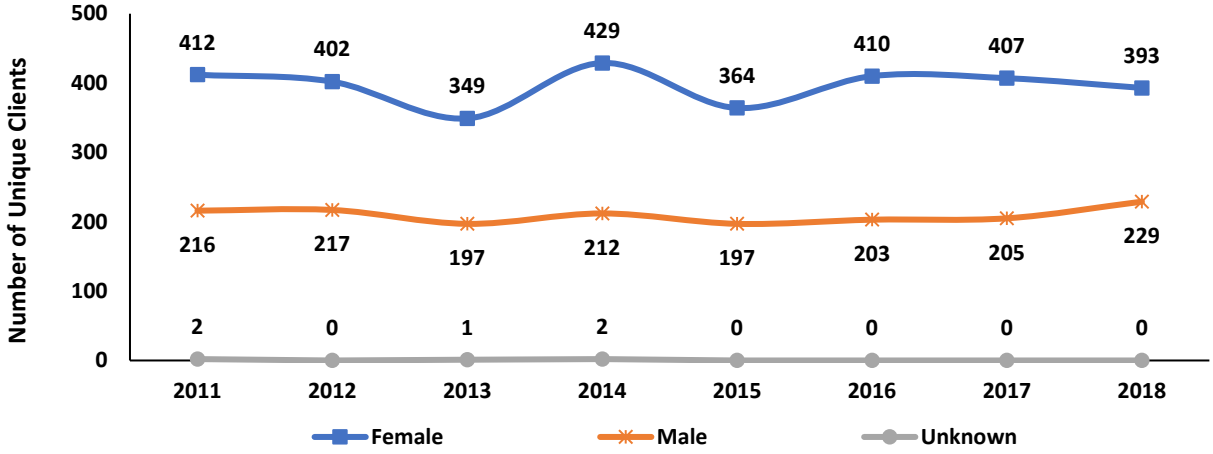
Source: Avatar.
~Program no longer active.
**A client is counted only once per year. Clients may be counted more than once across years.*

Figure 16. State-Funded Mental Health Clinics Utilization by County, 2018



Source: Avatar.
**A client is counted only once per year. Clients may be counted more than once across years.*
***Percent (%)**: Number of clients who utilize mental health services in that county, divided by total utilization.*
***Rate**: Number of clients who utilize mental health services in that county divided by county population per 100,000 people.*

Figure 17. State-Funded Mental Health Clinics Utilization* by Gender, Southern Nevada, 2011-2018.

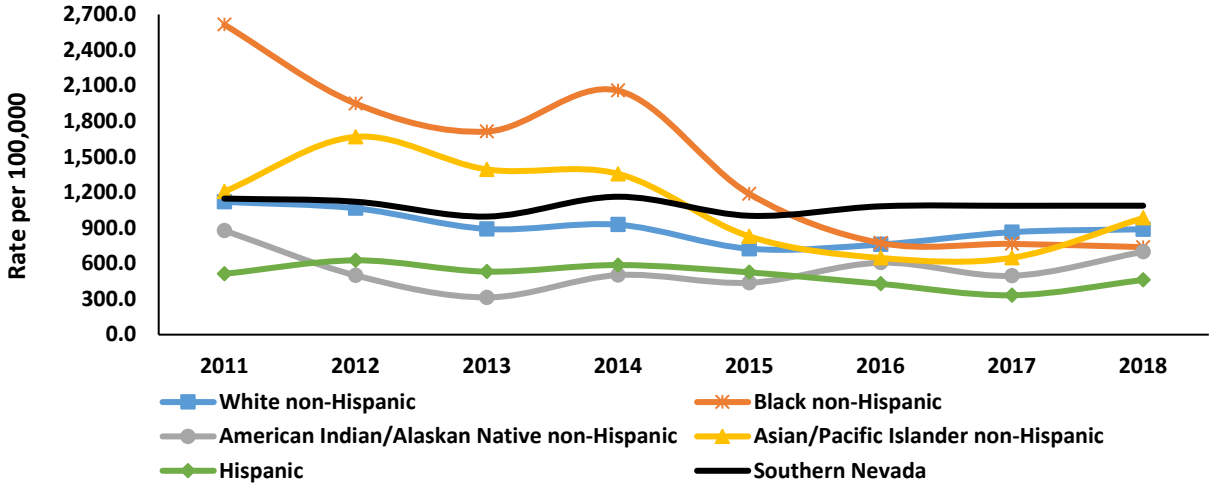


Source: Avatar.
**A client is counted only once per year. Clients may be counted more than once across years.*

From 2011 to 2018, females have significantly utilized state-funded mental health clinics more than males in Southern Nevada. In 2018, 1,388.2 females per 100,000 female population utilized state-funded mental health clinics compared to 783.0 males per 100,000 male population in Southern Nevada.

Of patients that utilized state-funded mental health services, the most common age group was 45-54-year-olds, on average accounting for 23.3% of all patients. On average, high school graduates accounted for 18.8% of the patients, followed by those with some college education at 12.7%.

Figure 18. State-Funded Mental Health Clinics Utilization* by Race/Ethnicity, Southern Nevada, 2011-2018.



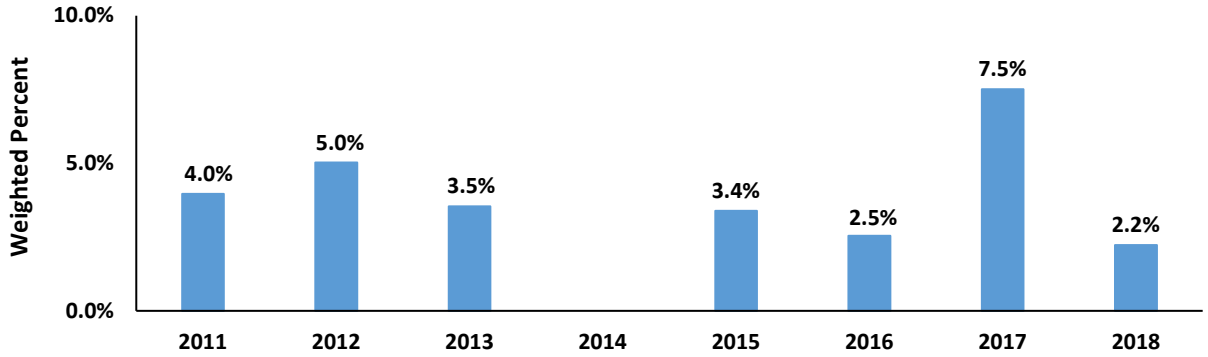
Source: Avatar and the Nevada State Demographer (vintage 2017).
Race "Unknown" not included in analysis.
**A client is counted only once per year. Clients may be counted more than once across years.*

From 2011 to 2018, the Black non-Hispanic population has had, on average, the highest utilization rate (1,474.4 cases per 100,000), while the Hispanic population has had the lowest rate (500.4 cases per 100,000). In 2018, roughly 25% of clients serverd report unknown race/ethncity.

Suicide

While suicide is not a mental illness, one of the most common causes of suicide is mental illness. Risk factors for suicide include depression, bipolar disorder, and personality disorders. Of those who attempt or die from suicide, many have a diagnosed mental illness.

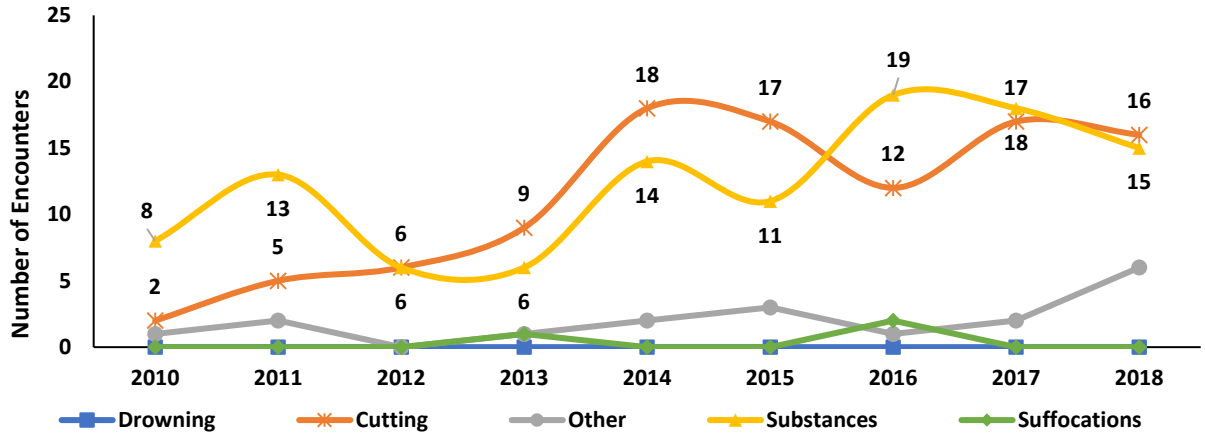
Figure 19. Percentage of Southern Nevada Adult Residents Who Have Seriously Considered Attempting Suicide, 2011-2018.



Source: Behavioral Risk Factor Surveillance System (BRFSS).
Charts scaled to 10% to display differences among groups.
Indicator was not measured in 2014.

Since 2011, the percentage of Southern Nevada adult residents who have seriously considered attempting suicide in the past year has not significantly changed, remaining at 2.2% in 2018. These trends were not significantly different to those across Nevada statewide.

Figure 20. Suicide Attempt Emergency Department Encounters by Method, Southern Nevada Residents, 2010-2018.



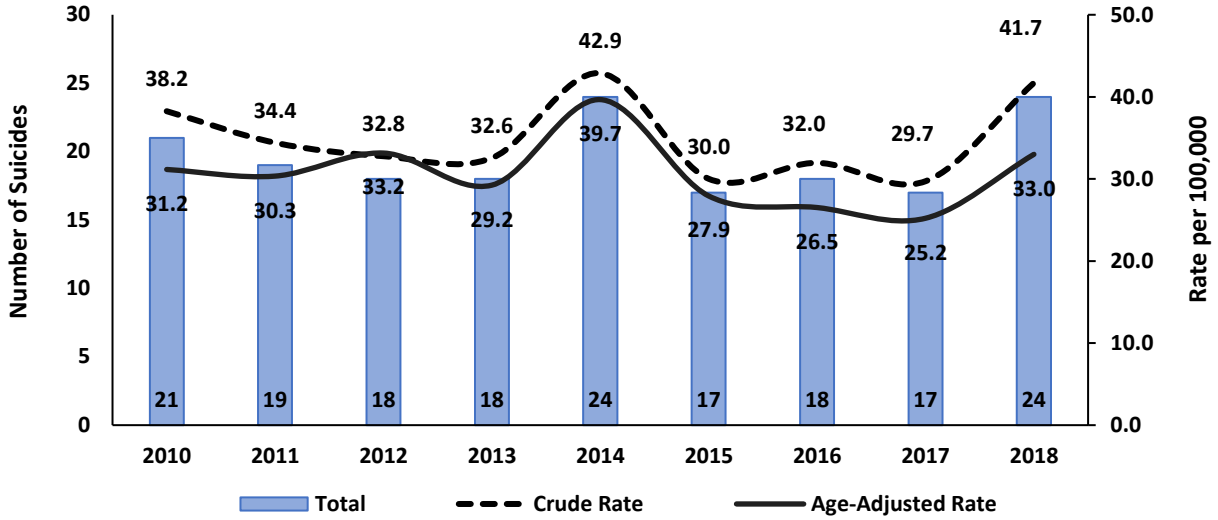
Source: Hospital Emergency Department Billing.
ICD-10 codes replaced ICD-9 codes in last quarter of 2015, therefore data prior to that may not be directly comparable.
A person can be included in more than category and therefore the counts above are not mutually exclusive.

Attempted suicides, where the patient did not expire at the hospital, have increased significantly in Southern Nevada from 2010-2018 of emergency department encounters from 2010 to 2018. The most common method for attempted suicides is substance or drug overdose and cutting attempts which is

different from the rest of the state where substance or drug overdose is the most common method of attempted suicides.

Inpatient admissions for attempted suicides where the patient was admitted and did not expire at the hospital, have increased from 1 to 2 instances each year in 2010-2015 to 10 in 2018, of which 50% the method involved substances.

Figure 21. Number of Suicides and Rates, Southern Nevada Residents, 2010-2018.



Source: Nevada Electronic Death Registry System.

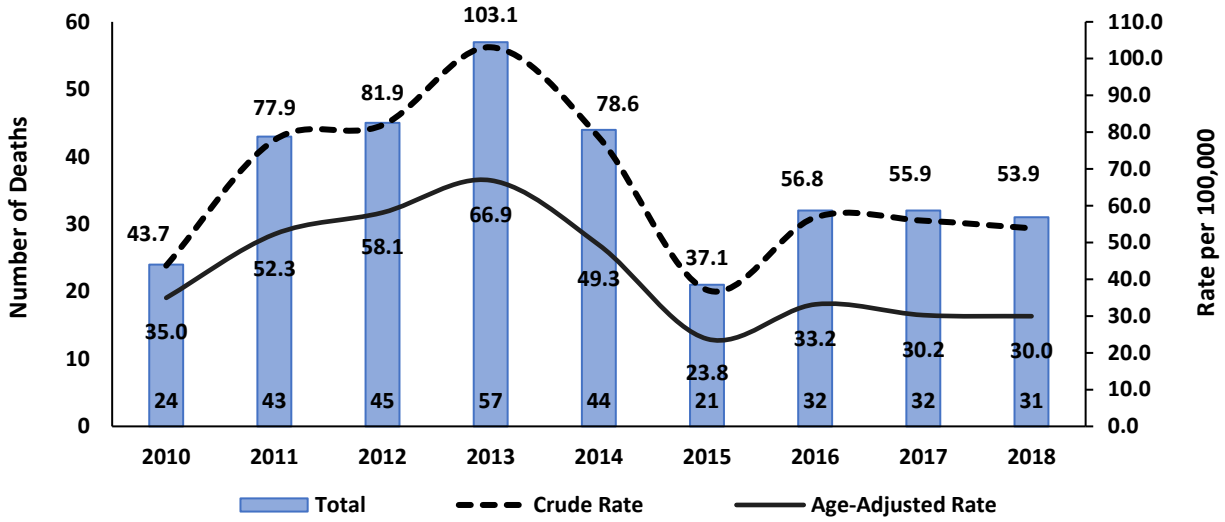
The age-adjusted suicide rate for 2018 in Nevada was 33.0 per 100,000 population. Rate both age-adjusted and crude rates have remained steady from 2010-2018. In 2018, there were 24 suicides in Southern Nevada, with 7 ages 65-74, and 22 of the 24 were White non-Hispanic at 37.2 per 100,000 population.

Mental Health-Related Deaths

Mental health-related deaths are deaths with the following ICD-10 codes groups listed as a contributing cause of death (F00-F99 excluding F10-F19):

- Organic, including symptomatic, mental disorders; Schizophrenia, schizotypal and delusional disorders
- Mood [affective] disorders
- Neurotic, stress-related and somatoform disorders
- Behavioral syndromes associated with physiological disturbances and physical factors
- Disorders of adult personality and behavior
- Mental retardation
- Disorders of psychological development
- Behavioral and emotional disorders with onset usually occurring in childhood and adolescence; Unspecified mental disorder

Figure 22. Mental Health-Related Deaths and Rates, Southern Nevada Residents, 2010-2018.



Source: Nevada Electronic Death Registry System.

The age-adjusted mental health-related deaths rate for 2018 in Southern Nevada was 30.0 per 100,000 population. Rate both age-adjusted and crude have remained steady from 2010-2018. In 2018, there were 31 deaths relating to mental health in Southern Nevada, with 18 over aged 84, and 30 of the 31 were White non-Hispanic at 31.1 per 100,000 population.

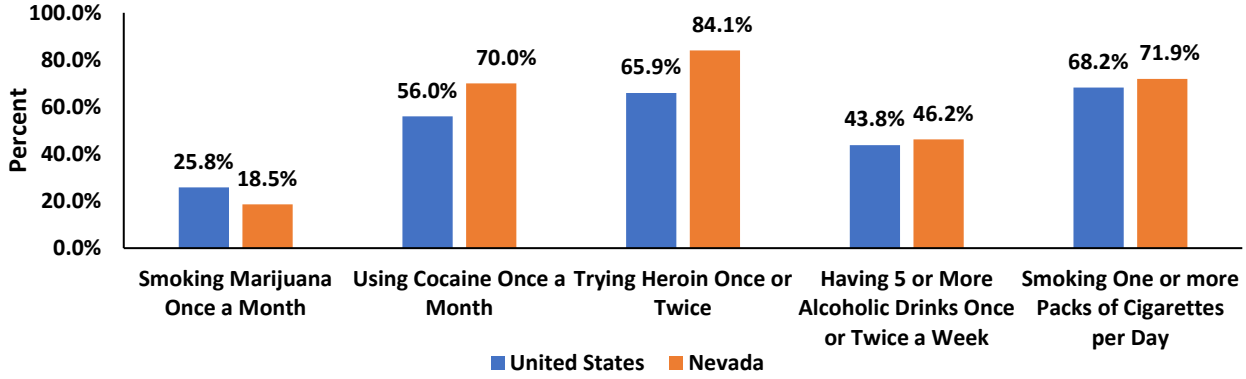
Substance Abuse

Substance use data are collected from hospital billing data, vital records data, and through national survey data including Substance Abuse and Mental Health Service Administration, BRFSS and YRBS.

National Survey on Drug Use and Health

The Substance Abuse and Mental Health Services Administration (SAMHSA) sponsors the National Survey on Drug Use and Health (NSDUH). The survey tracks trends of illicit drug, alcohol, and tobacco use, as well as mental health issues throughout the United States.

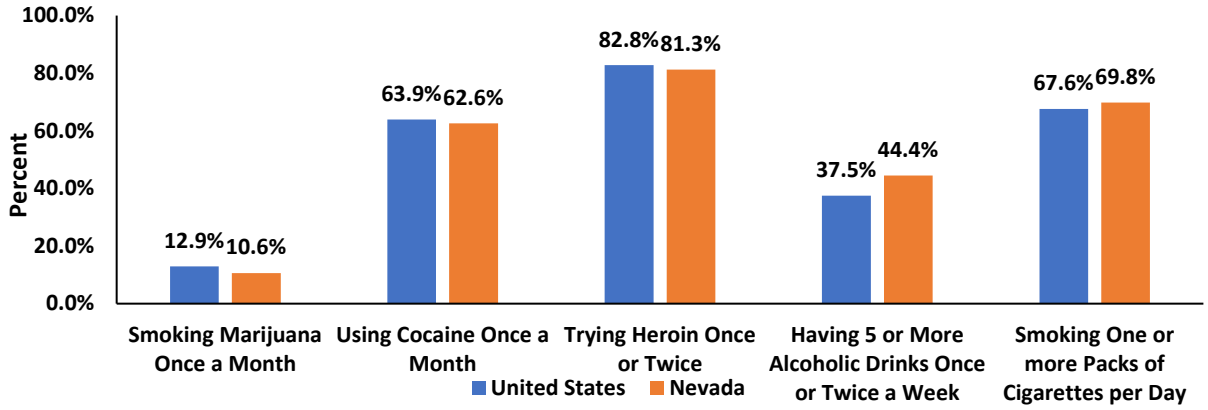
Figure 23. Perceptions of Great Risk from Alcohol or Substance, Ages 12-17, Nevada and the United States, 2017.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2011-2017.
Chart scaled to 15% to display differences among groups.

Nevadan teens perceived risk for using cocaine, trying heroin, drinking more than 5 drinks and smoking is greater than the United States with perceived risk. Whereas young adults perceived risk is lower than the united states for using cocaine and trying heroin.

Figure 24. Perceptions of Great Risk from Alcohol or Substance, Ages 18-25, Nevada and the United States, 2016-2017.

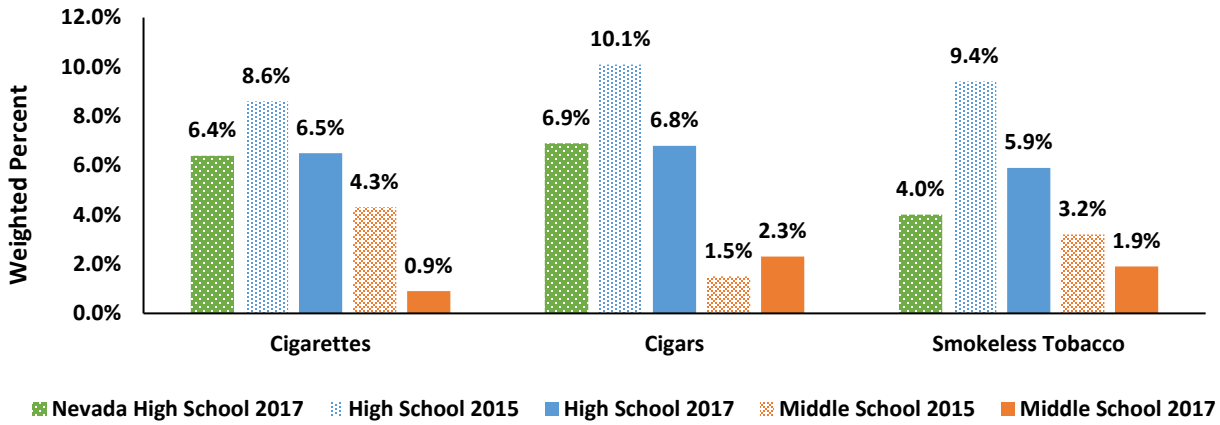


Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010-2016.
Chart scaled to 15% to display differences among groups.

Youth Risk Behavior Survey (YRBS)

The YRBS monitors six categories of health-related behaviors that contribute to leading causes of death and disabilities among youth and adults. Nevada high school and middle school students are surveyed during the odd years. In 2017, 445 high school and 458 middle school students participated in the YRBS. The University of Nevada, Reno maintains the YRBS data and publishes data on each survey. For more information on the YRBS survey, please go to the following site: UNR YRBS.

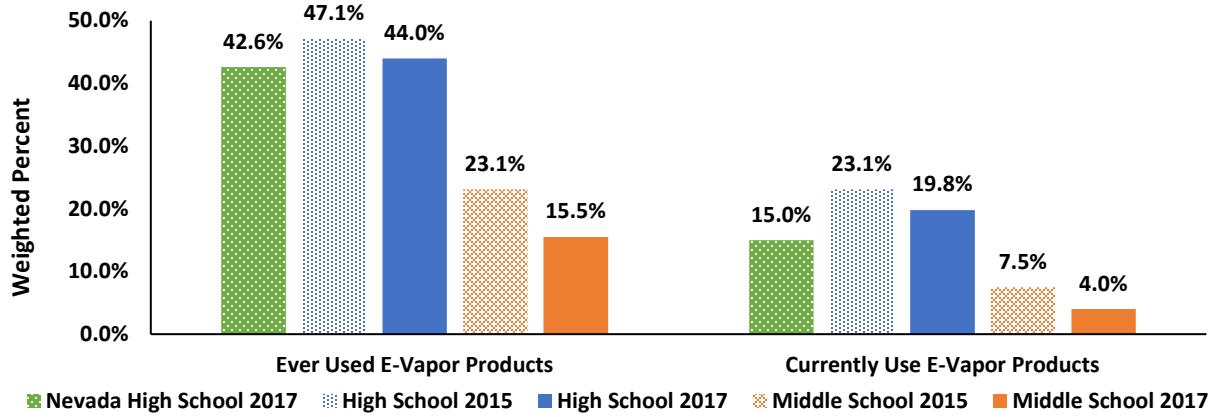
Figure 25. Current Tobacco Use, Southern Nevada Middle and High School Students, 2015 and 2017, and Nevada Statewide High School Students, 2017.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 14% to display differences among groups.

There is no significant change from 2015 and 2017 in both middle and high schools. Of Southern Nevada high school students in 2017, 6.5% have smoked cigarettes at one time; this is slightly higher than the state at 6.4%.

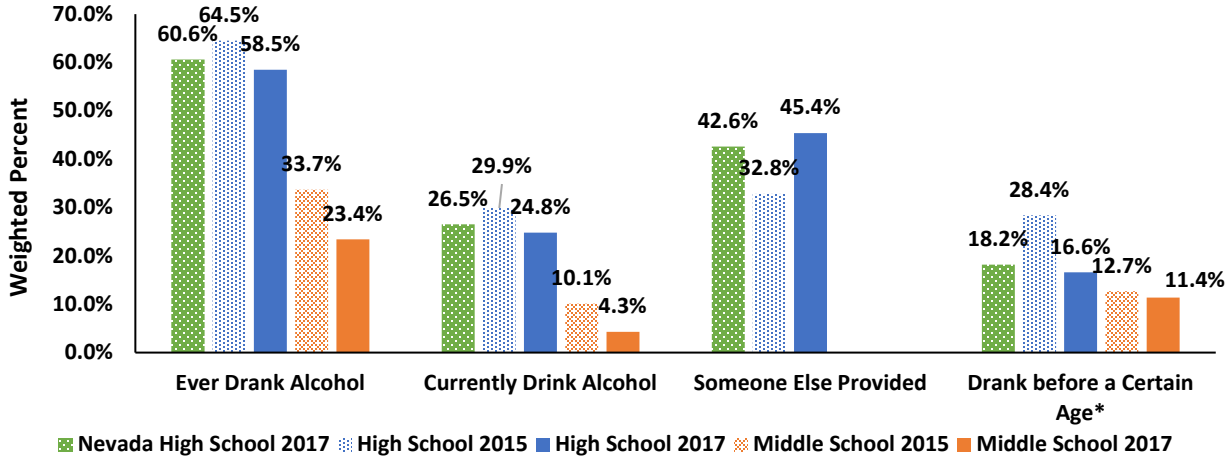
Figure 26. Electronic Vapor Product Use, Southern Nevada Middle and High School Students, 2015 and 2017, and Nevada Statewide High School Students, 2017.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 60% to display differences among groups.

There is no significant difference from 2015 to 2017 with electronic cigarette use in both Southern Nevada high school and middle school students. In 2017, 44.0% of Southern Nevada high students have ever used electronic products, which is similar to Nevada at 42.6%.

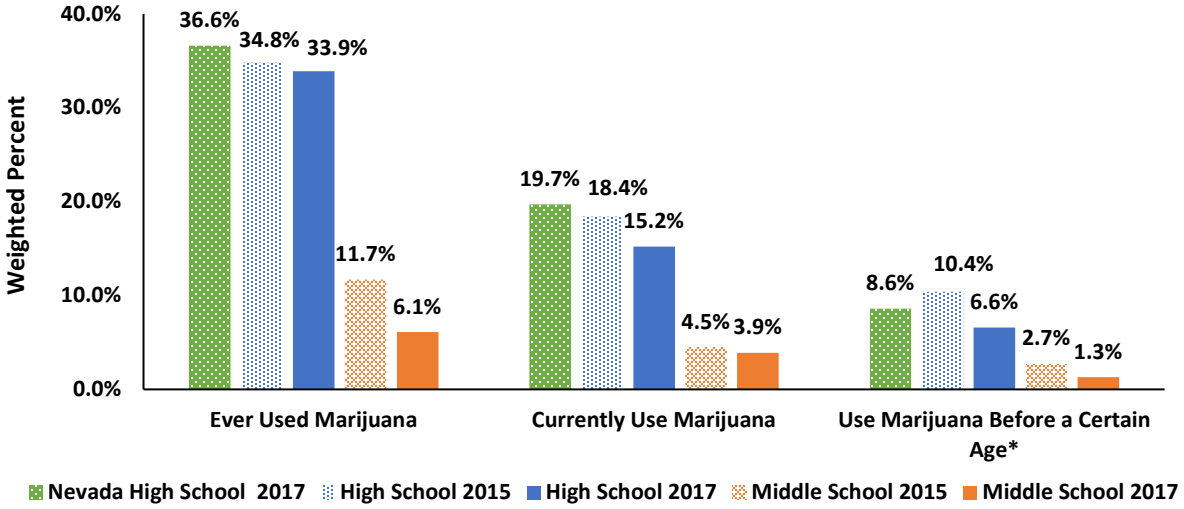
Figure 27. Alcohol Use, Southern Nevada Middle and High School Students, 2015 and 2017, and Nevada Statewide High School Students, 2017.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 70% to display differences among groups.
**In high school students, if they ever drank before age 13, and in middle school students if they ever drank before age 11.*

There was a significant decrease in both middle school and high school students from both ever drinking alcohol and current use between 2015 and 2017. Out of Southern Nevada high school students, 58.5% have drank alcohol before, 24.8% currently drink alcohol and 16.6% have had alcohol before the age of 13 with is slightly higher than Nevada at 18.2%.

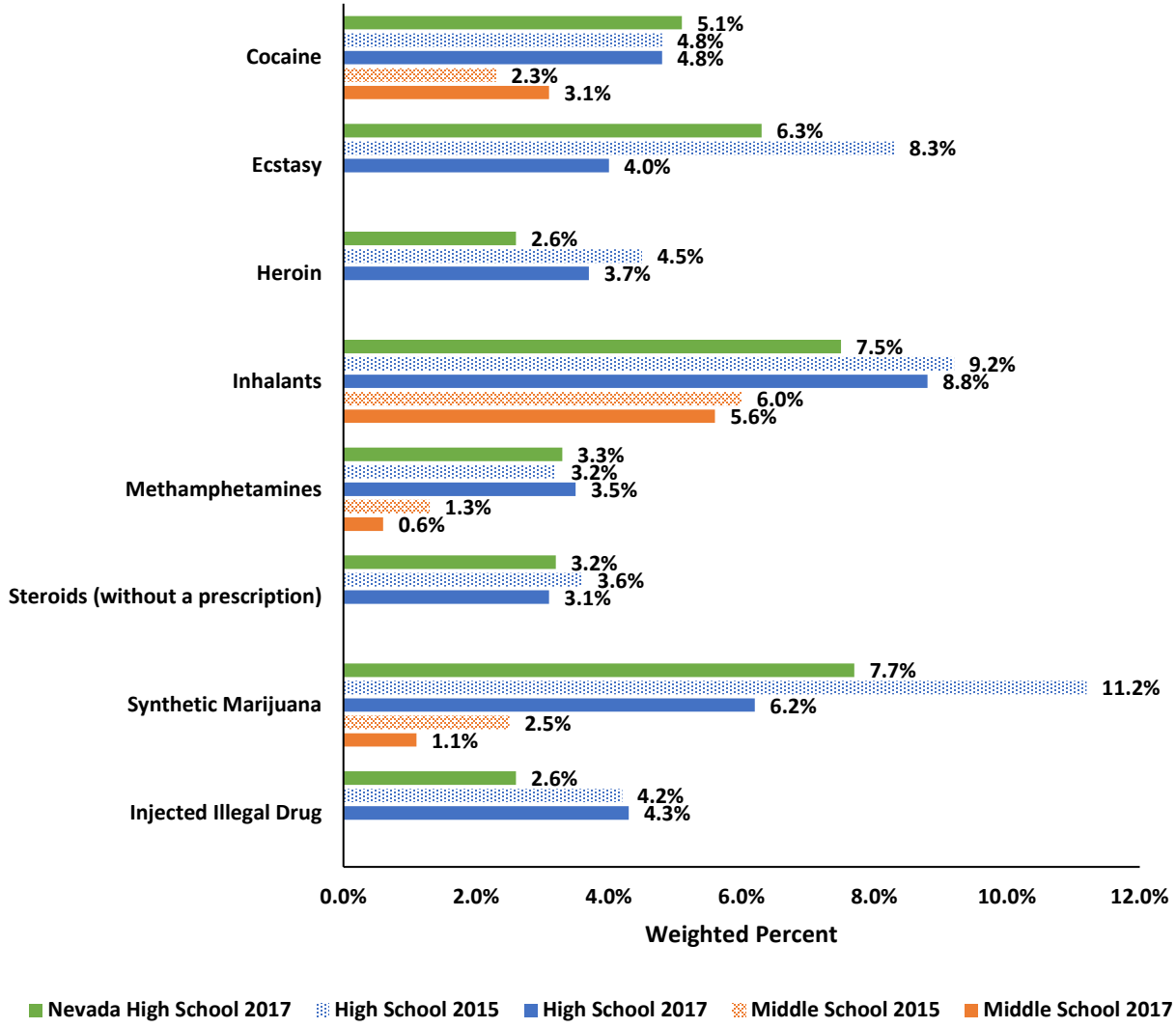
Figure 28. Marijuana Use, Southern Nevada Middle and High School Students, 2015 and 2017, and Nevada Statewide High School Students, 2017.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 45% to display differences among groups.
**In high school students, if they ever used marijuana before age 13, and in middle school students if they ever used marijuana before age 11.*

From 2015 to 2017, the percentage of ever using marijuana, current use of marijuana, and use of marijuana before a certain age has decrease for both Southern Nevada high school and middle school students. The largest decrease was in ever using marijuana for middle school students, decreasing by 5.6% over the two-year period. Of Southern Nevada high school students, 15.2% reported current use of marijuana in 2017, which is slightly lower than the state percent of 19.7%.

Figure 29. Lifetime Drug Use, Southern Nevada Middle and High School Students, 2015 and 2017, and Nevada Statewide High School Students, 2017.



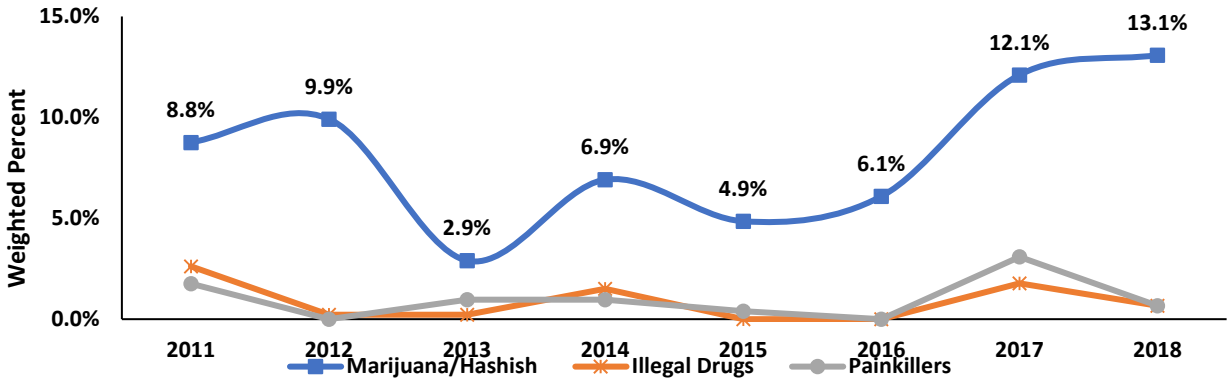
Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 12% to display differences among groups.

There was a significant decrease for life synthetic marijuana use from 2015 to 2017. Drug use among high school students is generally higher in Southern Nevada than the state. Of Southern Nevada high school students, 8.8% have use inhalants, while the state percentage is lower at 7.5%.

Behavioral Risk Factor Surveillance System

BRFSS collects information on adult health-related risk behaviors. According to the Centers for Disease Control and Prevention, BRFSS is a powerful tool for targeting and building health promotion activities. The survey has questions focusing on substance use including illegal drug use, e-cigarettes and drunkenness.

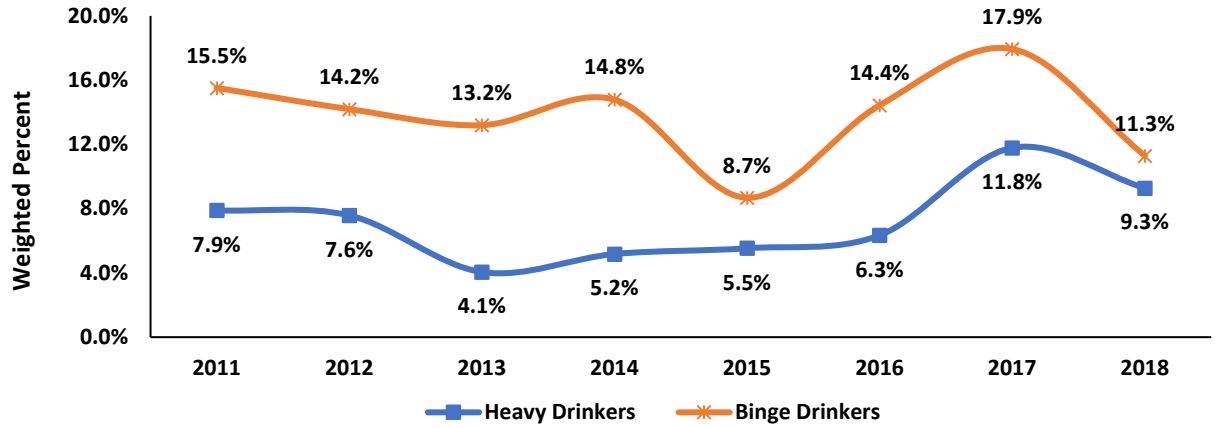
Figure 30. Percentage of Southern Nevada Adult Residents Who Used Illegal Substances, Marijuana/Hashish or Painkillers to Get High in the Last 30 Days, 2011-2018.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 10% to display differences among groups.

In 2018, 13.1% of Southern Nevada adults reported having used marijuana or hashish in the past 30 days. Since marijuana became legalized for recreational use in Nevada in 2017, cannabis usage is expected to increase. Usage of marijuana or hashish in Southern Nevada increased by 6.0% from 2016 to 2017. Only 0.7% of Southern Nevada adults reported using illegal drugs in the past month, and only 0.7% reported using painkillers to get high in the past month.

Figure 31. Percentage of Southern Nevada Adult Residents Who are Considered Binge Drinkers or Heavy Drinkers, 2011-2018.

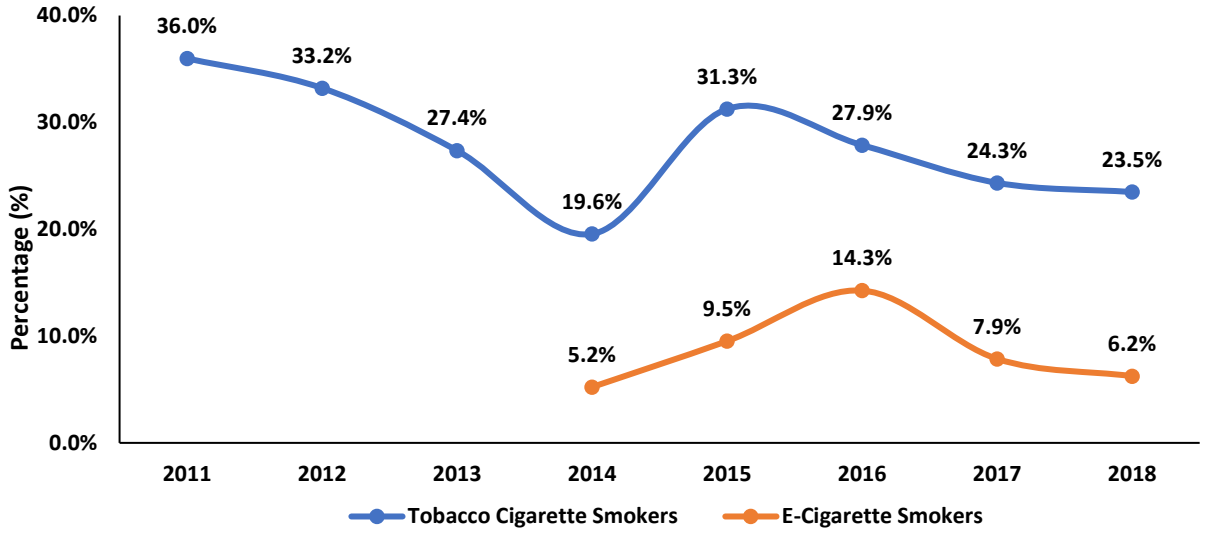


Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 20% to display differences among groups.
Heavy drinkers (adult men having more than 14 drinks per week and adult women having more than seven drinks per week).
Binge drinkers (adult men having five or more drinks on one occasion, adult women having four or more drinks on one occasion).

Binge drinking is defined in men as having five or more alcoholic beverages and woman having 4 or more alcoholic beverages on an occasion. Heavy drinking is defined in men as consuming more than two alcoholic beverages, and in women more than one alcoholic beverage per a day.

In 2018, 6.3% Southern Nevada adult men were classified as heavy drinkers, compared to 6.2% of all adult men across Nevada. Of Southern Nevada Adults, 9.3% are considered to be heavy drinkers in 2018, while the state percentage is 5.9%.

Figure 32. Percentage of Southern Nevada Adult Residents Who are Current Cigarette or E-Cigarette Smokers, 2011-2018.



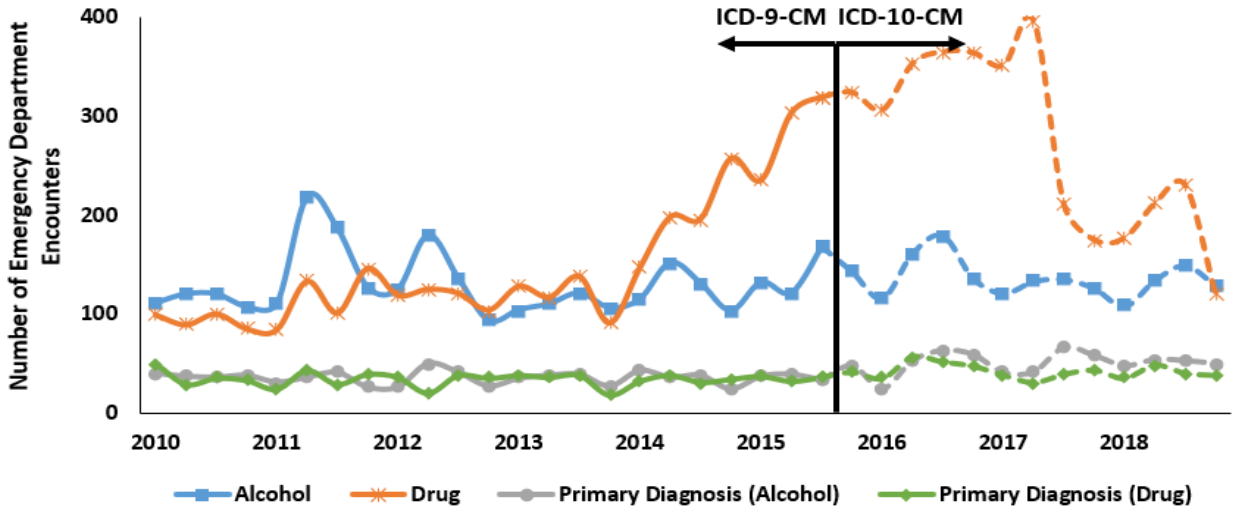
Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 20% to display differences among groups.
E-cigarette use was not collected until 2014.

In 2018, 23.5% of Southern Nevada adults are current cigarette smokers, which has decreased significantly since 2011. E-cigarette usage in Southern Nevada adults peaked at 14.3% in 2016, only to decrease to 6.2% in 2018, making e-cigarette usage in Southern Nevada similar to the state (6.1%).

Hospital Emergency Department Encounters

The hospital emergency department billing data provides health billing data for emergency departments patients for Nevada's non-federal hospitals. Since an individual can have more than one diagnosis during a single emergency department visit, the following numbers are not mutually exclusive.

Figure 33. Alcohol and Drug-Related Emergency Department Encounters by Quarter and Year, Southern Nevada, 2010-2018.

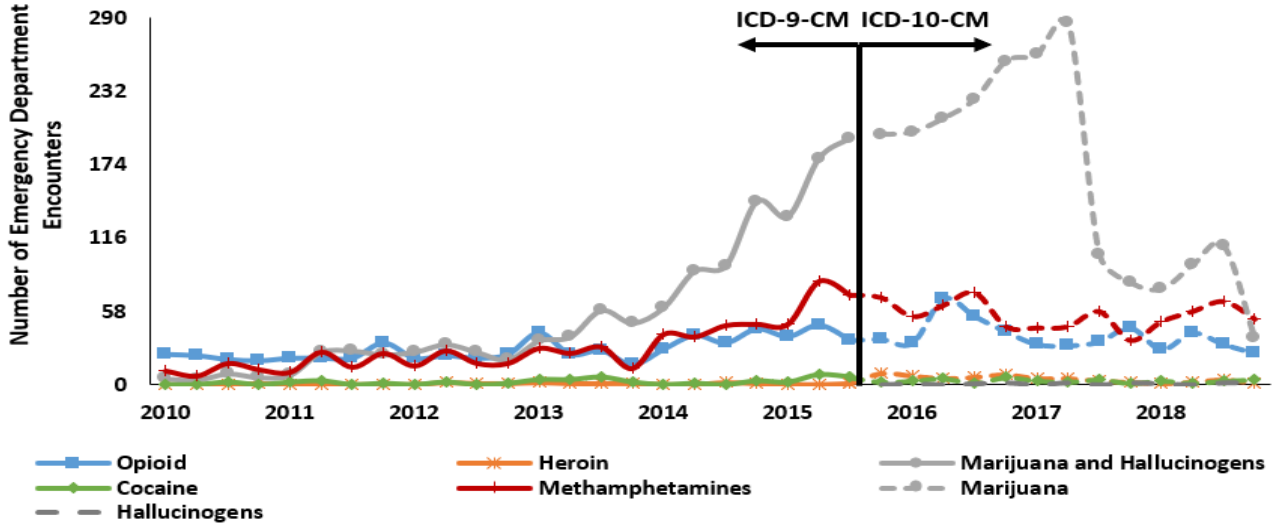


Source: Hospital Emergency Department Billing.
Categories are not mutually exclusive.
ICD-9 codes were replaced by ICD-10 codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

The "primary diagnosis" is the condition established to be chiefly responsible for the emergency department visit. The "alcohol" and "drug" categories are for any visits where alcohol/drugs were listed in any of the diagnoses.

Alcohol visits were more common than drug visits until 2014, where drugs visits to the emergency department surpassed alcohol and have remained higher through 2018. In 2018, there were a total of 1,259 alcohol and drug-related emergency department encounters in Southern Nevada. Out of this number, 205 were alcohol-related (primary diagnosis) and 161 were drug-related (primary diagnosis).

Figure 34. Drug-Related Emergency Department Encounters by Drug and Quarter and Year, Southern Nevada, 2010-2018.



Source: Hospital Emergency Department Billing.
Categories are not mutually exclusive.

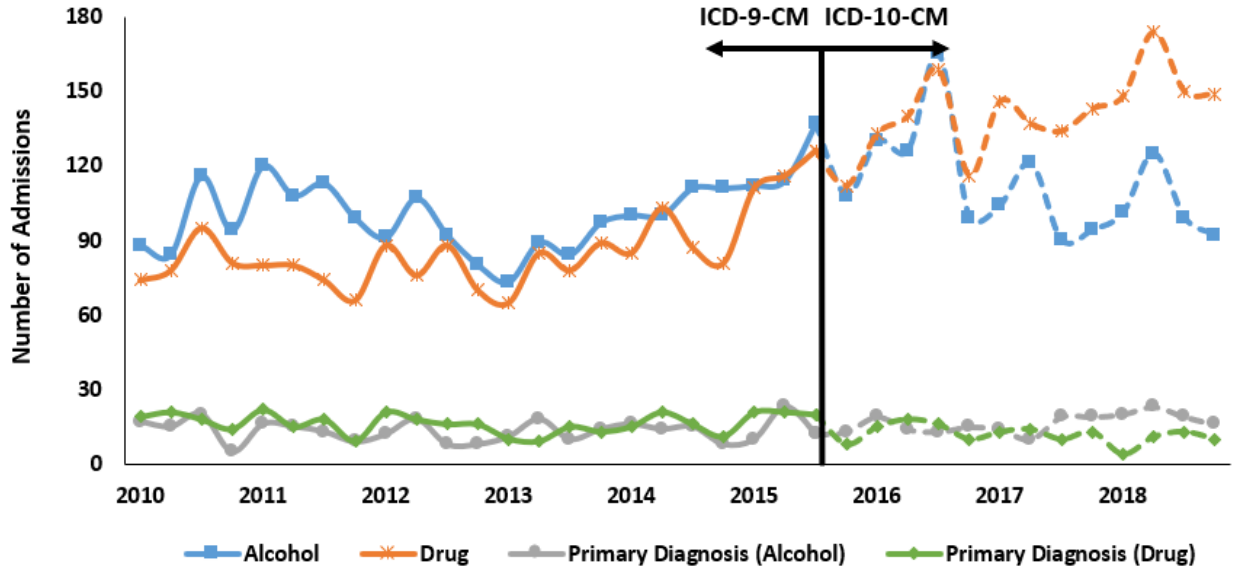
ICD-9 codes were replaced by ICD-10 codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Hallucinogens and marijuana were grouped together for ICD-9-CM, but in 2015 were separated into their own groups in the ICD-10-CM codes. Marijuana and methamphetamine drug use rates were significantly higher in 2018 than in 2010. In 2018, marijuana was the most common drug-related emergency department encounter in Southern Nevada, followed by methamphetamines and opioids.

Hospital Inpatient Admissions

The hospital inpatient admission billing data provides health billing data for patients admitted to hospital for longer than a 24-hour period. In 2018, more people were admitted into Nevada hospitals for drug-related issues than alcohol related issues. Of the 952 alcohol and drug-related admissions in Southern Nevada, 417 were alcohol-related and 621 were drug-related.

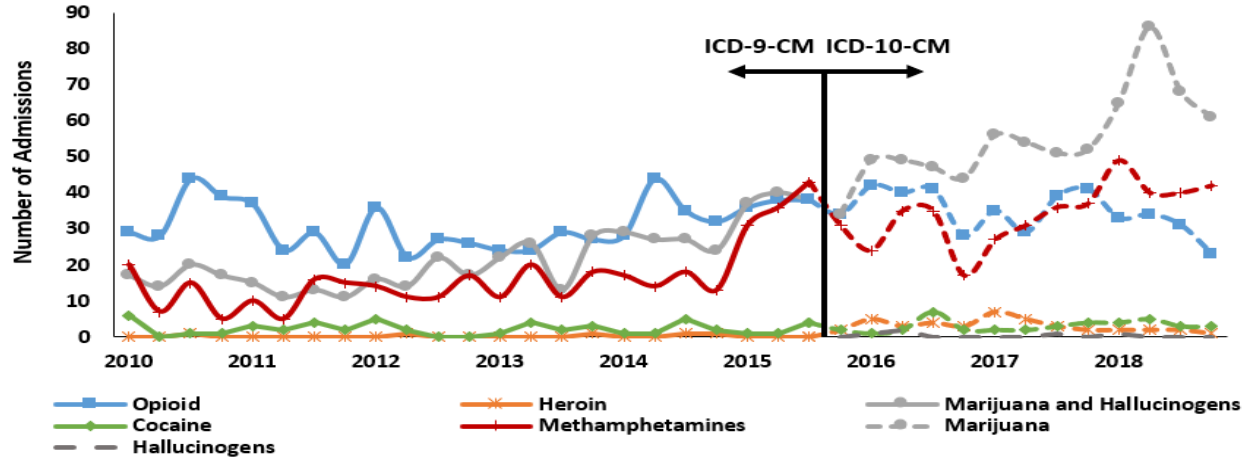
Figure 35. Alcohol and/or Drug-Related Inpatient Admissions by Quarter and Year, Southern Nevada, 2010-2018.



Source: Hospital Inpatient Billing.
Categories are not mutually exclusive.
ICD-9 codes were replaced by ICD-10 codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Alcohol-related admissions were more common than drug visits until 2015 where drug-related admissions started resembling alcohol admission. Drug-related admissions surpassed alcohol admissions by the end of 2016 and have remained higher through 2018.

Figure 36. Drug-Related Inpatient Admissions by Quarter and Year, Southern Nevada, 2010-2018.



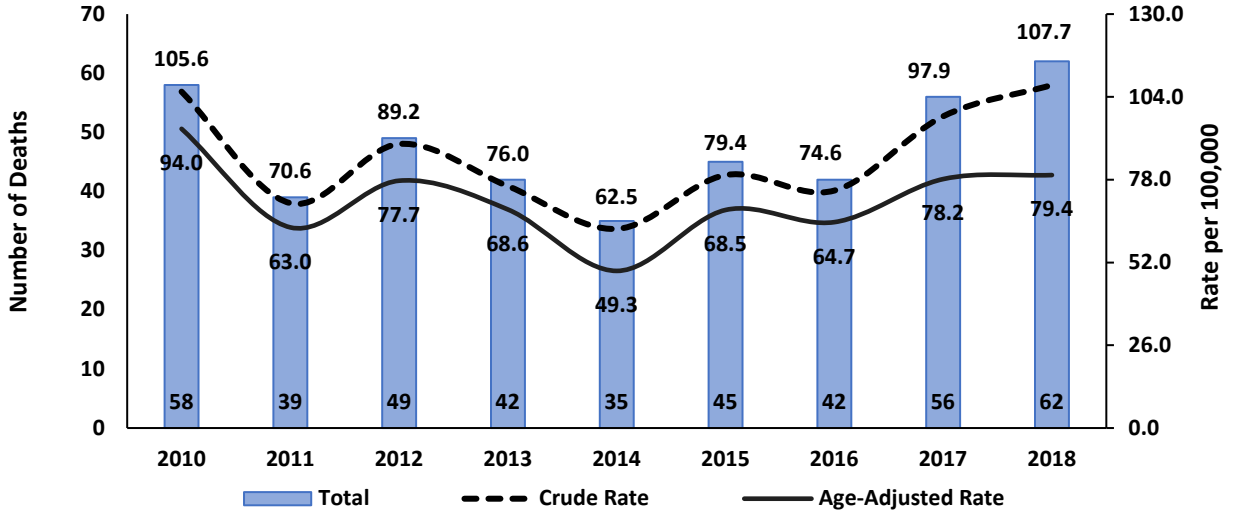
Source: Hospital Inpatient Billing.
Categories are not mutually exclusive.
ICD-9 codes were replaced by ICD-10 codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Hallucinogens and marijuana were grouped together for ICD-9-CM, but in 2015 were separated into their own groups in the ICD-10-CM codes. Methamphetamine inpatient admission increased significantly from 2017 to 2018, while opioid inpatient admissions have decreased slightly from 2017 to 2018.

Alcohol and/or Drug-Related Deaths

Alcohol and/or drug-related deaths include deaths where alcohol/drugs are listed as the cause of death. In previous reports, contributing causes of death for alcohol/drugs were included; therefore, counts will be lower than in the previous report. In 2018, 62 deaths were related to alcohol and drugs.

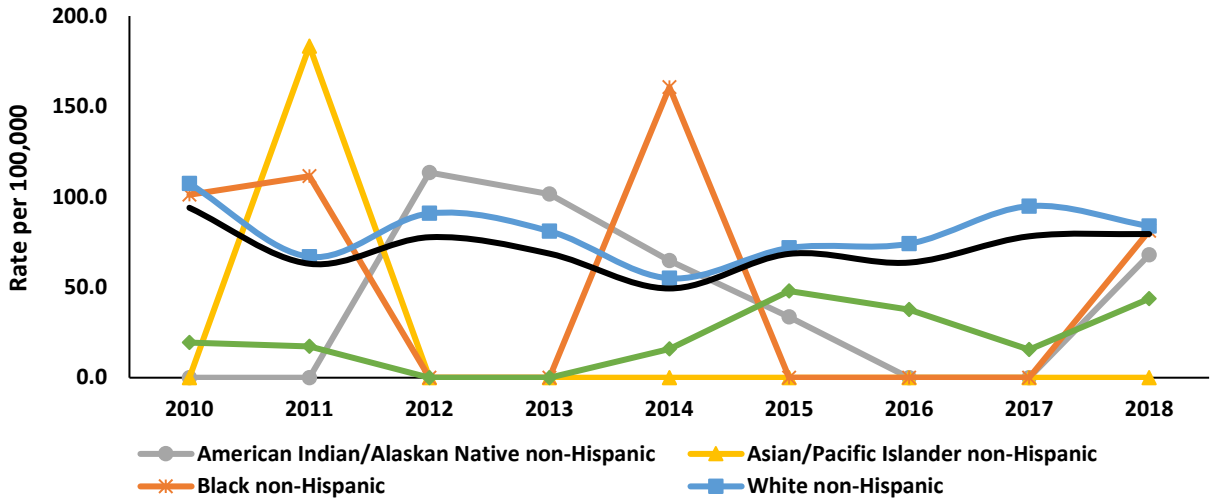
Figure 37. Alcohol and/or Drug-Related Deaths and Rates, Southern Nevada, 2010-2018.



Source: Electronic Death Registry System.

The alcohol and/or drug-related age-adjusted rate increased significantly in 2015 from previous years (95% confidence interval) and has remained at a higher rate through 2018. Southern Nevada had a significantly higher rate for 2018 at 107.7 while the state's rate was 55.5 per 100,000 population.

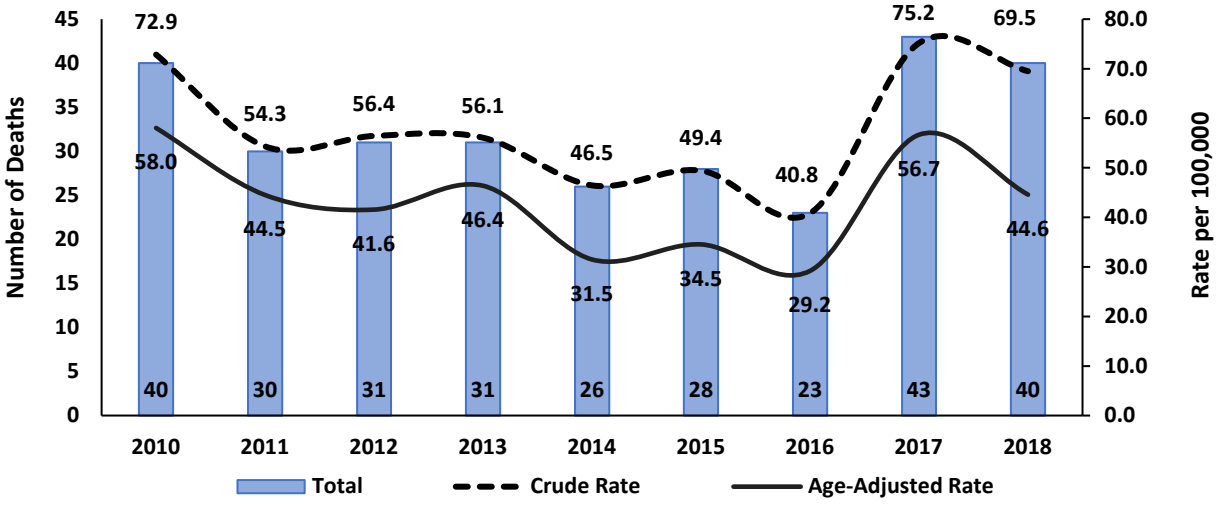
Figure 38. Age-Adjusted Rate for Alcohol and/or Drug-Related Deaths by Race, Southern Nevada, 2010-2018.



Source: Electronic Death Registry System.

The White non-Hispanic population have a significantly higher rate in alcohol and/or drug-related deaths in 2018. While American Indian/Alaskan Native non-Hispanic deaths increased in 2011 and 2016, these deaths are not statistically significant (95% confidence interval) due to the relatively small population size.

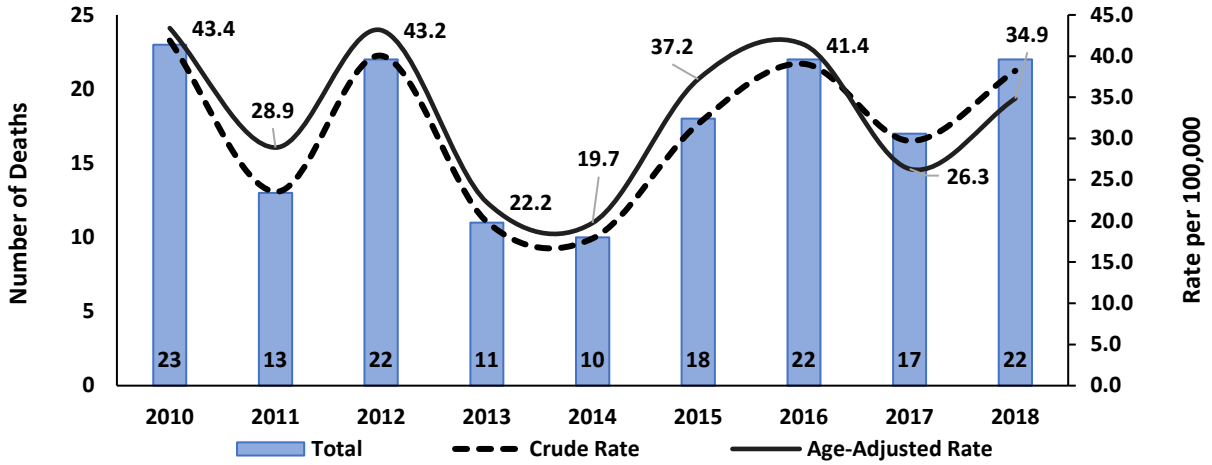
Figure 39. Alcohol-Related Deaths and Age-Adjusted Rates, Southern Nevada, 2010-2018.



Source: Electronic Death Registry System.

Alcohol-related deaths have increase since 2016 from 23 deaths to 40 deaths in 2018.

Figure 40. Drug-Related Deaths and Age-Adjusted Rates, Southern Nevada, 2009-2017.



Source: Electronic Death Registry System.

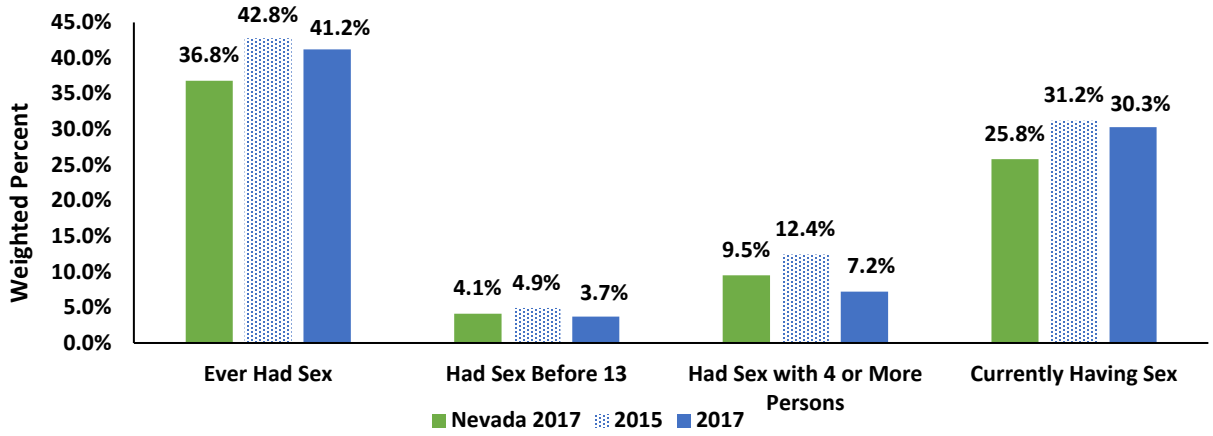
Drug-related deaths in Southern Nevada remained constant from 2010 to 2018. In 2018, there were 22 deaths relating to drug use at 34.9 per 100,000 population.

Youth

Youth Risk Behavior Survey (YRBS)

The YRBS monitors six categories of health-related behaviors that contribute to leading causes of death and disabilities among youth and adults. Nevada high school and middle school students are surveyed during the odd years. In 2017, 445 high school and 458 middle school students participated in the YRBS.

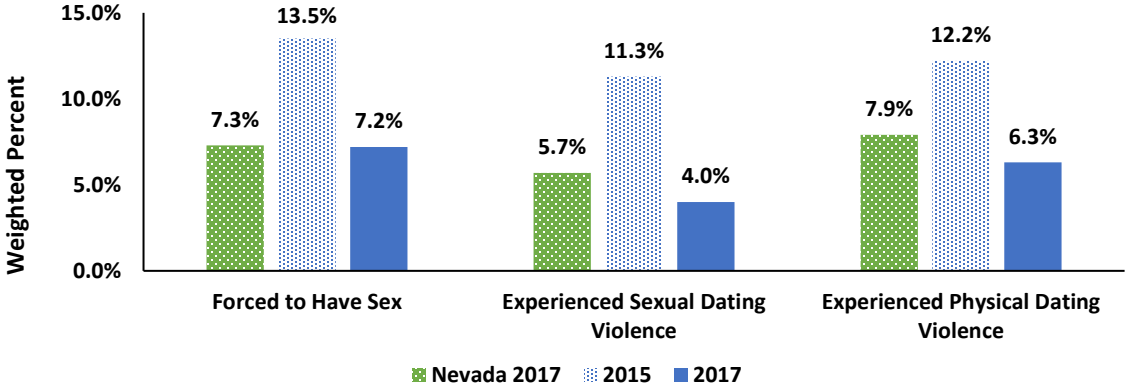
Figure 41. Sexual Behaviors Among Students, Southern Nevada High School Students, 2015 and 2017, and Nevada Statewide High School Students, 2017.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 45% to display differences among groups.

High school students from Esmeralda, Lincoln, Mineral and Nye counties have higher percent for ever having sexual intercourse (41.2%) and for currently having sex (30.3%) than the state (36.8% and 25.8%). However, Southern Nevada high school students have lower percent for having more than 4 sexual partners (7.2%) and for having had sex before the age of 13 (3.7%) compared to Nevada, 9.5% and 4.1% respectively.

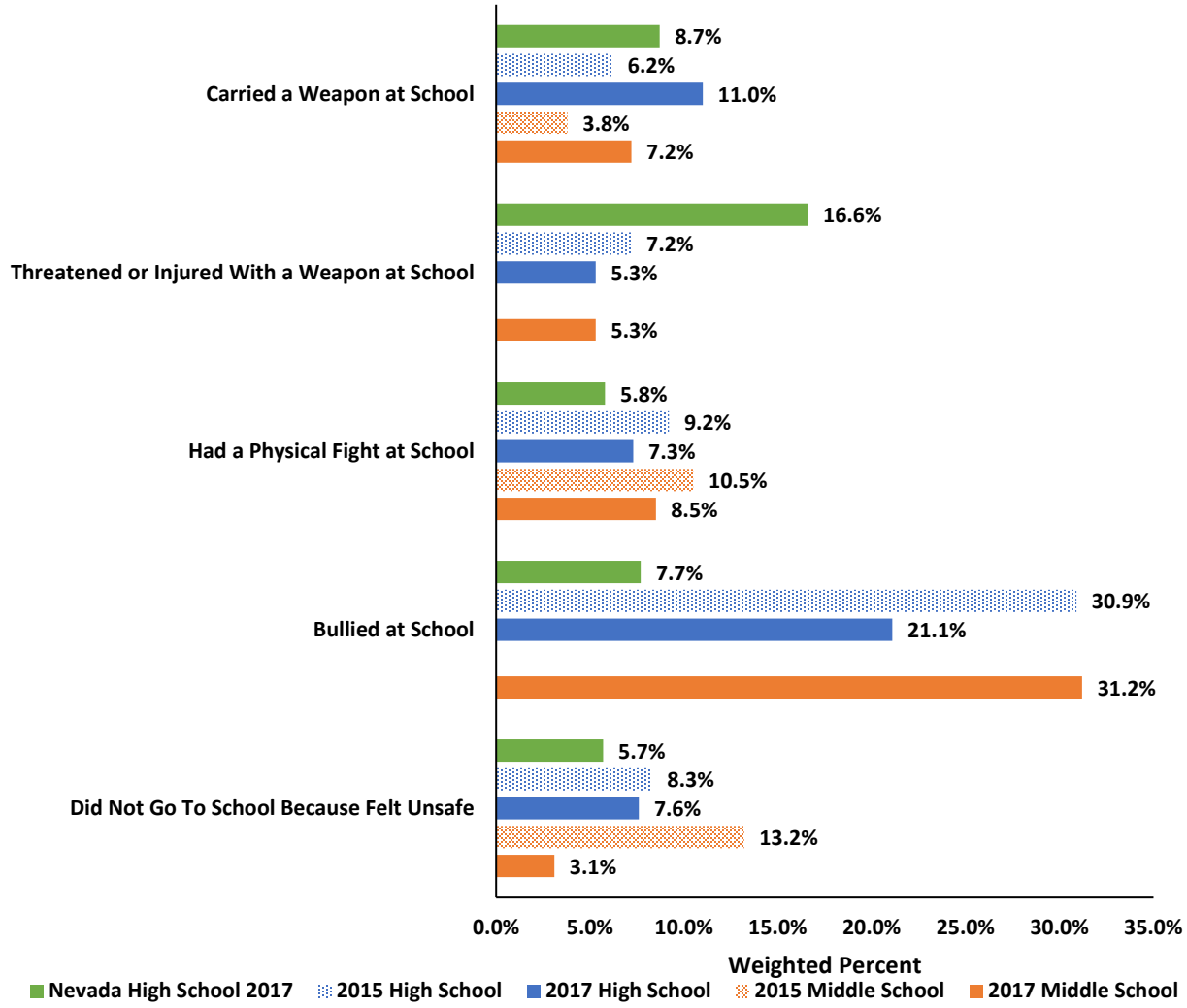
Figure 42. Sexual Violence Among High School Students in Southern Nevada, 2015 and 2017, and Nevada Statewide High School Students, 2017.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 16% to display differences among groups.

In 2017, high school students in Southern Nevada has slightly lower percentages for experienced sexual dating violence (4.0%) and experienced physical dating violence (6.3%) compared to Nevada as a whole (5.7% and 7.9%, respectively). From 2015 to 2017, there was a significant decrease from 11.3% to 4.0% in sexual dating violence among Southern Nevada high schoolers, as well as significant decreases in physical dating violence and being forced to have sex.

Figure 43. Violence, Bullying, and Lack of Safety at School Among Middle School and High School Students in Southern Nevada, 2015 and 2017, and Nevada Statewide High School Students, 2017.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 35% to display differences among groups.

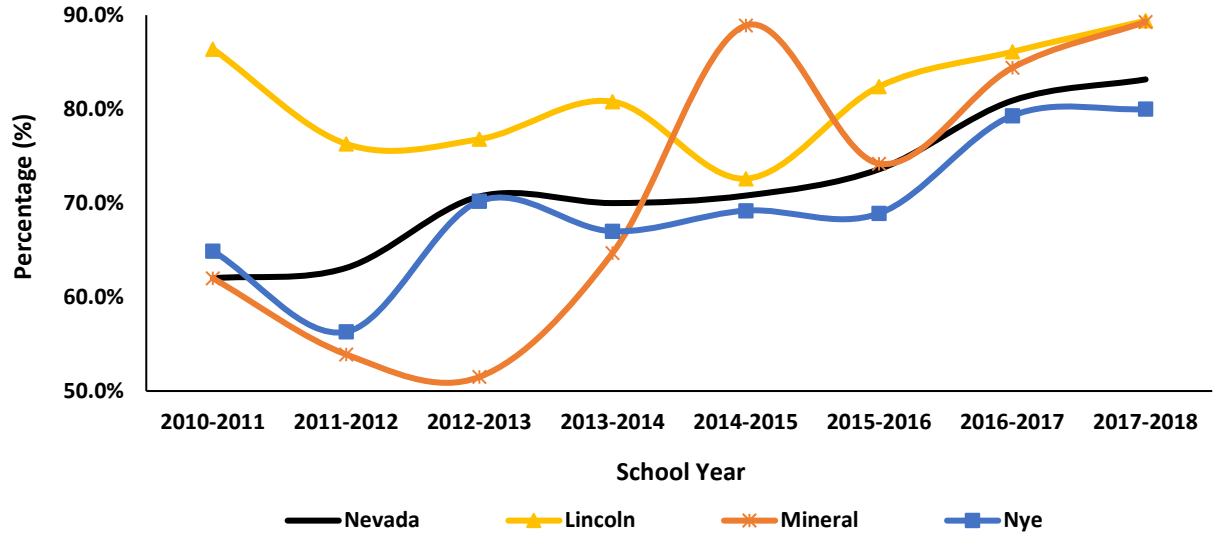
The percent of Southern Nevada middle school students who skipped school due to feeling unsafe significantly decreased from 13.2% to 3.1%, from 2015 to 2017. Meanwhile, the percent of Southern Nevada middle school students for carrying a weapon at school increased from 3.8% to 7.2% in 2015 to 2017. Between 2015 and 2017, Southern Nevada high school students that reported being bullied at school decreased from 30.9% to 21.1% and increased for carrying a weapon at school (6.2% to 11.0%).

Nevada Report Card

The Nevada Report Card is the accountability reporting website of the Nevada Department of Education. In compliance with federal and state law, it assists community members (parents, educators, researchers, lawmakers, etc.) in locating a wealth of detailed information pertaining to K-12 public education in Nevada. The web site has three categories: "school and district information," "assessment and accountability" and "fiscal and technology."

When student behavioral health needs are not identified or not provided with the necessary attention, they are more likely to experience difficulties in school. These include higher rates of suspensions, expulsions, dropouts, and truancy, as well as lower grades. Nationally, 50% of students age 14 and older who are living with a mental illness drop out of high school. This is the highest dropout rate of any disability group.

Figure 44. High School Graduation Percentage of Class Cohorts, Southern Nevada, 2010–2018.



Source: Nevada Department of Education, Report Card.
No data was available for Esmeralda County.

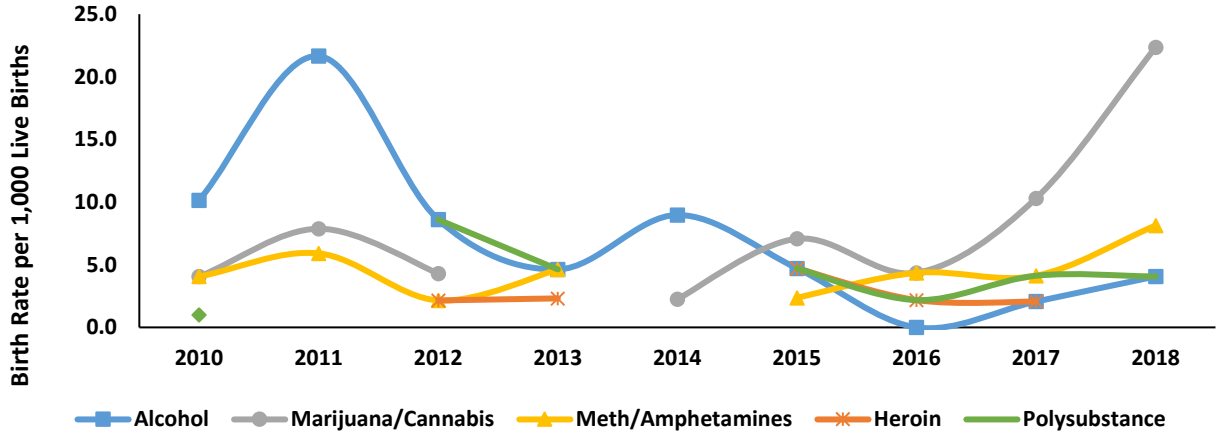
Graduation rate is defined as the rate at which 9th graders graduate by the end of the 12th grade (number of students who graduate in four years with a regular high school diploma divided by the number of students from the adjusted cohort for the graduation class). For the class of 2018, Nevada high schools statewide posted the highest graduation rate at 83.2%, while Lincoln and Mineral County high schools posted a graduation rate of 89.3%; Nye County high schools saw a graduation rate of 80.0%.

Maternal and Child Health

Substance Use Among Pregnant Women

The data in this section is reflective of self-reported information provided by the mother on the birth record. On average, there are 465 live births per year to Southern Nevada residents between 2010 and 2018. From 2010-2018, there were 31 birth certificates with indicated alcohol use, 30 birth certificates indicated marijuana use, 17 indicated meth/amphetamine use, 1 indicated opiate use, and 6 indicated heroin use during pregnancy.

Figure 45. Self-Reported Prenatal Substance Abuse Birth Rates for Select Substances, Southern Nevada, 2010-2018.

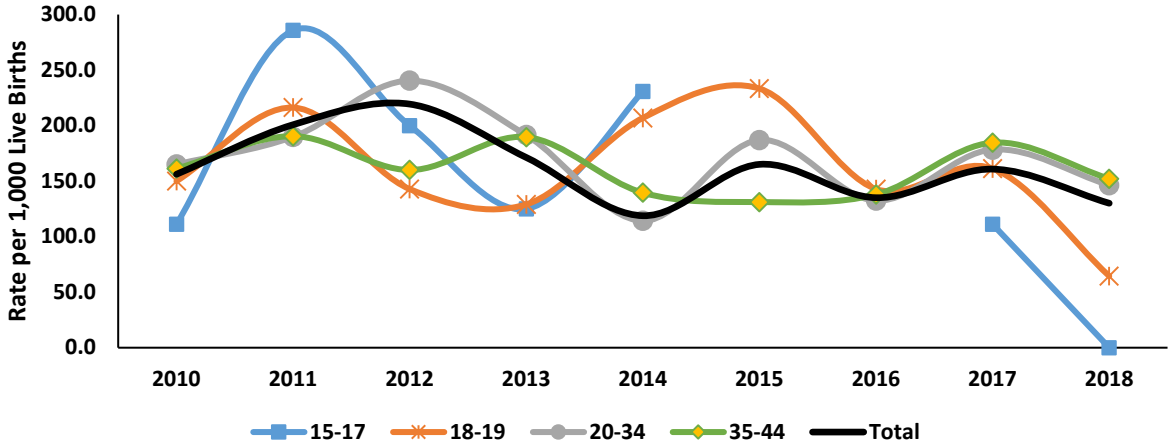


Source: Nevada Electronic Birth Registry System.

Of the self-reported substance use during pregnancy among Southern Nevada mothers who gave birth between 2010 and 2018, the highest rate was with marijuana use in 2018, at 22.3 per 1,000 live births. Since 2015, the marijuana use rate has surpassed the alcohol use rate, which was 4.1 per 1,000 births in 2018. In 2018, a rate of 8.1 per 1,000 live births was reported for meth/amphetamines. For polysubstance use, 4.1 per 1,000 live births reported in 2018.

Because alcohol and substance use during pregnancy is self-reported by the mothers, rates are likely lower than actual rates due to underreporting, and expectant mothers may be reluctant to be forthcoming on the birth record for a variety of reasons.

Figure 46. Self-Reported Prenatal Tobacco Use Birth Rates, Southern Nevada, 2010-2018.

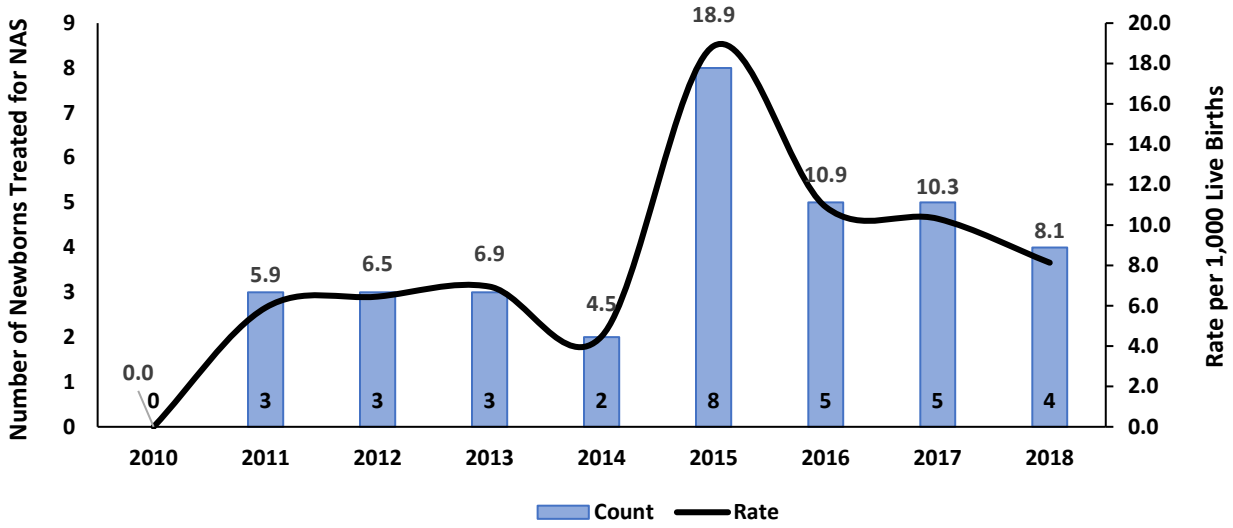


Source: Nevada Electronic Birth Registry System.

Woman over 45 were not included in the above graph due to small counts. Tobacco use during pregnancy has decrease among all age groups in Southern Nevada. In 2010, total reported tobacco use was at 156.2 per 1,000 live births, whereas in 2018, it was 130.1 per 1,000 live births.

Neonatal Abstinence Syndrome

Figure 47. Neonatal Abstinence Syndrome, Southern Nevada, 2010-2018.



Source: Hospital Inpatient Department Billing and Nevada Electronic Birth Registry System.
ICD-10 codes replaced ICD-9 codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Neonatal abstinence syndrome (NAS) refers to a cluster of problems that occur in a newborn who has been exposed to addictive illegal or prescription drugs while in the mother's womb. Withdrawal or abstinence symptoms develop shortly after birth. From 2011 to 2018, inpatient admissions have remained relatively similar with the exception of 2015, where NAS inpatient admissions spiked and the number of admissions more than doubled.

Appendix

Hospital billing data (emergency department and inpatient admissions) and mortality data both utilize International Classification of Diseases codes (ICD). Hospital billing uses ICD-CM which is a 7-digit code verses death where the ICD codes are 4-digit. In hospital billing data, the ICD codes are provided in the diagnosis fields, while death data the ICD codes are coded from the literal causes of death provided on the death certificate.

In October 2015, ICD-10-CM codes were implemented nationwide. Before October 2015, ICD-9-CM codes were used for medical billing. Therefore, 2015 data consists of two distinct coding schemes, ICD-9-CM and ICD-10-CM respectively. Due to this change in coding schemes, hospital billing data from October 2015 forward may not be directly comparable to previous data.

The following ICD-CM codes were used to define hospital encounters and admissions:

All Diagnosis:

Anxiety: 300.0 (9); F41 (10)
Bi-Polar: 296.40-296.89 (9); F32.89, F31 (10)
Depression: 296.20-296.36, 311 (9); F32.0-F32.5, F33.0-F33.4, F32.9 (10)
Post-Traumatic Stress Disorder: 309.81 (9); F43.10, F43.12 (10)
Schizophrenia: 295 V11.0 (9); F20, Z65.8 (10)
Suicidal Ideation: V62.84 (9); R45.851 (10)
Suicide Attempts: E95.0-E95.9 (9); X71-X83, T36-T65, T71 (10)

Primary and All Diagnosis:

Alcohol: 291, 303, 980, 305.0, 357.5, 425.5, 535.3, 571.0, 571.1, 571.2,571.3, 790.3 (9); F10, K70, G62.1, I42.6, K29.2, R78.0, T51 (10).
Drug: 292, 304, 965, 967, 968, 969, 970, 305.2, 305.3, 305.4, 305.5, 305.6, 305.7, 305.8, 305.9 (9); F11- F16, T39, T40, T43, F18, F19 T410, T41.1, T41.2, T41.3, T41.4, T42.3, T43.4, T42.6, T42.7, T42.8 (10).

*Alcohol and Drug Use encounters are both Primary Diagnosis and All diagnosis were analyzed:

The following ICD-10 codes were used to define mortality causes:

Suicide-related deaths: X60-X84, Y87.0 (Initial cause of death is suicide).
Mental and Behavioral-related deaths: F00-F09, and F20-F99 (Initial or contributing cause of death).
Alcohol-related deaths: K70, Y90, Y91, X45, X65, Y15, T51, K73, K74, G31.2, G62.1, I42.6, K29.2, K86.0, K85.0, R78.0, E24.4, O35.4, Q86.0, and Z72.1 (Initial cause of death).
Drug-related Deaths: X40-X44, X60-S64, X85, Y10-Y14 (Initial cause of death).
*The 218 EPI Profile utilized contributing cause of death for drug and alcohol related deaths, this methodology is changed to only the initial cause of death in this report, numbers will have decreased due to this change.

Data Tables

Table 1. Population Distribution, Southern Nevada Residents, 2010-2018.

	2010	2011	2012	2013	2014	2015	2016	2017	2018
Southern	54,902	55,223	54,931	55,289	55,970	56,640	56,318	57,204	57,558
Sex									
Female	27,069	27,261	27,163	27,392	27,753	27,776	27,666	28,080	28,311
Male	27,833	27,962	27,768	27,897	28,217	28,864	28,652	29,124	29,247
Age									
<1	514	513	462	414	482	404	444	448	452
1-4	2,344	2,241	2,108	2,029	2,011	1,871	1,774	1,818	1,814
5-14	6,176	6,144	6,149	6,114	6,023	5,918	5,798	5,930	5,953
15-24	6,293	6,584	6,980	7,108	7,117	7,218	7,156	6,904	6,720
25-34	4,773	4,716	4,622	4,706	5,100	5,762	6,177	6,534	6,706
35-44	5,499	5,413	5,236	5,175	5,015	4,990	4,749	4,926	5,214
45-54	7,715	7,586	7,272	7,123	7,110	7,044	6,750	6,617	6,438
55-64	8,340	8,541	8,393	8,521	8,671	8,768	8,672	8,811	8,899
65-74	8,262	8,268	8,266	8,375	8,486	8,328	8,235	8,398	8,290
75-84	3,957	4,188	4,314	4,557	4,758	5,061	5,236	5,379	5,540
85+	1,028	1,029	1,129	1,166	1,199	1,276	1,327	1,440	1,533
Race/Ethnicity									
White non-Hispanic	44,935	44,952	44,538	44,659	45,001	44,712	44,326	44,787	44,870
Black non-Hispanic	995	1,026	1,051	1,069	1,095	1,553	1,568	1,626	1,646
Native American/Alaskan Native non-Hispanic	1,595	1,601	1,591	1,593	1,599	1,814	1,814	1,860	1,851
Asian/Pacific Islander non-Hispanic	746	779	789	811	845	1,082	1,080	1,118	1,148
Hispanic	6,632	6,865	6,962	7,157	7,429	7,478	7,530	7,812	8,044

Source: Nevada State Demographer, Vintage 2018.

Table 2: Prevalence Estimates of Health Risk Behaviors by Region, Nevada Adults, 2018.

Indicator	Clark	Northern	Rural	Southern	Washoe	Nevada
Ever seriously considered attempting suicide during the past 12 months	2.9% (1.6-4.2)	5.0% (2.9-7.0)	5.8% (1.6-10.0)	2.2% (0.0-4.4)	4.4% (2.8-6.0)	3.4% (2.4-4.4)
Heavy Drinkers	5.5% (4.0-7.0)	5.9% (3.5-8.4)	6.8% (3.1-10.4)	9.7% (4.1-15.2)	7.4% (5.6-9.1)	5.9% (4.8-7.1)
Binge Drinkers	13.9% (11.5-16.3)	14.0% (10.3-17.7)	23.5% (17.1-29.8)	10.6% (4.9-16.3)	19.4% (16.4-22.4)	15.0% (13.2-16.9)
General Health Poor or Fair	20.6% (18.0-23.2)	23.8% (19.1-28.5)	20.7% (15.1-26.4)	25.2% (16.7-33.8)	18.4% (15.5-21.4)	20.6% (18.5-22.6)
Depressive Disorder Diagnosis	15.3% (13.0-17.6)	19.2% (15.0-23.4)	12.8% (7.9-17.7)	17.5% (9.8-25.1)	16.7% (13.7-19.6)	15.7% (14.0-17.5)
Ten or more days of poor mental health	15.2% (12.7-17.6)	22.3% (17.4-27.2)	13.6% (8.8-18.5)	13.8% (7.7-19.8)	19.1% (16.0-22.2)	16.1% (14.3-18.0)
Ten or more days of poor mental or physical health kept from usual activities	22.8% (18.8-26.7)	24.7% (18.5-30.8)	16.7% (10.0-23.4)	28.9% (18.4-39.3)	19.4% (15.5-23.3)	22.2% (19.3-25.1)
Used marijuana/hashish in the last 30 days	13.9% (11.2-16.7)	14.4% (10.6-18.1)	11.6% (6.1-17.1)	13.1% (7.2-19.0)	16.8% (13.9-19.8)	14.3% (12.3-16.4)
Used other illegal drugs in the last 30 days	1.1% (0.4-1.7)	2.8% (0.1-5.6)	3.1% (0.0-6.6)	0.7% (0.0-2.0)	1.7% (0.8-2.6)	1.3% (0.8-1.9)
Used prescription drugs/pain killer to get high in last 30 days	1.0% (0.3-1.8)	1.4% (0.0-3.8)	0.9% (0.0-2.8)	0.7% (0.0-2.0)	0.7% (0.1-1.3)	1.0% (0.4-1.6)
Current tobacco cigarette smokers	15.0% (12.6-17.4)	17.4% (13.0-21.8)	25.5% (19.2-31.7)	23.5% (15.3-31.7)	15.2% (12.5-18.0)	15.7% (13.9-17.5)
Currently e-cigarette smokers	5.8% (4.0-7.5)	7.2% (4.3-10.1)	6.2% (2.4-10.1)	6.2% (1.4-11.1)	7.0% (4.9-9.0)	6.1% (4.8-7.4)
Difficulty doing errands alone because of physical, mental, or emotional condition	7.0% (5.4-8.7)	9.4% (5.9-12.8)	7.4% (3.9-10.9)	6.4% (2.8-10.0)	8.2% (5.9-10.4)	7.4% (6.1-8.6)
Serious difficulty concentrating, remembering, or making decisions because of physical, mental, or emotional condition	13.0% (10.6-15.4)	14.9% (10.9-18.9)	13.5% (8.5-18.5)	10.8% (5.6-16.1)	13.1% (10.3-15.9)	13.1% (11.2-14.9)

Source: Behavioral Risk Factor Surveillance System (BRFSS).

For more information about BRFSS indictors: Office of Analytics Reports.

Table 3a. Age-Adjusted Rates per 100,000 of Mental Health-Related Emergency Department Encounters by Region, Nevada Residents, 2018.

Region	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicidal Ideation
Clark	9.2 (8.0-10.5)	137.3 (132.5-142.2)	70.1 (66.7-73.6)	33.5 (31.2-35.9)	10.8 (9.4-12.1)	17.3 (15.6-19.0)
Northern	116.0 (100.5-131.5)	1,632.3 (1,574.9-1,689.6)	817.7 (777.7-857.7)	426.8 (396.5-457.1)	140.2 (122.6-157.9)	230.2 (207.1-253.3)
Rural	33.7 (21.8-45.5)	392.7 (353.6-431.7)	183.7 (156.8-210.6)	84.4 (65.5-103.4)	18.5 (9.7-27.3)	96.4 (76.6-116.2)
Southern	226.5 (184.6-268.5)	1,675.4 (1,569.8-1,781.0)	913.0 (834.6-991.3)	493.4 (431.2-555.5)	153.0 (119.8-186.1)	617.9 (548.6-687.3)
Washoe	104.1 (95.1-113.2)	1,035.3 (1,006.7-1,063.9)	1,122.8 (1,092.9-1,152.7)	356.4 (339.5-373.3)	239.1 (225.0-253.3)	537.4 (516.0-558.9)
Nevada	361.5 (354.7-368.3)	1,912.7 (1,897.2-1,928.2)	1,172.1 (1,160.0-1,184.1)	654.1 (645.0-663.2)	194.1 (189.1-199.0)	566.7 (558.2-575.3)

Source: Hospital Emergency Department Billing.
Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2018.
Categories are not mutually exclusive.

Table 3b. Crude Rates per 100,000 of Mental Health-Related Emergency Department Encounters by Region, Nevada Residents, 2018.

Region	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicidal Ideation
Clark	9.6 (8.3-10.9)	139.5 (134.6-144.5)	72.0 (68.5-75.6)	34.2 (31.8-36.6)	10.9 (9.5-12.3)	17.1 (15.4-18.8)
Northern	113.0 (97.9-128.1)	1,637.5 (1,580.0-1,695.0)	845.3 (804.0-886.6)	401.1 (372.6-429.6)	127.7 (111.7-143.8)	200.3 (180.2-220.4)
Rural	32.3 (20.9-43.7)	404.5 (364.3-444.8)	186.6 (159.3-214.0)	79.2 (61.4-97.0)	17.7 (9.3-26.1)	94.9 (75.4-114.4)
Southern	194.6 (158.5-230.6)	1,680.0 (1,574.2-1,785.9)	906.9 (829.1-984.7)	420.4 (367.5-473.4)	142.5 (111.6-173.3)	529.9 (470.4-589.4)
Washoe	110.7 (101.1-120.4)	1,104.7 (1,074.2-1,135.2)	1,187.8 (1,156.2-1,219.5)	373.7 (355.9-391.4)	241.0 (226.7-255.2)	529.1 (508.0-550.2)
Nevada	360.5 (353.8-367.3)	1,929.5 (1,913.9-1,945.2)	1,195.8 (1,183.5-1,208.1)	652.0 (642.9-661.1)	192.1 (187.2-197.0)	556.4 (548.0-564.8)

Source: Hospital Emergency Department Billing.
Rates are per 100,000 population, provided by the state demographer, vintage 2018.
Categories are not mutually exclusive.

Table 4a. Age-Adjusted Rates per 100,000 of Mental Health-Related Inpatient Admissions by Region, Nevada Residents, 2018.

Region	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicidal Ideation
Clark	6.8 (5.8-7.9)	128.2 (123.6-132.8)	118.1 (113.7-122.6)	35.5 (33.1-37.9)	24.6 (22.6-26.6)	42.1 (39.4-44.8)
Northern	81.7 (69.1-94.3)	1,365.7 (1,316.7-1,414.7)	1,255.5 (1,208.4-1,302.6)	422.1 (393.2-451.0)	310.1 (284.4-335.8)	538.7 (504.3-573.0)
Rural	27.7 (16.4-39.0)	226.9 (197.5-256.3)	212.7 (184.2-241.2)	73.8 (56.8-90.7)	34.5 (22.3-46.6)	76.6 (59.2-93.9)
Southern	162.0 (128.0-196.0)	1,182.1 (1,102.3-1,261.8)	1,095.9 (1,017.6-1,174.2)	507.3 (448.9-565.7)	219.3 (181.3-257.2)	472.4 (413.6-531.2)
Washoe	104.1 (95.1-113.2)	1,035.3 (1,006.7-1,063.9)	1,122.8 (1,092.9-1,152.7)	356.4 (339.5-373.3)	239.1 (225.0-253.3)	537.4 (516.0-558.9)
Nevada	38.8 (23.3-54.4)	582.9 (524.9-640.9)	561.3 (504.7-617.9)	137.2 (108.4-166.1)	126.2 (97.1-155.4)	131.1 (103.6-158.7)

Source: Hospital Inpatient Billing.
Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2018.
Categories are not mutually exclusive.

Table 4b. Crude Rates per 100,000 of Mental Health-Related Inpatient Admissions by Region, Nevada Residents, 2018.

Region	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicidal Ideation
Clark	7.3 (6.1-8.4)	133.7 (128.9-138.5)	122.1 (117.5-126.7)	36.8 (34.3-39.3)	25.1 (23.0-27.2)	42.4 (39.7-45.1)
Northern	85.2 (72.0-98.3)	1,568.6 (1,512.4-1,624.9)	1,433.0 (1,379.2-1,486.8)	431.6 (402.1-461.1)	294.4 (270.0-318.8)	497.3 (465.6-529.0)
Rural	24.0 (14.2-33.8)	238.7 (207.8-269.7)	223.1 (193.2-253.0)	76.1 (58.6-93.6)	32.3 (20.9-43.7)	78.2 (60.5-95.9)
Southern	151.2 (119.4-182.9)	1,466.3 (1,367.4-1,565.3)	1,308.2 (1,214.8-1,401.7)	503.8 (445.9-561.8)	222.4 (183.9-260.9)	430.9 (377.2-484.5)
Washoe	110.7 (101.1-120.4)	1,104.7 (1,074.2-1,135.2)	1,187.8 (1,156.2-1,219.5)	373.7 (355.9-391.4)	241.0 (226.7-255.2)	529.1 (508.0-550.2)
Nevada	36.2 (21.7-50.7)	585.7 (527.4-644.0)	570.6 (513.1-628.1)	131.3 (103.7-158.9)	108.7 (83.6-133.8)	131.3 (103.7-158.9)

Source: Hospital Inpatient Billing.
Rates are per 100,000 population, provided by the state demographer, vintage 2018.
Categories are not mutually exclusive.

Table 5. Suicides (Crude) Rates by Age, Race/Ethnicity and Region, Nevada Residents, 2018.

	Clark	Northern	Rural	Southern	Washoe	Nevada
Age Group						
Less then 15	1.8 (0.5-03.0)	0.0 -	0.0 -	36.5 (0.0-77.8)	0.0 -	1.8 (0.8-2.9)
15-24	17.5 (12.7-22.3)	37.7 (4.7-70.8)	13.6 (0.0-29.1)	0.0 -	11.3 (2.9-19.8)	16.7 (12.7-20.7)
25-34	24.3 (18.8-29.8)	16.6 (0.0-35.3)	29.4 (7.6-51.2)	44.7 (0.0-95.4)	12.4 (3.8-20.9)	23.2 (18.7-27.8)
35-44	24.2 (18.8-29.6)	32.0 (0.0-68.3)	50.2 (19.1-81.3)	0.0 -	22.4 (10.2-34.6)	25.8 (20.9-30.7)
45-54	27.6 (21.6-33.5)	48.8 (9.8-87.9)	27.6 (7.2-48.1)	46.6 (0.0-99.3)	32.5 (17.5-47.5)	30.5 (25.0-35.9)
55-64	28.4 (21.9-34.9)	34.6 (0.7-68.5)	37.2 (14.1-60.3)	56.2 (6.9-105.4)	24.0 (11.4-36.6)	30.0 (24.4-35.7)
65-74	22.4 (15.6-29.3)	57.6 (7.1-108.0)	29.0 (7.5-50.5)	84.4 (21.9-147.0)	33.7 (16.6-50.8)	30.2 (23.6-36.7)
75-84	36.2 (23.6-48.7)	24.5 (0.0-72.4)	47.5 (9.5-85.6)	18.1 (0.0-53.4)	25.5 (3.1-47.8)	34.5 (24.4-44.6)
85+	30.2 (9.3-51.1)	93.9 (0.0-278.1)	64.8 (0.0-138.1)	130.5 (0.0-311.4)	64.3 (1.3-127.3)	45.1 (24.2-65.9)
Race/Ethnicity						
White non-Hispanic	31.7 (28.2-35.2)	32.9 (19.1-46.6)	32.6 (23.4-41.8)	49.0 (28.5-69.5)	25.8 (20.0-31.7)	32.3 (29.4-35.1)
Black non-Hispanic	14.0 (9.4-18.7)	0.0 -	0.0 -	0.0 -	0.0 -	13.2 (8.8-17.5)
Native American/Alaskan Native non-Hispanic	6.7 (0.0-19.7)	0.0 -	52.3 (0.0-111.5)	0.0 -	0.0 -	14.2 (1.8-26.7)
Asian/Pacific Islander non-Hispanic	13.1 (8.6-17.5)	0.0 -	0.0 -	0.0 -	12.6 (0.3-25.0)	13.4 (9.2-17.6)
Hispanic	8.6 (6.5-10.8)	28.4 (5.7-51.1)	6.6 (0.0-15.6)	24.9 (0.0-59.3)	4.4 (0.5-08.2)	8.6 (6.7-10.6)
Total	20.1 (18.3-22.0)	29.2 (18.4-40.0)	27.9 (20.4-35.4)	41.7 (25.0-58.4)	18.4 (14.5-22.4)	21.7 (20.0-23.3)

Source: Electronic Death Registry System.

Rates are per 100,000 population, provided by the state demographer, vintage 2018.

Table 6. Suicide Attempts and Suicides by Leading Method and Region, Nevada Residents, 2018.

Region	Suicide Attempts				Suicides		
	Emergency Department Encounters		Inpatient Admissions		Substance	Hanging/ Suffocation	Firearms/ Explosives
	Substance	Cutting	Substance	Cutting			
Clark	63.7 (60.4-67.0)	28.3 (26.1-30.5)	53.3 (50.3-56.3)	7.2 (6.1-08.3)	3.0 (2.3-03.8)	5.0 (4.1-05.9)	10.5 (9.2-11.9)
Northern	53.1 (42.7-63.4)	20.0 (13.6-26.3)	72.0 (60.0-84.1)	22.6 (15.8-29.4)	4.2 (1.3-07.1)	5.3 (2.0-08.5)	16.8 (11.0-22.7)
Rural	81.3 (63.3-99.4)	30.2 (19.2-41.2)	40.7 (27.9-53.4)	1.0 (0.0-03.1)	3.1 (0.0-06.7)	2.1 (0.0-05.0)	22.9 (13.4-32.5)
Southern	93.8 (68.8-118.8)	55.6 (36.3-74.9)	48.6 (30.6-66.7)	12.2 (3.2-21.2)	6.9 (0.1-13.8)	5.2 (0.0-11.1)	29.5 (15.5-43.6)
Washoe	64.5 (57.1-71.8)	11.4 (8.3-14.5)	66.7 (59.2-74.2)	11.0 (7.9-14.0)	3.7 (2.0-05.5)	2.4 (1.0-03.8)	10.5 (7.5-13.5)
Nevada	64.3 (61.4-67.1)	25.8 (24.0-27.6)	56.0 (53.3-58.7)	8.6 (7.6-09.7)	3.4 (2.7-04.1)	4.7 (3.9-05.4)	12.1 (10.9-13.3)

Source: Hospital Emergency Department Billing, Inpatient Billing, and the Electronic Death Registry System.
Rates are per 100,000 population, provided by the state demographer, vintage 2018.

Table 7. Mental Health-Related Deaths Age-Adjusted Rates by Region, Nevada Residents, 2018.

Region	White non-Hispanic	Black non-Hispanic	Native American/ Alaskan Native	Asian/Pacific Islander	Hispanic	Total
Clark	48.7 (45.0-52.5)	52.1 (41.0-63.2)	9.3 (0.0-27.5)	33.6 (25.2-42.0)	29.8 (22.3-37.4)	45.1 (42.1-48.1)
Northern	64.6 (55.0-74.2)	75.0 (0.0-222.0)	45.7 (0.0-97.4)	62.2 (0.0-148.4)	45.6 (9.1-82.1)	62.6 (53.7-71.6)
Rural	45.0 (29.2-60.9)	0.0 -	20.8 (0.0-61.6)	0.0 -	6.3 (0.0-18.5)	39.4 (26.0-52.9)
Southern	31.1 (19.9-42.2)	0.0 -	67.9 (0.0-201.0)	0.0 -	0.0 -	30.0 (19.4-40.5)
Washoe	62.0 (53.9-70.0)	116.1 (23.2-208.9)	73.7 (0.0-175.9)	48.5 (19.9-77.2)	28.0 (10.7-45.4)	60.3 (52.9-67.6)
Nevada	52.4 (49.3-55.4)	55.2 (44.0-66.3)	28.5 (8.8-48.3)	35.1 (27.1-43.1)	29.6 (23.0-36.1)	48.7 (46.1-51.3)

Source: Electronic Death Registry System.
Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2018.

Table 8a. Drug-Related Emergency Department Encounters Age-Adjusted Rates by Drug Type and Region, Nevada Residents, 2018.

Region	Opioids	Heroin	Cocaine	Methampetamines	Marijuana	Hallucinogens
Clark	204.4 (198.6-210.3)	9.7 (8.4-10.9)	91.1 (87.1-95.0)	474.4 (465.3-483.5)	424.6 (416.0-433.2)	19.9 (18.0-21.7)
North	193.9 (174.3-213.4)	8.3 (4.6-12.0)	26.4 (18.5-34.2)	274.6 (249.4-299.7)	327.1 (300.0-354.2)	4.9 (1.5-8.3)
Rural	167.1 (141.5-192.6)	11.9 (5.2-18.6)	16.0 (8.2-23.9)	298.6 (263.6-333.6)	379.9 (342.0-417.9)	1.0 (0.0-3.1)
Southern	213.5 (174.3-252.7)	9.7 (3.0-16.4)	20.5 (7.8-33.3)	406.2 (350.9-461.5)	610.5 (541.9-679.0)	9.3 (0.2-18.4)
Washoe	233.2 (219.4-247.0)	12.2 (9.0-15.3)	57.5 (50.5-64.5)	512.2 (491.0-533.4)	290.3 (274.5-306.1)	5.6 (3.4-7.7)
Nevada	300.1 (294.1-306.1)	12.3 (11.1-13.5)	73.7 (70.7-76.6)	393.9 (386.8-401.0)	443.0 (435.6-450.4)	6.7 (5.8-7.7)

Source: Hospital Emergency Department Billing.
Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2018.
Categories are not mutually exclusive.

Table 8b. Drug-Related Emergency Department Encounters Crude Rates by Drug Type and Region, Nevada Residents, 2018.

Region	Opioids	Heroin	Cocaine	Methampetamines	Marijuana	Hallucinogens
Clark	208.7 (202.7-214.7)	9.7 (8.4-11.0)	93.0 (89.0-97.0)	467.4 (458.5-476.4)	421.8 (413.3-430.4)	19.6 (17.7-21.4)
North	198.2 (178.2-218.2)	10.0 (5.5-14.5)	22.6 (15.8-29.4)	240.2 (218.2-262.3)	294.9 (270.5-319.3)	4.2 (1.3-7.1)
Rural	171.0 (144.8-197.1)	12.5 (5.4-19.6)	16.7 (8.5-24.9)	291.9 (257.7-326.1)	401.4 (361.3-441.5)	1.0 (0.0-3.1)
Southern	198.1 (161.7-234.4)	13.9 (4.3-23.5)	17.4 (6.6-28.1)	359.6 (310.6-408.6)	529.9 (470.4-589.4)	6.9 (0.1-13.8)
Washoe	240.1 (225.9-254.3)	12.5 (9.3-15.7)	57.0 (50.1-63.9)	492.1 (471.7-512.4)	285.3 (269.8-300.8)	5.5 (3.3-7.6)
Nevada	316.3 (310.0-322.7)	13.4 (12.1-14.7)	77.5 (74.4-80.6)	390.7 (383.7-397.8)	451.3 (443.7-458.9)	6.6 (5.7-7.5)

Source: Hospital Emergency Department Billing.
Rates are per 100,000 population, provided by the state demographer, vintage 2018.
Categories are not mutually exclusive.

Table 9a. Drug-Related Inpatient Admissions Age-Adjusted Rates by Drug Type and Region, Nevada Residents, 2018.

Region	Opioids	Heroin	Cocaine	Methampetamines	Marijuana	Hallucinogens
Clark	289.9 (283.0-296.8)	10.3 (9.0-11.6)	88.0 (84.2-91.8)	391.6 (383.4-399.8)	457.9 (449.1-466.7)	6.9 (5.8-8.0)
North	390.9 (363.9-417.8)	17.4 (11.8-23.0)	38.6 (29.5-47.8)	433.7 (402.3-465.2)	508.4 (475.6-541.3)	8.8 (4.2-13.4)
Rural	120.3 (98.9-141.7)	8.9 (3.7-14.2)	17.1 (8.1-26.0)	207.1 (178.7-235.5)	201.1 (172.8-229.4)	4.8 (0.1-9.5)
Southern	142.5 (114.6-170.4)	6.9 (.9-13.0)	23.3 (11.1-35.4)	272.2 (227.4-316.9)	425.5 (373.4-477.5)	2.0 (0.0-6.0)
Washoe	364.6 (347.8-381.5)	20.9 (16.9-24.8)	37.6 (31.9-43.2)	436.5 (417.1-455.8)	395.4 (377.3-413.4)	6.0 (3.7-8.4)
Nevada	300.1 (294.1-306.1)	12.3 (11.1-13.5)	73.7 (70.7-76.6)	393.9 (386.8-401.0)	443.0 (435.6-450.4)	6.7 (5.8-7.7)

Source: Hospital Inpatient Billing.
Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2018.
Categories are not mutually exclusive.

Table 9b. Drug-Related Inpatient Admissions Crude Rates by Drug Type and Region, Nevada Residents, 2018.

Region	Opioids	Heroin	Cocaine	Methampetamines	Marijuana	Hallucinogens
Clark	301.9 (294.7-309.1)	11.0 (9.6-12.4)	93.1 (89.1-97.1)	392.5 (384.3-400.8)	467.4 (458.4-476.4)	6.9 (5.8-8.0)
North	425.8 (396.5-455.1)	19.5 (13.2-25.7)	36.3 (27.7-44.8)	384.8 (356.9-412.7)	484.2 (452.9-515.4)	7.4 (3.5-11.2)
Rural	126.1 (103.7-148.6)	11.5 (4.7-18.2)	14.6 (6.9-22.2)	212.7 (183.5-241.9)	202.3 (173.8-230.7)	4.2 (0.1-8.3)
Southern	173.7 (139.7-207.8)	8.7 (1.1-16.3)	24.3 (11.6-37.1)	246.7 (206.1-287.3)	446.5 (391.9-501.1)	1.7 (0.0-5.1)
Washoe	392.9 (374.8-411.1)	23.2 (18.8-27.7)	37.5 (31.9-43.1)	429.6 (410.5-448.6)	403.9 (385.5-422.4)	5.7 (3.5-7.9)
Nevada	316.3 (310.0-322.7)	13.4 (12.1-14.7)	77.5 (74.4-80.6)	390.7 (383.7-397.8)	451.3 (443.7-458.9)	6.6 (5.7-7.5)

Source: Hospital Inpatient Billing.
Rates are per 100,000 population, provided by the state demographer, vintage 2018.
Categories are not mutually exclusive.

Table 10. Drug- and Alcohol-Related Age-Adjusted Death Rates by Race/Ethnicity and Region, Nevada Residents, 2018.

Region	White non-Hispanic	Black non-Hispanic	Native American/ Alaskan Native	Asian/ Pacific Islander	Hispanic	Total
Clark	59.6 (55.3-63.9)	47.4 (38.7-56.1)	55.1 (19.1-91.0)	18.8 (13.5-24.1)	28.0 (23.6-32.4)	45.1 (42.4-47.8)
Northern	60.7 (50.0-71.4)	75.0 (0.0-222.0)	10.5 (0.0-31.0)	0.0 -	43.8 (15.2-72.5)	55.0 (45.8-64.3)
Rural	49.0 (33.6-64.3)	134.3 (0.0-397.5)	84.9 (0.0-181.0)	0.0 -	31.4 (8.1-54.7)	51.5 (37.5-65.5)
Southern	83.9 (61.7-106.0)	81.2 (0.0-193.6)	67.9 (0.0-201.0)	0.0 -	43.7 (0.0-93.1)	79.4 (59.7-99.2)
Washoe	69.2 (69.2-69.2)	78.3 (78.3-78.3)	150.9 (150.9-150.9)	14.7 (14.7-14.7)	32.6 (32.6-32.6)	58.4 (58.4-58.4)
Nevada	63.7 (60.2-67.2)	50.4 (41.7-59.1)	69.3 (42.7-95.9)	18.2 (13.4-23.1)	30.2 (26.0-34.3)	50.3 (47.9-52.7)

Source: Electronic Death Registry System.

Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2018.