

*Substance Abuse Prevention and
Treatment Agency
2019 Epidemiologic Profile*

*Washoe 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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Washoe County SAPTA Epidemiologic Profile

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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 Washoe County 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, Sexual Behaviors, and Violence

- Female high school students are more likely to feel sad or hopeless, consider suicide, or purposely hurt themselves compared to males.
- Adults who have never been married or who are part of an unmarried couple are more likely to report poor mental health, diagnosis with depressive disorder(s), and suicidal ideation compared to married adults.
- Mental health-related emergency department encounters, and hospital inpatient admissions have increased since 2010, with anxiety and depression as the most common diagnoses.
- Males are more likely to be seen in emergency departments and hospitals for schizophrenia and suicidal ideation, while females are more likely to be seen in emergency departments for anxiety, depression, bipolar disorder, and PTSD.
- Compared to Nevada statewide, Washoe County has more PTSD-related inpatient admissions and a higher mental health-related death rate.
- Black non-Hispanics have the highest utilization rate of state-funded mental health facilities, while Asian/Pacific Islanders and Hispanics have the lowest rate.
- The most common method of attempted suicide encountered in emergency departments and inpatient admissions is substance or drug overdose, followed by cutting.
- Asian high school students are less likely to be currently having sex compared to White non-Hispanics or Hispanic students, and female high school students are more likely to have been physically forced to have sex compared to males.
- While on school property, male high school students are more likely to have carried a weapon, been threatened or injured with a weapon, or participated in a physical fight compared to females, and 9th graders are more likely to have been threatened or injured with a weapon or bullied compared to 12th graders.

Substance Use

- Male high school students are more likely to report current use of smokeless tobacco compared to females, while females are more likely to report having drunk alcohol that was given to them by someone else.
- Asian high school students are less likely to have ever tried electronic vapor products, alcohol, or marijuana compared to their Black non-Hispanics, White non-Hispanic, and Hispanic peers, and electronic vapor use in Washoe County high school students is higher than Nevada statewide.

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- Use of marijuana/hashish has increased (including among pregnant women) and are most commonly used by young adults without a college degree.
- Young to middle-aged males are more likely to binge drink compared to females or adults above 55 years.
- College graduates are less likely to smoke tobacco or electronic cigarettes compared to those with less education.
- The most common drugs seen in emergency departments and hospitals are marijuana and/or hallucinogens, methamphetamines, and opioids.
- Alcohol and drug-related death rates are higher in White non-Hispanics compared to Hispanics and Asian/Pacific Islanders; Washoe County has more alcohol-related deaths than Nevada statewide.
- Inpatient admissions for neonatal abstinence syndrome have more than doubled since 2011.

Demographic Snapshot

Figure 1. Selected Demographics for Washoe County.

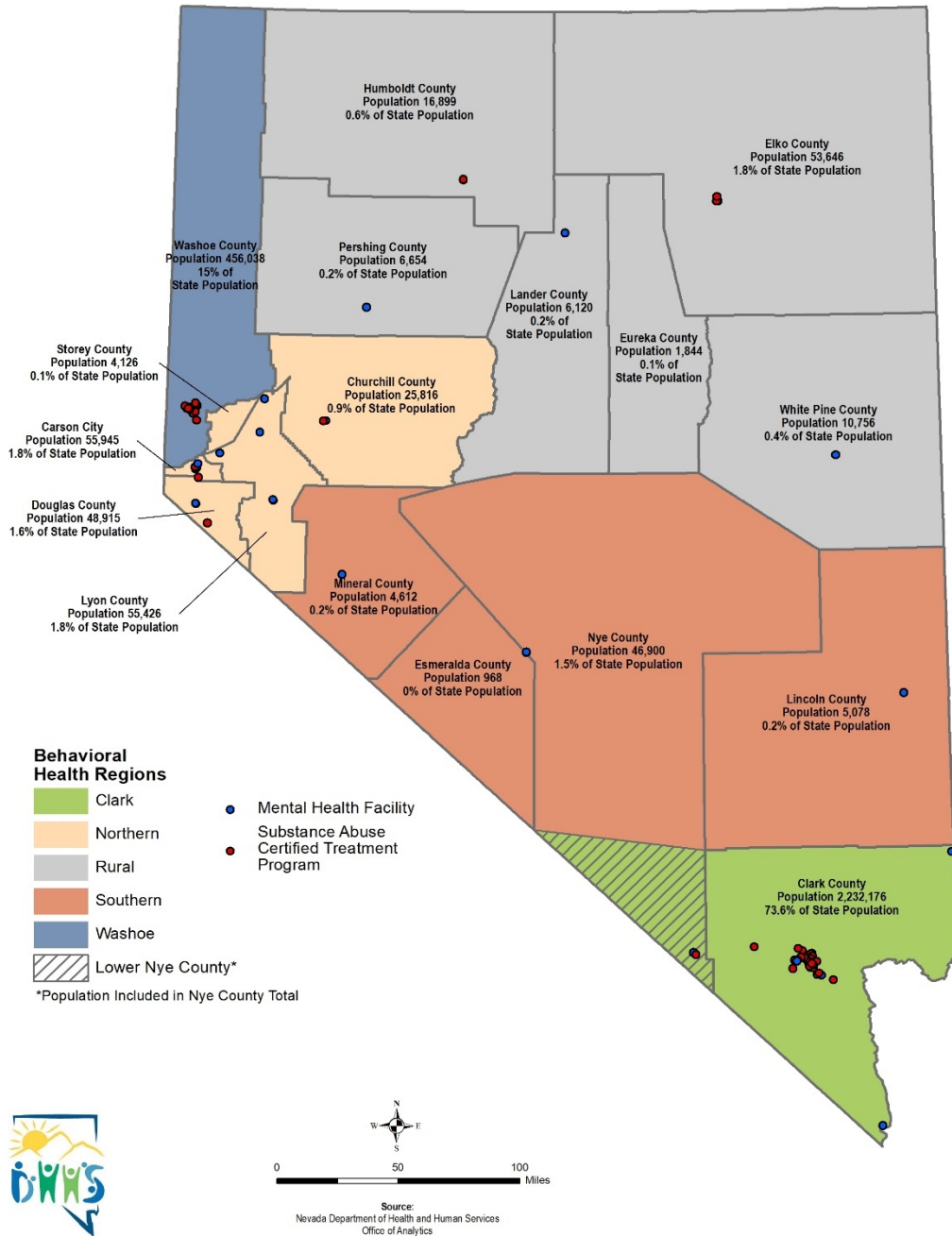
Population, 2018 estimate*	456,038
Population, 2010 estimate*	417,336
Population, percentage change*	9.3%
Male persons, 2018 estimate*	229,265 (50.3%)
Female Persons, 2018 estimate*	226,773 (49.7%)
Median household income (in 2017), 2013-2017**	\$58,595
Per capita income in the past 12 months (in 2017), 2013-2017**	\$31,879
Persons in poverty, percent (2017) **	11.1%
With a disability, under the age 65 years, percent, 2013-2017**	8.7%
Land area (square miles), 2017**	6,302.4

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



In 2018, the estimated population for Washoe County was 456,038, a 9.3% increase from the 2010 estimated population. The population is made up of approximately equal percentages of females and males. The median household income is \$58,595. Washoe County's land area is approximately 6,302 square miles.

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.

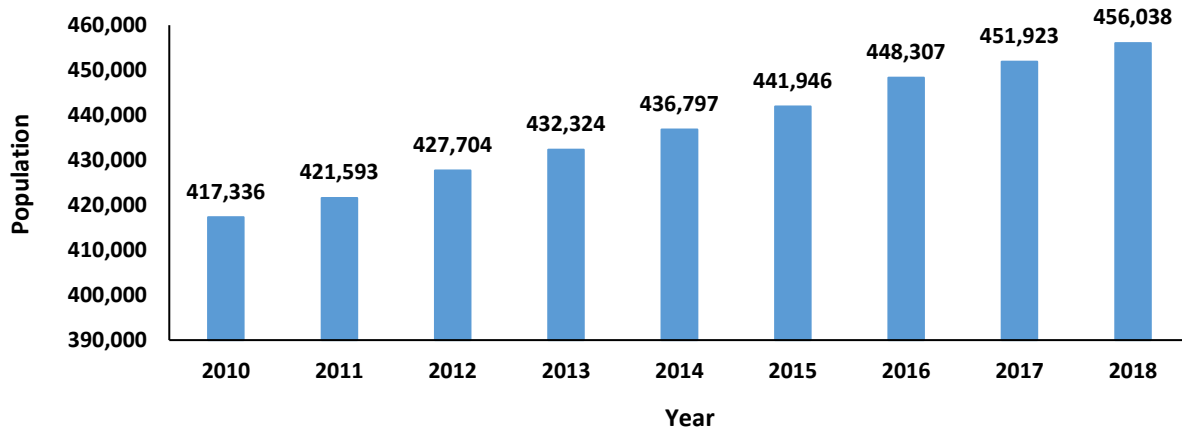
Southern Nevada Region: Esmeralda, Lincoln, and northern Nye County.

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.

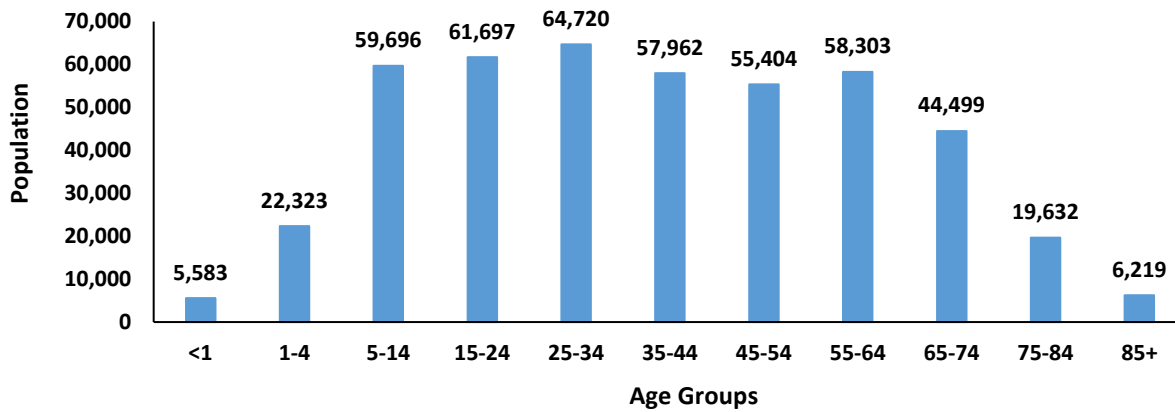
Washoe County SAPTA Epidemiologic Profile

Figure 3. Washoe County Population, 2010-2018.



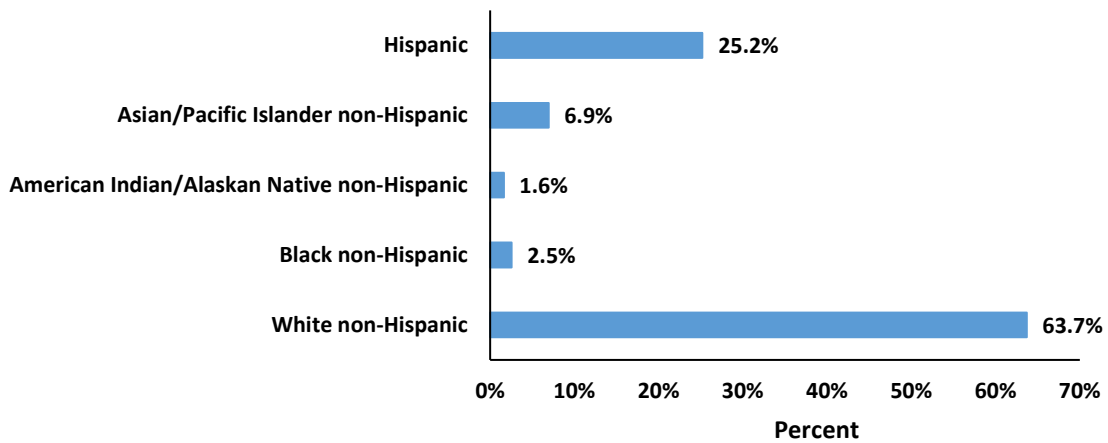
Source: Nevada State Demographer, Vintage 2018.
 Chart scaled to display differences among years.

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



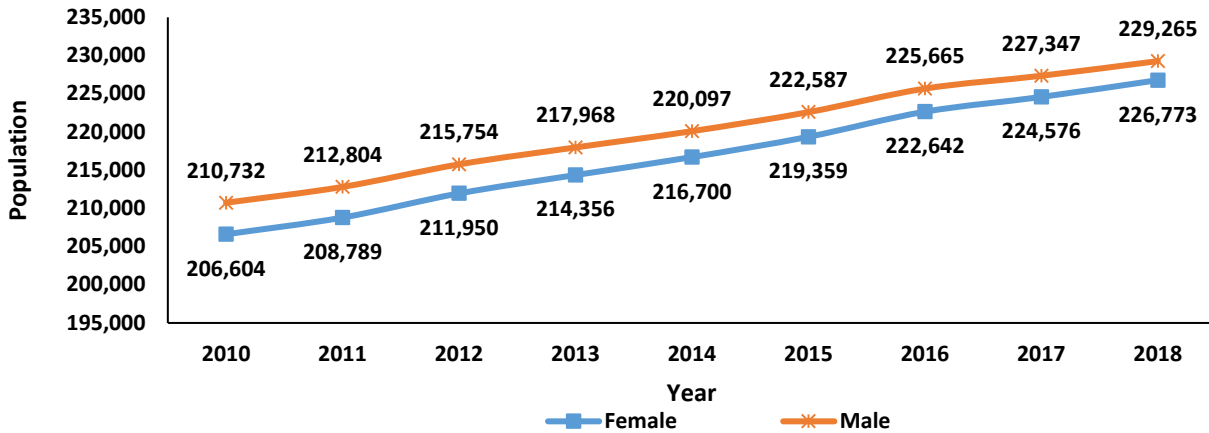
Source: Nevada State Demographer, Vintage 2018.

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



Source: Nevada State Demographer, Vintage 2018.
 Chart scaled to 70% to display differences among groups.

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



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

In 2018, the estimated population for Washoe County was 456,038, a 9.3% increase from the 2010 estimated population. More than half of the Washoe County population is made up of White non-Hispanics and a quarter of the population is made up of Hispanics. The population is made up of approximately equal percentages of females and males.

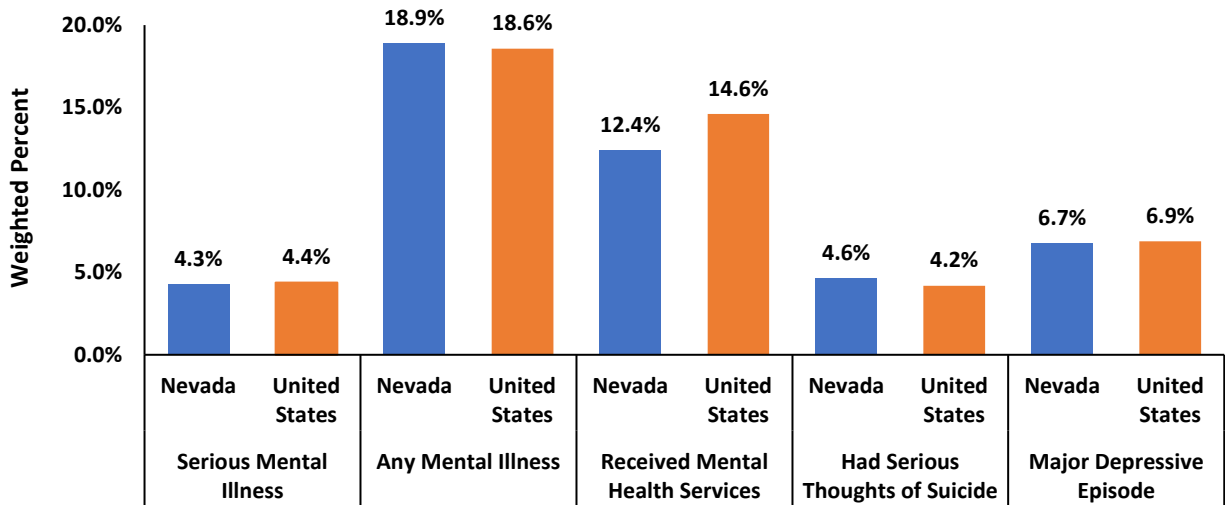
Mental Health

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.



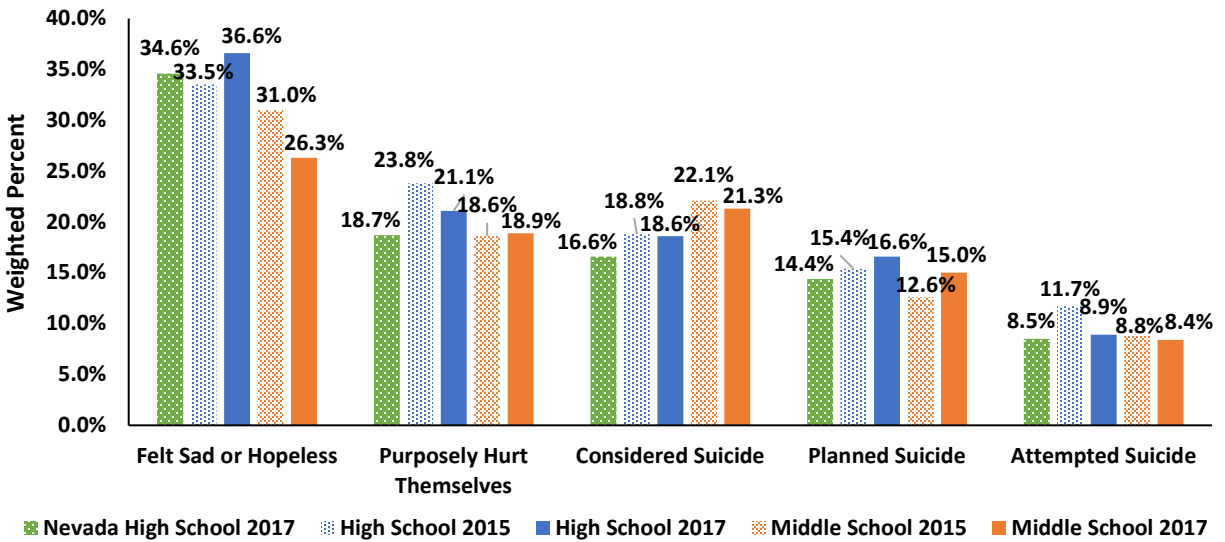
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2016-2017. Chart scaled to 20% to display differences among groups.

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, 1,310 high school, and 1,253 middle school students in Washoe 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, Washoe County Middle and High School Students, 2015 and 2017.



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

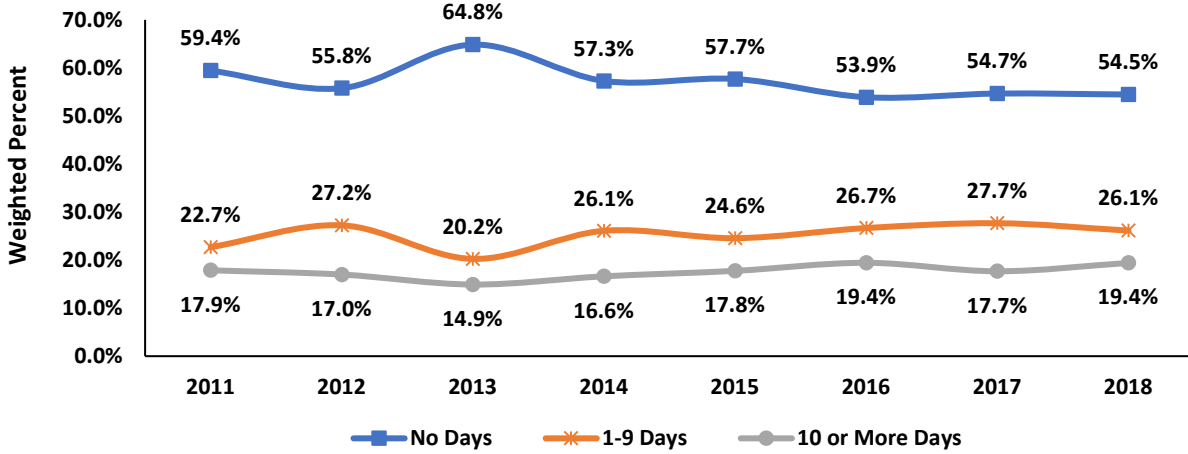
In 2018, Washoe County high schoolers who were female (46.4%) were significantly more likely to report feeling sad or hopeless compared to males (27.8%). Females (23.3%) were also significantly more likely to report having seriously considered attempting suicide compared to males (14.2%). Tenth graders (22.1%) and 11th graders (23.2%) were significantly more likely to report having seriously considered suicide compared to 12th graders (10.9%). Students who were 17 years old (4.1%) were significantly less likely to have attempted suicide compared to students who were 16 years old (11.3%). Twelfth graders (2.5%) were significantly less likely to have attempted suicide compared to 11th graders (10.6%). Females (26.7%) were significantly more likely to have purposely hurt themselves compared to males (16.1%). Ninth graders (22.8%) and 11th graders (26.2%) were significantly more likely to have purposely hurt themselves compared to 12th graders (14.1%).

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.

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



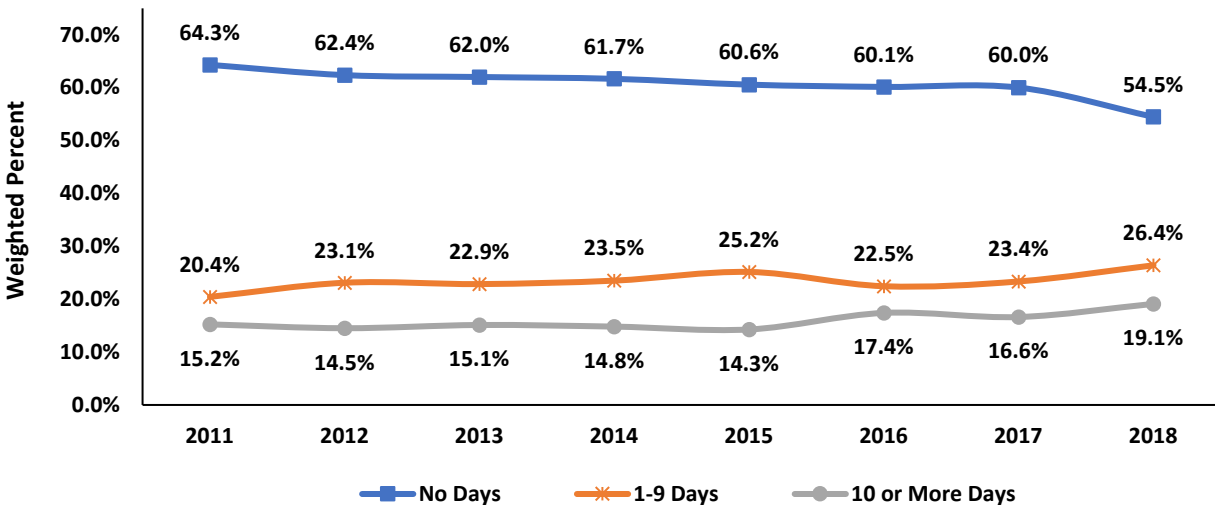
Source: Behavioral Risk Factor Surveillance System.

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?"

In 2018, 54.5% of Washoe County adults reported experiencing no days kept them from usual activities by poor mental or physical health, while 26.1% experienced one to 9 days and 19.4% experienced 10 or more such days. These trends experienced by Washoe County did not differ from those reported across Nevada statewide and remained relatively constant since 2011.

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



Source: Behavioral Risk Factor Surveillance System.

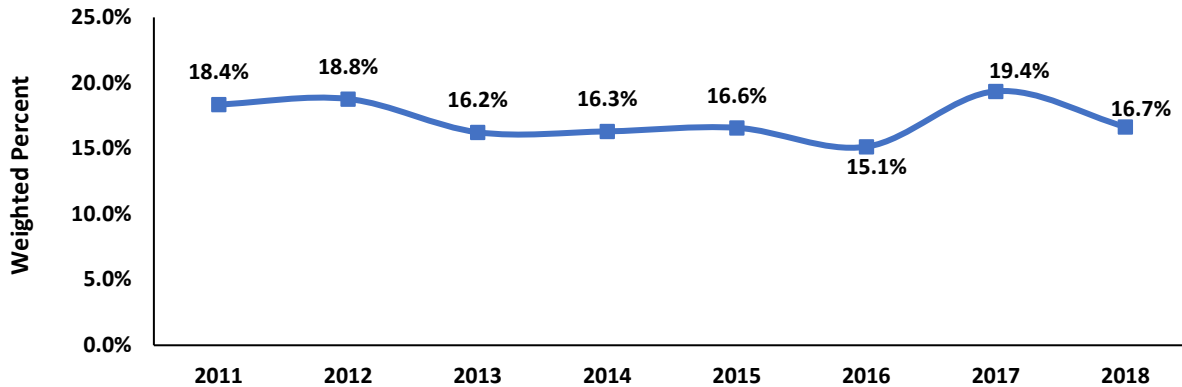
Chart scaled to 70% to display differences among groups.

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, 54.5% of Washoe County adults reported no days in the past month in which mental health was not good. In 2018, Washoe County adults who were married (13.6%) were significantly less likely to report

ten or more days of poor mental health compared to those who never married or who were part of an unmarried couple (25.2%). Those who were married (62.7%) were significantly more likely to report zero days of poor mental health compared to those who had never married or who were part of an unmarried couple (40.6%). From 2011 to 2018, there was a significant decrease in the prevalence of Washoe County adults who reported no days of poor mental health.

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



Source: Behavioral Risk Factor Surveillance System.

Chart scaled to 25% to display differences among groups.

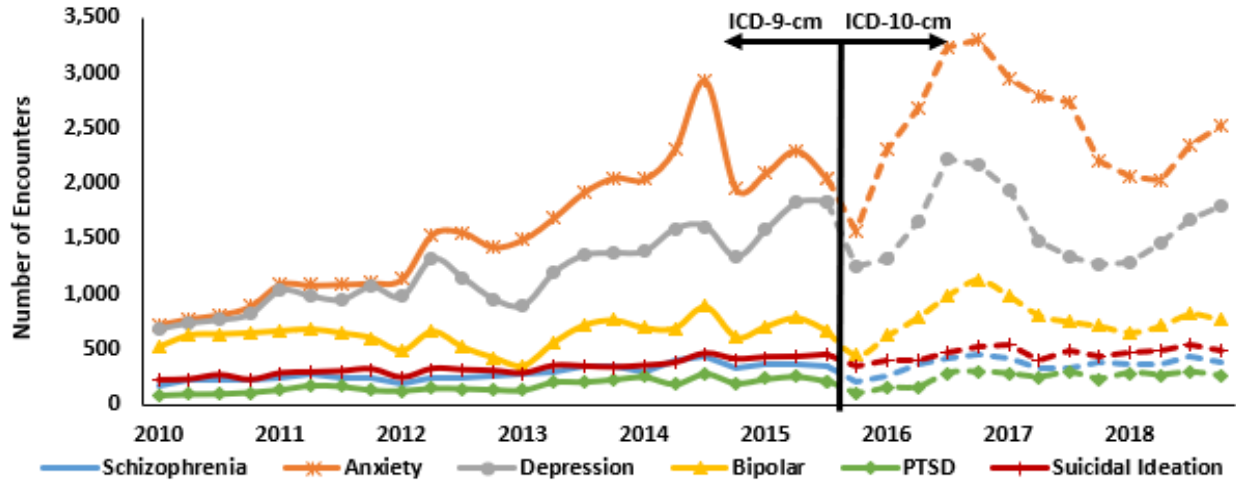
Question asked in survey: “(Ever told) you have a depressive disorder (including depression, major depression, dysthymia, or minor depression)?”

In 2018, 16.7% of Washoe County adults had ever been diagnosed with a depressive disorder. In 2018, Washoe County adults who were married (10.1%) were significantly less likely to have a depressive disorder diagnosis compared to those who were never married or part of an unmarried couple (22.1%) and those who were divorced, widowed, or separated (24.7%). In 2018, Washoe County Hispanics (7.8%) were significantly less likely to have a depressive disorder diagnosis compared to White non-Hispanics (18.9%).

Hospital Emergency Department Encounters

The hospital emergency department billing data includes data for emergency room patients for Nevada’s non-federal hospitals. There were 16,818 visits related to mental health disorders among Nevada residents in 2018. Since an individual can have more than one diagnosis during a single emergency department visit, the following numbers reflect the number of times a diagnosis in each of these categories was given, and therefore the following numbers are not mutually exclusive.

Figure 12. Mental Health-Related Emergency Department Encounters in Washoe 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.

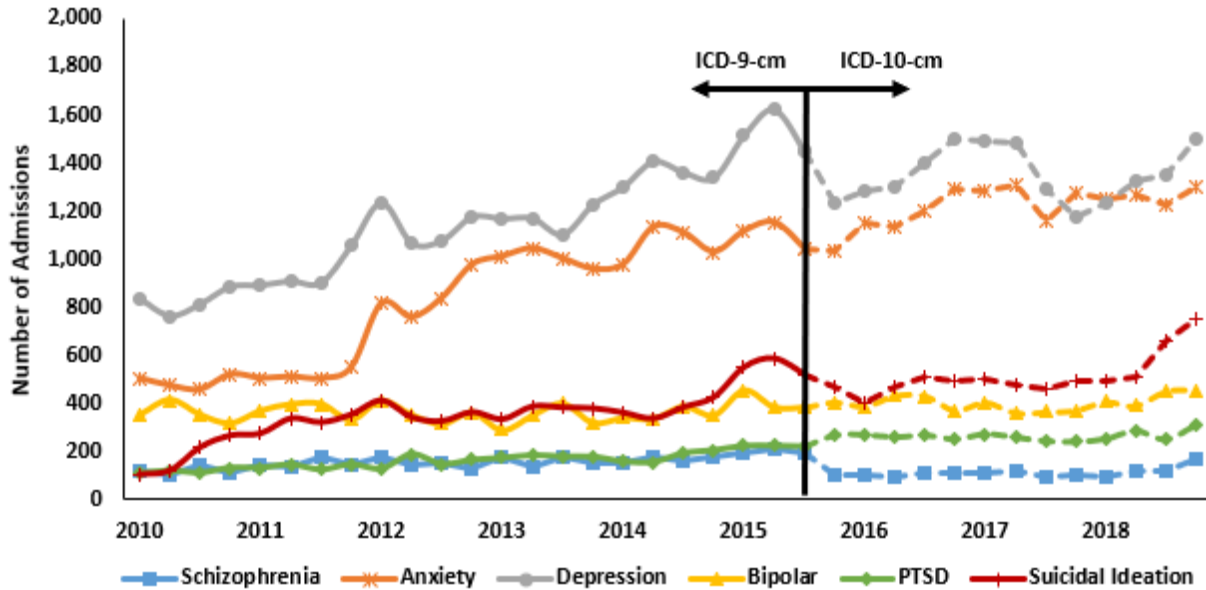
Anxiety has been the leading mental health-related diagnosis since 2012 in emergency department encounters in Washoe County, followed by depression. From 2010 to 2018, anxiety-related encounters increased significantly from 770.4 cases per 100,000 to 1,965.8 cases per 100,000, while depression-related encounters increased significantly from 720.3 cases per 100,000 to 1,360.6 cases per 100,000.

In 2018, based on number of encounters, males have significantly more visits for schizophrenia (63.3%) and suicidal ideation (59.1%), whereas females have significant higher visits for anxiety, depression, bipolar, and PTSD (65.2%, 65.0%, 61.4% and 63.5% respectively). In 2018, Black non-Hispanic Washoe County residents had significantly higher rates of schizophrenia, anxiety, depression, bipolar, and suicidal ideation compared to White non-Hispanics, Hispanics, Asian/Pacific Islanders, and American Indian/Alaskan Natives. In 2018, compared to Nevada statewide, Washoe County had a significantly higher rate for depression and PTSD and significantly lower suicidal ideation.

Hospital Inpatient Admissions

Hospital Inpatient Billing data includes data for patients discharged from Nevada’s non-federal hospitals. There were 10,696 inpatient admissions related to mental health disorders among Nevada residents in 2018. Since an individual can have more than one diagnosis during a single inpatient admission, the following numbers reflect the number of times a diagnosis was given and therefore the following numbers are not mutually exclusive.

Figure 13. Mental Health-Related Inpatient Admissions in Washoe 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 has been the leading diagnosis for mental health-related inpatient admissions in Washoe County from 2010 to 2017. Depression, anxiety, PTSD, and suicidal ideation hospital inpatient admissions have increased significantly from 2010 to 2018; namely, anxiety-related admissions increased from 468.9 cases per 100,000 to 1,104.7 cases per 100,000, while depression-related admissions increased from 789.8 cases per 100,000 to 1,187.8 cases per 100,000.

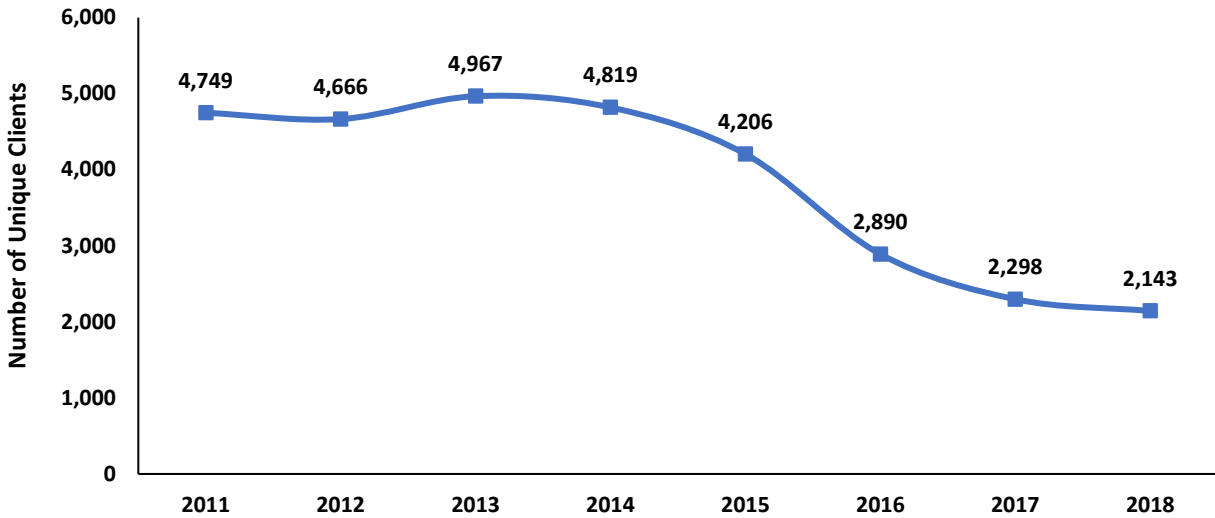
In 2018, based on number of admissions, Washoe County males had significantly higher inpatient admission rates for schizophrenia (65.1%) and suicidal ideation (52.9%) compared to females. Meanwhile, females had significantly higher inpatient admission rates for anxiety (65.6%), depression (63.1%), bipolar disorder (57.5%), and PTSD (58.7%). In 2018, Washoe County had significantly higher admissions for PTSD compared to Nevada statewide, while significantly lower admissions for schizophrenia, anxiety, and bipolar disorder.

Suicidal ideation increased from 2010 to 2018, but it should be noted that in 2016, inpatient admissions statewide dropped and then continued increase in 2017. This may be due to ICD-9-CM conversion to ICD-10-CM, or other changes 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 Washoe 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 2,143 clients served in 2018, which has decreased significantly from 2011 (4,749). The Affordable Care Act (ACA) went into effect in 2014. Therefore, many Washoe County residents are now able to access non-state-funded facilities through the expansion of Medicaid. This likely contributes to the decline of the clients represented in the above chart.

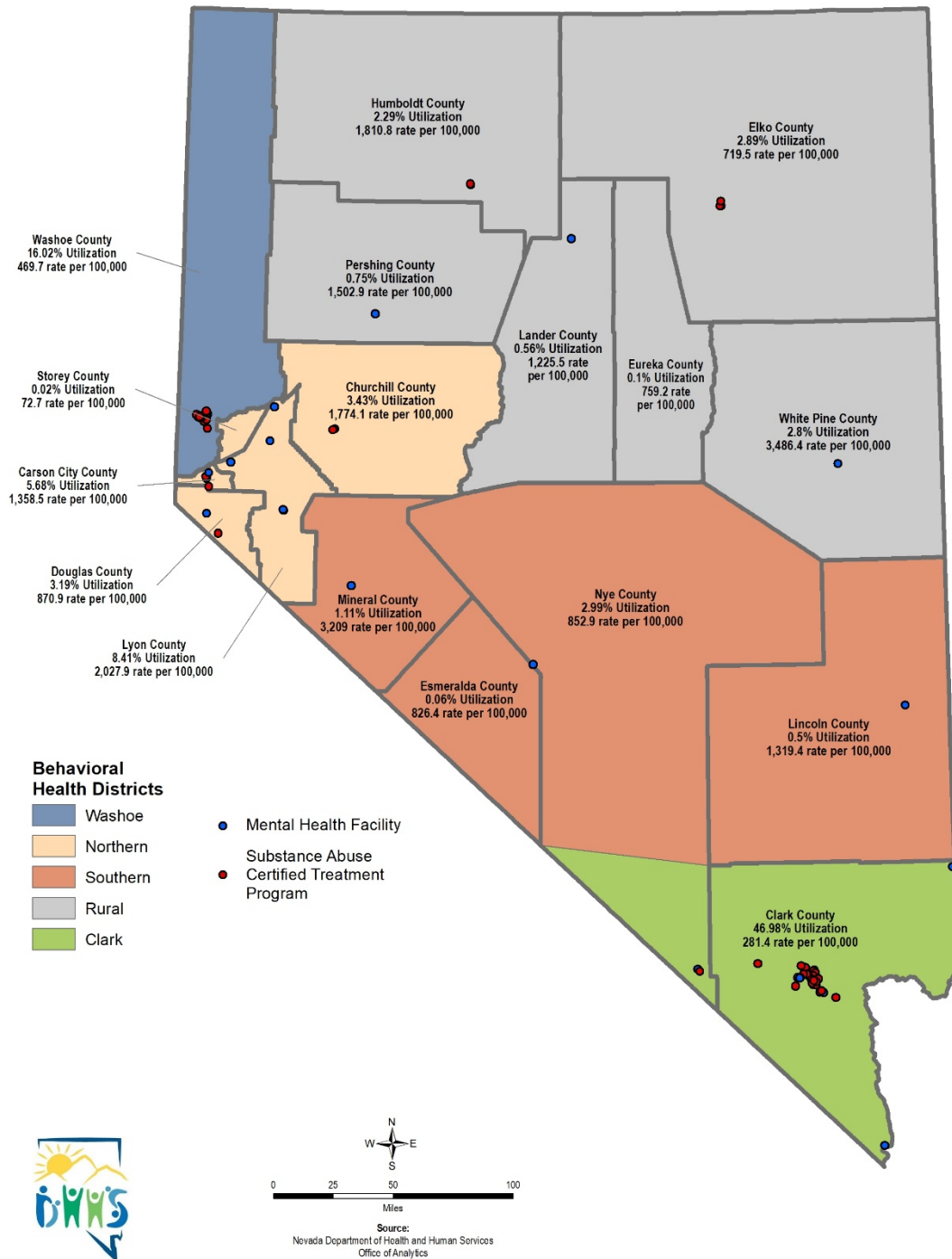
Figure 15. Top Mental Health Clinic Services by Number of Clients Served* in Washoe County, 2011-2018.

Program**	Year							
	2011	2012	2013	2014	2015	2016	2017	2018
NNAMHS Medication Clinic	3,563	3,492	3,405	3,241	2,906	2,119	1,764	1,794
NNAMHS Ambulatory Service	1,677	1,256	1,408	1,424	1,181	507	51	13
NNAMHS Outpatient Counseling	672	772	738	708	532	245	193	159
NNAMHS Inpatient Hospital	406	328	299	793	479	426	351	264
NNAMHS Service Coordination	559	535	511	527	258	187	179	126
NNAMHS Co-Occurring Disorder	538	571	559	557	316	119	0	0
NNAMHS Mental Health Court	372	268	312	323	316	268	207	170
NNAMHS Observation Unit (Inactive)	603	834	772	0	0	0	0	0

Source: Avatar.
 *A client is counted only once per year. Clients may be counted more than once across years.
 **All programs are exclusively for adults.

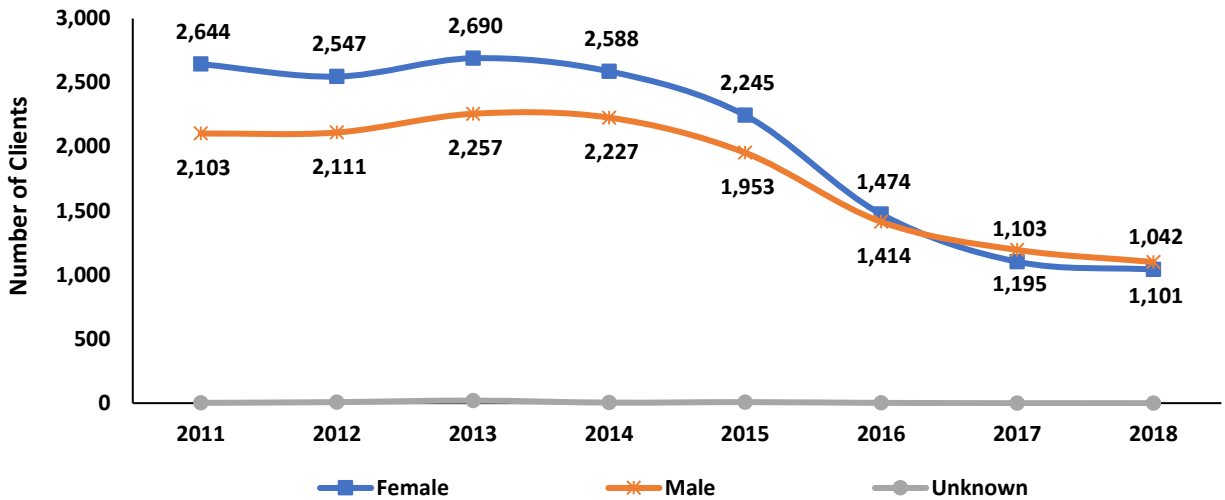
Clients were counted only once per program per year. Since a client can receive services in more than one program, the counts above are not mutually exclusive.

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* by Gender in Washoe County, 2011-2018.

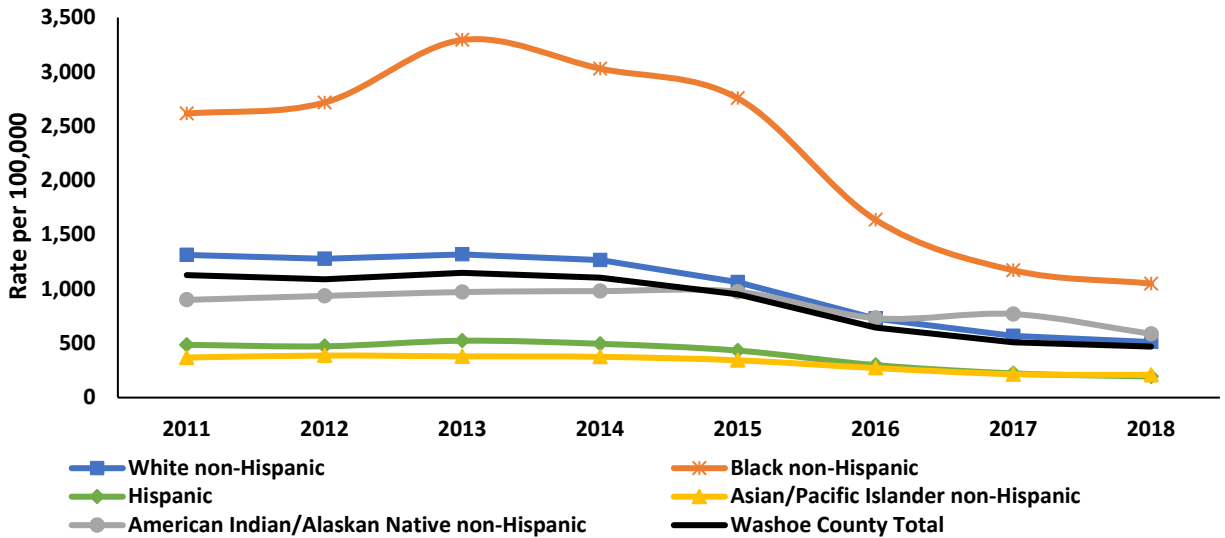


Source: Avatar.
 *A client is counted only once per year. Clients may be counted more than once across years.

From 2011 to 2015, Washoe County females have significantly utilized the state-funded mental health clinics more than males except from 2016 to 2018, where the difference between males and females was no longer not significant (95% confidence interval). In 2018, 480.2 clients per 100,000 male population utilized the state-funded mental health clinics, compared to females at 459.5 clients per 100,000 female population.

Of clients that utilized state-funded mental health services, the most common age group was 45-54-year-olds, on average accounting for 25.6% of the clients. On average, Washoe County high school graduates accounted for 26.5% of clients, followed by those with some college education (23.5%) and GED (11.8%).

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



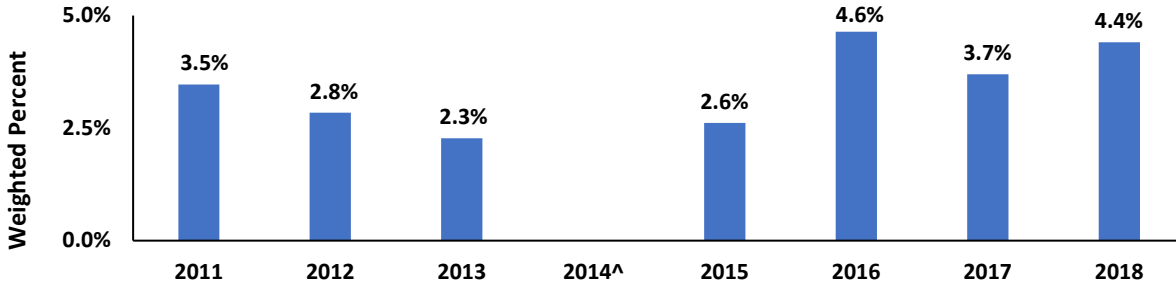
Source: Avatar and Nevada State Demographer, Vintage 2018
 Race "Unknown" not included in analysis.
 *A client is counted only once per year. Clients may be counted more than once across years.

The Affordable Care Act (ACA) went into effect in 2014. Therefore, many Washoe County residents are now able to access non-state-funded facilities through the expansion of Medicaid. This likely contributes to the decline of the clients represented in the above chart. The utilization crude rate has declined significantly for most races, particularly Black non-Hispanic Washoe County residents, from 2011 to 2018. The Black non-Hispanic population has had the highest rate over the seven-year period at 1,049.6 per 100,000 population in 2018, whereas Asian/Pacific Islanders and Hispanics have had the lowest rates of mental health clinic utilization.

Suicide

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

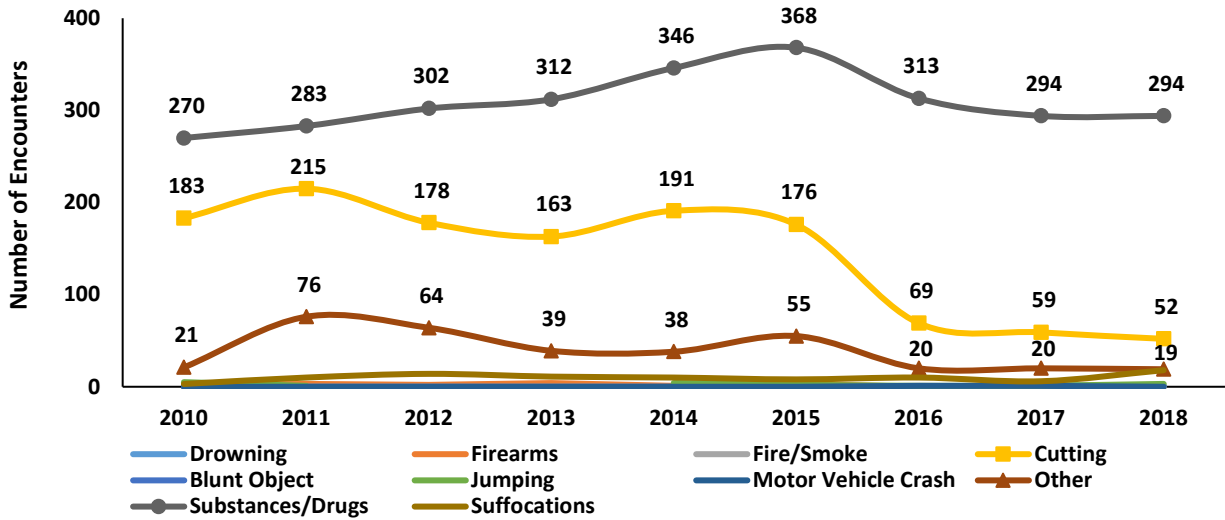
Figure 19. Percentage of Washoe County Adult Residents Who Have Seriously Considered Attempting Suicide, 2011-2018.



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

Between 2011 and 2018, the average prevalence for suicide consideration in Washoe County was 3.0%. In 2018, 4.4% of Washoe County residents reported having seriously considered attempting suicide in the past 12 months. In 2018, Washoe County residents who had never married or who were part of an unmarried couple (8.5%) were significantly more likely to report suicide consideration compared to those who were married (2.0%). This indicator was not measured in 2014.

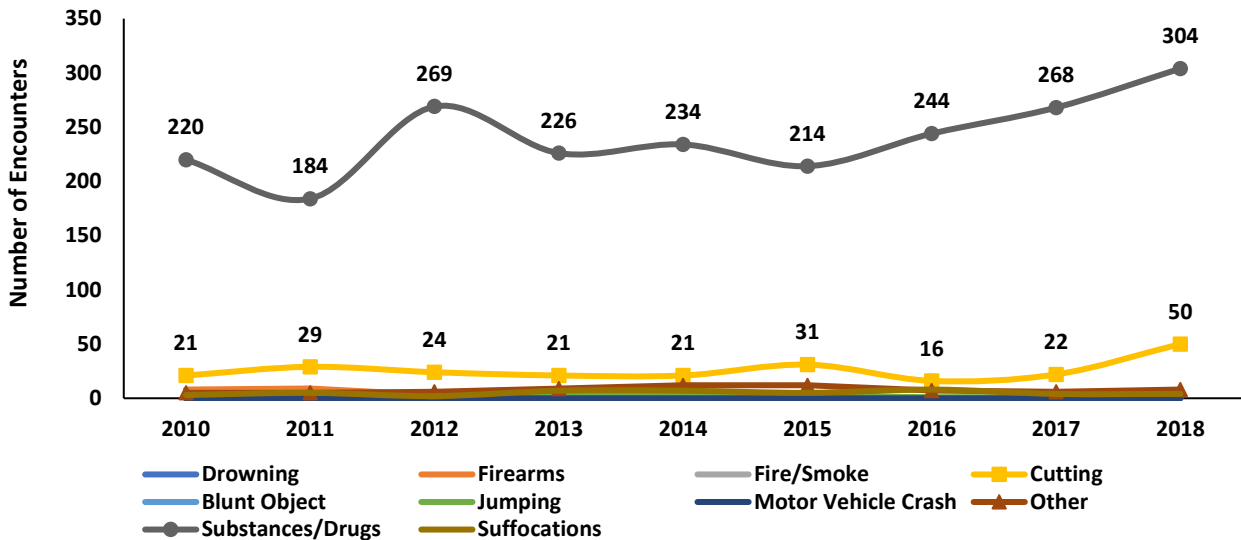
Figure 20. Suicide Attempt Emergency Department Encounters by Method, Washoe County Residents, 2010-2018.



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.

In Washoe County, the most common method of attempted suicide encountered in emergency departments was substance or drug overdose, followed by cutting. From 2010 to 2018, emergency department encounters that were related to substance or drug overdose attempts were relatively constant in Washoe County. However, from 2010 to 2018, emergency department encounters related to cutting have significantly decreased.

Figure 21. Suicide Attempt Inpatient Admissions by Method, Washoe County Residents, 2011-2018.



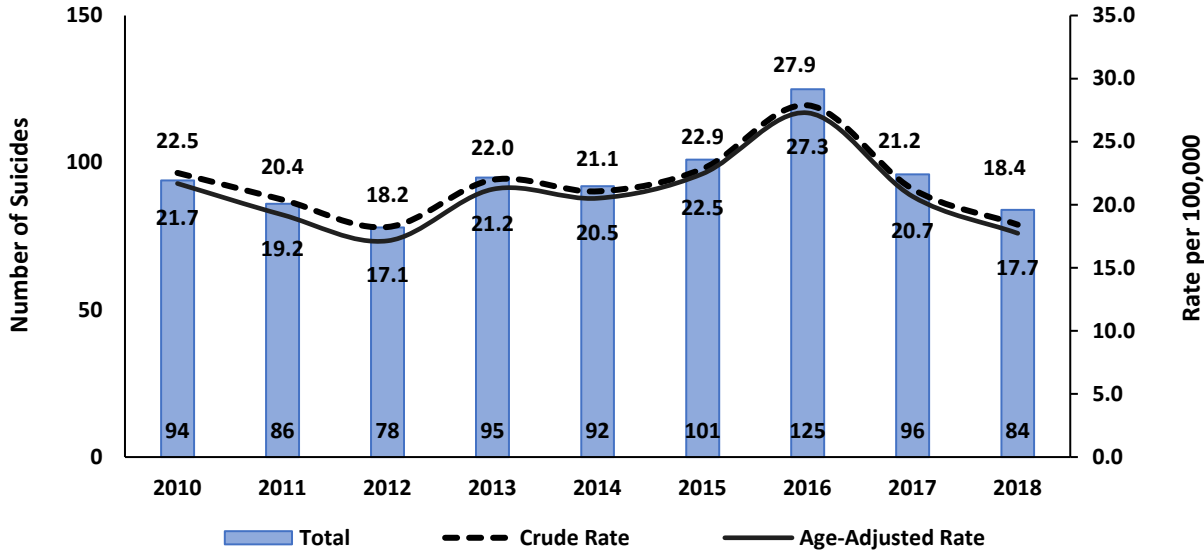
Source: Hospital Inpatient Billing.
 ICD-10 codes replaced ICD-9 codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

From 2010 to 2018, inpatient admissions for attempted suicides overall have increased in Washoe County. In Washoe County, inpatient admissions for attempted suicides where the patient was admitted and did

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not expire at the hospital, have increased where the method was substance or drug overdose. From 2017 to 2018, inpatient admissions for cutting have increased.

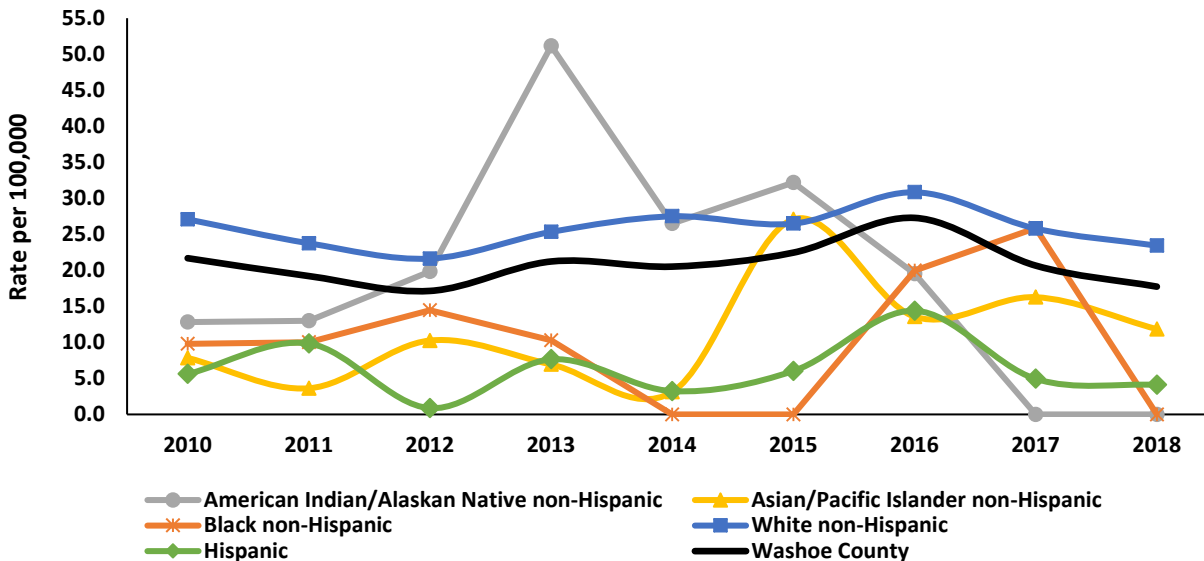
Figure 22. Number of Suicides and Rates, Washoe County Residents, 2010-2018.



Source: Nevada Electronic Death Registry System.

In 2018, the suicide rate in Washoe County was not significantly different compared to Nevada. In 2018, suicides in Washoe County were highest among those aged 45 to 54 years, with 18 suicides, and among high school graduates or those with a GED, with 40 suicides.

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



Source: Nevada Electronic Death Registry System.

In 2018, White non-Hispanics in Washoe County had higher suicide rates compared to Black non-Hispanics, Hispanics, Asian/Pacific Islanders, and American Indian/Alaskan Natives, at 23.4 deaths per

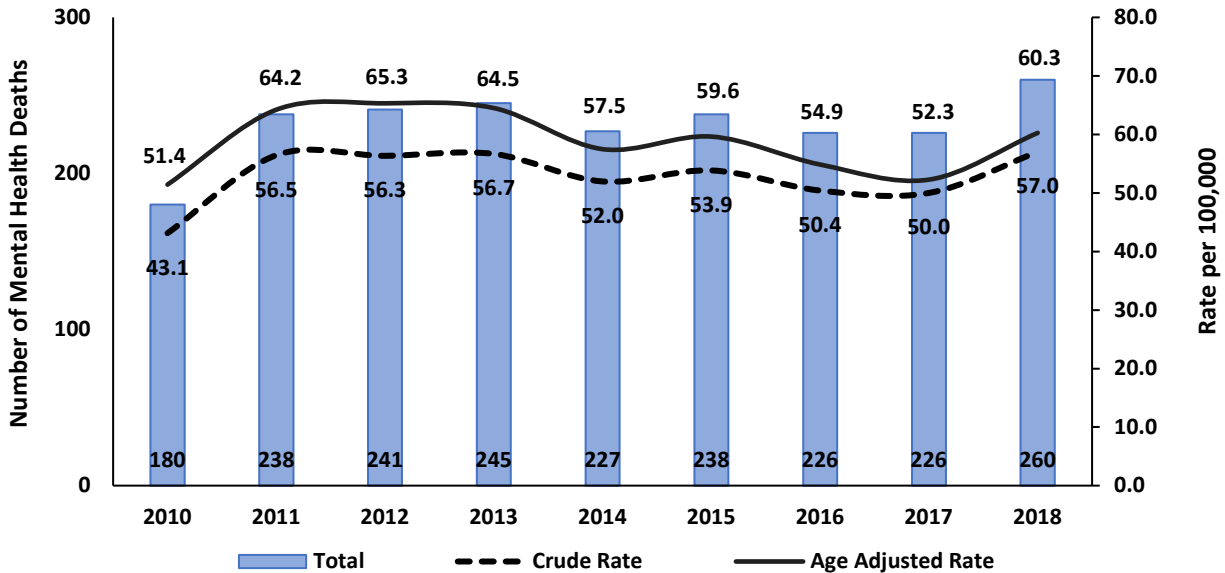
100,000 population. Regarding suicide rates, the Hispanic population has remained below that of Washoe County from 2010 to 2018.

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

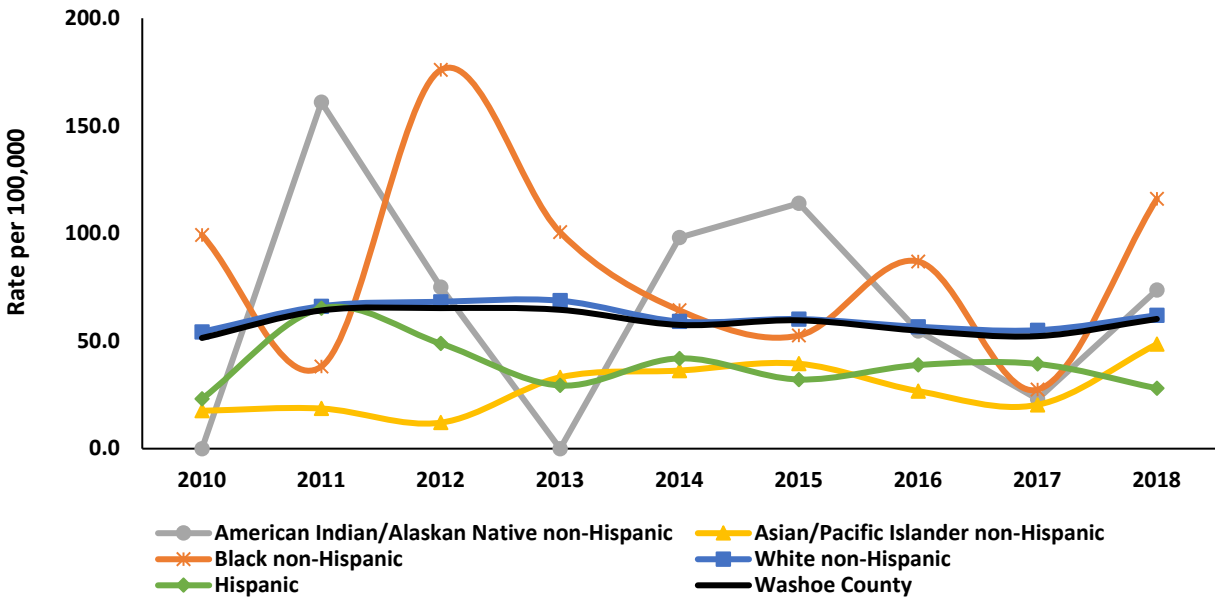
Figure 24. Mental Health-Related Deaths and Age-Adjusted Rates, Washoe County, 2010-2018.



Source: Nevada Electronic Death Registry System.

Washoe County had a significantly higher age-adjusted mental health-related death rate at 60.3 per 100,000 population compared to Nevada statewide. In Washoe County, the age group with the highest count of mental health-related deaths were aged 85 years or older, with 153 deaths in 2018. In Washoe County, high school graduates or those with a GED made up the highest count of mental health-related deaths, with 103 deaths in 2018.

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



Source: Nevada Electronic Death Registry System.

In 2018, Washoe County Hispanic residents (28.0 per 100,000) had a significantly lower mental health-related death rate compared to Washoe County overall (60.2 per 100,000). From 2010 to 2018, Asian/Pacific Islanders have lower mental health-related death rates compared to Washoe County overall, although not necessarily significant for all years.

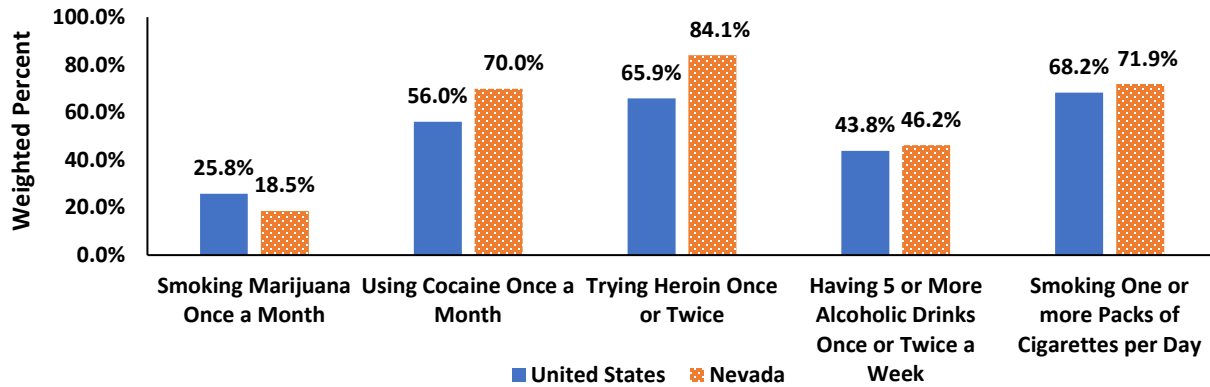
Substance Use

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.

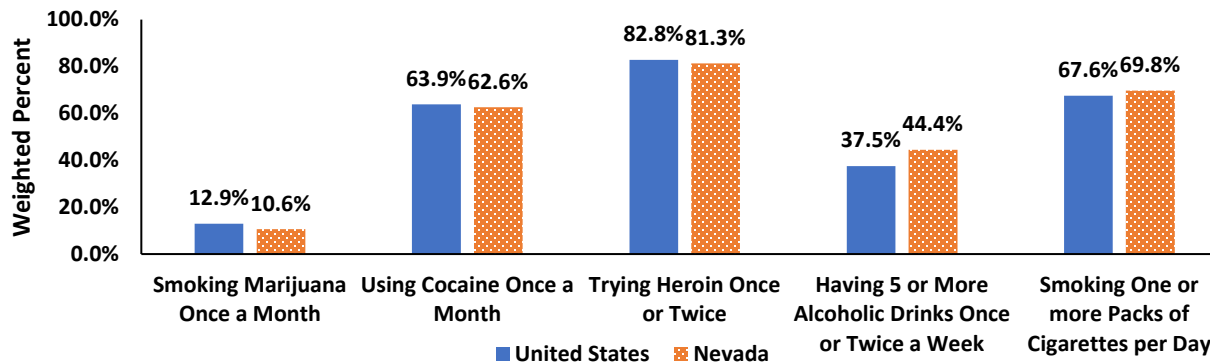
Figure 26. Perceptions of Great Risk from Alcohol or Substances, Ages 12-17, Nevada and the United States, 2017.



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 for using cocaine, trying heroin, drinking more than 5 drinks and smoking is greater than that of the United States, whereas for young adults 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 Substances, Ages 18-25, Nevada and the United States, 2016-2017.

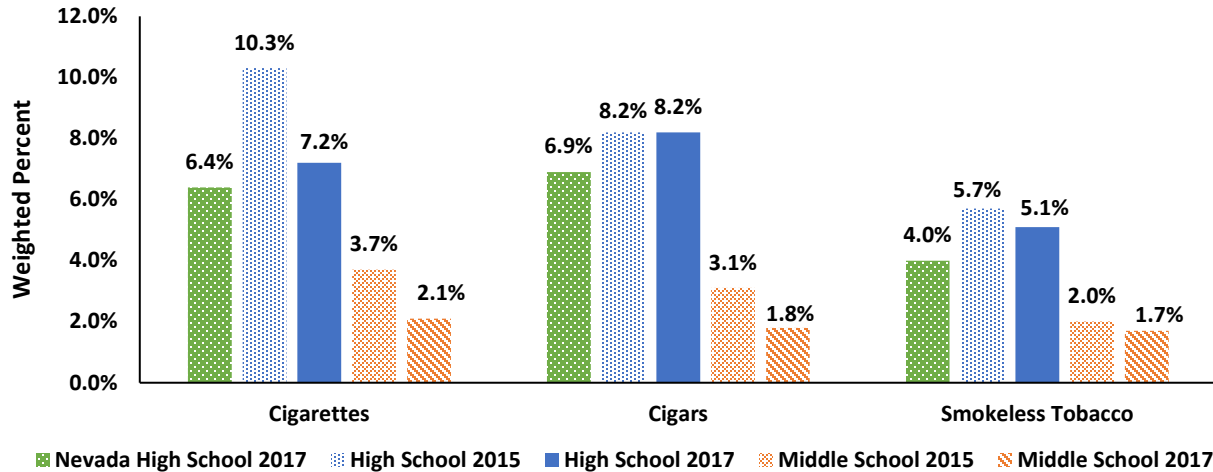


Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010-2016. Chart scaled to 100% to display differences among groups.

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, 1,310 high school, and 1,253 middle school students in Washoe 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](#).

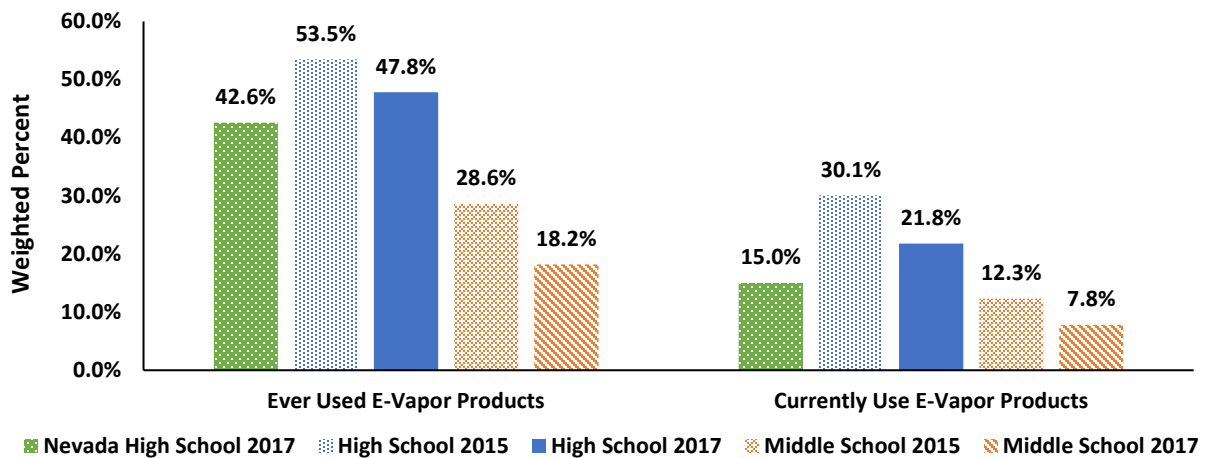
Figure 28. Current Tobacco Use, Washoe County Middle and High School Students, 2015 and 2017.



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

From 2015 to 2017, there were no significant changes in tobacco usage among Washoe County middle and high schoolers. In 2017, Washoe County male high schoolers (8.1%) were significantly more likely to currently be using smokeless tobacco compared to females (1.7%). Overall, in 2017, tobacco usage patterns in Washoe County students did not differ significantly to those across Nevada statewide.

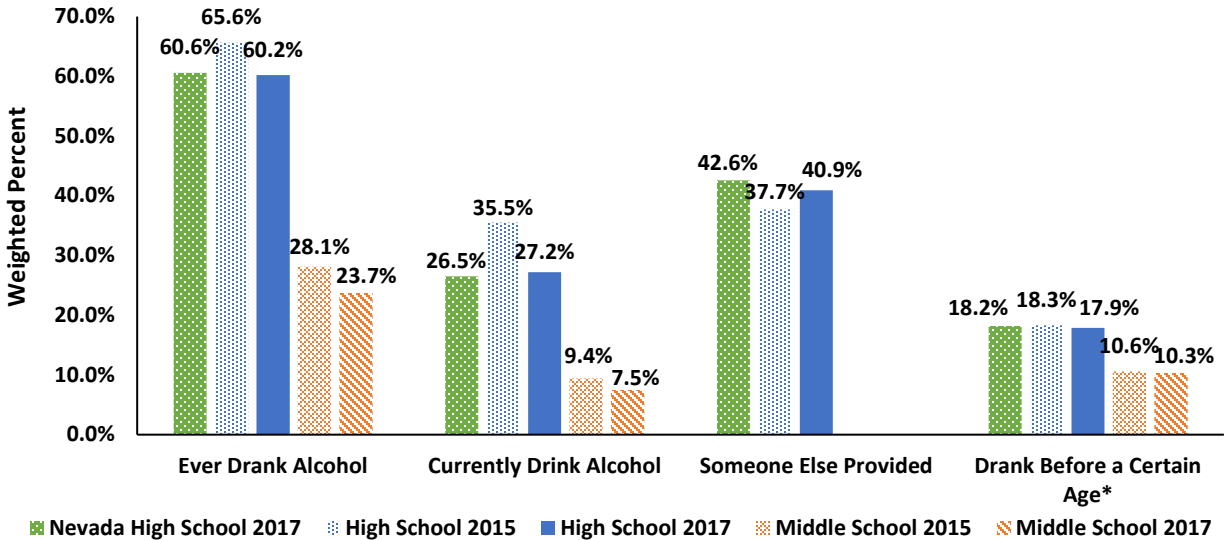
Figure 29. Electronic Vapor Product Use, Washoe County Middle and High School Students, 2015 and 2017.



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

From 2015 to 2017, there was a significant decline in current e-vapor use among Washoe County high schoolers. From 2015 to 2017, there was a significant decline in having ever used e-vapor products among Washoe County middle schoolers. In 2017, Washoe County high schoolers who were Asian (23.8%) were significantly less likely to have ever used e-vapor products compared to high schoolers who were Black non-Hispanic (67.4%), White non-Hispanic (48.1%), or Hispanic (51.4%). In 2017, Washoe County high schoolers (21.8%) were significantly more likely to currently use e-vapor products compared to Nevada statewide (15.0%).

Figure 30. Alcohol Use, Washoe County Middle and High School Students, 2015 and 2017.



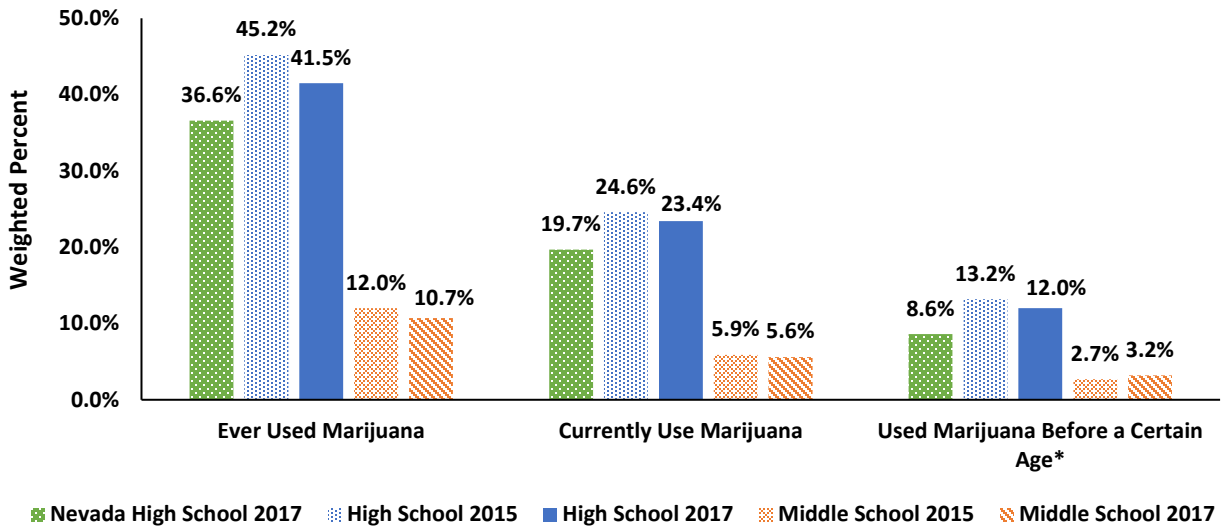
Source: Nevada Youth Risk Behavior Survey.

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.

From 2015 to 2017, there was a significant decline in Washoe County high schoolers who currently drank alcohol. Overall, rates of alcohol use among Washoe County students did not significantly differ to those across Nevada statewide. In 2017, among Washoe County high schoolers, 18-year-old students (70.3%) were significantly more likely to have ever drank alcohol compared to those 14 years or younger (50.0%). In 2017, among Washoe County high schoolers, Asian students (32.5%) were significantly less likely to have ever drank alcohol compared to Black non-Hispanics (68.1%), Native Hawaiian/Pacific Islanders (80.2%), White non-Hispanics (61.4%), and Hispanic (61.4%) students. In 2017, among Washoe County high schoolers, females (50.5%) were significantly more likely to drank alcohol given to them by someone else compared to males (29.2%).

Figure 31. Marijuana Use, Washoe County Middle and High School Students, 2015 and 2017.



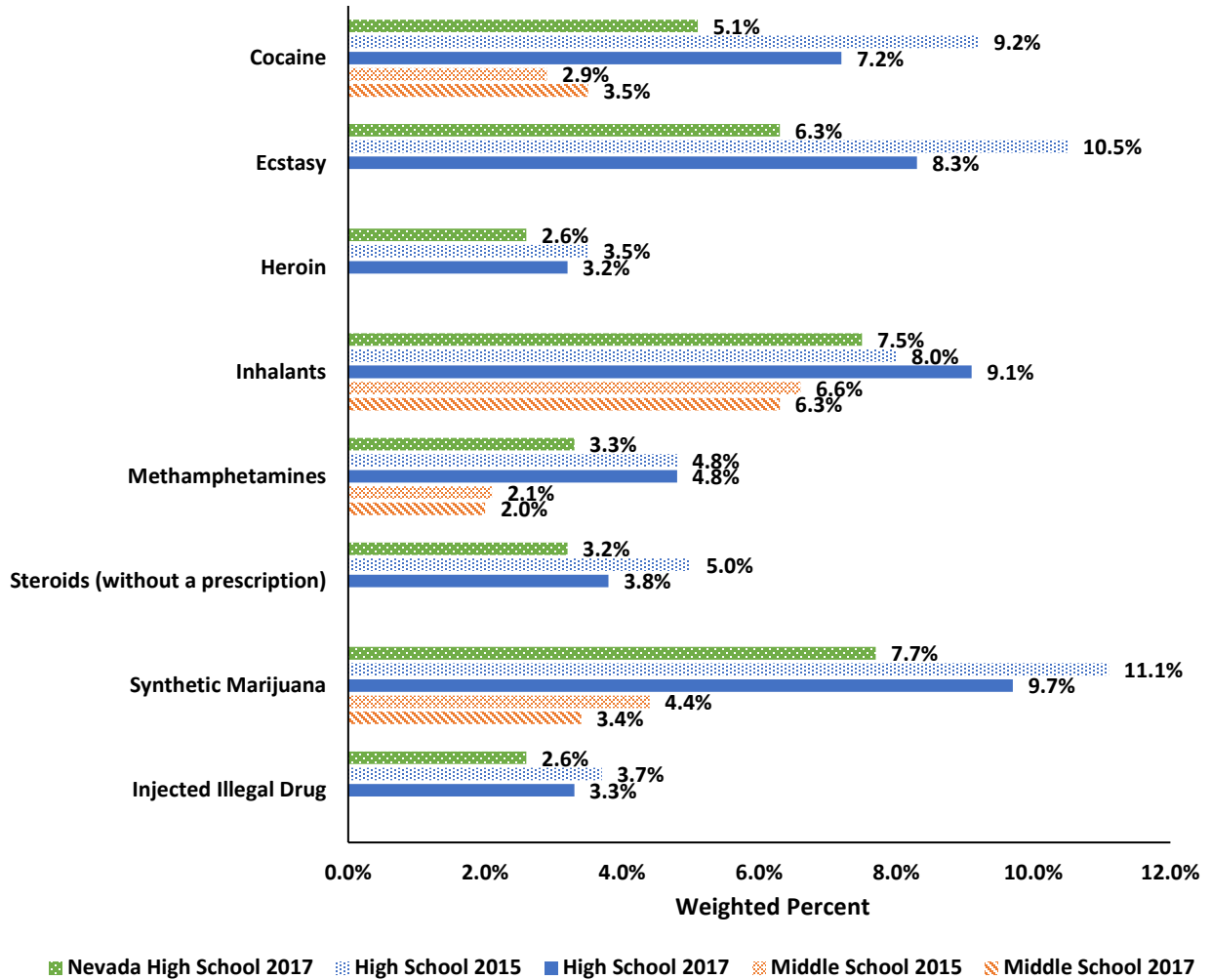
Source: Nevada Youth Risk Behavior Survey.

Chart scaled to 50% 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.

There was no significant change for marijuana use from 2015 to 2017 among Washoe County students. Marijuana use patterns in Washoe County did not significantly differ from those across Nevada statewide. Less than half of Washoe County high schoolers reported ever trying marijuana and less than one-third reported currently using marijuana. In 2017, Washoe County high schoolers who were Asian (16.4%) were significantly less likely to have ever tried marijuana compared to Black non-Hispanics (58.3%), White non-Hispanics (38.5%), or Hispanic/Latino (46.6%). In 2017, Washoe County high schoolers who were Asian (8.8%) were significantly less likely to currently use marijuana compared to American Indian/Alaskan Natives (46.6%), White non-Hispanics (20.7%), and Hispanic/Latinos (24.8%).

Figure 32. Lifetime Drug Use, Washoe County Middle and High School Students, 2015 and 2017.



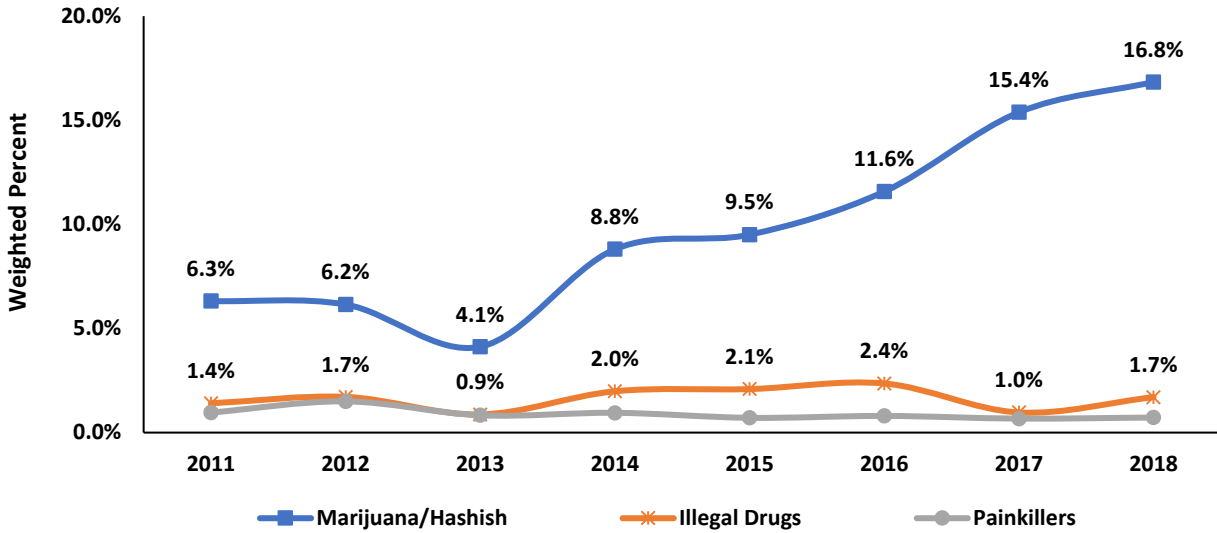
Source: Nevada Youth Risk Behavior Survey.
 Chart scaled to 12% to display differences among groups.

From 2015 to 2017, there were no significant changes in lifetime drug use among Washoe County students. Trends in drug use in Washoe County were not significantly different from those across Nevada statewide. Less than 10% of Washoe County high schoolers had ever tried other drugs.

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. Use of Marijuana/Hashish, Illegal Substances, or Painkillers to Get High in the Last 30 Days, Washoe County Adult Residents, 2011-2018.



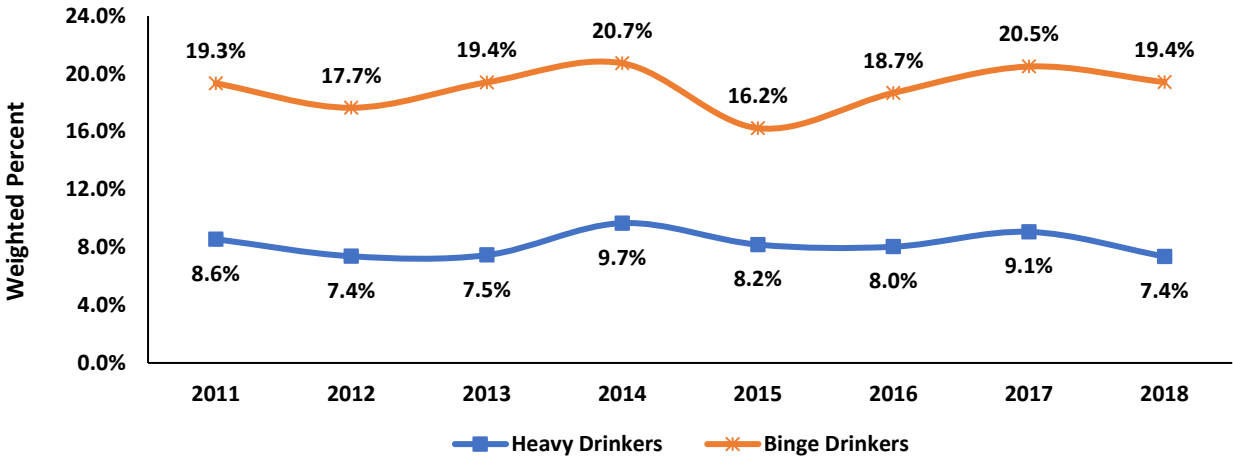
Source: Behavioral Risk Factor Surveillance System.

Chart scaled to 20% 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 2018, 16.8% of Washoe County adults reported using marijuana or hashish, compared to 6.3% in 2011. Self-reported marijuana use is expected to increase as marijuana was legalized in Nevada in 2017. In 2018, Washoe County college graduates (10.0%) were significantly less likely to use marijuana or hashish compared to those who had some college experience (21.3%). In 2018, Washoe County seniors who were aged 65 or older (6.3%) were significantly less likely to use marijuana or hashish compared to younger adults aged 18 to 24 (25.5%) or aged 25 to 34 years (33.8%). From 2011 to 2018, on average, 1.6% of Washoe County adults used illegal drugs and 0.9% used painkillers to get high in the past 30 days. Washoe County had similar marijuana/hashish usage rates compared to Nevada statewide.

Figure 34. Percentage of Washoe County Adults Who are Considered Binge Drinkers or Heavy Drinkers, 2011-2018.



Source: Behavioral Risk Factor Surveillance System.

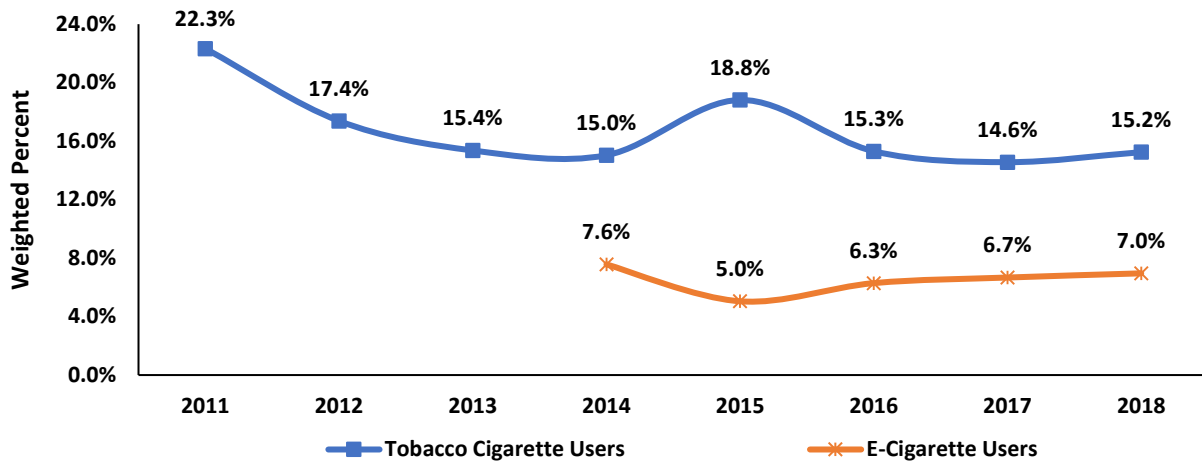
Chart scaled to 24% to display differences among groups.

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 a single occasion. Heavy drinking is defined in men as consuming more than two alcoholic beverages, and in women as more than one alcoholic beverage per day. In 2018, Washoe County males (28.1%) were significantly more likely to be binge drinkers compared to females (10.6%). In 2018, Washoe County adults who did not have a high school diploma (1.3%) were significantly less likely to be heavy drinkers than those who had graduated high school (8.0%) or had higher education. In 2018, Washoe County adults who were aged 55 years or older were significantly less likely to be binge drinkers compared to those aged 18 to 44 years.

Figure 35. Percentage of Washoe County Adults Who are Current Cigarette or E-Cigarette Smokers, 2011-2018.



Source: Behavioral Risk Factor Surveillance System.

Chart scaled to 24% 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.

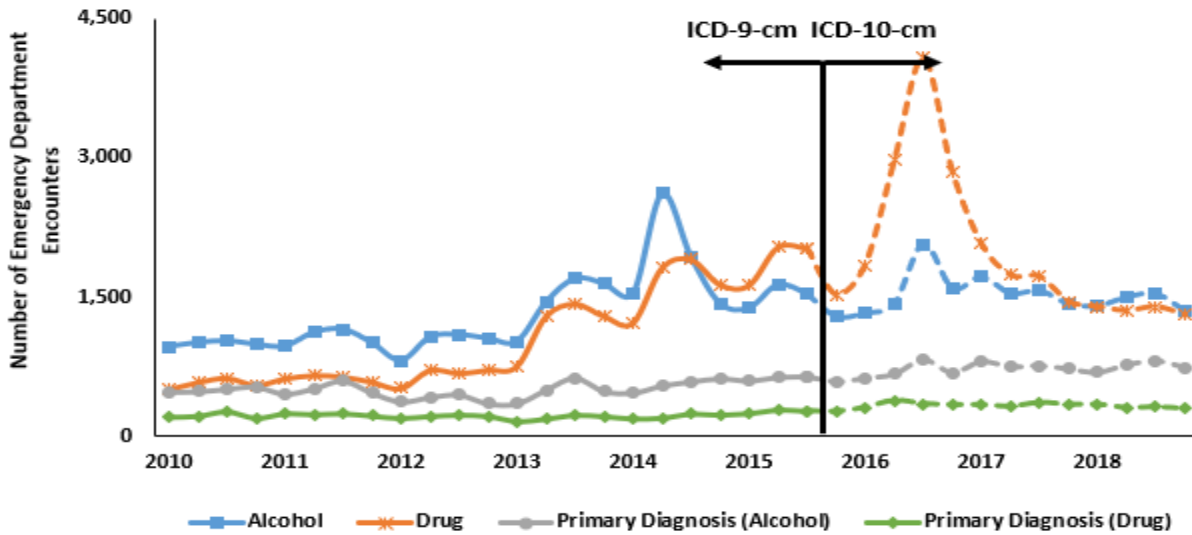
In 2018, 15.2% of Washoe County adults reported being current tobacco cigarette smokers, which is a significant decrease from the prevalence in 2011 (22.3%). In 2018, Washoe County adults who were college graduates (6.2%) were significantly less likely to report being current tobacco smokers compared to those with some college (17.4%), high school diploma (19.6%), or less than completed high school educations (18.6%).

In 2018, 7.0% of Washoe County adults reported being currently e-cigarette users. In 2018, Washoe County college graduates (2.8%) were significantly less likely to report being e-cigarette users compared to those who only had some college experience (9.6%). In 2018, Washoe County adults who were 45 to 54 years (2.2%) or 65 years and older (2.9%) were significantly less likely to report using e-cigarettes compared to those aged 18 to 24 (14.6%) and 25 to 34 years (14.1%).

Hospital Emergency Department Encounters

The hospital emergency department billing data provides health billing data for emergency departments patients for Nevada’s non-federal hospitals. Since an individual can have more than one diagnosis during a single emergency department visit, the following numbers are not mutually exclusive. In 2018, there were a total of 10,563 alcohol and/or drug-related (all diagnosis) emergency department encounters in Washoe County. Out of this number, 3,008 were related to alcohol (primary diagnosis) and 1,249 were drug-related (primary diagnosis).

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



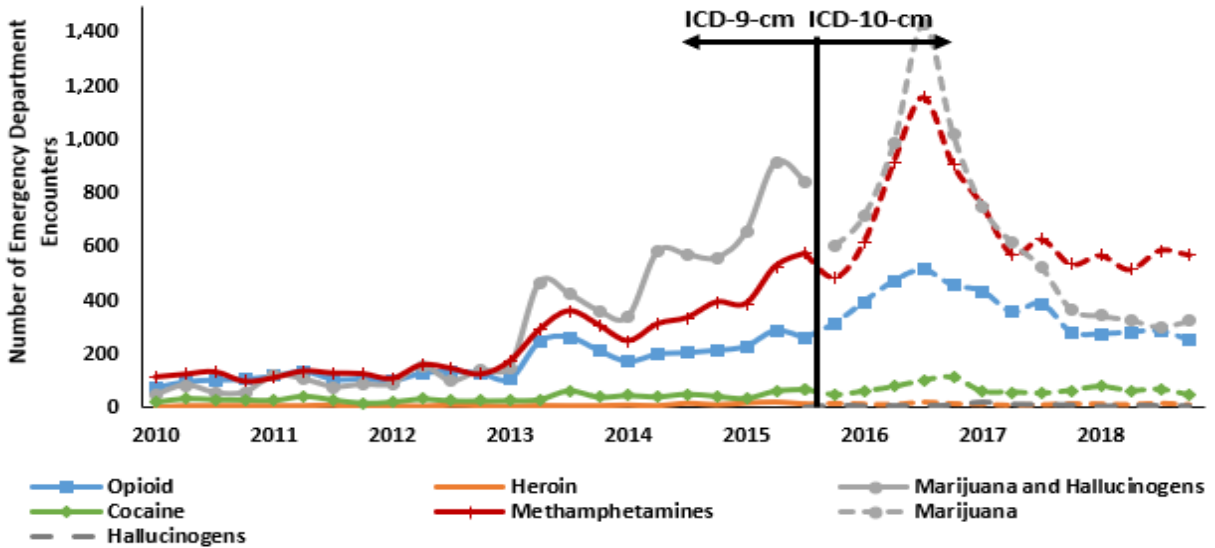
Source: Hospital Emergency Department Billing.
Categories are not mutually exclusive.

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 2014, alcohol-related emergency department encounters were more common than drug-related encounters in Washoe County. However, from 2015 to 2017, drug-related emergency department encounters surpassed alcohol-related encounters. In 2018, there were relatively equal numbers of alcohol (1,268.8 cases per 100,000) and drug-related (1,193.1 cases per 100,000) emergency department encounters in Washoe County.

Figure 37. Drug-Related Emergency Department Encounters in Washoe 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.

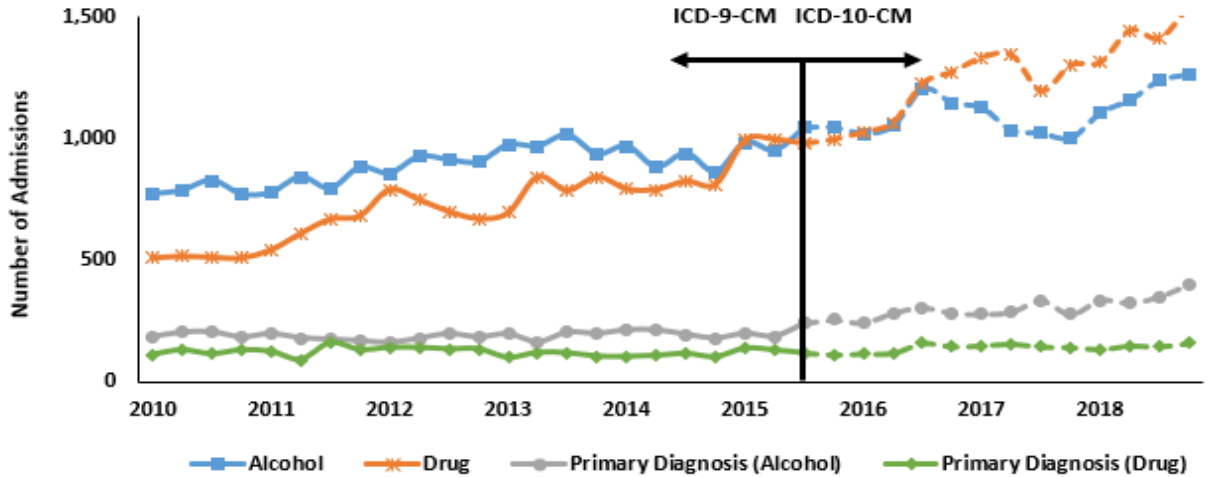
Hallucinogens and marijuana were grouped together for ICD-9-CM, but in 2015 were separated into their own groups in the ICD-10-CM codes. Methamphetamine and opioid use rates in Washoe County were significantly higher in 2018 compared to 2010. In 2018, methamphetamines (492.1 cases per 100,000) were the most common drug-related emergency department encounter in Washoe County, followed by marijuana (285.3 cases per 100,000) and opioids (240.1 cases per 100,000).

Males in Washoe County had significantly more emergency department encounters for cocaine, methamphetamines, and marijuana/cannabis than females in 2018. In 2018, the most common age group seen in emergency department encounters for opioids, cocaine, methamphetamines, and marijuana in Washoe County was those aged 25 to 34 years.

Hospital Inpatient Admissions

The hospital inpatient admission billing data provides health billing data for patients admitted to hospital for longer than a 24-hour period. In 2018, more people were admitted into Washoe County hospitals for drug-related issues than alcohol related issues. Of the 9,169 alcohol and/or drug-related admissions in Washoe County in 2018, there were 4,768 that had alcohol-related diagnosis and 5,712 had drug-related. 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 38. Alcohol and/or Drug-Related Inpatient Admissions in Washoe County by Quarter and Year, 2010-2018.

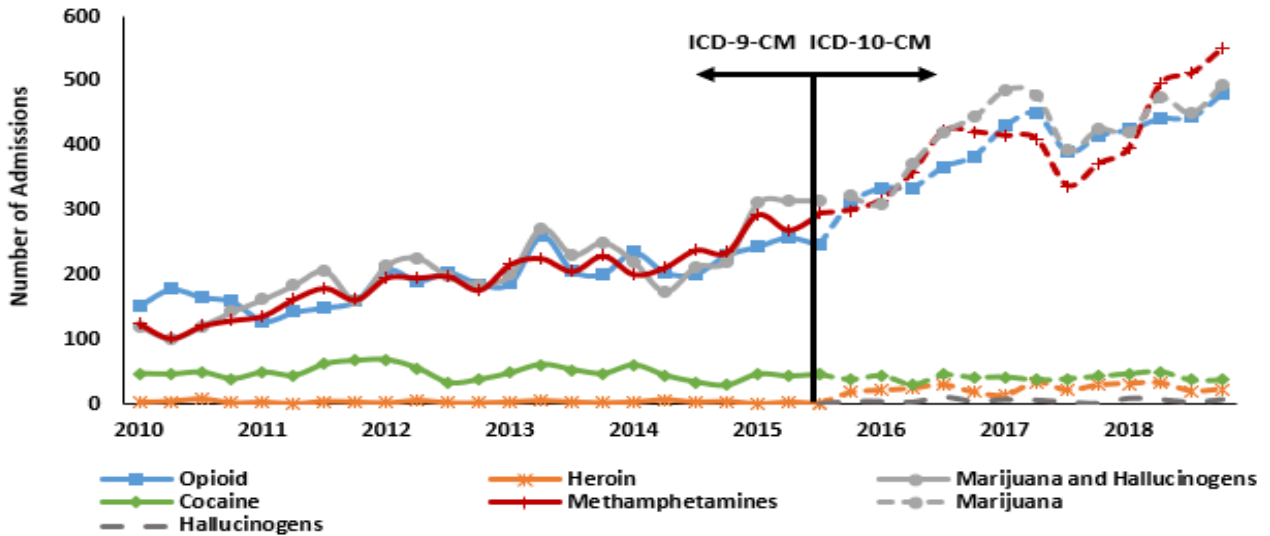


Source: Hospital Inpatient Billing.
 Categories are not mutually exclusive.
 ICD-9 codes were replaced by ICD-10 codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Alcohol-related inpatient admissions in Washoe County were more common than drug-related admissions from 2010 to 2015. From mid-2016 to 2018, drug-related admissions surpassed alcohol-related admissions. In 2018, there were 1,045.5 alcohol-related admissions per 100,000 and 1,252.5 drug-related admissions per 100,000.

In 2018, Washoe County males were significantly more likely to be seen for alcohol-related inpatient admissions compared to females. In 2018, the age group more commonly seen for alcohol and/or drug-related inpatient admissions was 55 to 64 years in Washoe County

Figure 39. Drug-Related Inpatient Admissions in Washoe 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.

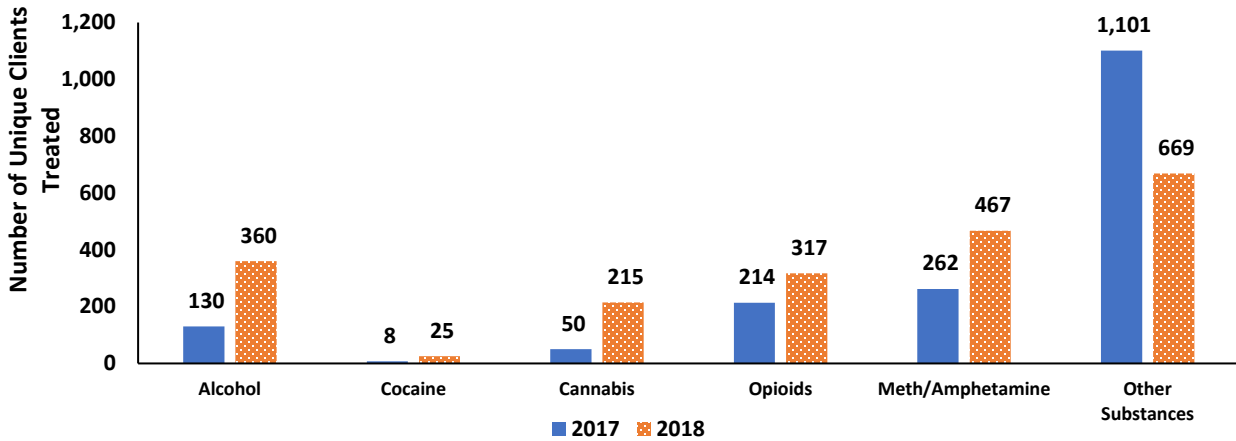
Hallucinogens and marijuana were grouped together for ICD-9-CM, but in 2015 were separated into their own groups in the ICD-10-CM codes. In Washoe County, opioid, marijuana, and methamphetamine inpatient admission increased significantly from 2010 to 2018. In 2018, methamphetamines (429.6 cases per 100,000) were the most common drug-related hospital inpatient admission in Washoe County, followed by marijuana (403.9 cases per 100,000), and opioids (392.9 cases per 100,000).

In 2018, inpatient admissions for males were significantly higher for cocaine, methamphetamine, marijuana and hallucinogens compared to females. However, females had more inpatient admissions than males for opioids and heroin. Washoe County had significant higher rates of inpatient admissions for opioids, heroin, and methamphetamines compared to Nevada statewide.

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 Washoe County, 2017 and 2018.



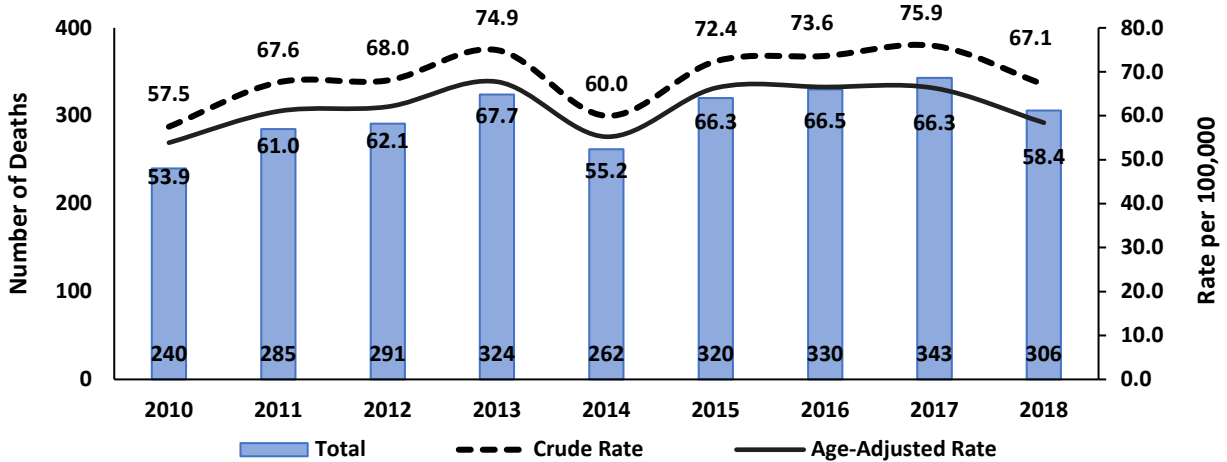
Data Source: Treatment Episode Data Sets.

The number of unique clients at substance abuse treatment centers have increased from 2017 to 2018 for alcohol, cannabis, and methamphetamines, this could be due to more complete reporting of treatment center data. In 2018, males made up 61.1% of clients seen for alcohol and 73.0% of clients seen for cannabis in Washoe County. In 2018, females made up 53.7% of clients seen for methamphetamines. Among Washoe County residents in 2018, methamphetamines were the primary substance seen at treatment centers for White non-Hispanics and Asian/Pacific Islanders, while alcohol was the primary substance seen in American Indian/Alaskan Natives and Black non-Hispanics.

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, 2,701 deaths were related to alcohol and drugs in Washoe County.

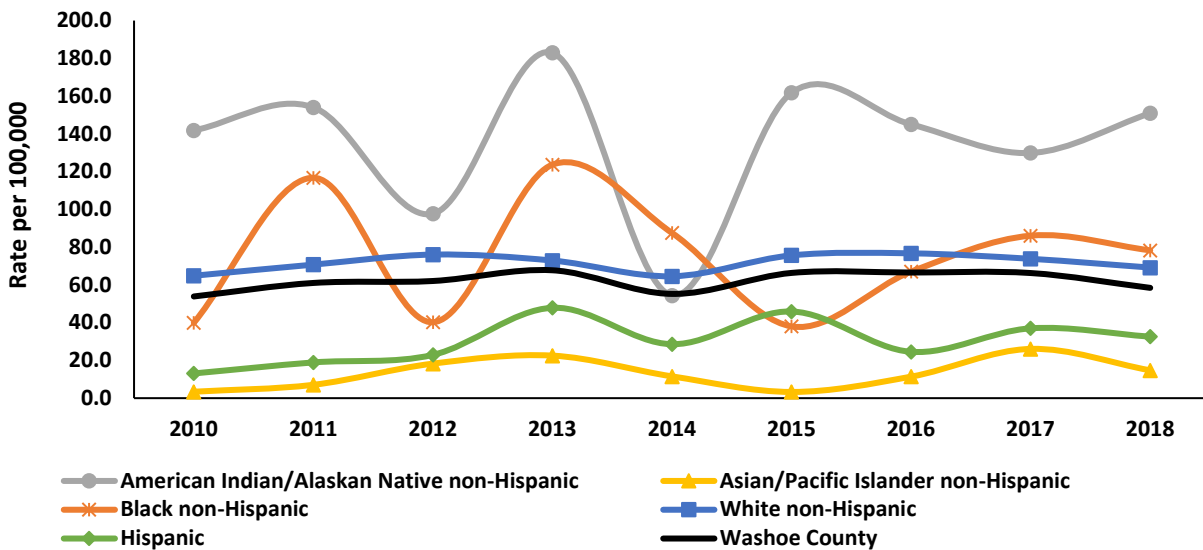
Figure 41. Alcohol and/or Drug-Related Deaths and Age-Adjusted Rates in Washoe County, 2010-2018.



Source: Electronic Death Registry System.

From 2010 to 2018, patterns in alcohol and/or drug-related deaths did not significantly change in Washoe County. In 2018, Washoe County residents who were aged 55 to 64 years were the most common age group among alcohol and/or drug-related deaths. In 2018, Washoe County did not have significantly different death rates for alcohol and/or drug-related use compared to Nevada statewide.

Figure 42. Age-Adjusted Rates of Alcohol and/or Drug-Related Deaths by Race in Washoe County, 2010-2018.

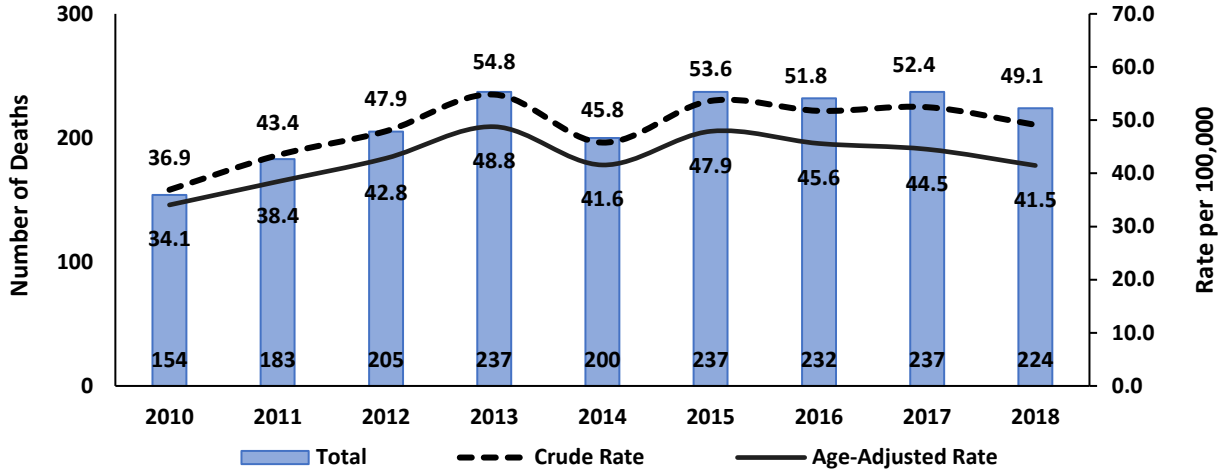


Source: Electronic Death Registry System.

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In 2018, Washoe County residents who were White non-Hispanics (69.2 per 100,000) had significantly higher age-adjusted alcohol and/or drug-related death rates compared to those who were Hispanic (32.6 per 100,000) and Asian/Pacific Islander (14.7 per 100,000).

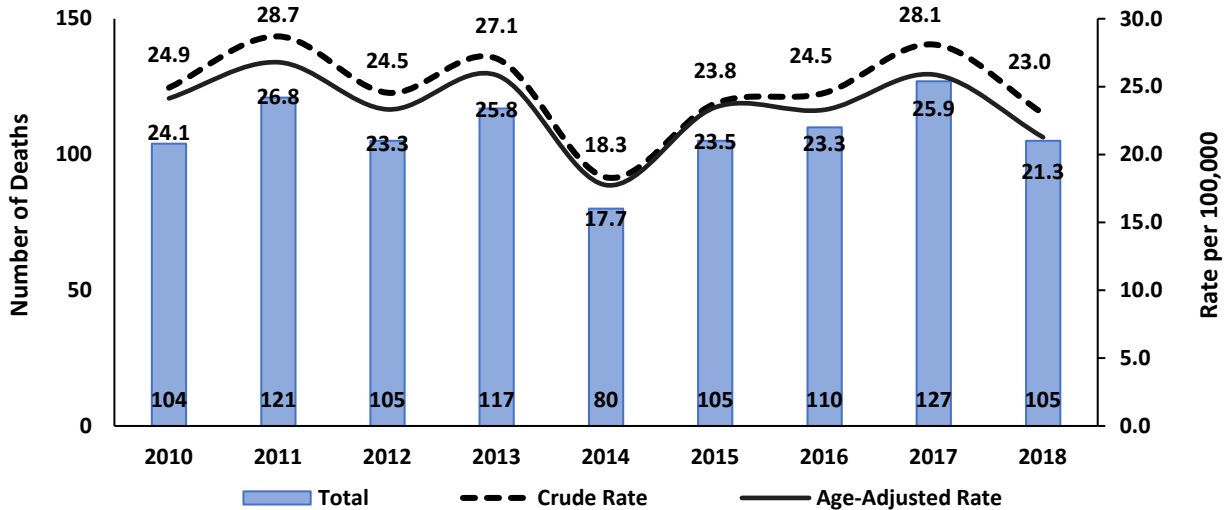
Figure 43. Alcohol-Related Deaths and Age-Adjusted Rates in Washoe County, 2010-2018.



Source: Electronic Death Registry System.

Alcohol-related deaths in Washoe County have not increased significantly between 2010 to 2018. On average, from 2010 to 2018, the age group with the highest number of alcohol-related deaths in Washoe County were aged 55 to 64 years. In 2018, there were significantly more alcohol-related deaths in Washoe County (41.5 per 100,000) compared to Nevada statewide (32.1 per 100,000).

Figure 44. Drug-Related Deaths and Age-Adjusted Rates in Washoe County, 2010-2018.



Source: Electronic Death Registry System.

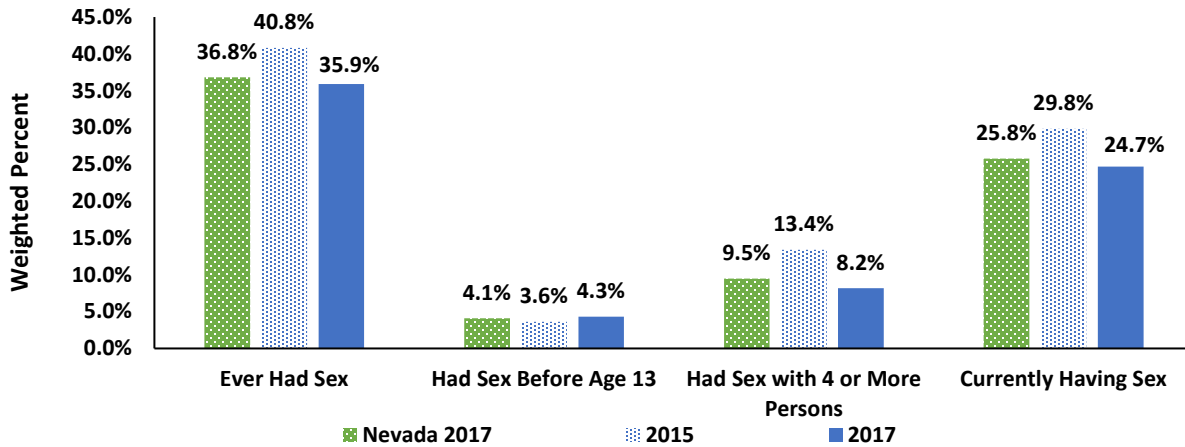
Drug-related deaths in Washoe County have not increased significantly between 2010 to 2018. On average, from 2010 to 2018, the age group with the highest number of drug-related deaths in Washoe County were aged 45 to 54 years. In 2018, the age-adjusted drug-related death rate in Washoe County did not significantly differ to that of Nevada statewide.

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, 1,310 high school, and 1,253 middle school students in Washoe County participated in the YRBS.

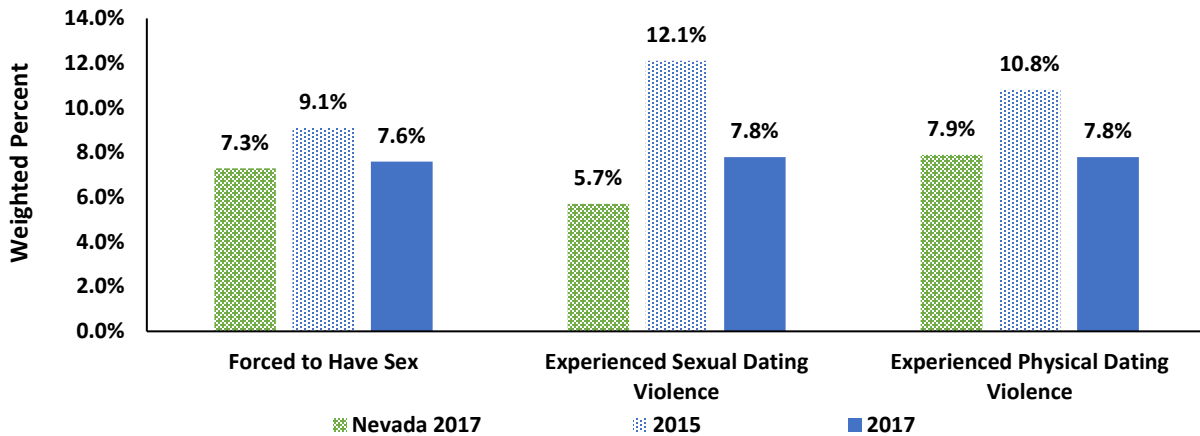
Figure 45. Sexual Behaviors, Washoe County High School Students, 2015 and 2017.



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

From 2015 to 2017, there were no significant changes in sexual behaviors among Washoe County high schoolers. Sexual behaviors in Washoe County were not significantly different to those across Nevada statewide. Over a third of Washoe County high schoolers had ever had sexual intercourse and a quarter were currently having sex in 2017. In 2017, Washoe County 9th graders (15.8%) were significantly less likely to have ever had sex compared to 10th (31.7%), 11th (47.8%), and 12th graders (47.4%). In 2017, Washoe County high schoolers who were Asian (9.2%) were significantly less likely to be currently having sex compared to White non-Hispanics (26.5%) or Hispanic (24.6%) students. Approximately 20.9% of Washoe County high schoolers reported drinking alcohol or using drugs before their last sexual encounter.

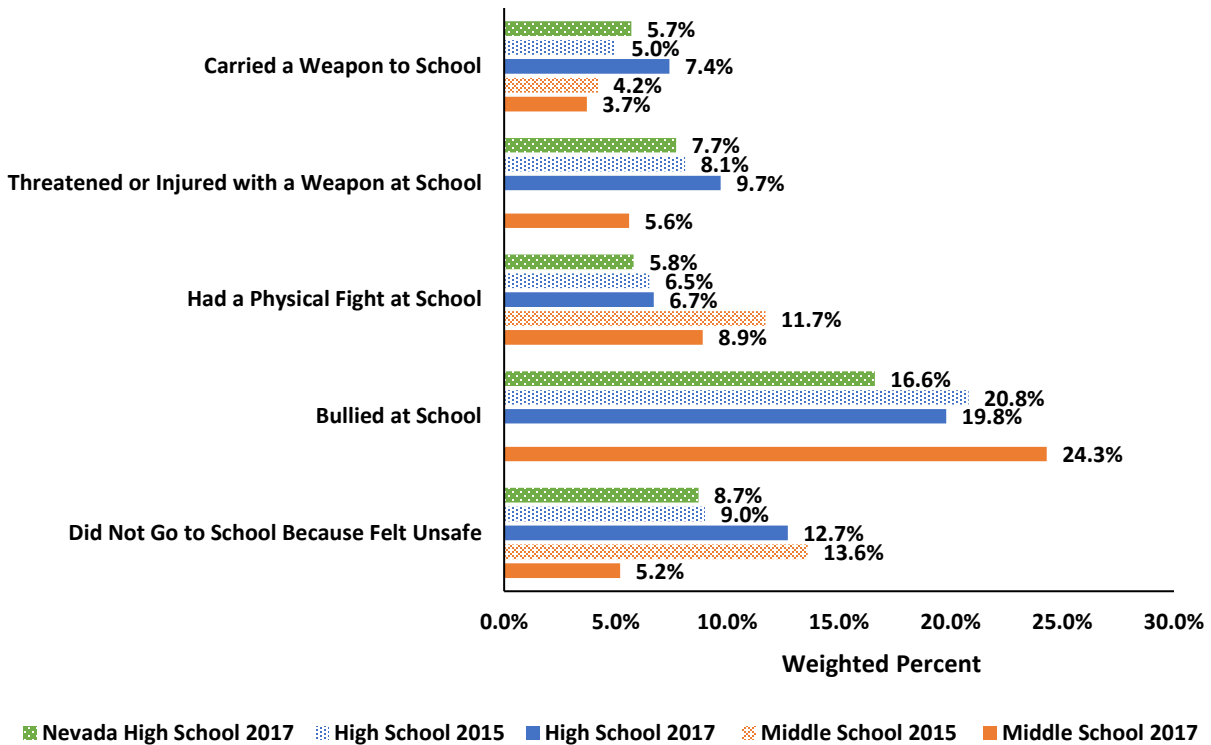
Figure 46. Sexual Violence Among High School Students in Washoe County, 2015 and 2017.



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

From 2015 to 2017, there was a significant decrease in sexual dating violence from 12.1% to 7.8% among Washoe County high schoolers, but no significant change in physical dating violence or being forced to have sex. From 2015 to 2017, sexual violence trends in Washoe County did not significantly differ from those across Nevada statewide. In 2017, Washoe County female high schoolers (9.3%) were significantly more likely to have been physically forced to have sex compared to their male counterparts (5.3%).

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



Source: Nevada Youth Risk Behavior Survey.
 Chart scaled to 30% to display differences among groups.

Washoe County SAPTA Epidemiologic Profile

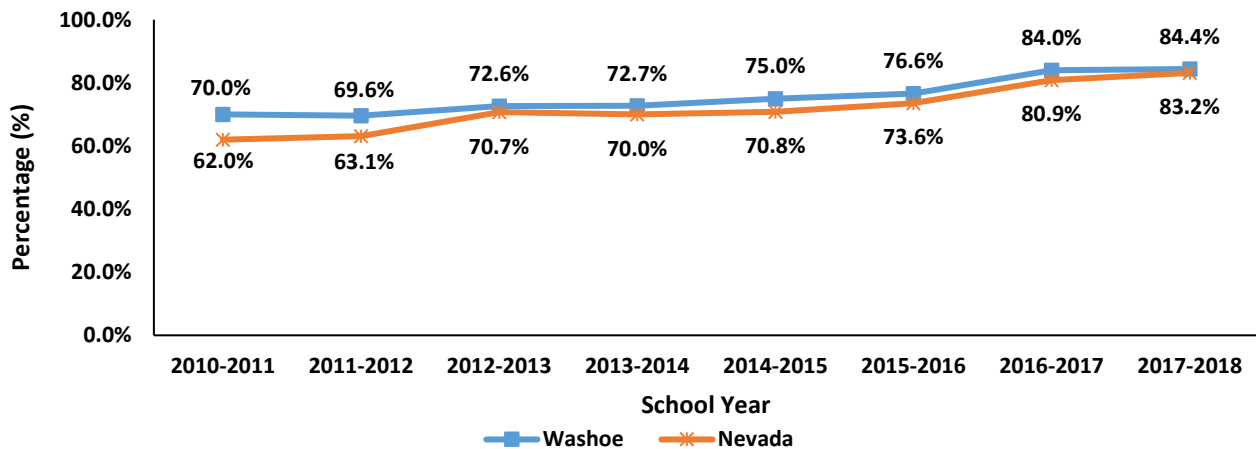
In 2017, among Washoe County high schoolers, males (10.3%) were significantly more likely to report having carried a weapon on school property (10.3%), having been threatened or injured with a weapon on school property (13.0%), and having been in a physical fight on school property (9.1%) compared to females (3.8%, 5.8%, and 4.2%, respectively). Additionally, in 2017, 9th graders (12.9%) were significantly more likely to report having been threatened or injured with a weapon on school property compared to 12th graders (4.9%). In 2017, Hispanic/Latino high schoolers in Washoe County (10.4%) were significantly more likely to report having been in a physical fight on school property in the past 12 months compared to White non-Hispanics (3.8%). In 2017, 9th graders (26.2%) were significantly more likely to report having been bullied on school property in the past 12 months compared to 12th graders (12.8%). Among Washoe County middle schoolers, from 2015 to 2017, there was a significant decrease in the prevalence of skipping school due to feeling unsafe (from 13.6% to 5.2%).

Nevada Report Card

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

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

Figure 48. High School Graduation Percentage of Class Cohorts, Washoe County, 2010–2018.



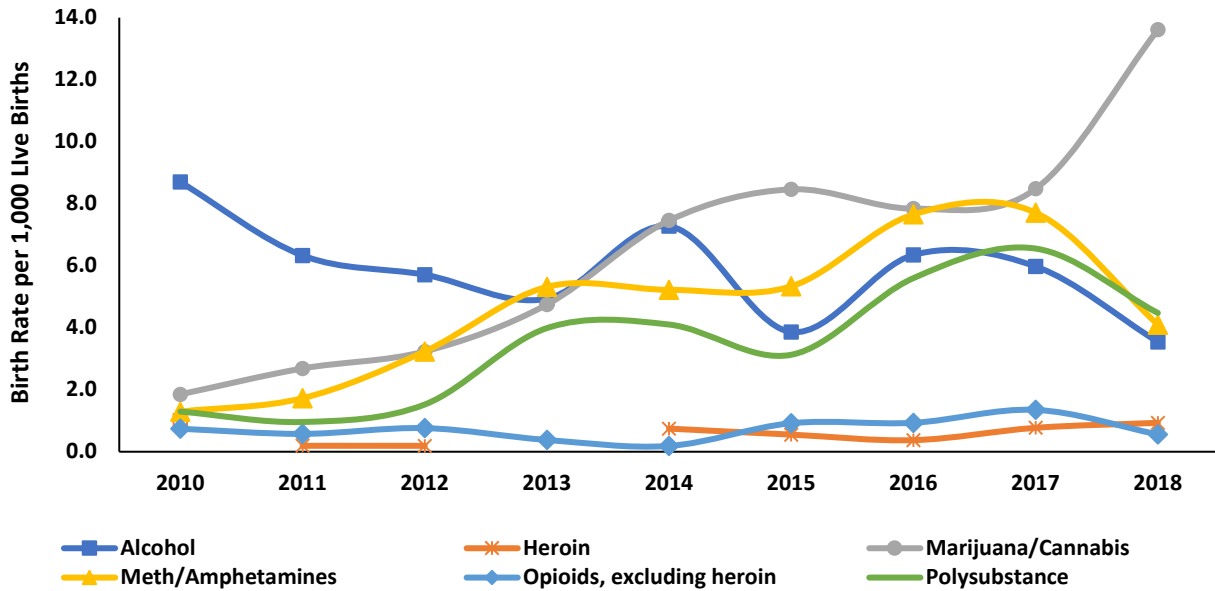
Source: Nevada Department of Education, Report Card.

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 posted the highest graduation rate at 83.2%; Washoe County high schools also posted the highest graduation rate at 84.4%.

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 are 5,316 live births per year to Washoe County residents between 2010 and 2018. In 2018, 19 birth certificates indicated alcohol use, 73 birth certificates indicated marijuana use, 22 indicated meth/amphetamine use, three indicated opiate use (excluding heroin), and five indicated heroin use during pregnancy. Additionally, 24 birth certificates indicated polysubstance use.

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

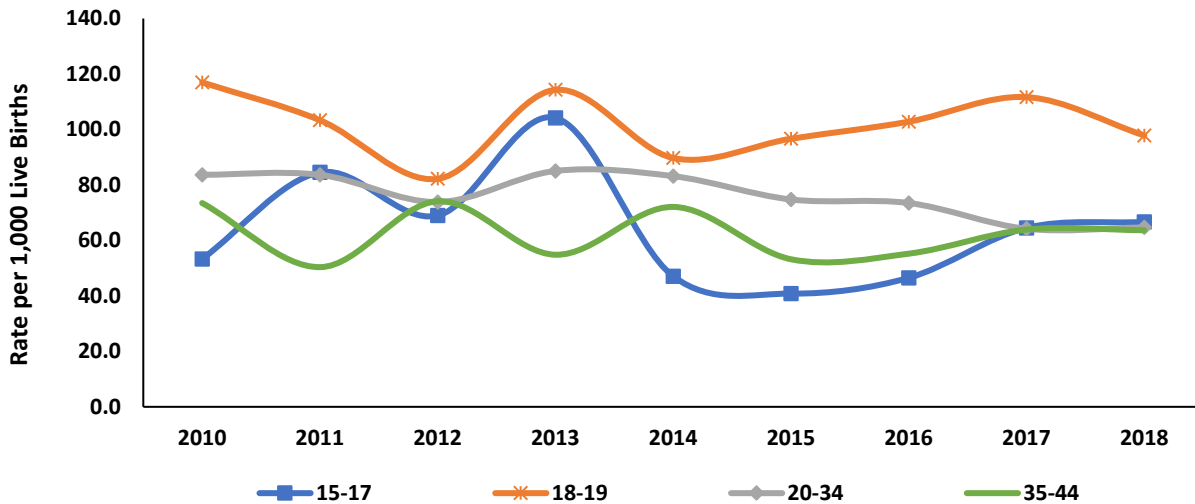


Source: Nevada Electronic Birth Registry System.

In 2018, the most commonly reported substance abused during pregnancy was marijuana and cannabis, at 13.6 cases per 1,000 live births. From 2010 to 2018, prenatal use of marijuana and cannabis has significantly increased in Washoe County. The largest increase in marijuana and cannabis usage by Washoe County mothers during pregnancy occurred from 2017 to 2018, possibly due to marijuana legalization in Nevada in 2017 and/or increased transparency in self-reporting. From 2010 to 2018, prenatal usage of alcohol has decreased from 8.7 cases per 1,000 live births to 3.5 cases per 1,000 live births in Washoe County. From 2010 to 2018, prenatal use of methamphetamines and polysubstance have increased. Prenatal use of opioids and heroin have remained rare, unchanging from 2010 to 2018 in Washoe County.

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.

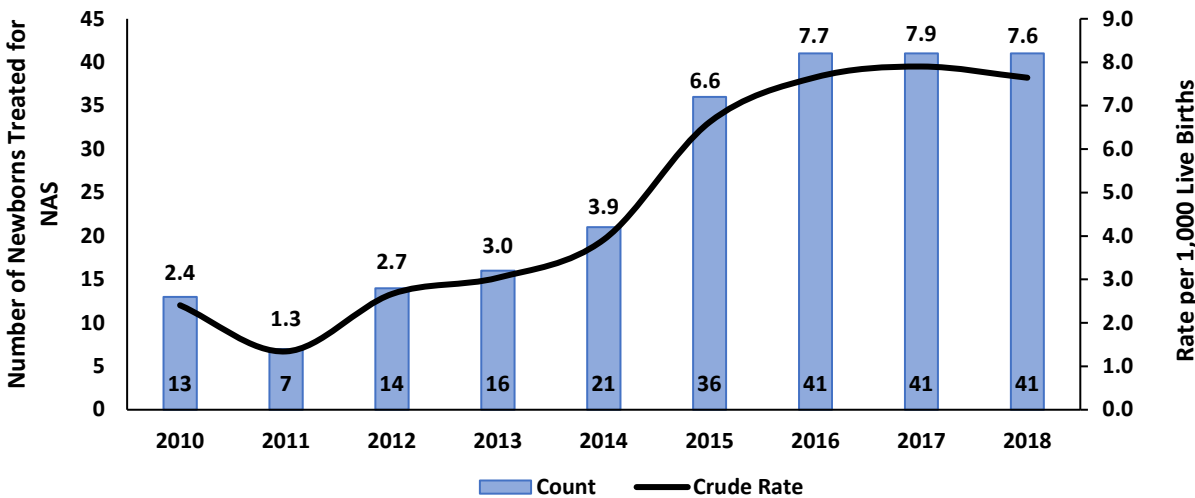
Figure 50. Self-Reported Prenatal Tobacco Use Birth Rates, Washoe County, 2010-2018.



Source: Nevada Electronic Birth Registry System.

From 2010 to 2018, prenatal tobacco usage remained relatively constant among pregnant women who were aged 15 to 17, 18 to 19, and 35 to 44 years, except prenatal tobacco usage was significantly decreased among pregnant women aged 20 to 34 years. In 2018, prenatal tobacco usage was higher in women aged 18 to 19 years (97.8 cases per 1,000 live births), compared to other age groups, although not statistically significant (95% confidence interval).

Figure 51. Neonatal Abstinence Syndrome, Washoe 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. Inpatient admissions for NAS has more than doubled in Washoe County since 2011, from 13 newborns admitted to 41 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 versus 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.

Washoe County SAPTA Epidemiologic Profile

Data Tables

Table 1. Population Distribution, Washoe County, Nevada, 2010-2018.

	2010	2011	2012	2013	2014	2015	2016	2017	2018
Washoe	417,336	421,593	427,704	432,324	436,797	441,946	448,307	451,923	456,038
Sex									
Female	206,604	208,789	211,950	214,356	216,700	219,359	222,642	224,576	226,773
Male	210,732	212,804	215,754	217,968	220,097	222,587	225,665	227,347	229,265
Age									
<1	5,379	5,145	5,267	5,261	5,286	5,432	5,406	5,512	5,583
1-4	24,094	23,274	22,465	22,028	21,777	21,665	22,103	22,102	22,323
5-14	55,790	57,214	58,633	59,483	60,005	60,479	60,434	60,073	59,696
15-24	57,734	57,512	57,928	57,984	58,269	58,834	60,302	60,969	61,697
25-34	58,752	60,058	61,160	62,038	62,794	63,585	64,366	64,737	64,720
35-44	53,238	52,947	53,268	53,463	53,879	54,595	55,474	56,395	57,962
45-54	59,047	58,678	58,554	58,265	57,980	57,477	57,132	56,469	55,404
55-64	51,716	53,215	54,452	55,579	56,230	56,977	57,766	57,898	58,303
65-74	32,207	33,535	35,816	37,423	39,042	40,501	41,873	43,026	44,499
75-84	13,859	14,355	14,437	14,985	15,591	16,363	17,354	18,570	19,632
85+	5,521	5,661	5,723	5,814	5,943	6,038	6,097	6,173	6,219
Race/Ethnicity									
White non-Hispanic	280,744	281,817	283,789	284,964	286,042	287,346	289,219	289,739	290,456
Black non-Hispanic	10,020	10,122	10,354	10,562	10,740	10,996	11,258	11,433	11,622
Native American/Alaskan Native non-Hispanic	7,002	7,047	7,100	7,140	7,181	7,243	7,280	7,323	7,373
Asian/Pacific Islander non-Hispanic	26,562	27,119	27,912	28,514	29,103	29,787	30,613	31,104	31,649
Hispanic	93,008	95,487	98,548	101,145	103,730	106,575	109,937	112,324	114,937

Source: Nevada State Demographer, Vintage 2018.

Washoe County SAPTA Epidemiologic Profile

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 indicators: [Office of Analytics Reports](#).

Washoe County SAPTA Epidemiologic Profile

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.

Washoe County SAPTA Epidemiologic Profile

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.

Washoe County SAPTA Epidemiologic Profile

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

	Clark	Northern	Rural	Southern	Washoe	Nevada
Age Group						
Less than 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.

Washoe County SAPTA Epidemiologic Profile

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.

Washoe County SAPTA Epidemiologic Profile

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

Region	Opioids	Heroin	Cocaine	Methamphetamines	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	Methamphetamines	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.

Washoe County SAPTA Epidemiologic Profile

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

Region	Opioids	Heroin	Cocaine	Methamphetamines	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	Methamphetamines	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.

Washoe County SAPTA Epidemiologic Profile

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.