Substance Abuse Prevention and Treatment Agency 2019 Epidemiologic Profile

Clark County Behavioral Health Region
November 2019

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

Mental Health

- Female high school students are more likely to seriously consider attempting suicide than males.
- Female adults are more likely to have depressive disorder(s) and experience ten or more days kept from usual activities by poor mental or physical health compared to males; Hispanic adults are less likely to have depressive disorder(s) than White non-Hispanics and Blacks non-Hispanics.
- Emergency department encounters and hospital inpatient admissions related to anxiety, depression, bipolar, PTSD, and suicidal ideation have increased since 2010, with males more likely to be seen for schizophrenia and females more likely to be seen for anxiety, depression, bipolar disorder, and PTSD.
- The number of clients served at state-funded mental health clinics are decreasing; Black non-Hispanics are the most frequent race/ethnicity group served, while Asian/Pacific Islanders are the least frequently served.
- The most common method of attempted suicide seen at emergency departments and hospital inpatient admissions is substance(s) or drug overdose, followed by cutting.
- Since 2010, suicide rates have remained the same, elevated in White non-Hispanics compared to other races/ethnicities.

Substance Use

- High school males are more likely to be current users of smokeless tobacco or cigars compared to females; Black non-Hispanic high school students are more likely to currently smoke cigars compared to Asian/Pacific Islander, White non-Hispanic, and Hispanic peers.
- From 2015 to 2017, usage of electronic vapor products decreased among middle and high school students.
- Asian/Pacific Islander high school students are less likely to use electronic vapor products compared to Hispanics and Native Hawaiian/Pacific Islanders, and less likely to have ever tried or currently use marijuana compared to Black non-Hispanics and Hispanics.
- 11th and 12th graders are more likely to have ever drank alcohol compared to 9th and 10th graders.
- Marijuana use in Clark County adults has more than doubled since 2011; Hispanics are less likely to use marijuana compared to White non-Hispanics or Black non-Hispanics, and married adults are less likely to use marijuana compared to those who have never married or are part of an unmarried couple.
- Males are more likely to binge drink compared to females, and adults who have never married or are part of an unmarried couple are more likely to binge drink compared to

married adults; younger and middle-aged adults are more likely to binge drink than those aged 55 and older.

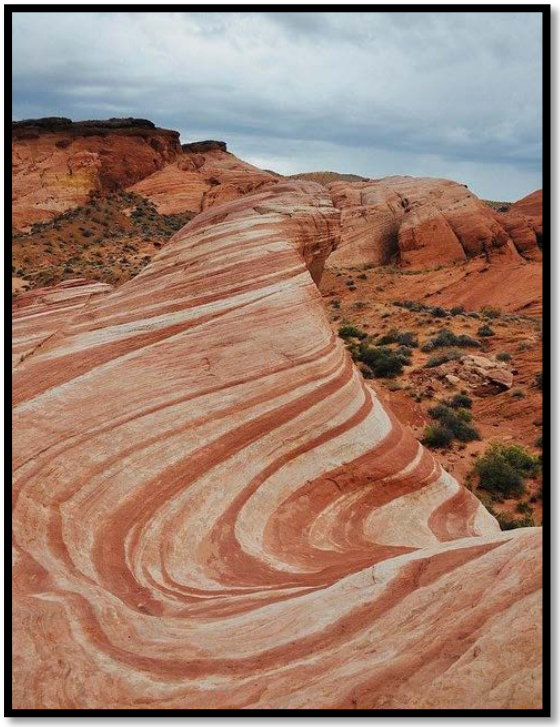
- Cigarette smoking has decreased since 2011, and high school graduates are more likely to smoke cigarettes compared to college graduates.
- Adults who have never married or who are part of an unmarried couple are more likely to use e-cigarettes compared to married, divorced, widowed, or separated adults; young adults aged 18 to 24 years are more likely to use e-cigarettes compared to older adults 45 and over.
- Emergency department encounters related to alcohol and/or drugs have increased since 2010, with males more likely to be seen in emergency departments and hospital admissions for alcohol-related reasons compared to females; Asian/Pacific Islanders, followed by Hispanics, had the lowest crude rate of alcohol and/or drug-related emergency department encounters.
- Most drug-related emergency department encounters are attributed to marijuana and methamphetamines, followed by opioids, all of which have increased since 2010; males are more likely to be seen in emergency departments for cocaine, methamphetamines, marijuana/cannabis, and hallucinogens compared to females.
- Age-adjusted rates for alcohol and/or drug-related deaths in Clark County are lower than those across Nevada statewide; Asian/Pacific Islanders have the lowest rate of alcohol and/or drug-related deaths, while White non-Hispanics have the highest rate of all races/ethnicities (except American Indian/Alaskan Natives).
- 12th graders are more likely to be currently having sex or report having had sex compared to students from earlier grades, and male high school students are more likely to have had sex before age 13 compared to females.
- From 2015 to 2017, sexual dating violence among high school students and the percentage of middle school students who skipped school due to feeling unsafe decreased; Hispanic high school students are more likely to skip school due to feeling unsafe compared to White non-Hispanics.
- While on school property, male high school students are more likely to have carried a weapon and participated in a physical fight compared to females; Hispanics and 10th graders are more likely to have been in a physical fight compared to Asian/Pacific Islanders and 12th graders, respectively.
- Female high school students are more likely to be bullied at school compared to males; Native Hawaiian/Pacific Islanders are more likely to be bullied at school compared to Black non-Hispanics and Hispanics.
- High school graduation rates have increased since 2010 in Clark County.
- Marijuana/cannabis is the most common self-reported substance used during pregnancy in Clark County, and has increased (along with prenatal usage of methamphetamines and polysubstance) since 2010.
- Inpatient admissions for neonatal abstinence syndrome have doubled since 2010.

Demographic Snapshot

Figure 1. Selected Demographics for Clark County.

Population, 2018 estimate*	2,232,176
Population, 2010 estimate*	1,959,491
Population, percentage change*	13.9%
Male persons, 2018 estimate*	1,116,623 (50.0%)
Female persons, 2018 estimate*	1,115,553 (50.0%)
Median household income (in 2017), 2013-2017**	$54,882
Per capita income in the past 12 months (in 2017), 2013-2017**	$27,719
Persons in poverty, percent (2017)**	14.0%
With a disability, under the age 65 years, percent, 2013-2017**	8.6%
Land area (square miles), 2017**	7,891.4

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

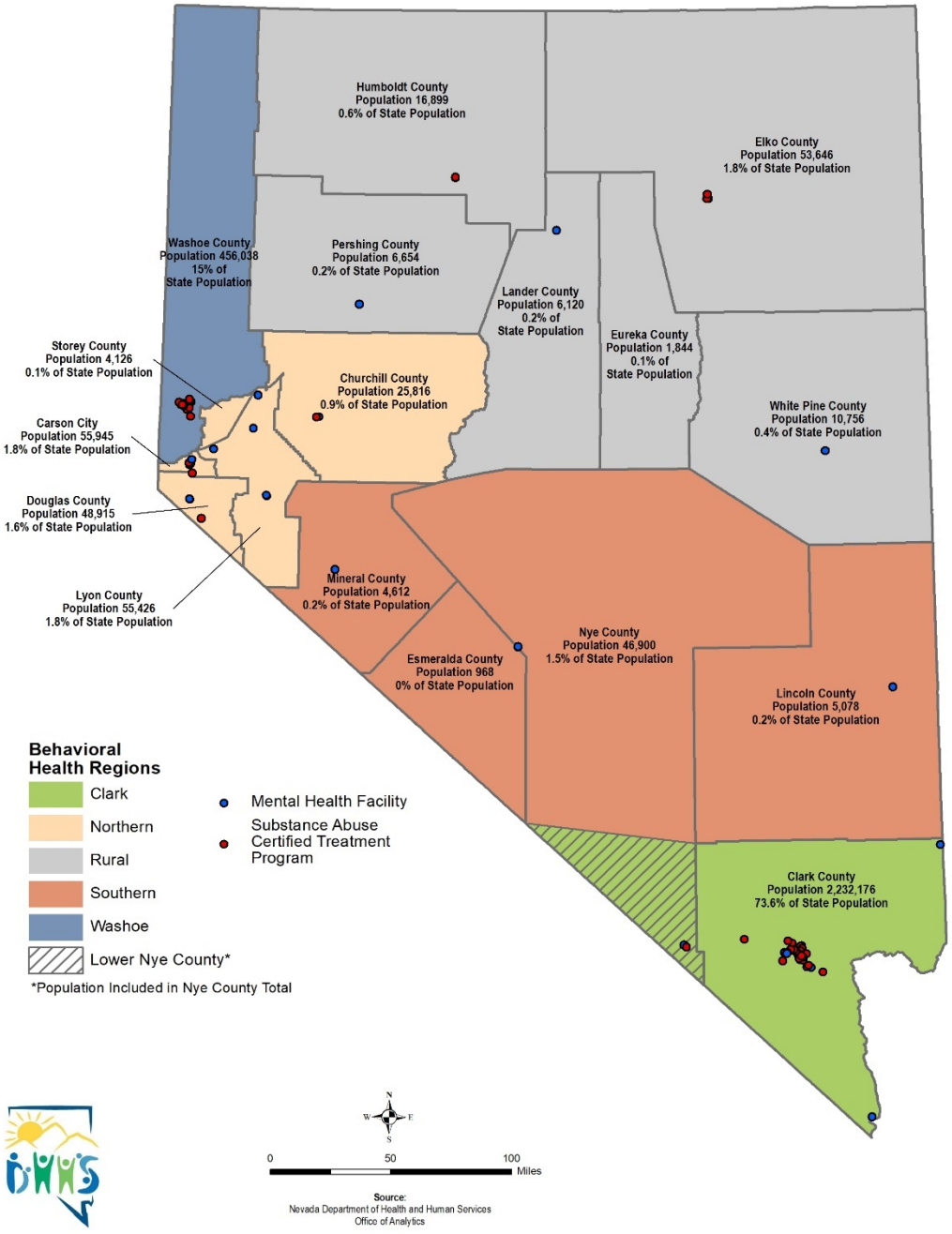


In 2018, the estimated population for Clark County was 2,232,176, a 13.9% increase from the 2010 estimated population. With 73.6% of Nevada's population living in Clark County, it is the most populated area in the state, with an estimated 2,232,176 persons.

The population of Clark County is made up of approximately equal percentages of females and males. The median household income is $54,882. Clark County's land area is approximately 7,891 square miles.

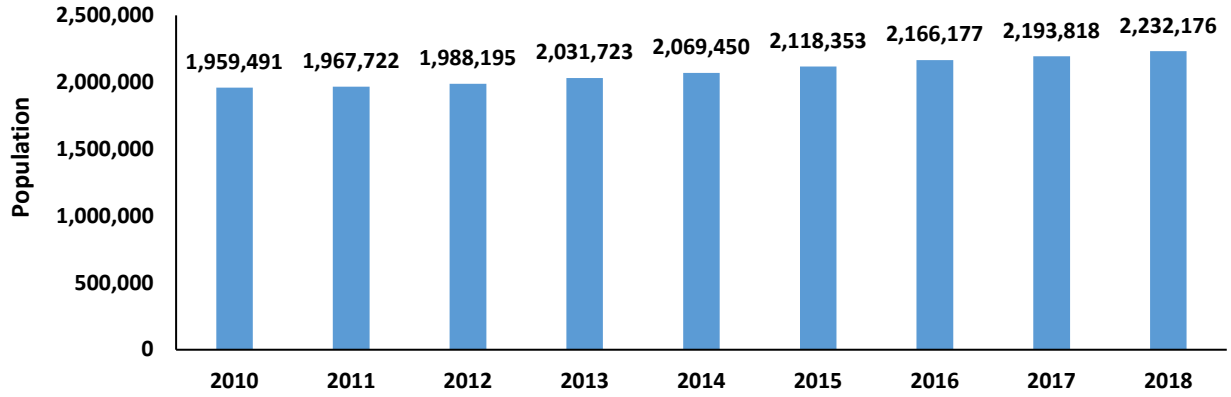
During the 2017 session, regional behavioral health boards were formed to address behavioral health in Nevada. The regions were redrawn during the 2019 session, and Nye County was split into regions. The northern half of Nye County is part of the Southern Nevada region and the southern half of Nye County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

Figure 2. Nevada Population Distribution by County, 2018.



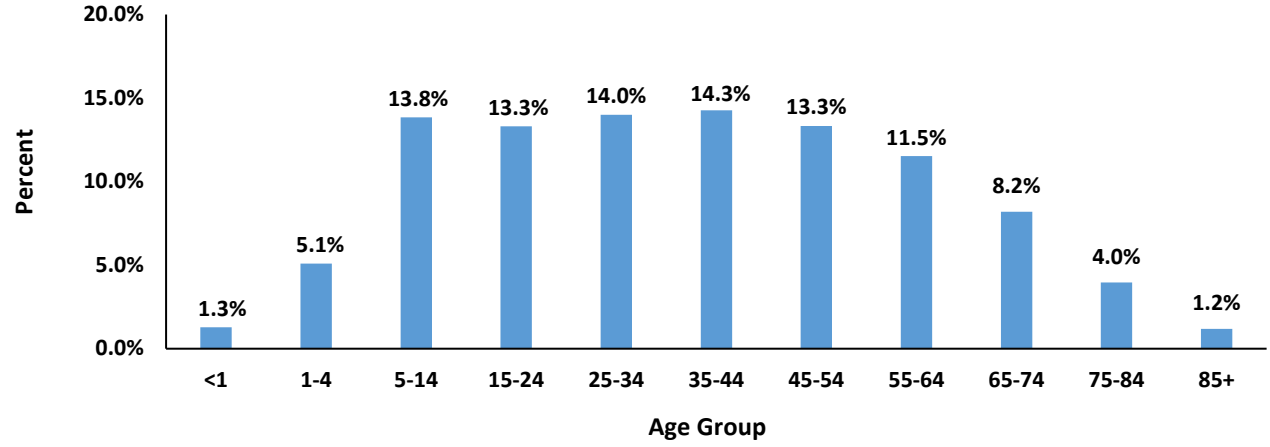
Source: Nevada State Demographer, Vintage 2018;
***Clark Region**: Clark County and southern Nye County*
***Northern Nevada Region:** Carson City, Churchill, Douglas, Lyon, and Storey Counties.*
***Rural Nevada Region:** Elko, Eureka, Humboldt, Pershing, and White Pine Counties.*
***Southern Nevada Region:** 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. Clark County Population, 2010-2018.



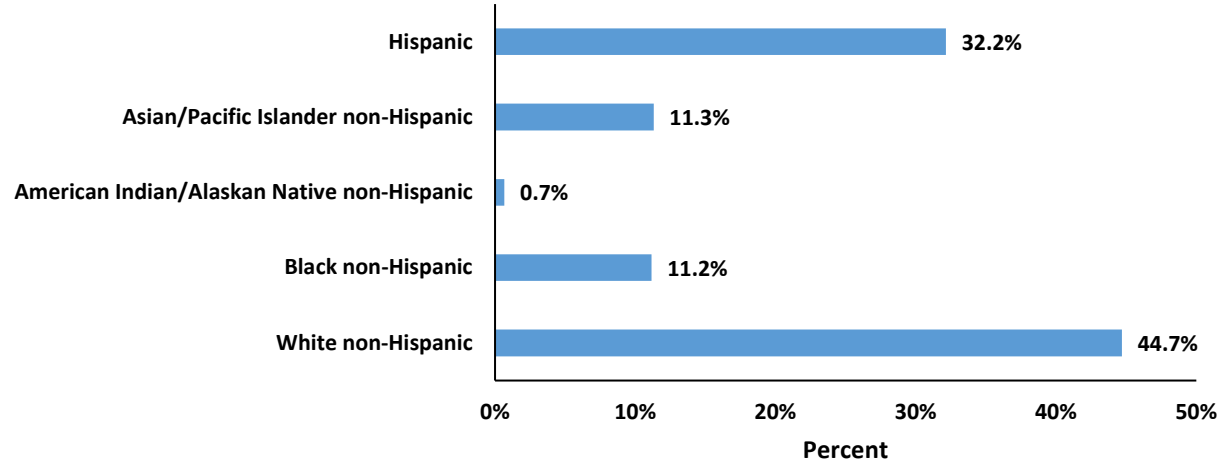
Source: Nevada State Demographer, Vintage 2018.

Figure 4. Clark County Population by Age Group, 2018.



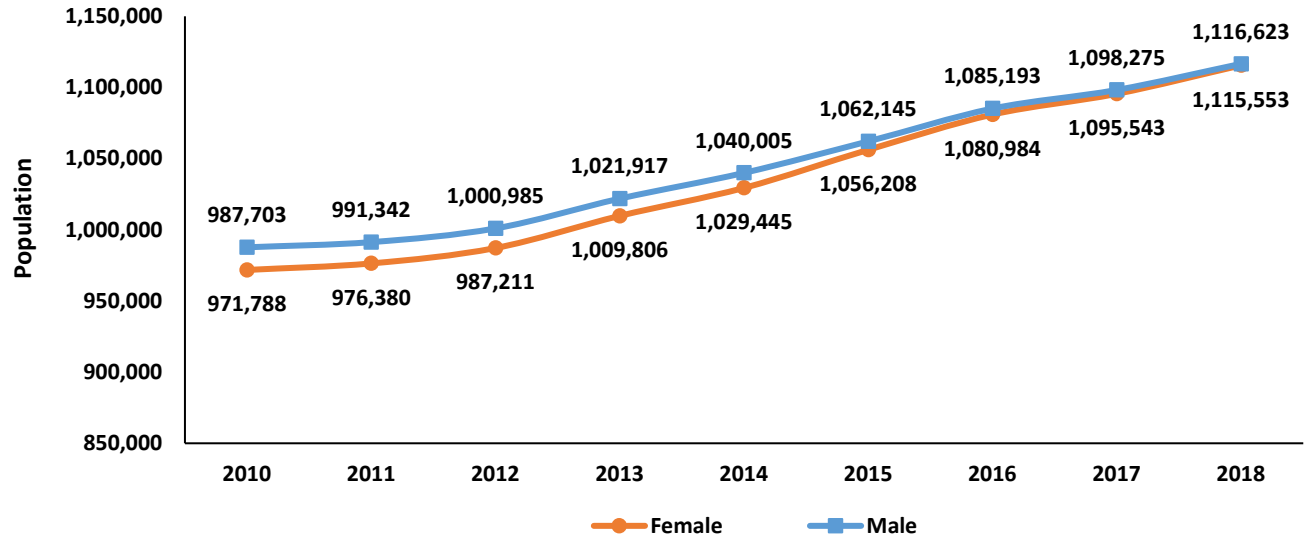
Source: Nevada State Demographer, Vintage 2018.
Chart scaled to 20% to display differences among groups.

Figure 5. Clark County Population by Race/Ethnicity, 2018.



Source: Nevada State Demographer, Vintage 2018.
Chart scaled to 50% to display differences among groups.

Figure 6. Clark County Population Distribution by Sex, 2010-2018.



Source: Nevada State Demographer, Vintage 2017.

In 2018, the estimated population for Clark County was 2,232,176, a 13.9% increase from the 2010 estimated population. With 73.6% of Nevada's population living in Clark County, it is the most populated area in the state, with an estimated 2,232,176 persons.

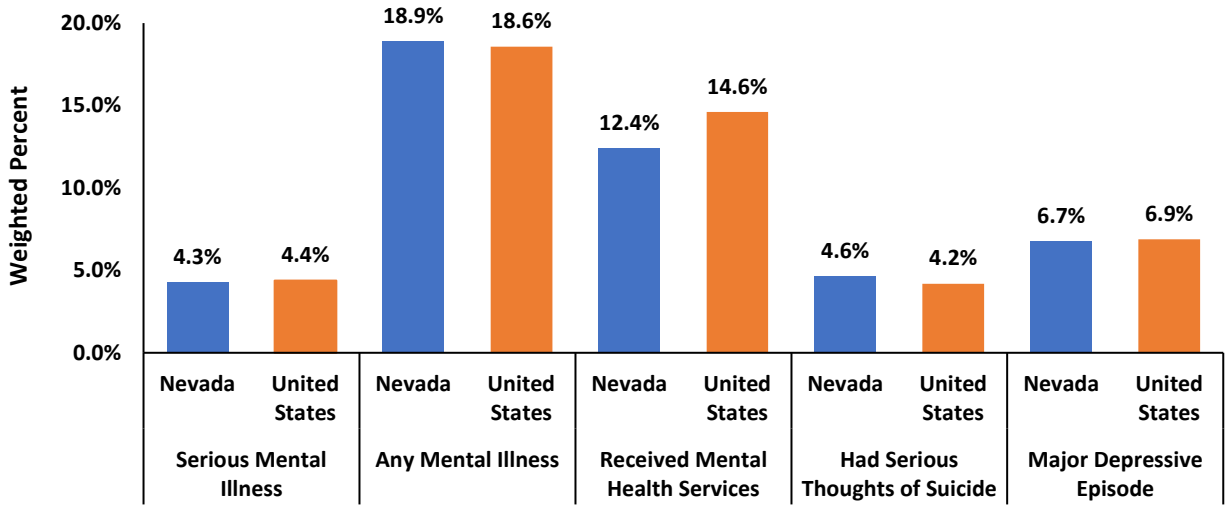
Mental Health

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.



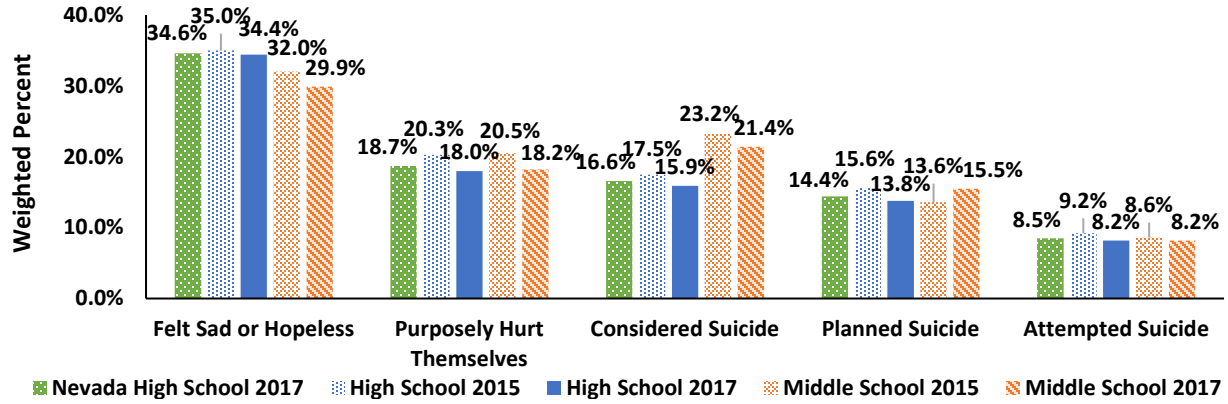
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2016-2017.
Chart scaled to 20% to display differences among groups.

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, 2,019 high school students and 2,137 middle school students from Clark County 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, Clark County Middle and High School Students, 2015 and 2017, and Nevada Statewide High School Students, 2017.



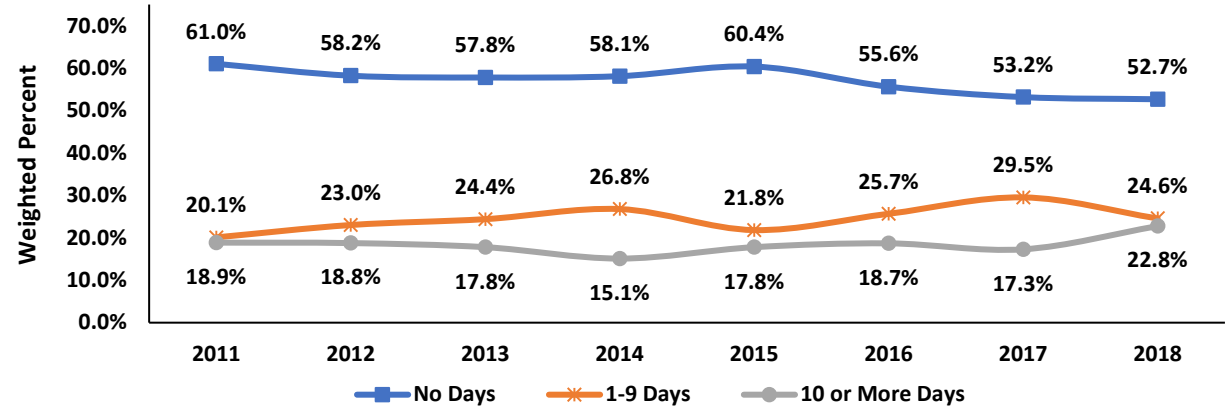
Source: Nevada Youth Risk Behavior Survey (YRBS).
Chart scaled to 40% to display differences among groups.

Patterns of mental health behaviors among Clark County students were similar to those trends across Nevada statewide. In 2017, Clark County middle schoolers were more likely to report having seriously considered attempting suicide (21.4%) compared to high schoolers (15.9%). Approximately one-third of Clark County students reported feeling sad or hopeless from 2015 to 2017. In 2017, among Clark County high schoolers, females (46.2%) were significantly more likely to report feeling sad or hopeless compared to males (23.3%). Females (21.5%) were also significantly more likely to have seriously considered attempting suicide than males (10.6%). Females (18.2%) were significantly more likely to have planned about how they would attempt suicide compared to males (9.4%). Females (23.6%) were significantly more likely to have done something to purposely hurt themselves compared to males (12.4%).

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.

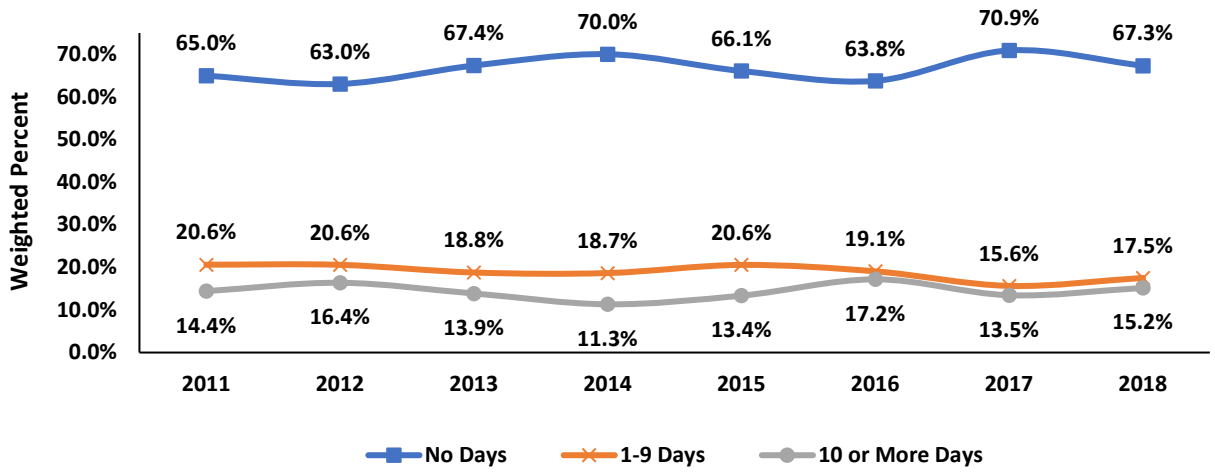
Figure 9. Percentages of Adults Who Experienced Poor Mental or Physical Health That Prevented Them From Doing Usual Activities in Past Month by Days Affected, Clark County Residents, 2011-2018.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 70% to display differences among groups. Question asked in survey: "During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?"

From 2011 to 2018, 40% or more of Clark County adults reported experiencing any day(s) kept from usual activities by poor mental or physical health in the past month. In 2018, 26.6% of Clark County females reported ten or more days kept from usual activities by poor mental or physical health, compared to 17.9% of males. In 2018, 32.8% of Clark County adults who were divorced, separated, or widowed reported ten or more days kept from usual activities, compared to 20.0% of those who were married.

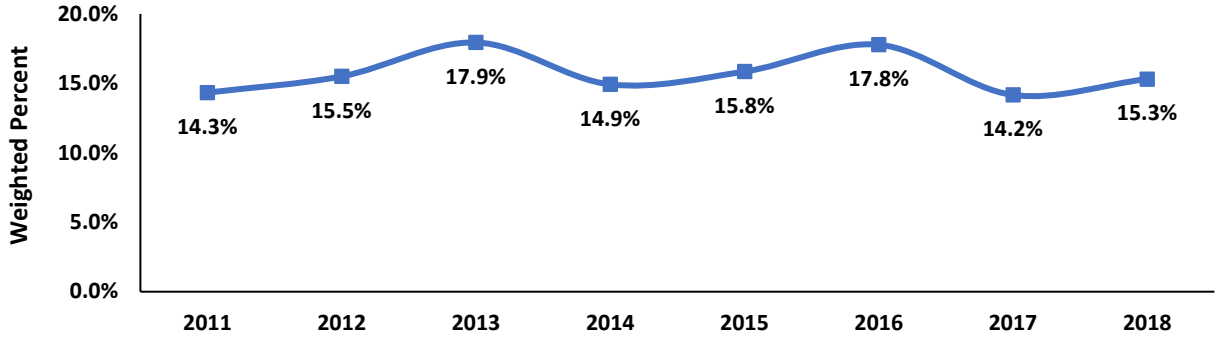
Figure 10. Percentages of Adults In Which Their Mental Health Was Not Good in Past Month by Number of Days Experienced, Clark County Residents, 2011-2018.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 70% to display differences among groups.
Question asked in survey: "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"

In 2018, 15.2% of Clark County adult residents reported 10 or more days of poor mental health experienced in the past month. Clark County residents who were aged 18 to 24 years had the highest prevalence of experiencing 10 or more days of poor mental health, at 26.9%. In 2018, 20.0% of Clark County females reported ten or more days of poor mental health, compared to 10.2% of males. In 2018, 21.1% of Washoe County adults who had never married or were part of an unmarried couple reported 10 or more days of poor mental health compared to 11.3% of married adults.

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



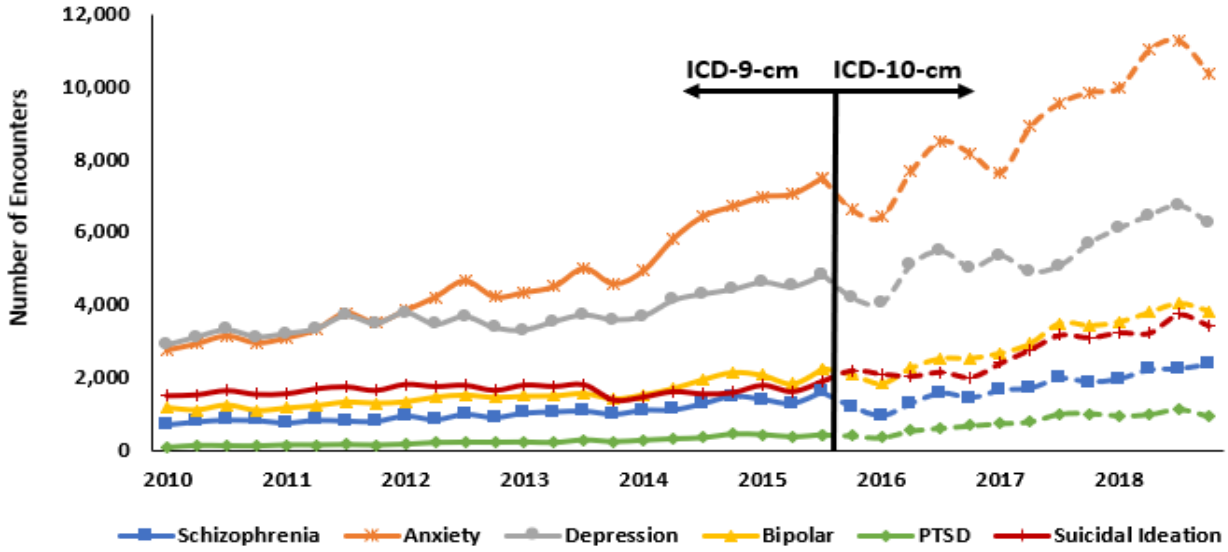
Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 20% to display differences among groups.
Question asked in survey: "(Ever told) you have a depressive disorder (including depression, major depression, dysthymia, or minor depression)?"

In 2018, roughly 15.3% of Clark County adults have ever been told they have a depressive disorder. Clark County females (19.6%) had significantly higher prevalence of depressive disorder(s) than males (10.9%). In 2018, Hispanics had significantly lower prevalence (8.5%) of depressive disorder(s) than White non-Hispanics (19.5%) or Black non-Hispanics (20.1%).

Hospital Emergency Department Encounters

The hospital emergency department billing data includes data for emergency room patients for Nevada's non-federal hospitals. There were 80,040 emergency department visits related to mental health disorders among Clark County 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 in Clark County, by Quarter and Year, 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.

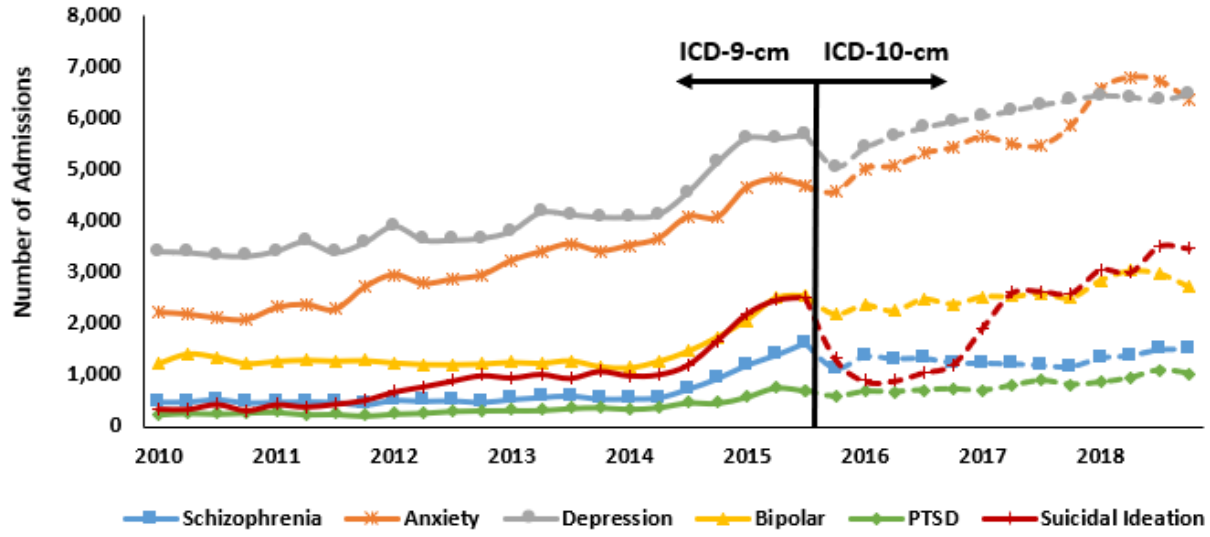
Anxiety has been the leading mental health-related diagnosis since mid-2012 in emergency department encounters. Emergency department encounters related to anxiety, depression, bipolar, PTSD, and suicidal ideation have significantly increased from 2010 to 2018. In 2010, there were 606.4 anxiety-related visits per 100,000 and 637.5 depression-related visits per 100,000 in Clark County, which have increased to 1,913.4 per 100,000 and 1,146.4 per 100,000, respectively, in 2018.

In Clark County, males made up 67.3% of visits for schizophrenia and 64.0% of visits for suicidal ideation, whereas females made up 63.5% of visits for anxiety, 59.2% of visits for depression, 51.0% of visits for bipolar disorder, and 53.1% of visits for PTSD. In 2018, Clark County females had significantly higher age-adjusted rates for anxiety (192.5 per 100,000), depression (100.4 per 100,000), bipolar (47.4 per 100,000), and PTSD (15.2 per 100,000) than males (80.8 per 100,000; 39.4 per 100,000; 19.8 per 100,000; 6.5 per 100,000).

Hospital Inpatient Admissions

Hospital Inpatient Billing data includes data for patients discharged from Nevada's non-federal hospitals. There were 56,720 inpatient admissions related to mental health disorders among Clark County 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 in Clark County, by Quarter and Year, 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 from 2010 through 2017. In 2010, there were 687.6 depression-related visits per 100,000 and 440.3 anxiety-related visits per 100,000 in Clark County, which have increased to 1,149.5 per 100,000 and 1,183.9 per 100,000, respectively, in 2018.

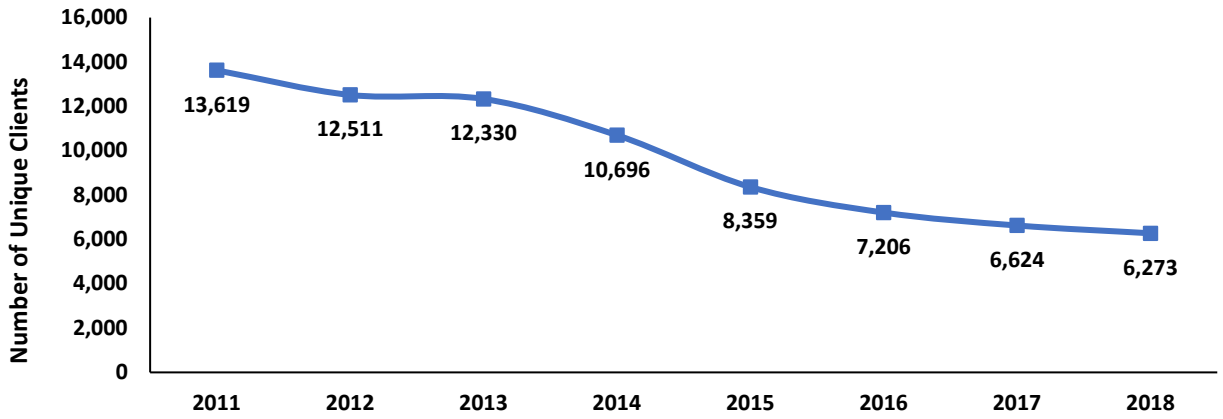
In 2018, there were nearly twice as many males admitted for schizophrenia as females in Clark County. In 2018, Clark County females had significantly higher age-adjusted rates for anxiety (158.4 per 100,000), depression (147.4 per 100,00), bipolar (42.2 per 100,000), and PTSD-related (30.7 per 100,000) inpatient admissions compared to males.

Suicidal ideation in Clark County also increased from 2010 to 2018, but the number of admissions dropped in 2016 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 or reporting.

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 in Clark County, 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 continues to decline. There were 6,273 clients served in 2018, which has decreased significantly from 2011 (13,619). 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. This likely contributes to the decline of the clients represtented in the above chart.

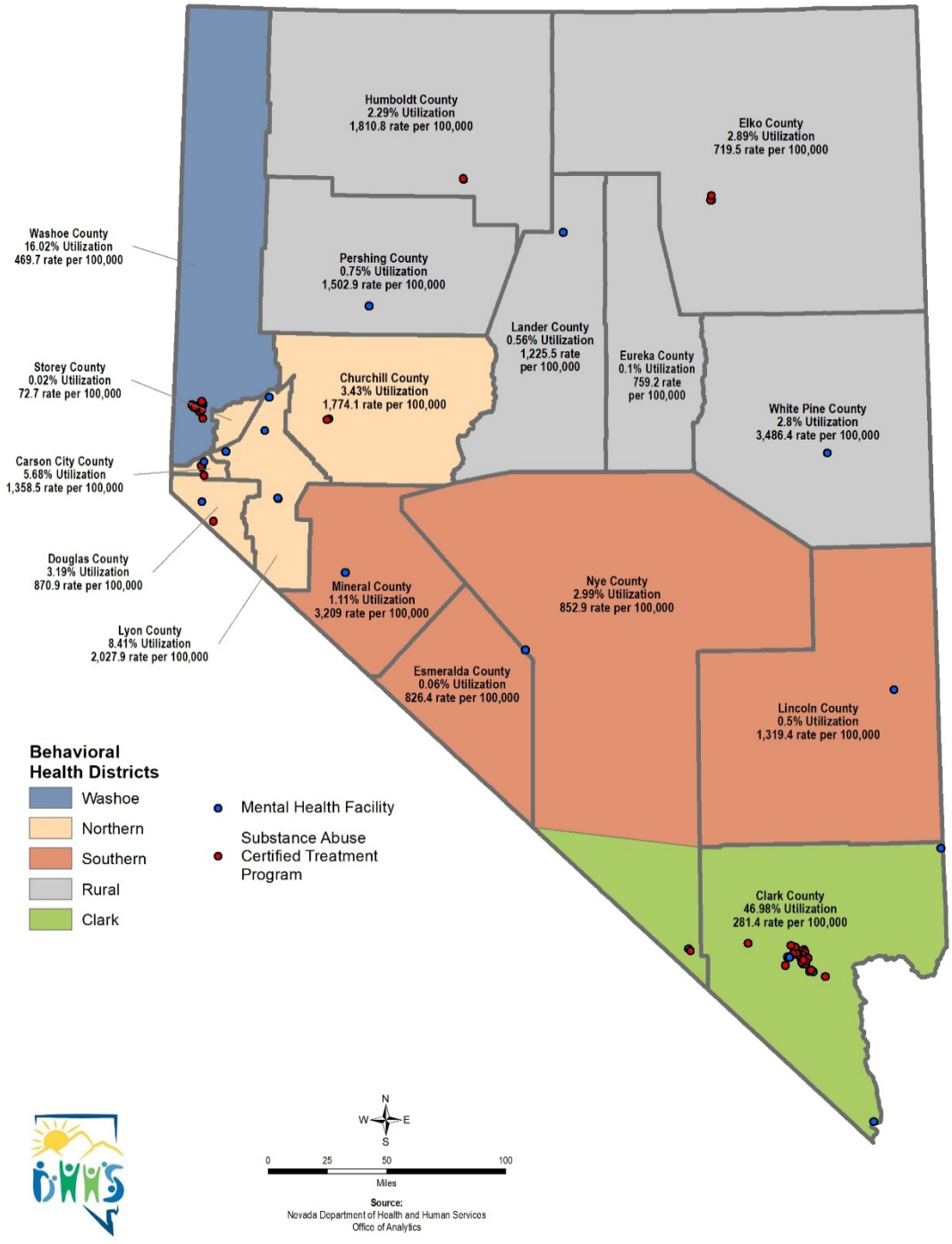
Figure 15. Top Mental Health Clinic Services by Number of Patients Served* (SNAMHS), 2011-2018.

Program*	Year							
	2011	2012	2013	2014	2015	2016	2017	2018
Medication Clinic	8,288	7,920	8,310	7,899	5,386	4,212	3,817	3,350
Inpatient Hospital	1,876	1,998	2,165	2,368	2,545	1,849	1,807	1,774
Ambulatory Service Coordination	3,235	3,069	2,625	1,459	796	1,781	1,463	1,199
Observation Unit~	3,972	4,179	2,810	0	0	0	0	0
Service Coordination	681	728	1,014	1,009	841	620	511	621
Outpatient Counseling	1,043	948	655	626	514	565	544	444
Mesquite Outpatient Counseling^	125	151	148	181	215	209	265	244

Source: State Funded Mental Health: Avatar.
~Program no longer active.
^Mesquite Outpatient is not part of SNAMHS.
**A client is counted only once per year. Clients may be counted more than once across years.*

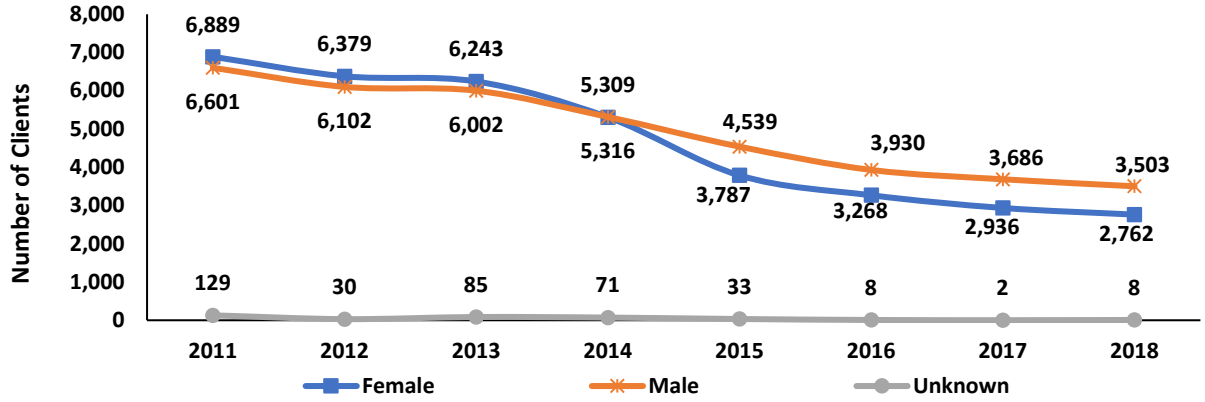
Patients were counted only once per program per year. Since a patient can receive services in more than one program, the count above are not mutually exclusive.

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* in Clark County by Gender, 2011-2018.

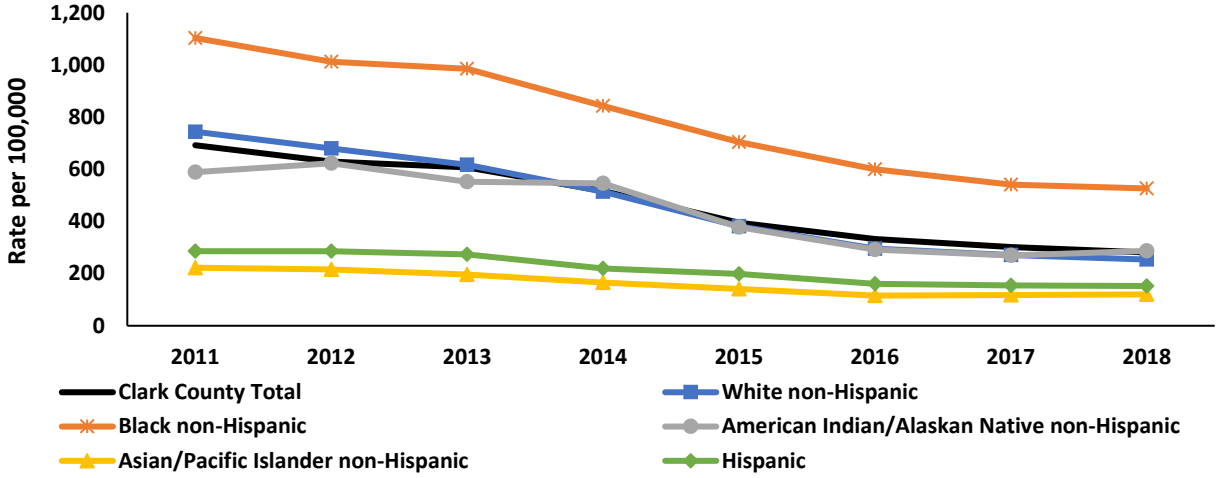


Source: Avatar.
**A client is counted only once per year. Clients may be counted more than once across years.*

From 2011 to 2014, there were similar numbers of males and females in Clark County who utilized state-funded mental health clinics. However, from 2015 to 2018, males utilized the state-funded mental health clinics more than females. In 2018, there was an average of 313.7 males per 100,000 male population who utilized the state-funded mental health clinics, compared to an average of 247.6 females per 100,000 female population.

In 2018, of the clients that utilized state-funded mental health services, the most common age group was 25 to 34 years, accounting for 23% of the clients. High school graduates accounted for 24.7% of the clients, followed by those with those with less than 12th grade, no diploma education at 23.3% in 2018.

Figure 18. State-Funded Mental Health Clinics Utilization* in Clark County by Race/Ethnicity, 2011-2018.



Source: Avatar.
Race "Unknown" not included in analysis.
**A client is counted only once per year. Clients may be counted more than once across years.*

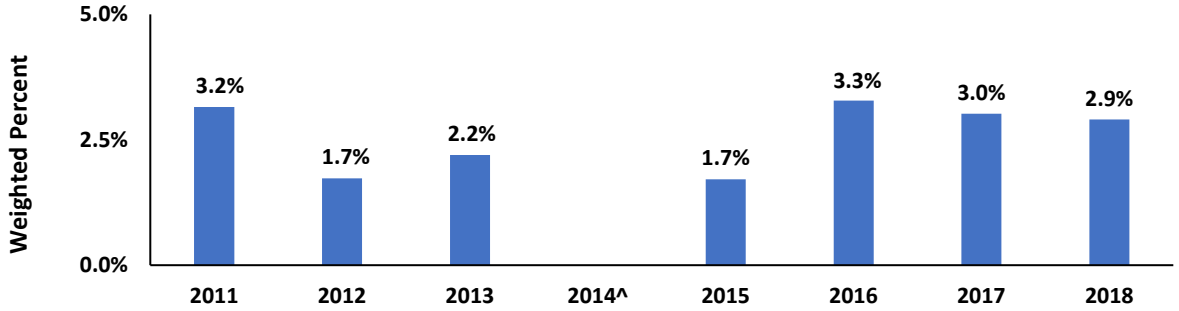
The Affordable Care Act (ACC) went into effect in 2014. Therefore, many Clark County residents are now able to access non-state-funded facliites through the expansion of Medicaid. This likely contributes to the decline of the clients represtented in the above chart. The patient utilization crude rate has gone down significantly across all races from 2011 to 2018. The Black non-Hispanic population have had the highest

rate over the seven-year period, whereas Asian/Pacific Islanders have had the lowest rate. Clients were counted only once per program per year. Since a patient can receive services in more than one program, the counts above are not mutually exclusive.

Suicide

While suicidal ideation 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.

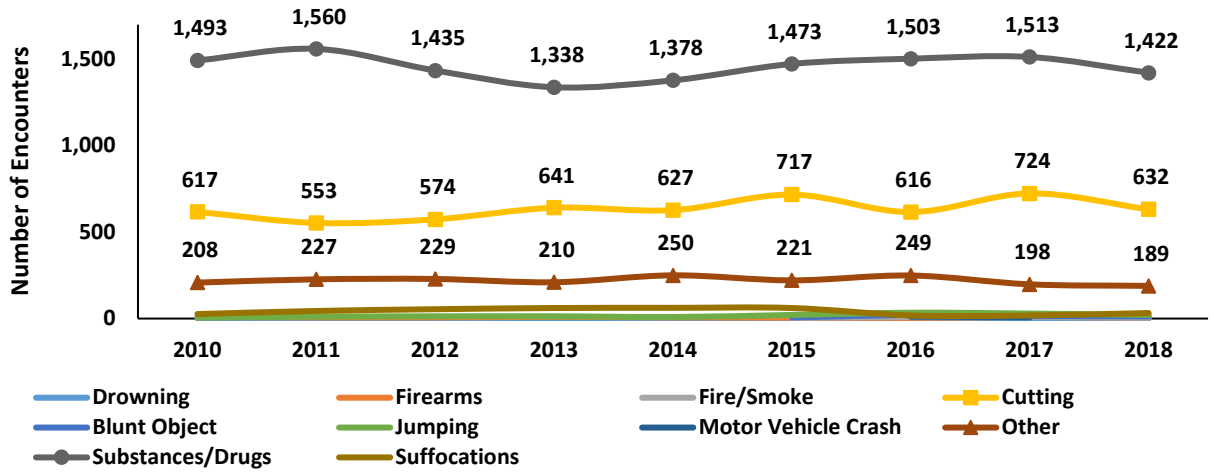
Figure 19. Percentage of Adult Clark County Residents Who Have Seriously Considered Attempting Suicide, 2011-2018.



Source: Behavioral Risk Factor Surveillance System (BRFSS).
Charts scaled to 5% to display differences among groups.
^Indicator was not measured in 2014.

In 2018, 2.9% of Clark County adults reported having seriously considered attempting suicide during the past 12 months. Between 2011 and 2018, the average prevalence for suicidal ideation in Clark County was 2.6%. Suicidal ideation in Clark County adults in 2018 did not significantly differ from that across Nevada statewide. This indicator was not measured in 2014.

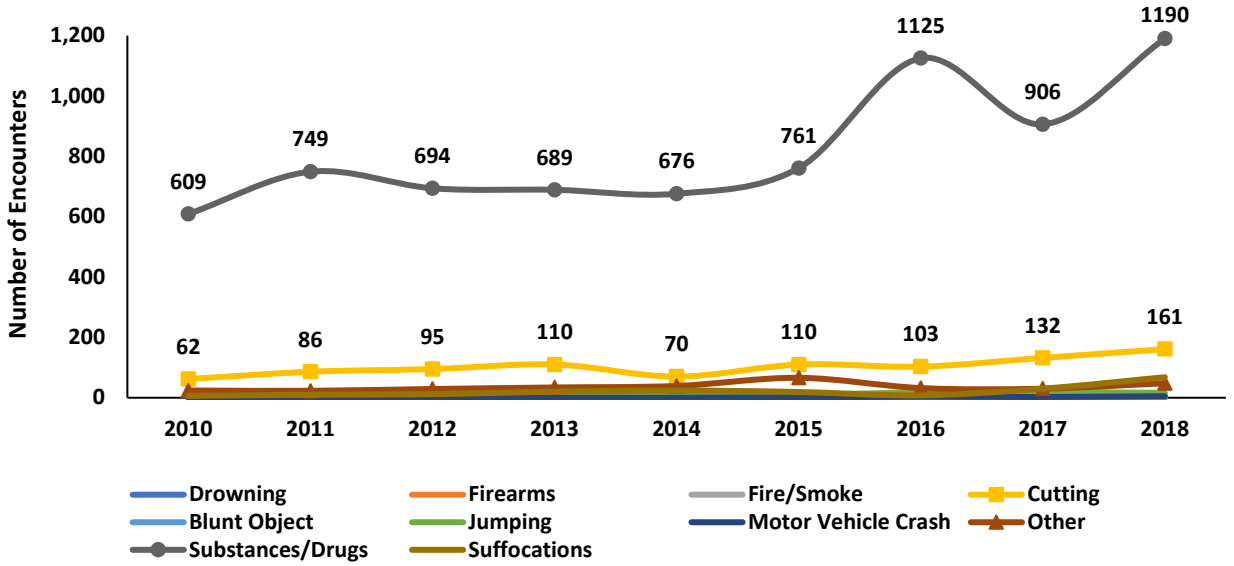
Figure 20. Suicide Attempts Emergency Department Encounters by Method, Clark County Residents, 2010-2018.



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 remained steady from 2010 to 2018 in Clark County. The most common method for attempted suicides seen in emergency departments is a substance or drug overdose attempt, followed by cutting.

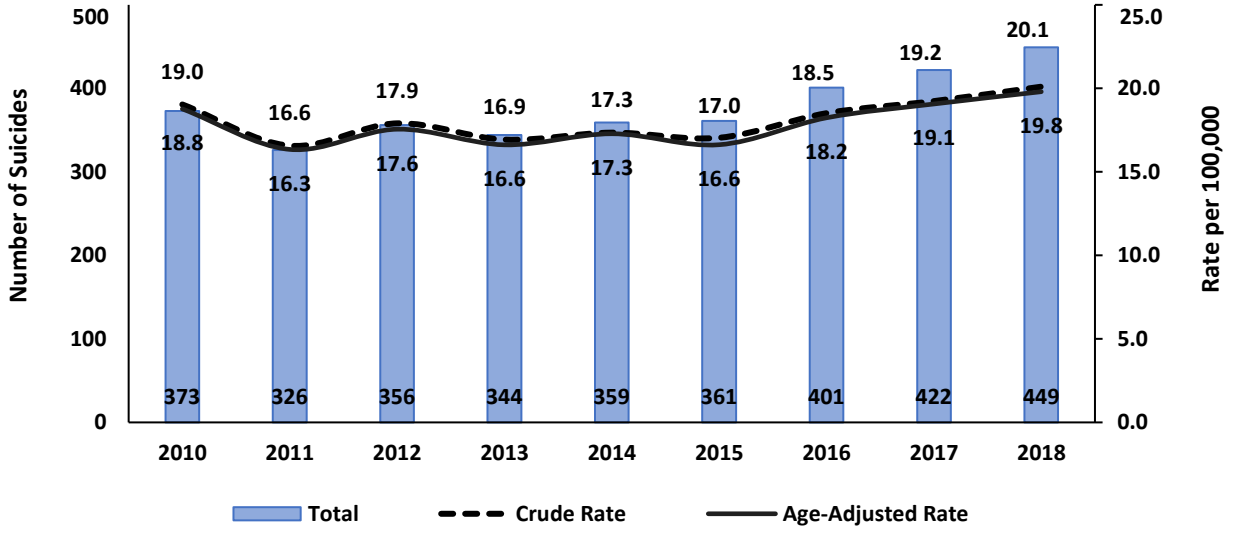
Figure 21. Suicide Attempt Inpatient Admissions by Method, Clark County Residents, 2010-2018.



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

In Clark County, inpatient admissions for attempted suicides where the patient was admitted and did not expire at the hospital, have increased significantly from 2010 to 2018, where method was substance or drug overdose. The most common method for attempted suicide seen in inpatient admissions in Clark County is a substance or drug overdose attempt, followed by cutting.

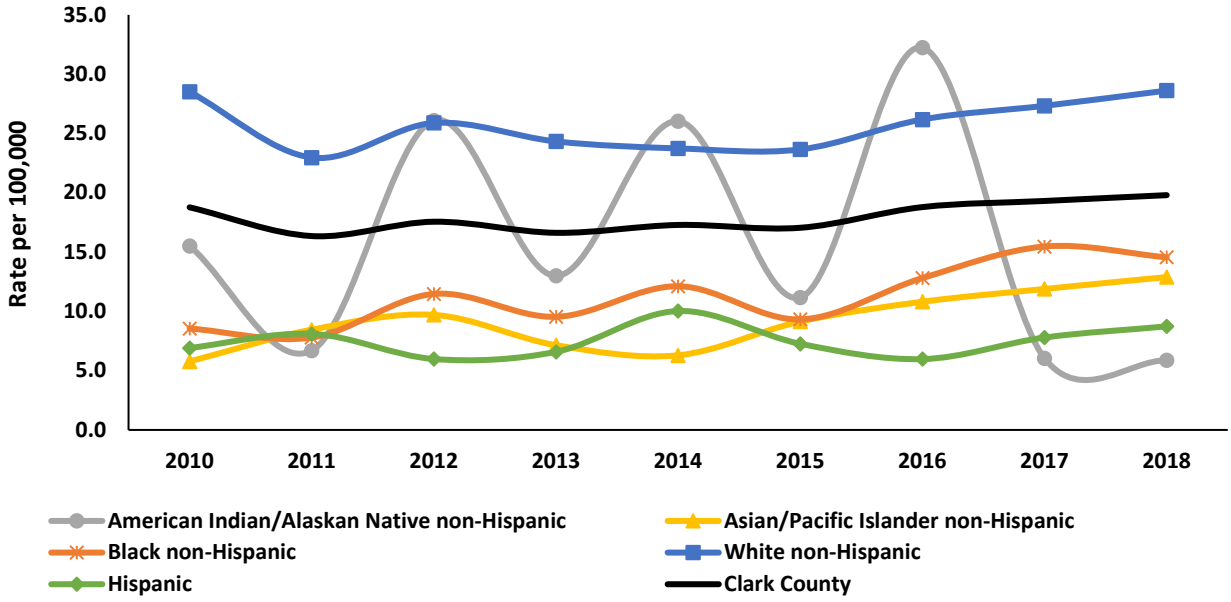
Figure 22. Number of Suicides and Age-Adjusted Rates, Clark County Residents, 2010-2018.



Source: Nevada Electronic Death Registry System.

The age-adjusted suicide rate in Clark County was 19.8 suicides per 100,000 population in 2018, which was not significantly different from the rate across Nevada statewide. In Clark County, in 2018, the greatest number of suicides occurred in those aged 45 to 54 years (82 suicides) and those with only a high school degree (176 suicides).

Figure 23. Age-Adjusted Suicides Rates by Race/Ethnicity, Clark County Residents, 2010-2018.



Source: Nevada Electronic Death Registry System.

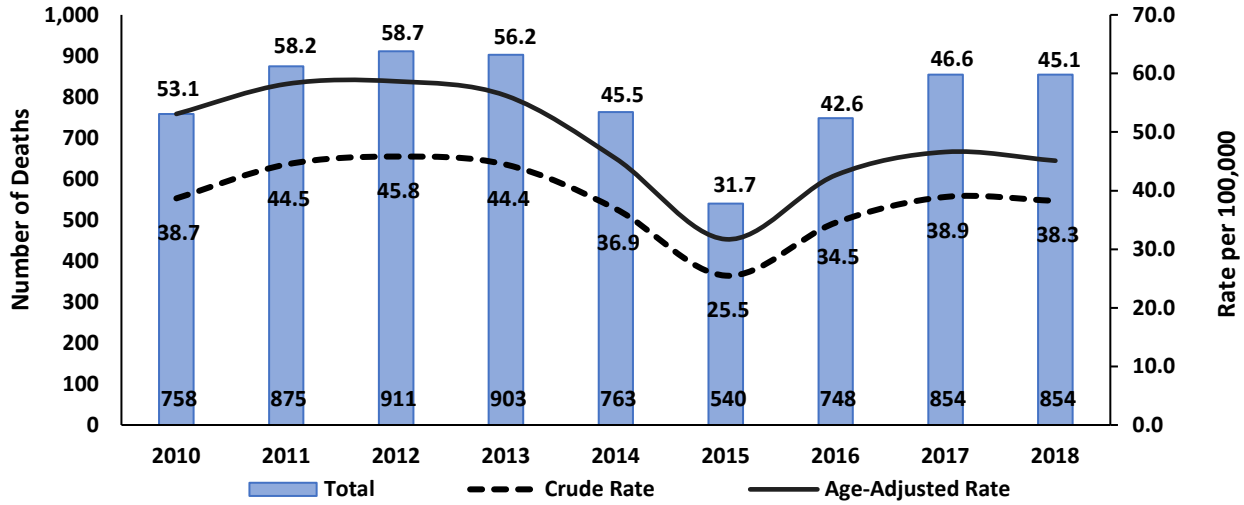
In 2018, the age-adjusted suicide rates for White non-Hispanics (28.6 cases per 100,000) were significantly higher than the rates for Native Americans/Alaskan Natives (5.9 cases per 100,000), Asian/Pacific Islanders (12.9 cases per 100,000), Black non-Hispanics (14.6 cases per 100,000), and Hispanics (8.7 cases per 100,000), as well as the overall Clark County rate (19.8 cases per 100,000).

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

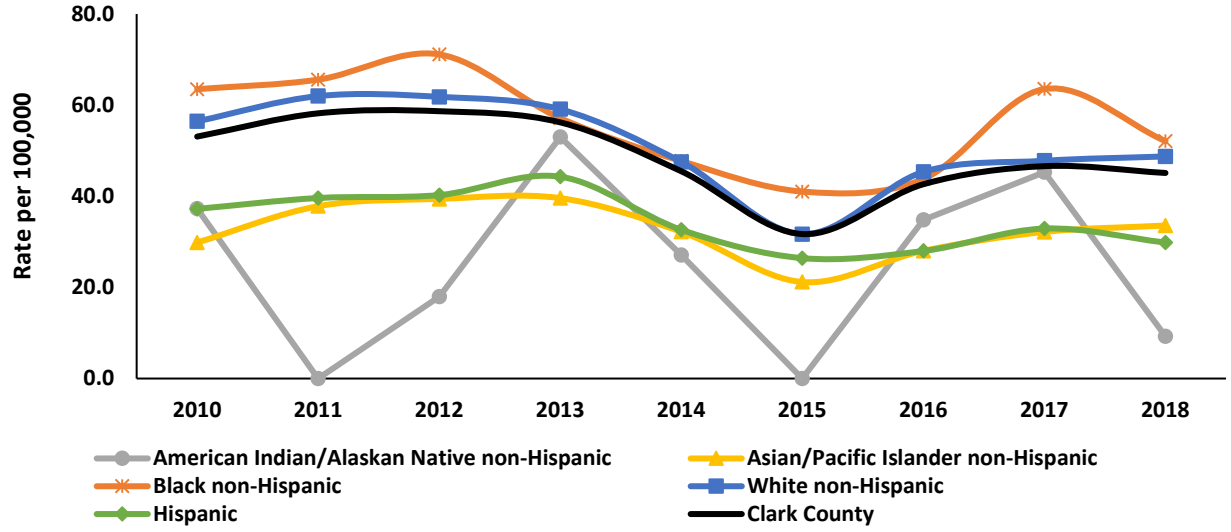
Figure 24. Mental Health-Related Deaths and Age-Adjusted Rates, Clark County Residents, 2010-2018.



Source: Nevada Electronic Death Registry System.

There were 854 deaths related to mental health in Clark County in 2018. As age increased, deaths related to mental health increased, such that Clark County residents who were aged 85 years or older made up the largest proportion of mental health-related deaths. In 2018, the educational group with the highest count of mental health-related deaths (379 deaths) was high school graduates. In 2018, the mental health-related age-adjusted death rate in Clark County was not significantly different compared to Nevada statewide.

Figure 25. Age-Adjusted Mental Health-Related Death Rates by Race/Ethnicity, Clark County Residents, 2010-2018.



Source: Nevada Electronic Death Registry System.

In 2018, in Clark County, there were significantly lower age-adjusted mental health-related death rates in American Indian/Alaskan Natives (9.3 cases per 100,000) and Hispanics (29.8 cases per 100,000) compared to Black non-Hispanics (52.1 cases per 100,000) and White non-Hispanics (48.7 cases per 100,000). In 2018, Clark County Asian/Pacific Islanders (33.6 cases per 100,000) had significantly lower age-adjusted mental health-related death rates compared to White non-Hispanics.

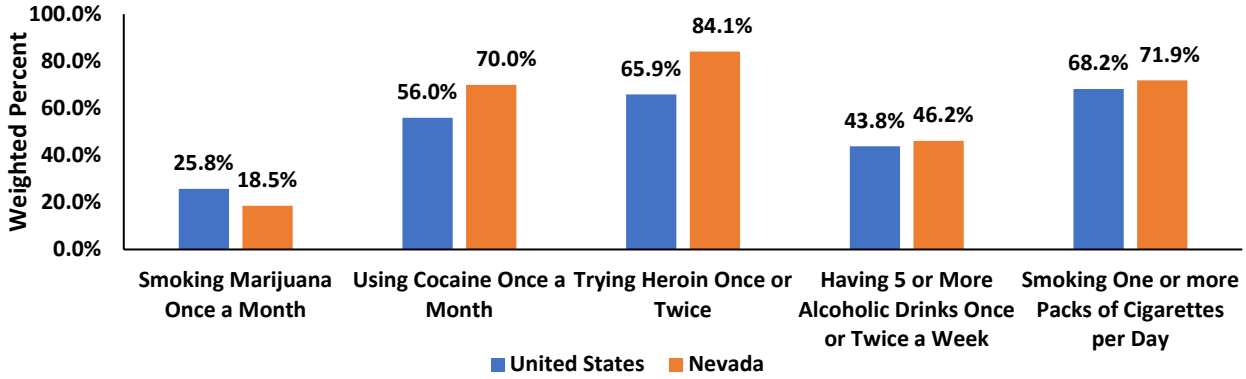
Substance Use

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.

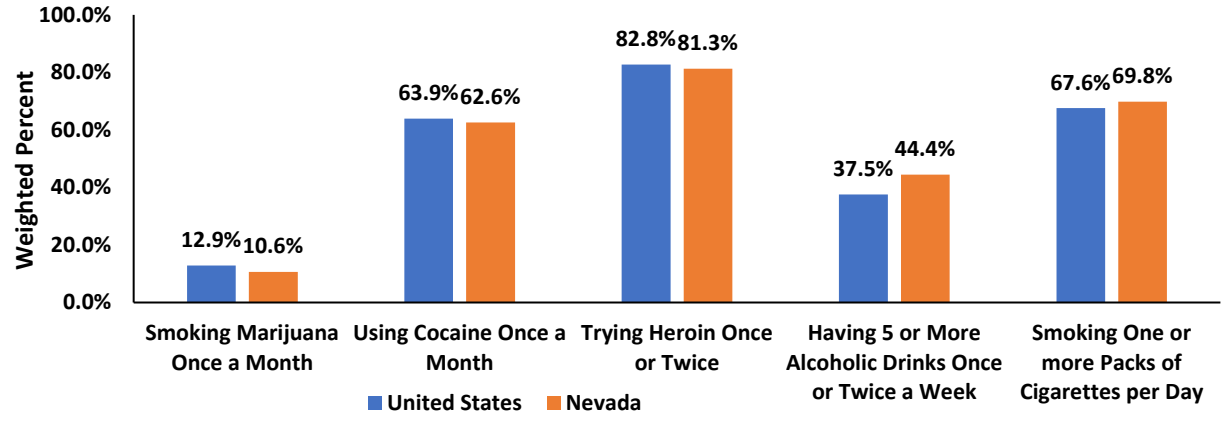
Figure 26. Perceptions of Great Risk from Alcohol or Substance, Ages 12-17, Nevada and the United States, 2017.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2011-2017.
Chart scaled to 100% to display differences among groups.

Perceived risk of Nevadan teens (age 12-17) for using cocaine, trying heroin, drinking more than 5 drinks and smoking is greater than that of the United States, whereas for young adults (age 18-25), their perceived risk is lower than the United States for using cocaine and trying heroin.

Figure 27. Perceptions of Great Risk from Alcohol or Substance, Ages 18-25, Nevada and the United States, 2016-2017.

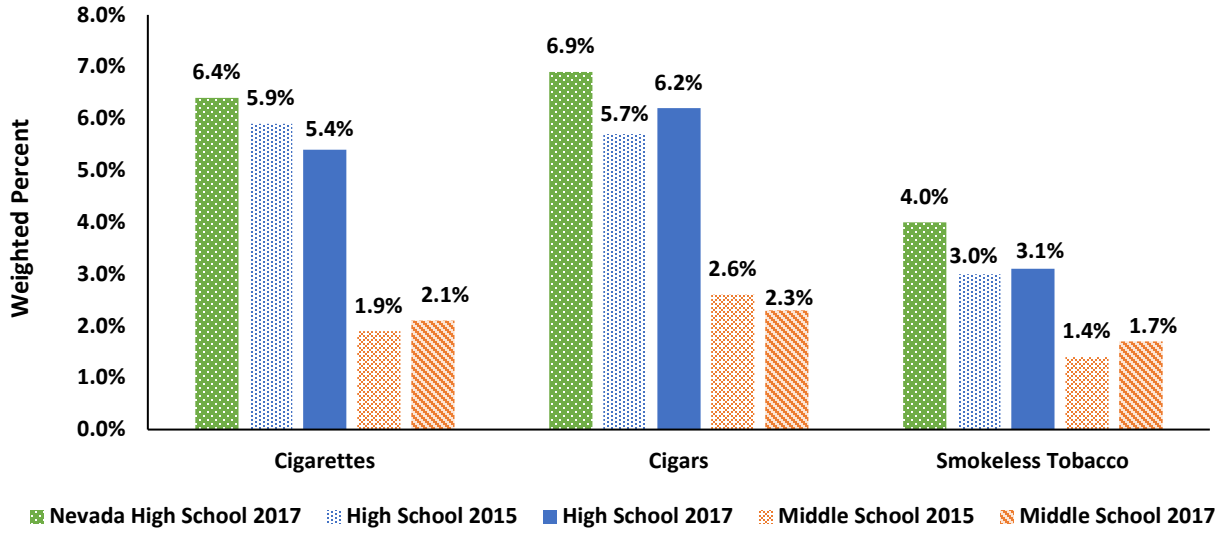


Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010-2016.
Chart scaled to 100% to display differences among groups.

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, 2,019 high school students and 2,137 middle school students from Clark County 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.

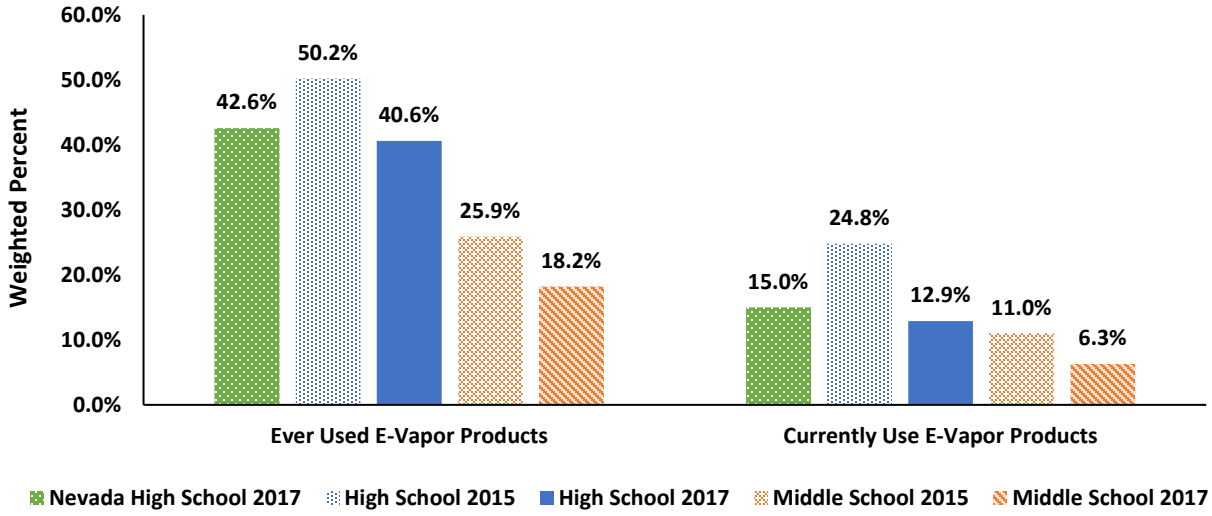
Figure 28. Current Tobacco Use, Clark County Middle and High School Students, 2015 and 2017, and Nevada Statewide High School Students, 2017.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 8% to display differences among groups.

There were no significant changes in current tobacco-related use from 2015 and 2017 in both middle and high schoolers in Clark County. In 2017, 21.8% of Clark County high schoolers reported ever trying cigarettes (even just one to two puffs). In 2017, Native Hawaiian or Pacific Islander high schoolers were more likely to report ever smoking cigarettes (42.7%) compared to all other race/ethnicities. In 2017, Clark County high school males (4.4%) were more likely to report currently using smokeless tobacco compared to females (1.6%). In 2017, high school males (8.6%) were also more likely to report currently smoking cigars compared to females (3.6%). In 2017, Clark County Black non-Hispanic high schoolers were more likely to report currently smoking cigars (13.7%) compared to Asian/Pacific Islander, White non-Hispanics, and Hispanic/Latino high schoolers. Tobacco usage patterns among Clark County high schoolers in 2017 did not significantly differ from those across Nevada statewide.

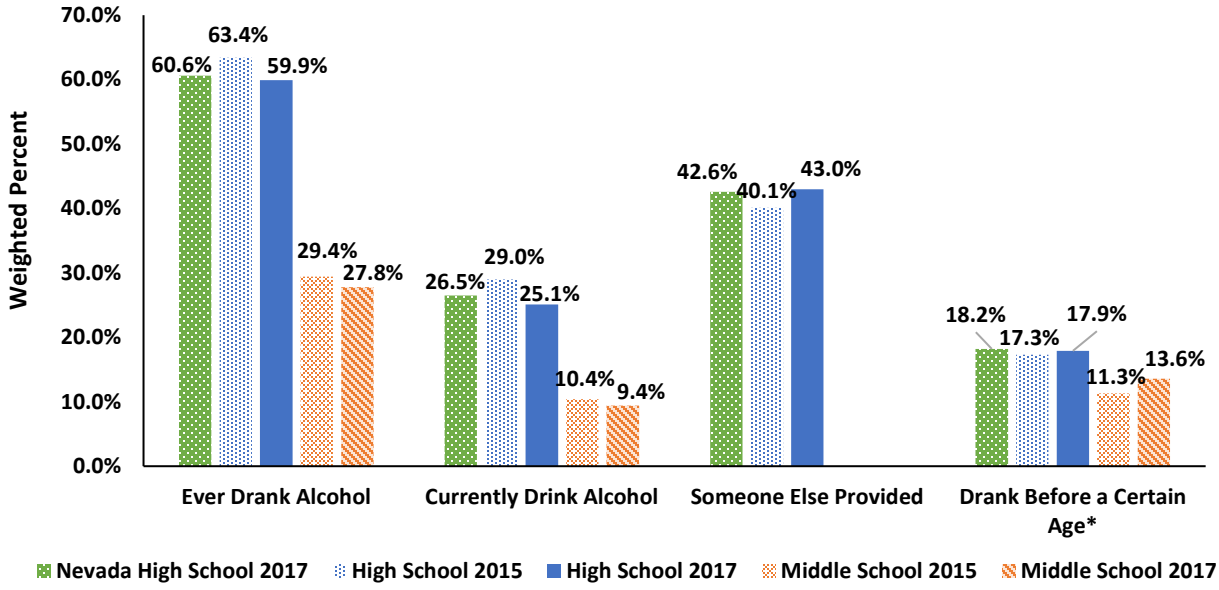
Figure 29. Electronic Vapor Product Use, Nevada Middle and High School Students in Clark County, 2015 and 2017, and Nevada Statewide High School Students, 2017.



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

Regarding electronic vapor products, there were significant decreases in usage from 2015 to 2017 among Clark County students. Among Clark County high schoolers in 2017, Hispanic/Latino students (44.6%) and Native Hawaiian/Pacific Islander students (54.8%) were more likely to have ever tried electronic vapor products compared to Asian/Pacific Islander students (23.6%). Trends in e-vapor product usage among Clark County high schoolers did not significantly differ from those in Nevada statewide in 2017.

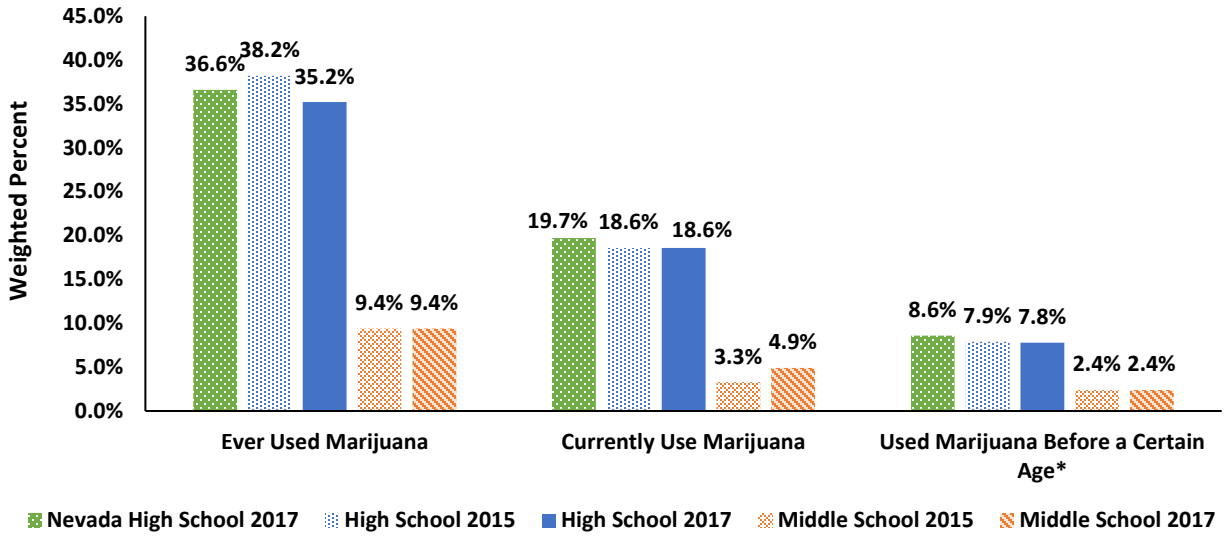
Figure 30. Alcohol Use, Clark County Middle and High School Students, 2015 and 2017, and Nevada Statewide High School Students, 2017.



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.*

In 2017, 59.9% of Clark County high schoolers reported ever drinking alcohol, compared to 27.8% of Clark County middle schoolers. Trends in drinking patterns among Clark County students did not significantly differ from 2015 to 2017 and did not significantly differ by race/ethnicity. Approximately 9.8% of Clark County high schoolers reported recent binge drinking in 2017. In 2017, 11th and 12th graders were significantly more likely to have ever drank alcohol compared to 9th and 10th graders. Trends in alcohol usage in Clark County high schoolers in 2017 did not significantly differ from those across Nevada statewide.

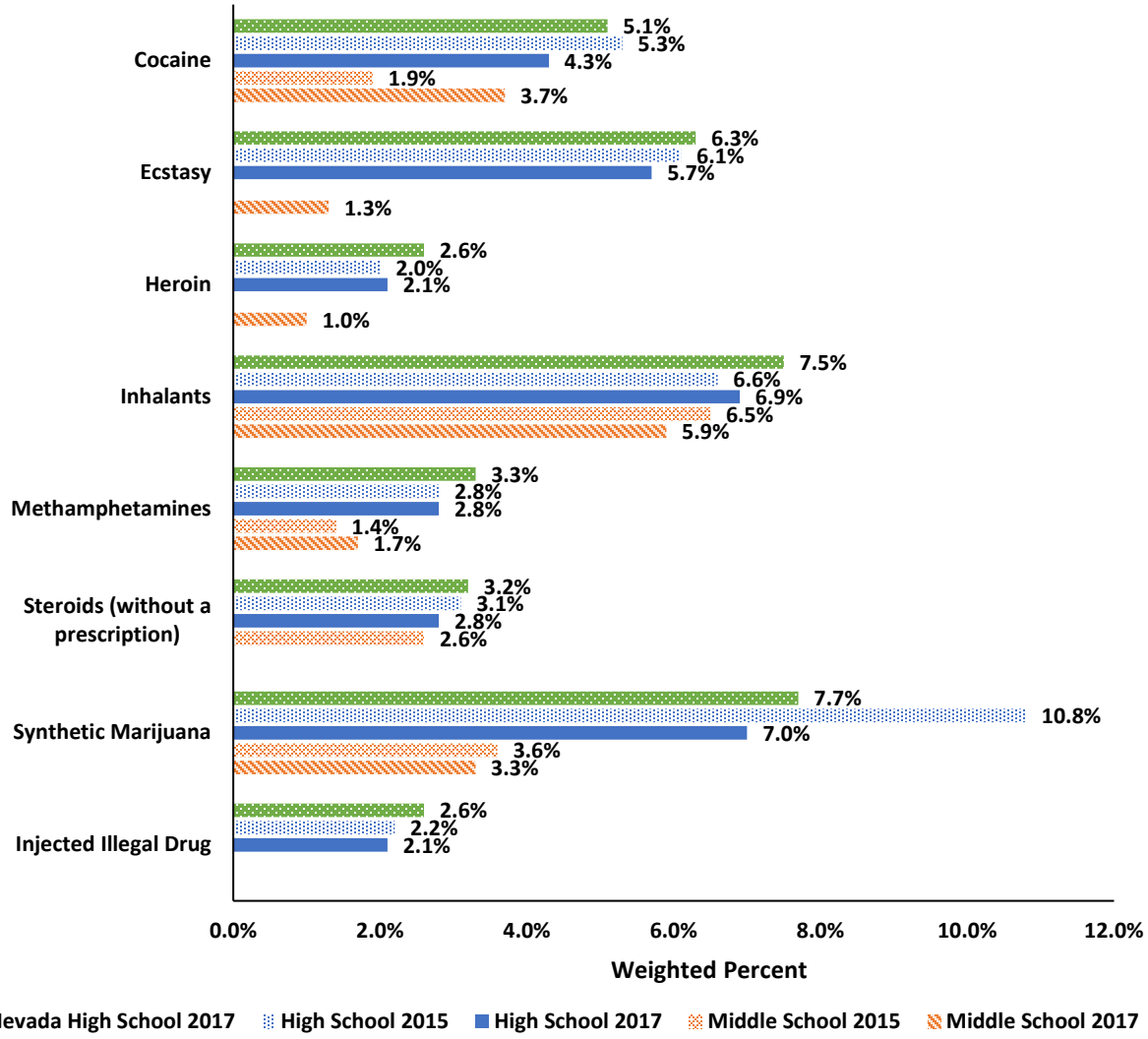
Figure 31. Marijuana Use, Clark County Middle and High School Students, 2015 and 2017, and Nevada Statewide High School Students, 2017.



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.*

More than a third of Clark County high schoolers reported ever trying marijuana. There were no significant changes in marijuana usage in Clark County middle and high schoolers from 2015 to 2017. In 2017, Black non-Hispanic (45.2%) and Hispanic/Latino (37.1%) high schoolers were more likely to have ever tried marijuana compared to Asian/Pacific Islander students (20.0%) in Clark County, as well as more likely to have ever tried marijuana before age 13. In 2017, Black non-Hispanic (27.7%) and Hispanic (19.2%) high schoolers in Clark County were more likely to be current marijuana users compared to Asian/Pacific Islanders (8.7%). In 2017, among Clark County high schoolers who currently used marijuana, 84.0% smoked marijuana in a joint, bong, pipe, or blunt. Trends in marijuana usage in Clark County high schoolers did not significantly differ from those across Nevada statewide.

Figure 32. Lifetime Drug Use, Clark County Middle and High School Students, 2015 and 2017, and Nevada Statewide High School Students, 2017.



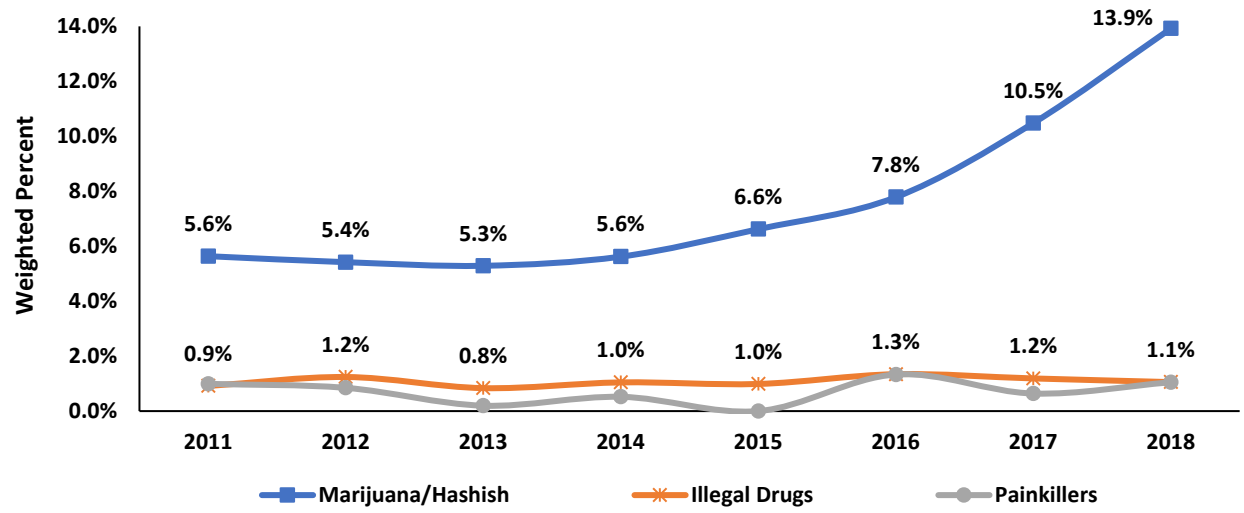
Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 12% to display differences among groups.

There was a significant decrease in use of synthetic marijuana from 2015 to 2017 among Clark County high schoolers. Among middle schoolers in Clark County, there was a significant increase in cocaine lifetime use from 2015 to 2017. Lifetime drug use in Clark County students were comparable to that of Nevada statewide.

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.

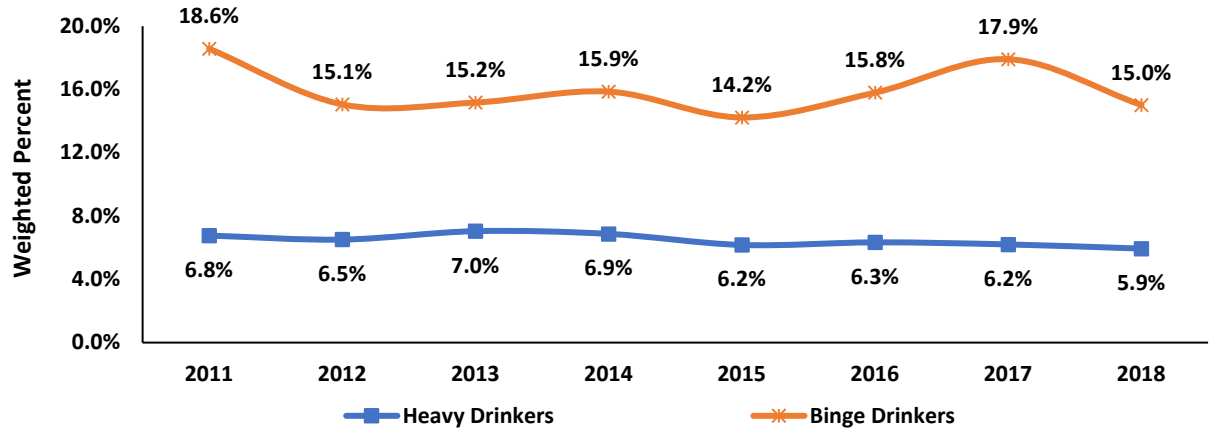
Figure 33. Clark County Adult Residents Who Used Illegal Substances, Marijuana/Hashish or Painkillers to Get High in the Last 30 Days, 2011-2018.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 14% to display differences among groups.
Question asked in survey: "During the past 30 days, on how many days did you use marijuana or hashish / any other illegal drug / prescription drugs without a doctor's order, just to "feel good", or to "get high"?"

In Clark County, marijuana use has more than doubled since 2011, with 13.9% currently using marijuana or hashish in 2018, compared to 5.6% in 2011. Self-reported marijuana use is expected to increase as marijuana was legalized in Nevada in 2017. Meanwhile, usage rates of illegal substances and painkillers in Clark County have remained consistent from 2011 to 2018, around 1%. In 2018, Hispanic Clark County adults reported significantly lower usage rates of marijuana (5.9%) compared to White non-Hispanics (14.9%) and Black non-Hispanics (23.8%) adults. In 2018, Clark County adults who were married reported significantly lower marijuana usage (9.2%) compared to adults who were never married or part of an unmarried couple (22.1%). Patterns of drug usage among Clark County adults in 2018 did not significantly differ from those across Nevada statewide.

Figure 34. Percentage of Clark County Adult Residents Who are Considered Binge Drinkers or Heavy Drinkers, 2011-2018.

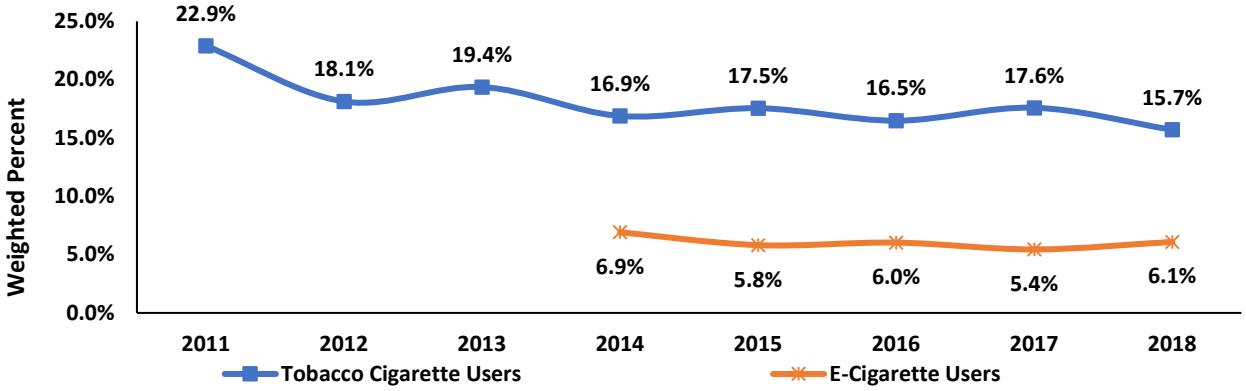


Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 20% to display differences among groups.
Heavy drinkers (adult men having more than 14 drinks per week and adult women having more than seven drinks per week).
Binge drinkers (adult men having five or more drinks on one occasion, adult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

Binge drinking is defined in men as having five or more alcoholic beverages and in women as having four 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. Overall, rates of binge drinking were significantly higher than rates of heavy drinking from 2011 to 2018.

Clark County males were significantly more likely to be binge drinkers (18.2%) compared to females (9.7%) in 2018. Clark County adults who were never married or part of an unmarried couple had higher rates of binge drinking (19.5%) compared to those who were married (11.1%) in 2018. Clark County White non-Hispanic adults were more likely to be heavy drinkers (7.7%) compared to adults who identified as other ethnicities rather than White non-Hispanic, Black non-Hispanic, or Hispanic (2.0%). Binge drinking was elevated in Clark County adults who were aged 18 to 44 years relative to older adults aged 55 or older in 2018. Drinking patterns among Clark County adults in 2018 did not significantly differ from those across Nevada statewide.

Figure 35. Percentage of Clark County Adult Residents Who Are Current Cigarette or E-Cigarette Smokers, 2011-2018.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 25% to display differences among groups.
E-cigarette use was not collected until 2014.
Current cigarette smokers are defined as individuals who have smoked at least 100 cigarettes in their lifetime and currently smoke. Current e-cigarette smokers are defined as individuals who currently have smoked on at least one day in the past 30 days or who currently report using e-cigarettes or other electronic "vaping" products every day or some days.

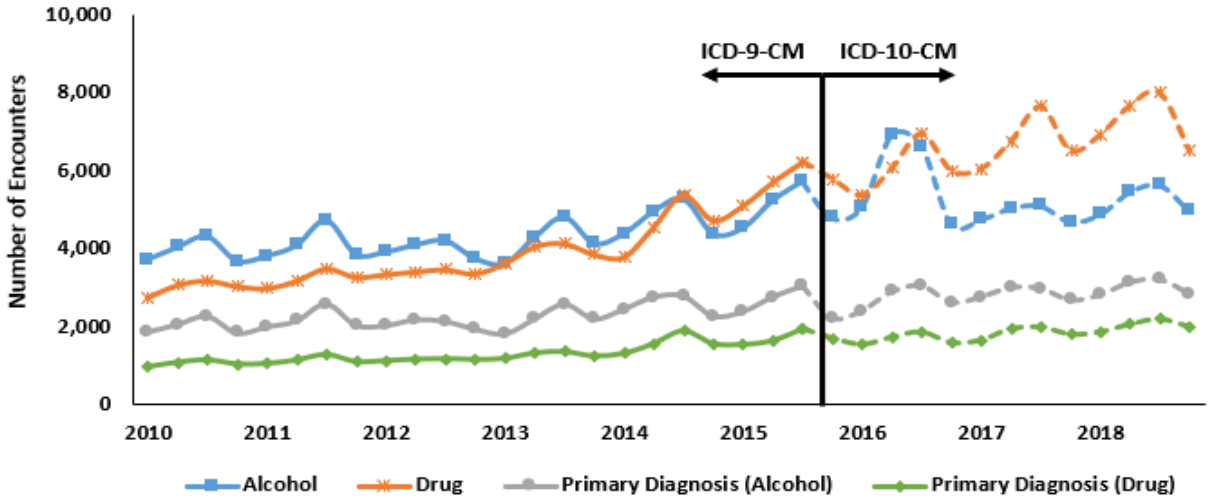
In 2018, 15.7% of Clark County adults were current cigarette smokers, which has decreased significantly since 2011. Tobacco cigarette usage in 2018 was significantly higher in those with only a high school diploma (21.1%) compared to those who were college graduates (10.5%). In 2018, e-cigarette use was significantly higher among those never married or who were part of an unmarried couple (11.9%) compared to those who were married (3.1%) or divorced, widowed, or separated (2.7%). In 2018, young adults aged 18 to 24 years reported greater e-cigarette usage (16.8%) compared older adults aged 45 years or older. Patterns of tobacco cigarette and e-cigarette usage in Clark County adults did not significantly differ from those across Nevada statewide.

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. In 2018, there

were a total of 47,368 alcohol and/or drug-related emergency department encounters in Clark County. Out of this number, 12,033 were related to alcohol (primary diagnosis) and 8,164 were drug-related (primary diagnosis).

Figure 36. Alcohol and/or Drug-Related Emergency Department Encounters in Clark County by Quarter and Year, 2010-2018.



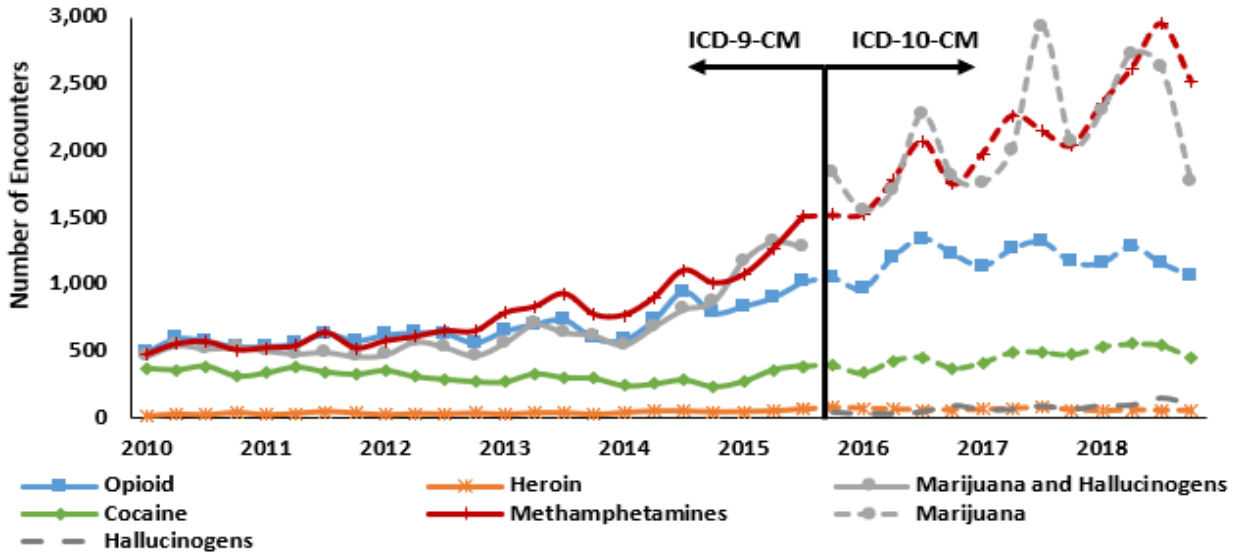
Source: Hospital Emergency Department Billing.
Categories are not mutually exclusive.
ICD-9 codes were replaced by ICD-10 codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

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.

From 2010 to 2018, the number of emergency department encounters related to alcohol and drug usage have steadily increased in Clark County. The number of emergency department encounters related to alcohol were higher than those related to drugs from 2010 to 2013, after which encounters related to alcohol and drugs were comparable. However, from 2017 to 2018, drug-related emergency department encounters surpassed that of alcohol-related encounters. In 2010, there were 1,423.4 alcohol and drug-related encounters per 100,000 population in Clark County which increased to 2,246.4 encounters per 100,000 in 2018.

In 2018, there were over twice as many males with alcohol-related emergency department encounters in Clark County than there were females. In 2018, Clark County residents who were aged 45 to 54 years of age had the greatest number of alcohol-related visits, while those aged 25 to 34 years had the greatest number of drug-related visits. In 2018, Asian/Pacific Islanders had the lowest crude rate of alcohol and/or drug-related emergency department encounters, followed by Hispanics, while Black non-Hispanics and White non-Hispanics had the highest rates.

Figure 37. Drug-Related Emergency Department Encounters in Clark County by Drug and Quarter and Year, 2010-2018.



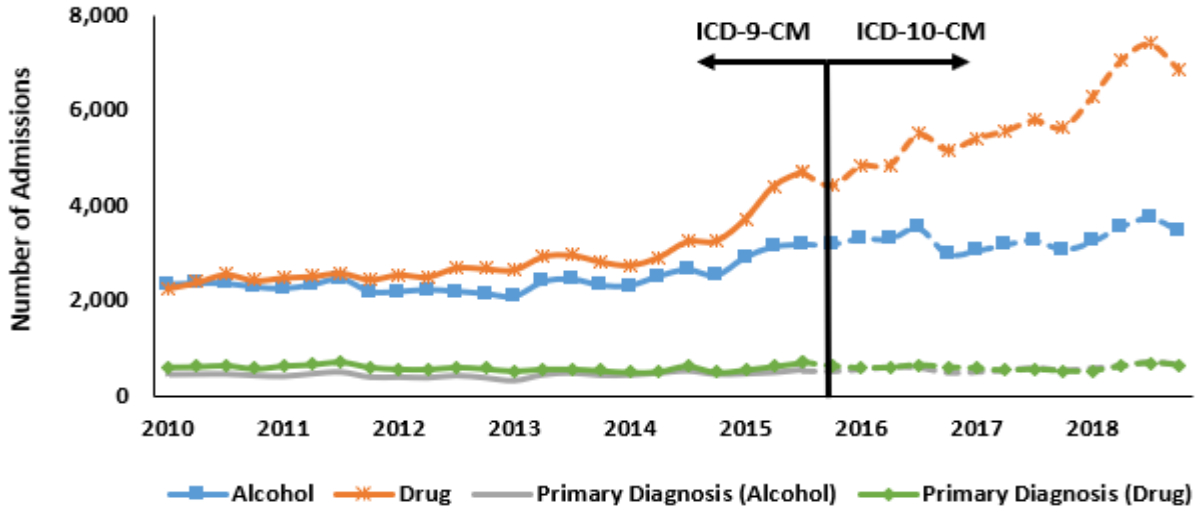
Source: Hospital Emergency Department Billing.
Categories are not mutually exclusive.
ICD-9 codes were replaced by ICD-10 codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

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. In 2018, most drug-related emergency department encounters were attributed to marijuana and methamphetamines, followed by opioids. From 2010 to 2018, the number of emergency department encounters related to methamphetamine and marijuana have increased markedly. In 2018, Clark County males had significantly higher emergency department encounters for cocaine, methamphetamines, marijuana/cannabis, and hallucinogens use compared to females. Clark County males were over three times more likely to been seen in emergency departments for hallucinogen use than females. In 2018, the greatest number of opioids, cocaine, methamphetamine, and marijuana-related emergency department encounters was seen in Clark County residents aged 25 to 34 years. In 2018, the race/ethnicity group with the greatest number of cocaine or hallucinogen-related encounters was Black non-Hispanic Clark County residents.

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. Of the 37,831 alcohol and/or drug related hospital inpatient admissions in Clark County in 2018, 14,098 were alcohol-related and 27,706 were drug-related.

Figure 38. Alcohol and/or Drug-Related Inpatient Admissions in Clark County by Quarter and Year, 2010-2018.

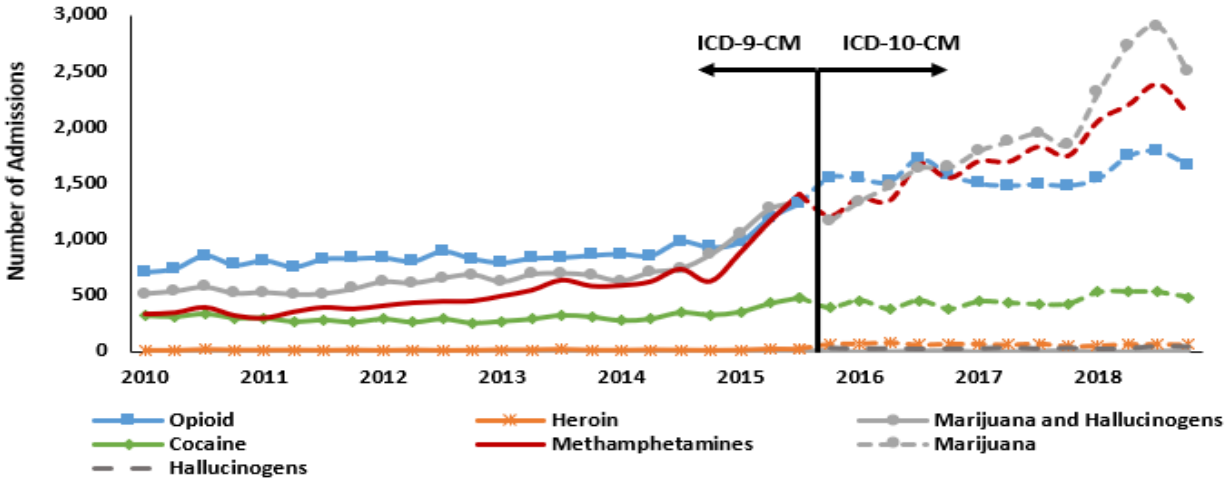


Source: Hospital Inpatient Billing.
Categories are not mutually exclusive.
ICD-9 codes were replaced by ICD-10 codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

From 2010 to 2018, drug-related inpatient admissions have increased steadily in Clark County, surpassing that of alcohol-related inpatient admissions. In 2010, there were 976.2 alcohol and drug-related admissions per 100,000 population in Clark County, which have increased to 1,872.8 admissions per 100,000 in 2018.

In 2018, males in Clark County were twice as likely as females to be seen for alcohol-related hospital admissions. In 2018, the highest number of alcohol-related inpatient admissions were seen in Clark County residents aged 55 to 64 years, while the highest number of drug-related inpatient admissions were seen in those aged 25 to 34 years.

Figure 39. Drug-Related Inpatient Admissions in Clark County by Quarter and Year, 2010-2018.



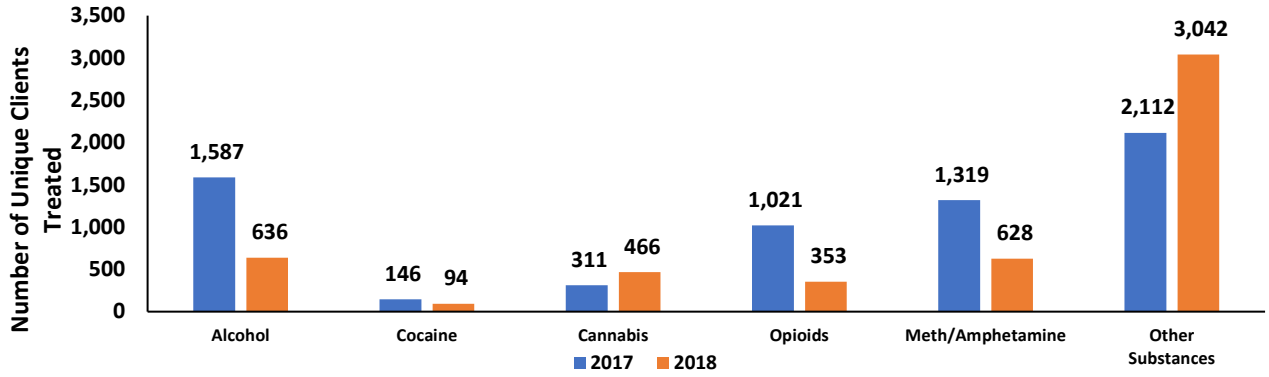
Source: Hospital Inpatient Billing.
Categories are not mutually exclusive.
ICD-9 codes were replaced by ICD-10 codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

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. Marijuana inpatient admissions in Clark County increased from 2017 to 2018. In 2018, overall, there were more males who were admitted for drug-related reasons compared to females in Clark County; males were twice as likely as females to be admitted for methamphetamine and hallucinogen-related reasons. In 2018, the race/ethnicity group with the highest number of cocaine and hallucinogen-related admissions was seen in Black non-Hispanic Clark County residents. In 2018, Clark County residents aged 25 to 34 years were the most frequently seen age group for all combined drug-related deaths.

Substance Abuse Treatment Centers

Treatment Episode Data Sets (TEDS) are a compilation of persons who are receiving publicly funded substance use and/or mental health services. The state role in submitting TEDS to the Substance Abuse and Mental Health Services Administration (SAMHSA) is critical, since TEDS is the only national data source for client-level information on persons who use substance use treatment services.

Figure 40. Primary Substance Used by Clients at Substance Abuse Treatment Centers in Clark County, 2017 and 2018.



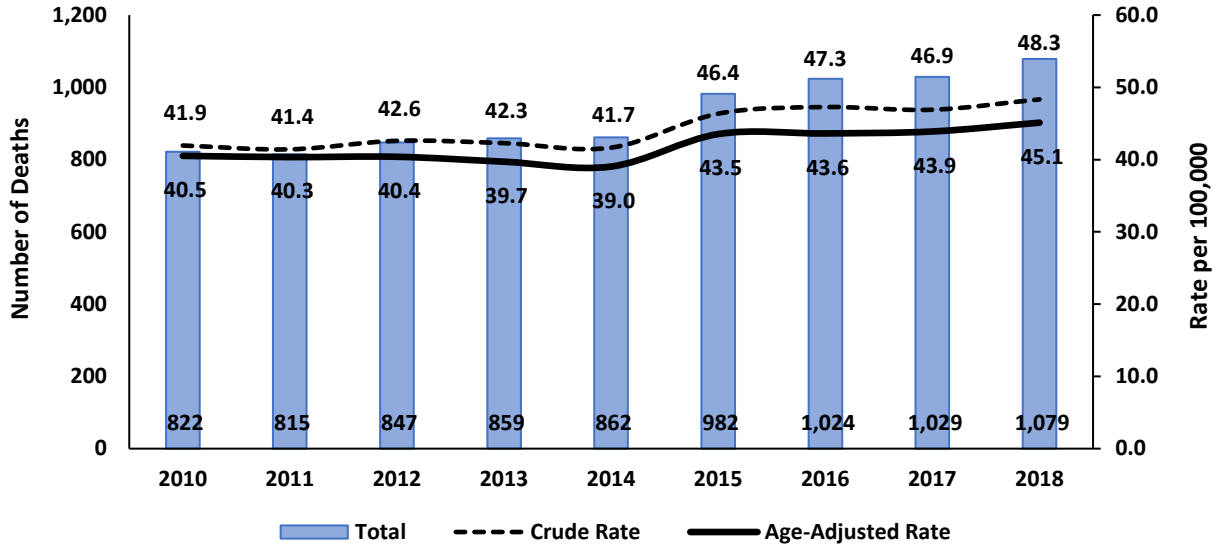
Data Source: Treatment Episode Data Sets.

In 2018, males made up 67.3% of the total treatment episodes in Clark County. In 2018, the age group in Clark County with the greatest number of unique clients treated were aged 25 to 34 years. In 2018, for White non-Hispanic Clark County residents, methamphetamines were the most common primary substance seen at treatment centers, while marijuana/cannabis was the most common among Black non-Hispanics. In 2018, for young people aged 10 to 24 years, marijuana/cannabis was the most common primary substance that was treated in Clark County.

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, 1,079 deaths were related to alcohol and drugs in Clark County.

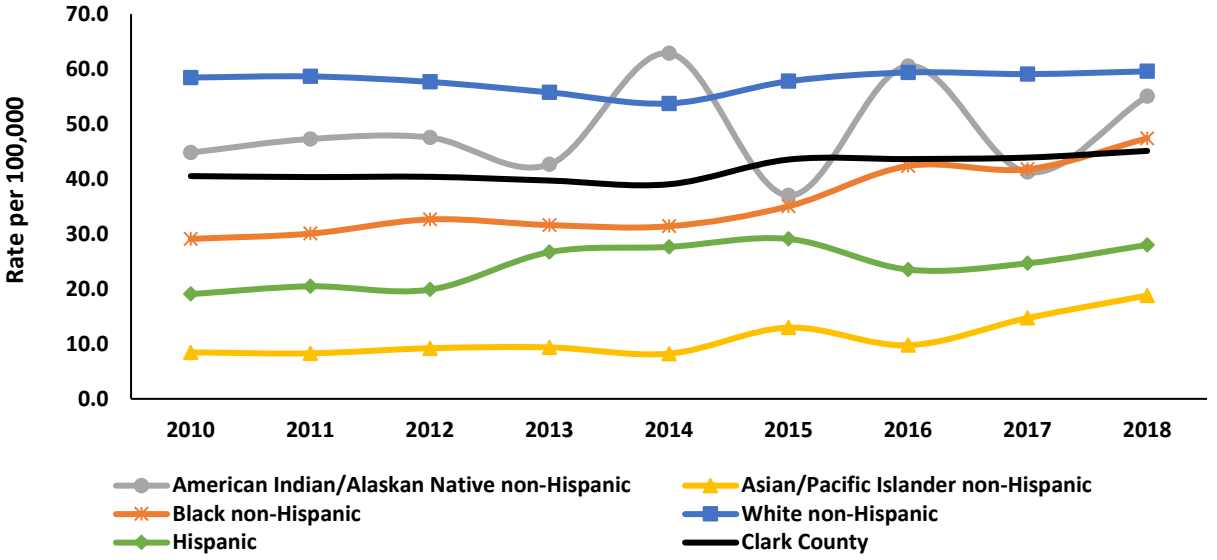
Figure 41. Alcohol and/or Drug-Related Deaths and Age-Adjusted Rates in Clark County, 2010-2018.



Source: Electronic Death Registry System.

The alcohol and/or drug-related age-adjusted death rate was significantly higher in 2018 compared to 2014 in Clark County. In 2018, age-adjusted rates for alcohol and/or drug-related deaths in Clark County (45.1 deaths per 100,000) were significantly lower than those across Nevada statewide (50.3 deaths per 100,000).

Figure 42. Age-Adjusted Rate for Alcohol and/or Drug-Related Deaths by Race/Ethnicity in Clark County, 2010-2018.

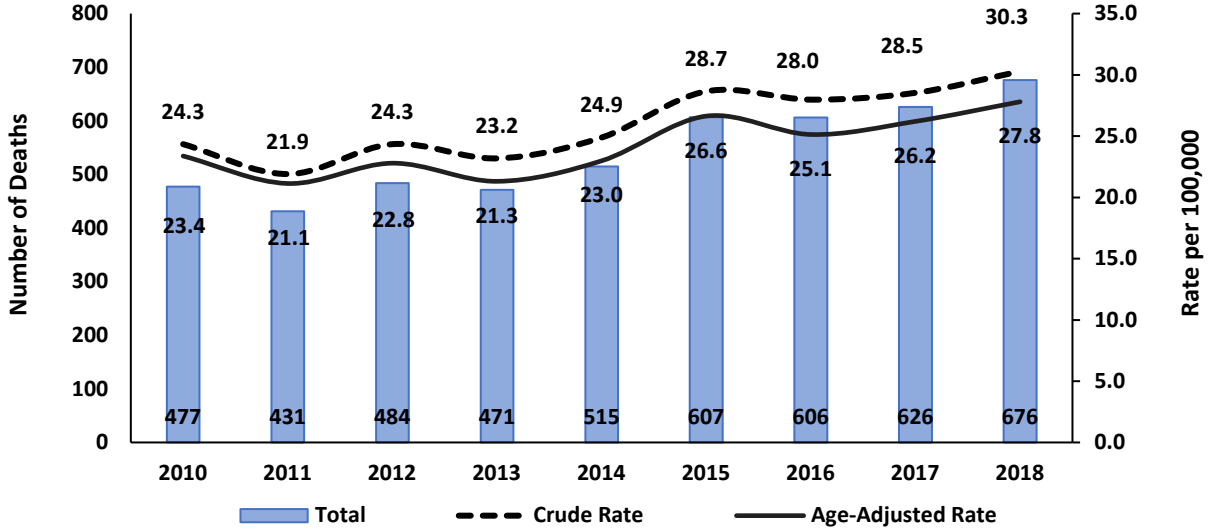


Source: Electronic Death Registry System.

The White non-Hispanic population in Clark County has a significantly higher rate in alcohol and/or drug-related deaths from 2010 to 2018 compared to other ethnicities except American Indian/Alaskan Natives. Asian/Pacific Islanders have the lowest rate of alcohol and/or drug-related deaths from 2010 to 2018. In 2018, Clark County residents who were Asian/Pacific Islander (18.8 deaths per 100,000) and Hispanic (28.0

deaths per 100,000) had lower age-adjusted death rates related to alcohol and/or drugs compared to those who were Black non-Hispanic (47.4 deaths per 100,000) or White non-Hispanic (59.6 deaths per 100,000).

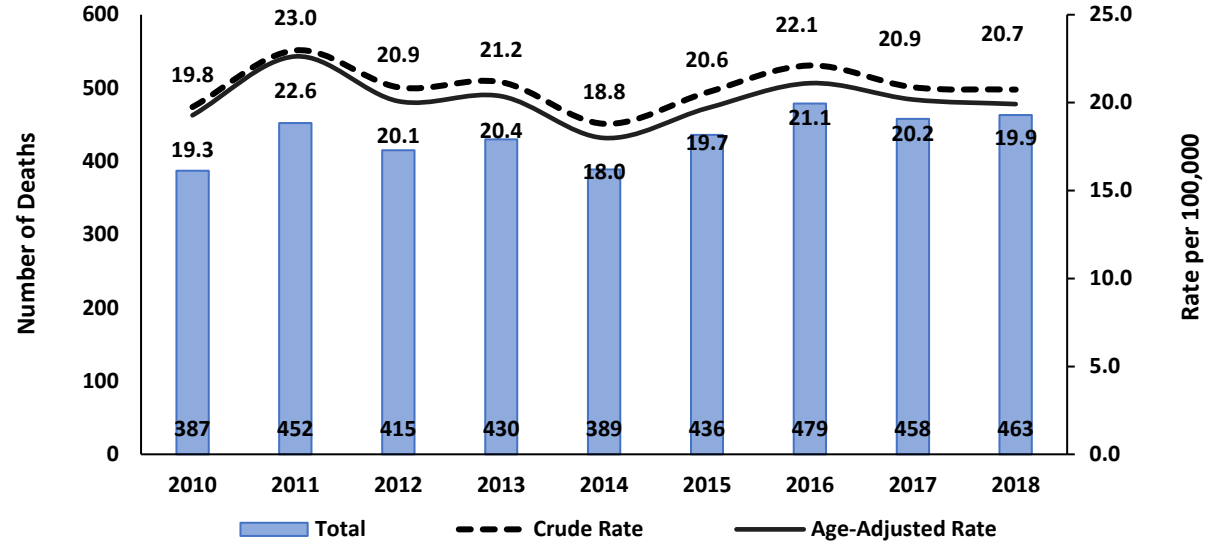
Figure 43. Alcohol-Related Deaths and Age-Adjusted Rates in Clark County, 2010-2018.



Source: Electronic Death Registry System.

Alcohol-related deaths have increased significantly between 2010 to 2018. In 2018, Clark County had a significantly lower age-adjusted rate of alcohol-related deaths (27.8 deaths per 100,000) compared to Nevada statewide (32.1 deaths per 100,000).

Figure 44. Drug-Related Deaths and Age-Adjusted Rates in Clark County, 2009-2017.



Source: Electronic Death Registry System.

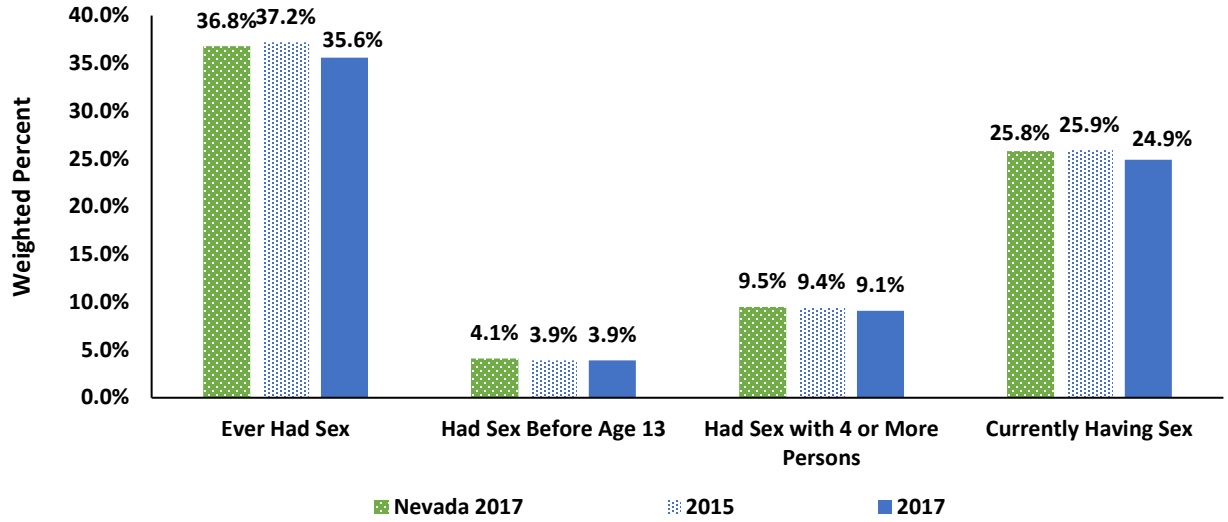
In Clark County, drug-related deaths remained consistent from 2010 to 2018. Age-adjusted rates of drug-related deaths in Clark County did not significantly differ from those across Nevada statewide in 2018.

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, 2,019 high school students and 2,137 middle school students from Clark County participated in the YRBS.

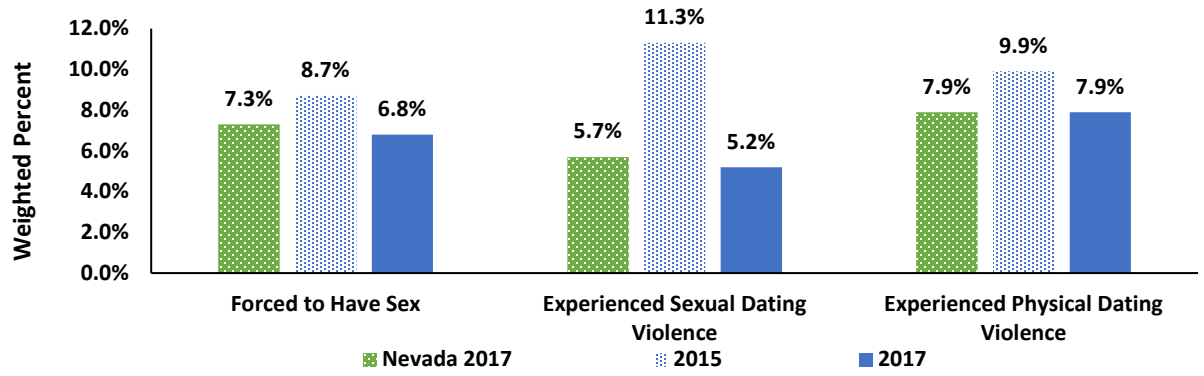
Figure 45. Sexual Behaviors Among High School Students in Clark County, 2015 and 2017, and Nevada Statewide High School Students, 2017.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 40% to display differences among groups.

In 2017, 35.6% of Clark County high schoolers reported ever having had sexual intercourse, compared to 36.8% of all Nevada high schoolers. Sexual behaviors among Clark County high schoolers did not significantly differ from 2015 to 2017. About a quarter of Clark County high schoolers reported currently having sex, like the rates reported statewide. In 2017, 12th graders (51.7%) were significantly more likely to report having had sex compared to 10th graders (27.1%) and 9th graders (16.0%). In 2017, Clark County male high schoolers (5.5%) were significantly more likely to report having had sex before age 13 compared to females (2.3%). In 2017, 40.3% of 12th graders reported currently having sex compared to 16.6% of 10th graders.

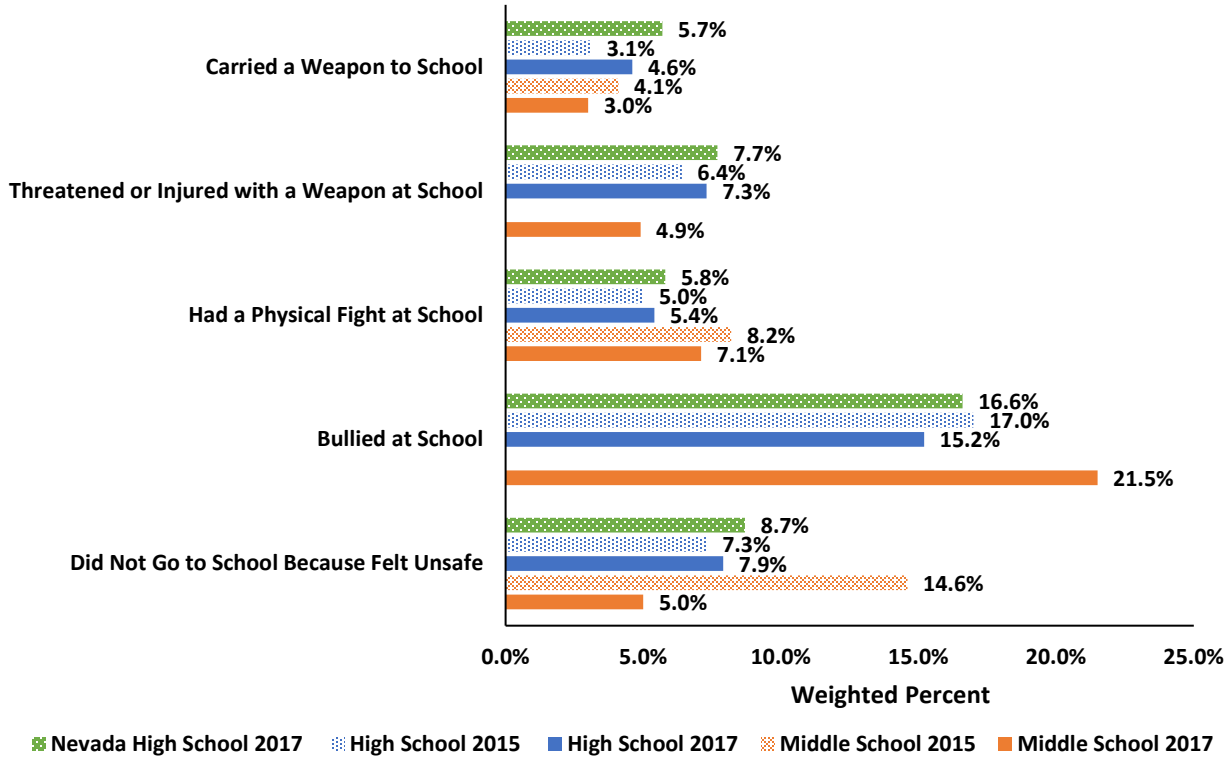
Figure 46. Sexual Violence Among High School Students in Clark County, 2015 and 2017, and Nevada Statewide High School Students, 2017.



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

Fewer than one in 10 Clark County high schoolers have been forced to have sex or have experienced physical dating violence. From 2015 to 2017, there was a significant decrease from 11.3% to 5.2% in sexual dating violence among Clark County high schoolers, but no significant changes in physical dating violence or being forced to have sex.

Figure 47. Violence, Bullying, and Lack of Safety at School Among Middle School and High School Students in Clark County, 2015 and 2017, and Nevada Statewide High School Students, 2017.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 25% to display differences among groups.

The percentage of Clark County middle schoolers who skipped school due to feeling unsafe significantly decreased by 9.6% from 2015 to 2017. In 2017, Clark County male high schoolers were significantly more likely to report having carried a weapon onto school property (6.9%) and having participated in a physical fight on school property (7.1%) in the past 12 months compared to their female counterparts (2.1% and 3.6%, respectively). In 2017, Hispanic/Latino high schoolers (6.2%) were significantly more likely to report participating in a physical fight on school property compared to Asian/Pacific Islanders (1.8%), and 10th graders (6.2%) were significantly more likely to have participated in a physical fight at school compared to 12th graders (2.0%).

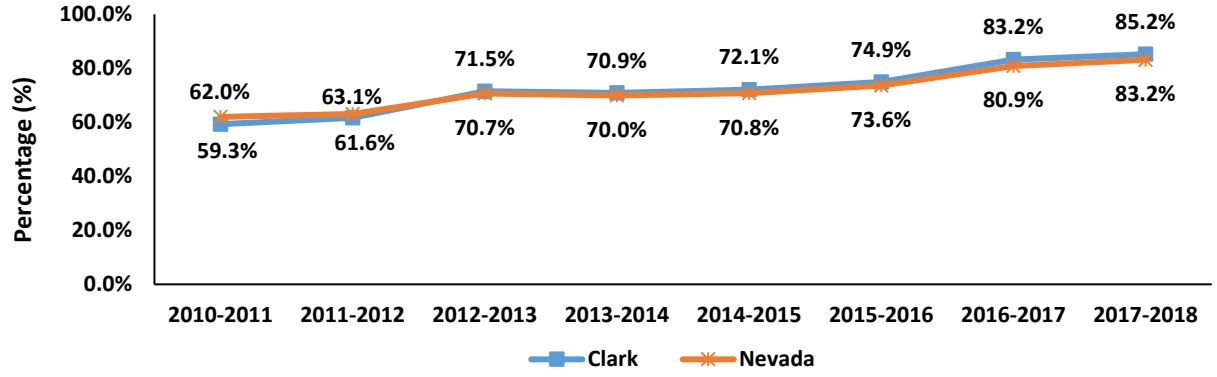
In 2017, female high schoolers in Clark County (18.3%) were significantly more likely to have been bullied at school compared to males (12.2%), and Native Hawaiian/Pacific Islander high schoolers (32.9%) were significantly more likely to report having been bullied at school compared to Black non-Hispanics (11.8%) and Hispanic/Latinos (13.2%). In 2017, Hispanic/Latino high schoolers (9.5%) were significantly more likely to report skipping school due to feeling unsafe compared to White non-Hispanics s (4.7%).

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, students are more likely to experience difficulties in school, such as higher rates of suspensions, expulsions, dropouts, and truancy, as well as poorer grades. Nationally, 50% of students aged 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 48. High School Graduation Percentage of Class Cohorts, Clark County, 2010–2018.



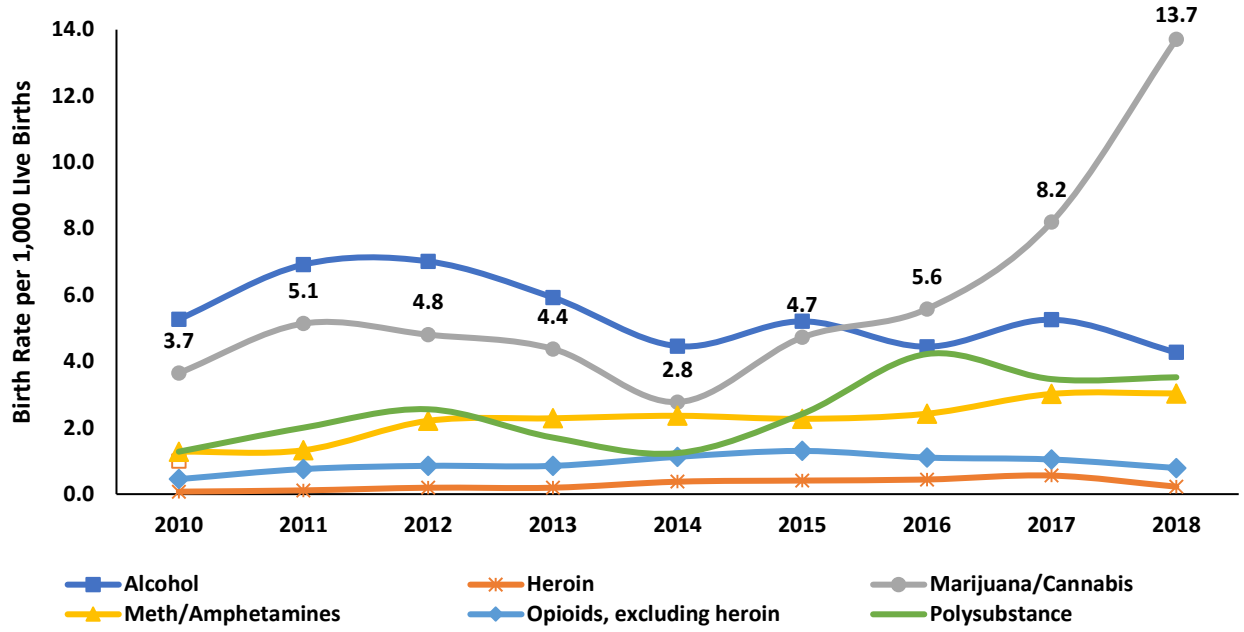
Source: Nevada Department of Education, Report Card.

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%; Clark County high schools also posted the highest graduation rate at 85.2%.

Maternal and Child Health

The data in this section is reflective of self-reported information provided by the mother on the birth record. On average, there were 26,548 live births per year to Clark County residents between 2010 and 2018. In 2018, 114 birth certificates indicated alcohol use, 366 birth certificates indicated marijuana use, 81 indicated methamphetamine use, 21 indicated opiate use (excluding heroin), 11 indicated cocaine use, and six indicated heroin use during pregnancy. Additionally, 94 birth certificates indicated polysubstance use.

Figure 49. Self-Reported Prenatal Substance Abuse Birth Rates for Select Substances, Clark County, 2010-2018.

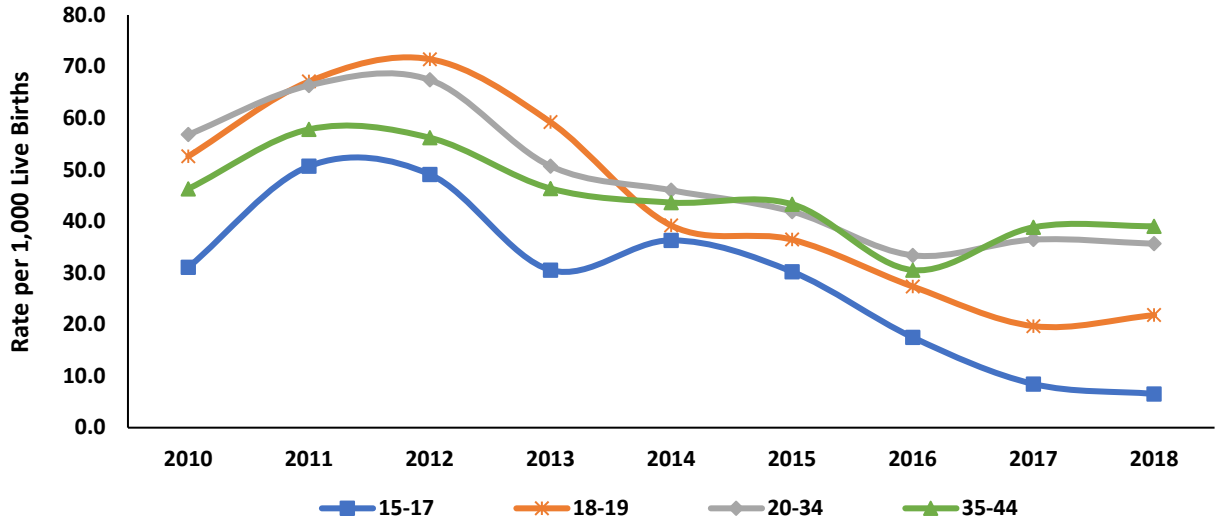


Source: Nevada Electronic Birth Registry System.

Of the self-reported substance use during pregnancy among Clark County mothers who gave birth between 2010 and 2018, the highest rate was with marijuana/cannabis use in 2018, at 13.7 per 1,000 live births. This may be attributed to marijuana legalization in Nevada in 2017 and/or increased transparency in self-reporting. From 2010 to 2018, prenatal usage of marijuana and cannabis has increased. From 2010 to 2018, prenatal usage of methamphetamines and polysubstance have also increased. In 2018, there were 3.0 instances of prenatal usage of methamphetamines per 1,000 live births and 3.5 instances of polysubstance usage per 1,000 live births. From 2010 to 2018, prenatal use of alcohol has remained constant, at 4.3 cases per 1,000 live births 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.

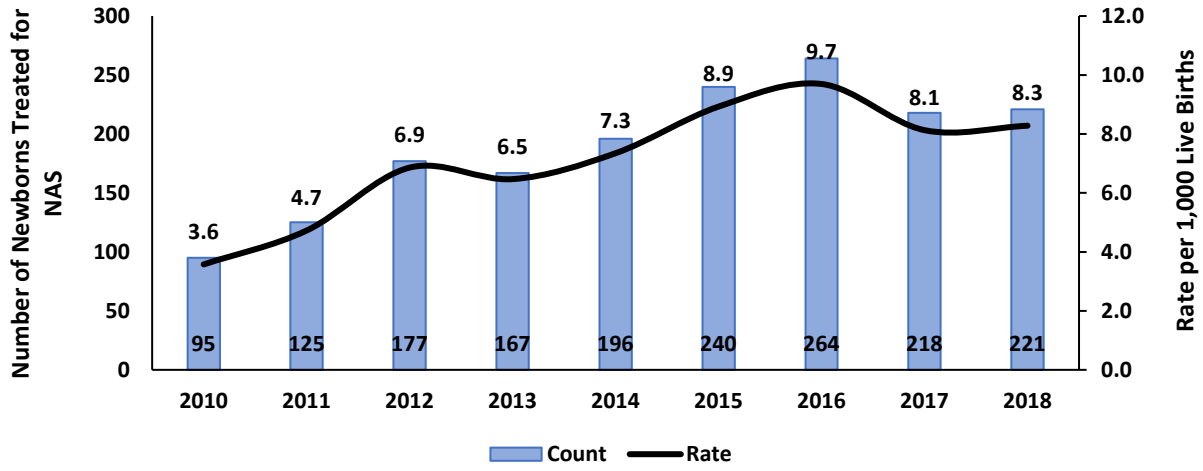
Figure 50. Self-Reported Prenatal Tobacco Use Birth Rates, Clark County, 2010-2018.



Source: Nevada Electronic Birth Registry System.

In Clark County, the prenatal tobacco usage rate per 1,000 live births has significantly decreased from 2010 to 2018 for all age groups except 35 to 44 years. In 2018, Clark County teens aged 15 to 17 years (6.5 cases per 1,000) and those aged 18 to 19 years (21.8 cases per 1,000) had significantly lower rate of prenatal tobacco usage compared to those aged 20 to 34 years (35.7 cases per 1,000) and 35 to 44 years (39.1 cases per 1,000).

Figure 51. Neonatal Abstinence Syndrome, Clark County, 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. In Clark County, inpatient admissions for NAS has doubled since 2010, from 95 newborns admitted to 221 newborns admitted in 2018.

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, Clark County, Nevada, 2010-2018.

	2010	2011	2012	2013	2014	2015	2016	2017	2018
Clark	1,959,491	1,967,722	1,988,195	2,031,723	2,069,450	2,118,353	2,166,177	2,193,818	2,232,176
Sex									
Female	971,788	976,380	987,211	1,009,806	1,029,445	1,056,208	1,080,984	1,095,543	1,115,553
Male	987,703	991,342	1,000,985	1,021,917	1,040,005	1,062,145	1,085,193	1,098,275	1,116,623
Age									
<1	27,214	26,416	25,778	25,766	27,156	26,829	27,658	28,357	28,724
1-4	120,731	116,512	111,709	109,003	107,498	109,444	110,667	111,363	113,812
5-14	264,582	269,842	277,599	286,221	291,394	304,637	307,778	308,203	308,944
15-24	258,918	258,737	260,630	266,774	271,719	280,770	288,540	291,397	297,151
25-34	288,483	282,903	279,240	281,152	282,754	292,925	299,546	305,043	312,620
35-44	294,144	294,461	298,055	304,228	308,571	307,932	313,075	314,897	318,390
45-54	266,222	268,312	270,717	276,837	283,538	286,194	293,497	295,811	297,552
55-64	212,237	216,361	220,293	227,371	233,618	239,885	246,670	251,401	257,150
65-74	140,629	144,178	151,822	159,316	164,726	169,259	173,582	177,562	182,827
75-84	65,896	68,350	69,707	71,568	74,136	75,939	79,834	83,767	88,512
85+	20,436	21,650	22,644	23,486	24,339	24,539	25,330	26,016	26,494
Race/Ethnicity									
White non-Hispanic	971,255	970,115	971,165	977,281	982,223	985,690	992,118	993,805	997,699
Black non-Hispanic	206,115	207,641	211,021	217,814	223,543	231,243	238,599	243,157	249,224
Native American/Alaskan Native non-Hispanic	13,200	13,255	13,324	13,413	13,548	14,553	14,727	14,851	14,998
Asian/Pacific Islander non-Hispanic	194,881	195,410	199,045	208,021	215,690	229,502	239,493	244,808	252,590
Hispanic	574,040	581,302	593,640	615,194	634,447	657,366	681,240	697,196	717,664

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.