Behavioral Health Epidemiologic Profile 2024: Nevada

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Executive Summary

Purpose

This report is intended to provide an overview of behavioral health in Nevada for public health authorities, Nevada legislators, behavioral health boards, and the public. The analysis can provide insights to inform policies, programs, and resource allocation to address behavioral health needs effectively.

By monitoring changes in behavioral health indicators, stakeholders can evaluate the impact of emerging trends and areas requiring attention.

Key Findings 2024

Mental Health

- Anxiety (37.1%) and depression (20.5%) are the leading diagnoses for mental health-related emergency department encounters for 2023 (Mental Health - ER).
- Anxiety (32.6%) and depression (27.1%) are the leading diagnoses for mental health-related inpatient admissions for 2023 (Mental Health - IP).
- Mineral County had the highest rate of adults accessing state mental health services in 2023 (Mental Health - Clinic Utilization).
- In 2023, Black non-Hispanic Nevadans, had the highest age adjusted rate of state mental health service utilization (483.8 per 100,000 population) (Avatar - State-Funded Mental Health Services).
- Nevada high school females in 2023 self-reported higher percentages of feeling sad or hopeless, purposely hurting themselves, considering suicide, planning suicide, and attempting suicide, compared to their male counterparts (Youth Risk Behavior Survey).
- Adults reporting poor mental health for 14 or more days in the past 30 days has increased from 9.8% in 2014 to 19.8% in 2023 (Mental Health - BRFSS).

National Violent Death Reporting System (NVDRS)

- Firearms were used in 58.9% of suicides and 72.8% of homicides among Nevada residents from 2018-2022 (Firearm Deaths - NVDRS).
- Males accounted for 77.2% of suicide cases and 77.7% of homicide cases from 2018-2022 (Deaths by Sex - NVDRS).
- The rate of suicide deaths among Nevada residents from 2018-2022 was highest in the 75+ age group at 39.5 per 100,000 population (Deaths by Age Group - NVDRS).
- Among suicide deaths among Nevada residents from 2018-2022, it was reported that 40.3% had been identified as currently having a mental health problem, and 36.6% had a history of suicidal thoughts or plans (Circumstances of Deaths - NVDRS).

Substance Use

- Males are disproportionately affected by opioid emergency room overdose encounters (Opioid Overdose - ER), inpatient admissions (Opioid Overdose - IP) and deaths (Opioid Overdose - Deaths).
- The rates of stimulant-related overdose deaths have steadily increased since 2014, with the exception for a small decrease in 2019, resulting in a 327% overall increase from 2014 to 2023 (Stimulant-Related Overdose Deaths).
- Emergency department encounters, inpatient admissions and deaths from diseases and chronic conditions related to long-term alcohol use have all increased over the reporting period, particularly in the years during and immediately following the COVID-19 pandemic (Chronic Alcohol Diseases).
    - American Indians and Alaska Natives suffer from these conditions at a higher rate than any other racial or ethnic demographic in the state (Chronic Alcohol Diseases by Race/Ethnicity).
- The rate of overdose deaths, when considering all substances including alcohol, has increased substantially since the start of the COVID-19 pandemic (Alcohol- and/or Drug-Related Overdose Deaths).

State Unintentional Drug Overdose Reporting System (SUDORS)

- Of the 836 unintentional/ undetermined intent drug overdose deaths among Nevada residents in 2022, 60.0% had non-specified opioids and 56.7% had methamphetamines listed in the cause of death (Toxicology - SUDORS).

Youth – Adverse Childhood Experiences

- Combined data from 2019-2023 shows that 14.3% of Nevadan adults have been touched sexually at least once during childhood (ACEs - BRFSS).
- Nevadan adults with four or more Adverse Childhood Experiences (ACEs) were significantly more likely to have depression compared to those with no ACEs (ACEs - BRFSS).

Maternal and Child Health

- The rate of neonatal abstinence syndrome among Nevada residents from 2014-2023 was highest in 2022 (10.7 per 1,000 live births) (Rate of NAS).

LGBT

- LGBT Nevadan adults were significantly more likely to report having worse mental health and substance use behaviors than non-LGBT Nevadans, including attempting suicide, poor or fair general health, depressive disorder diagnosis, 14+ days of poor mental health in a month, binge drinking, marijuana use in past 30 days, and being a current e-cig smoker (LGBT Adults - BRFSS).

Data Sources

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 400,000 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.

Enterprise Supervision
Enterprise Supervision is the Division of Child and Family Services (DCFS) case management system for the state-level juvenile justice system. This system is used to document youth placements and services while in custody of the state-level juvenile justice system. Data are obtained using the Booking, Referral Status History, and Individual tables in Enterprise Supervision.

Hospital Emergency Department Billing (HEDB)
The Hospital Emergency Department Billing data provides health billing data for emergency room patients for Nevada's non-federal hospitals. NRS 449.485 mandates all hospitals in Nevada to report all patients discharged in a form prescribed by the Director of the Department of Health and Human Services. The data are collected using a standard universal billing form. The data in this report are for patients who used emergency room and inpatient services. 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 (up to 33 diagnoses respectively). 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, length of hospital stay, discharge status, and external cause of injury codes. The billing data information is for billed charges and not the actual payment received by the hospital. Due to lag in the reporting of billing information, numbers may differ from prior reporting.

Hospital Inpatient Billing (HIB)
The Hospital Inpatient Billing data provides health billing data for patients discharged from Nevada's non-federal hospitals. NRS 449.485 mandates all hospitals in Nevada to 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 is for patients who spent at least 24 hours as an inpatient, but do not include patients who were discharged from the emergency room. 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 (up to 33 diagnoses respectively). ICD-10-CM diagnoses codes replaced ICD-9-CM diagnoses codes in the last quarter of 2015. Therefore, data prior to last quarter of 2015 may not be directly comparable to data thereafter. In addition, the data includes billed hospital charges, procedure codes, length of hospital stay, discharge status, and external cause of injury codes. The billing data

information is for billed charges and not the actual payment received by the hospital. Due to lag in the reporting of billing information, numbers may differ from prior reporting.

International Gaming Institute
The University of Nevada, Las Vegas International Gaming Institute (IGI) provides research and insights to global gaming leaders. The IGI with Department of Health and Human Services prepares an annual report on Nevada Problem Gambling Study. A short summary taken from this report is included in this profile.

Medicaid Data Warehouse
The Medicaid Data Warehouse is a database which stores medical and pharmacy claims data for the Medicaid Managed Care and Fee for Service populations, at a claim line level. The data includes provider information, member demographics such as age, gender, race/ethnicity, eligibility/enrollment information, and information of the diagnoses given to members and treatment received. It 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, as well as standard billing and coding schemes such as CPT/HCPCS, NDC, etc.

National Violent Death Reporting System (NVDRS)
NVDRS is a CDC-funded program that collects information about violent deaths including homicides, suicides, and deaths caused by law enforcement acting in the line of duty. Data are collected from death certificates, coroner/medical examiner reports (including toxicology), and law enforcement reports. Data elements collected provide valuable context about violent deaths, such as relationship problems, mental health conditions and treatment, toxicology results, and life stressors, including recent money- or work-related or physical health problems.

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 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.” For more information: Nevada Report Card

Nevada State Demographer – Nevada Population Data
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.

Prescription Drug Monitoring Program (PDMP)
The Prescription Drug Monitoring Program (PDMP) is a state-operated, CDC-supervised electronic database that monitors the prescribing and dispensing of controlled substances. It serves as a tool to identify and prevent drug misuse while equipping healthcare providers and public health authorities with timely insights into patient prescription behaviors. For more information, Nevada: NV PMP. CDC: CDC PDMP

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. These data are representative of clients served at 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. It is conducted annually by the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency within the US Department of Health and Human Services that focuses on behavioral health. For more information on the survey: SAMHSA NSDUH

Treatment Episode Data Sets
Treatment Episode Data Sets (TEDS) are a compilation of demographic, substance use, mental health, clinical, legal, and socioeconomic characteristics of persons who are receiving publicly funded substance use and/or mental health services. State administrative data systems, claims, and encounter data are the primary data sources. 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. TEDS also provide a mechanism for states to report treatment admissions and discharges of persons receiving mental health services. This reporting framework supports SAMHSA's initiative to build a national behavioral health data set accessible (with appropriate confidentiality protection) by the public; local, state, and federal policymakers; researchers; and many others for comparisons and trends on the characteristics of persons receiving substance use and/or mental health treatment services. TEDS provides outcomes data in support of SAMHSA's program, performance measurement, and management goals.

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. For more information: United States Census Bureau.

UNITY
The Unified Nevada Information Technology for Youth and is Nevada's Comprehensive Child Welfare Information System (CCWIS) which holds the official case record for child welfare related case management activities in Nevada. This information system and its data are dynamic and constantly being modified or updated.

Vibrant Emotional Health
Vibrant Emotional Health provides crisis-support services and reports data and analytics nationally on behalf of SAMHSA regarding call volume, answer rates, and other metrics for 988 services.

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. WEVRRS includes the Nevada Electronic Birth Registry System and the Nevada Electronic Death Registry System.

Youth Risk Behavior Survey (YRBS)

The Youth Risk Behavior Survey (YRBS) is a national surveillance system that was established by the Centers for Disease Control and Prevention (CDC) to monitor the prevalence of health risk behaviors among youth. Every two years high schools from Nevada are randomly chosen by the CDC to represent Nevada. However, to ensure greater representation from schools in all Nevada districts, the Nevada Division of Public and Behavioral Health contracts with the University of Nevada, Reno School of Public Health to conduct the YRBS in all high schools throughout the state. The Nevada High School YRBS is a biennial, anonymous, and voluntary survey of students in 9th through 12th grade in regular public, charter, and alternative schools. Students self-report their behaviors in six major areas of health that directly lead to morbidity and mortality.

Nevada is among few states that collect data in middle schools. The Nevada Middle School YRBS is biennial, anonymous and voluntary survey of students in 6th through 8th grade in regular public, charter, and alternative schools. Students self-report their behaviors in five major areas of health that directly lead to morbidity and mortality.

For more information on CDC's Youth Risk Behavior Surveillance System (YRBSS): CDC YRBSS

For more information on Nevada YRBS: Nevada YRBS

Terminology

Age-Adjusted Rate
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 of time. 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 Population Projections and Standard Age Groups) and based on Nevada population per the 2023 vintage from the State Demographer. 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.

Confidence Interval
A confidence interval is a range of numbers defined to contain an estimated value with a specified probability. For example, a 95% confidence interval for the average in an observed population will contain the "true" average 95% of the time.

Crude Rate
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 of time. A crude rate is the frequency with which an event or circumstance occurs per unit of population.

P-value
A p-value is the probability that an observed result could have occurred by chance alone given a specified statistical relationship. In practice, a p-value less than a defined level of significance (0.05 is used in this report) suggests that a result is unlikely to have occurred by chance and may be deemed statistically significant.

Data and Equity

Demographic language may differ throughout this report depending on the sources from which data were retrieved. To report the data accurately, variables such as race, ethnicity, and sex are described in this report as they were in the source data. Every effort has been made to be inclusive and equitable across every demographic to provide a fair and accurate representation of the people of Nevada. We recognize the terms “female” and “woman” do not include all birthing people but are used as descriptors presented from source data. We also recognize that all sexual preferences and gender identities may not be present in the source data.

Demographic Snapshot

Table 1. Select Demographics for Nevada and the United States, 2023.

Population, Nevada, 2023 estimate*	3,271,898
Population, Nevada, 2014 estimate*	2,843,301
Population, Nevada, percent change*	15.1%
Female persons, Nevada, 2023 estimate*	1,640,562 (50.1%)
Male persons, Nevada, 2023 estimate*	1,631,336 (49.9%)
Median household income, Nevada (2023) **	$75,561
Median household income, United States (2023)**	$78,535
Per capita income in the past 12 months, Nevada (2023)**	$39,963
Per capita income in the past 12 months, United States (2023)**	$43,289
Percent of persons below poverty level, Nevada (2023) **	12.6%
Percent of persons below poverty level, United States (2023)**	12.5%
Percent uninsured, Nevada (2023)**	11.4%
Percent uninsured, United States (2023)**	8.6%
Percent of land federally owned, Nevada***	80.1%
Percent of land federally owned, United States***	28.0%

*Source: *Nevada State Demographer, Vintage 2023**U.S. Census Bureau, ***Congressional Research Service.*

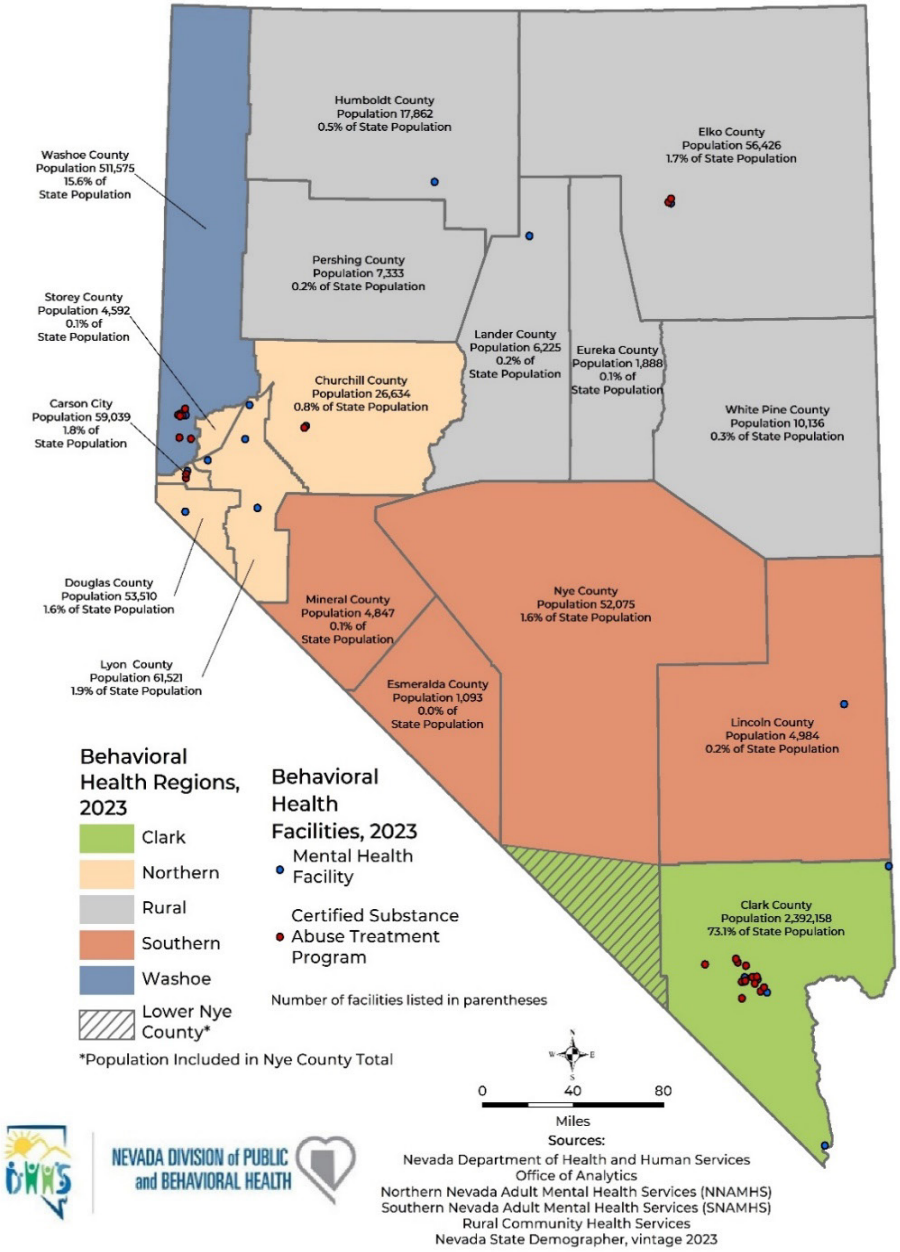
In 2023, the estimated population for Nevada was 3,271,898, a 15.1% increase from the 2014 estimated population. The population was made up of approximately equal percent of females and males. The median household income was $75,561, lower than the United States median income of $78,535. The percent of uninsured Nevadans in 2023 was 11.4%, higher than the national percentage of 8.6%.

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

With 73.1% of Nevada's population living in Clark County, it is the most populous area in the state, with an estimated 2,392,158 persons. Esmeralda County is the least populous county, with less than one percent of Nevada's population, an estimated 1,093 persons.

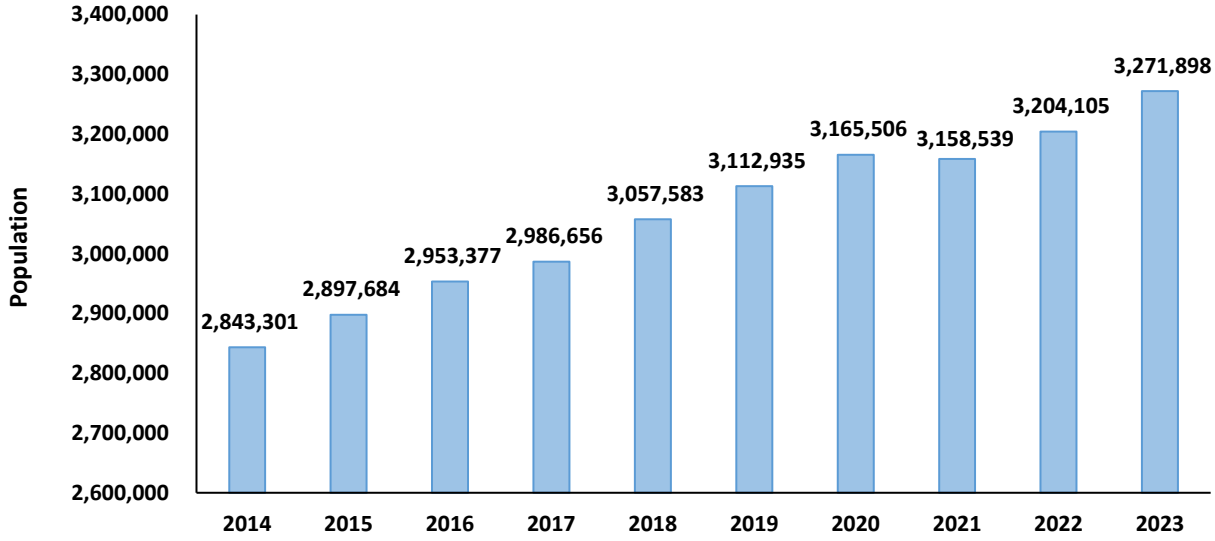
Figure 1 below shows the population for each of Nevada's 17 counties, the percent of Nevada population each county represents, the behavioral health regions, and the locations of mental health and substance abuse facilities.

Figure 1. Nevada Population Distribution by County, 2023.



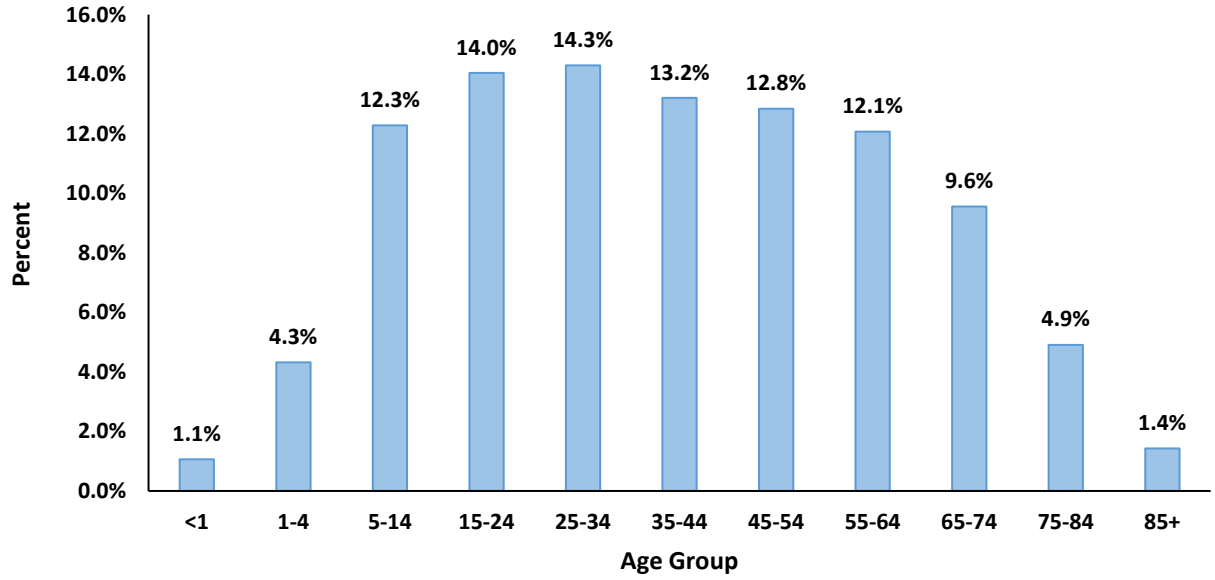
Source: Nevada State Demographer, Vintage 2023.
***Clark Region**: Clark County and southern Nye County.*
***Northern Nevada Region:** Carson City, Churchill, Douglas, Lyon, and Storey Counties.*
***Rural Nevada Region:** Elko, Eureka, Humboldt, Lander, Pershing, and White Pine Counties.*
***Southern Nevada Region:** Esmeralda, Lincoln, Mineral Counties, and northern Nye County.*
***Washoe Region**: Washoe County.*
**Nye County: Northern 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 2. Nevada Population, 2014-2023.



Source: Nevada State Demographer, Vintage 2023.

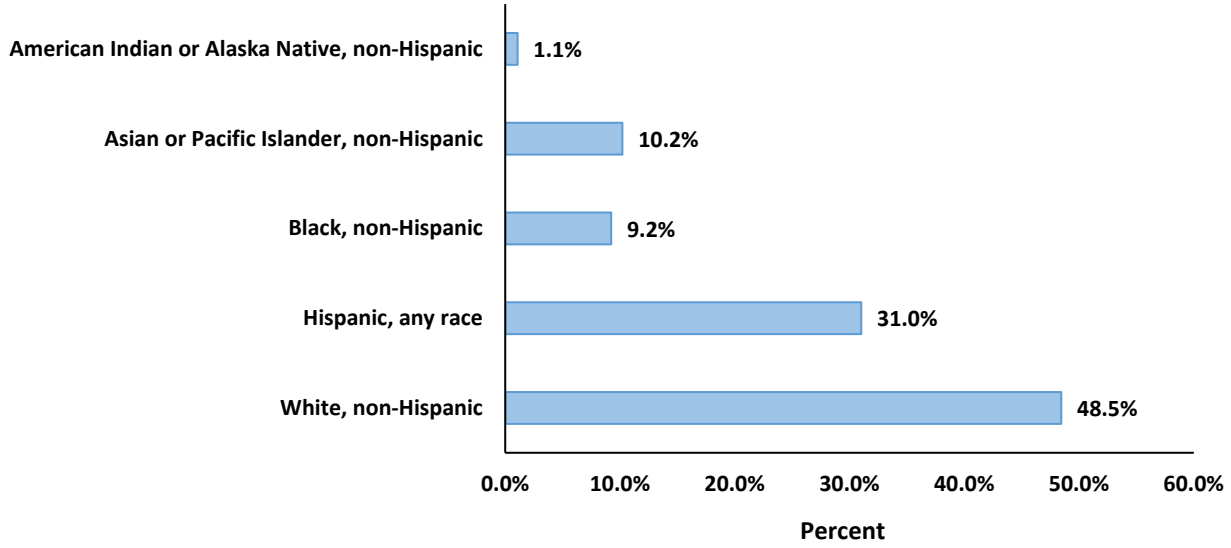
Figure 3. Nevada Population by Age Group, 2023.



Source: Nevada State Demographer, Vintage 2023.
Chart scaled to 16.0% to display differences among groups.

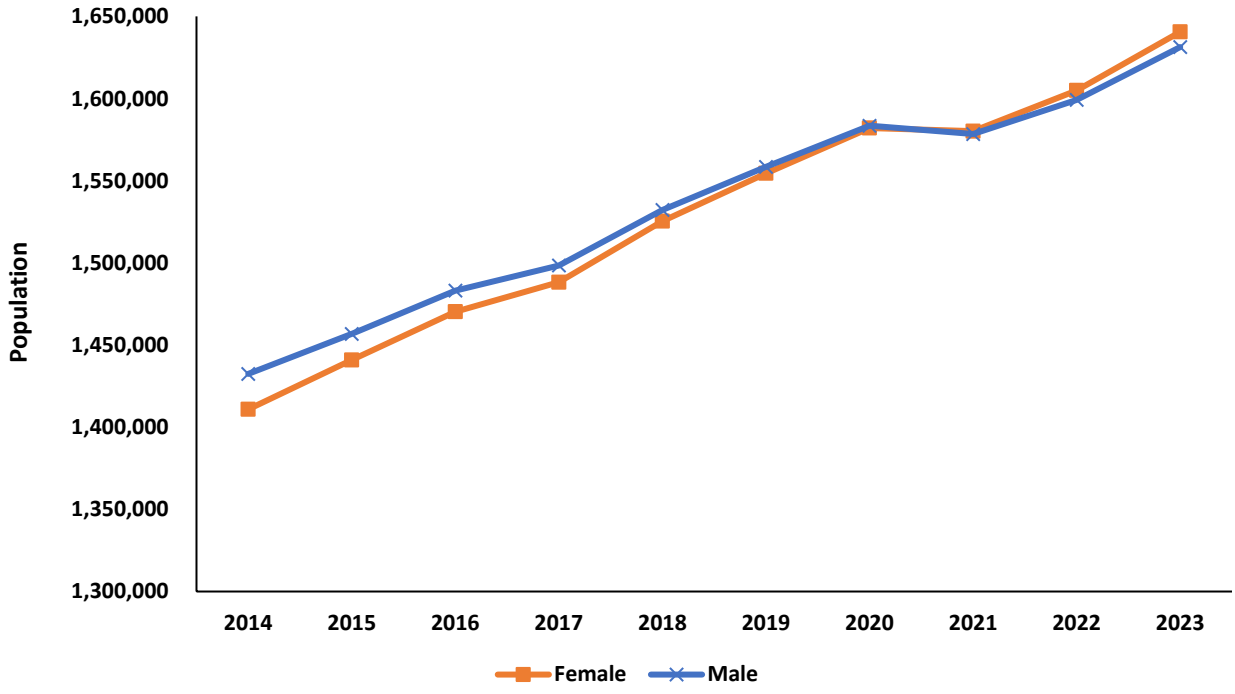
White non-Hispanic comprises 48.5% of Nevada's population, followed by Hispanic (31.0%), Asian/Pacific Islander non-Hispanic (10.2%), Black non-Hispanic (9.2%), and American Indian/Alaska Native non-Hispanic (1.1%). The population consists of approximately equal percentages of males and females.

Figure 4. Nevada Population by Race/Ethnicity, 2023.



Source: Nevada State Demographer, Vintage 2023.
Chart scaled to 60.0% to display differences among groups.

Figure 5. Nevada Population Distribution by Sex, 2014-2023.



Source: Nevada State Demographer, Vintage 2023.

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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.

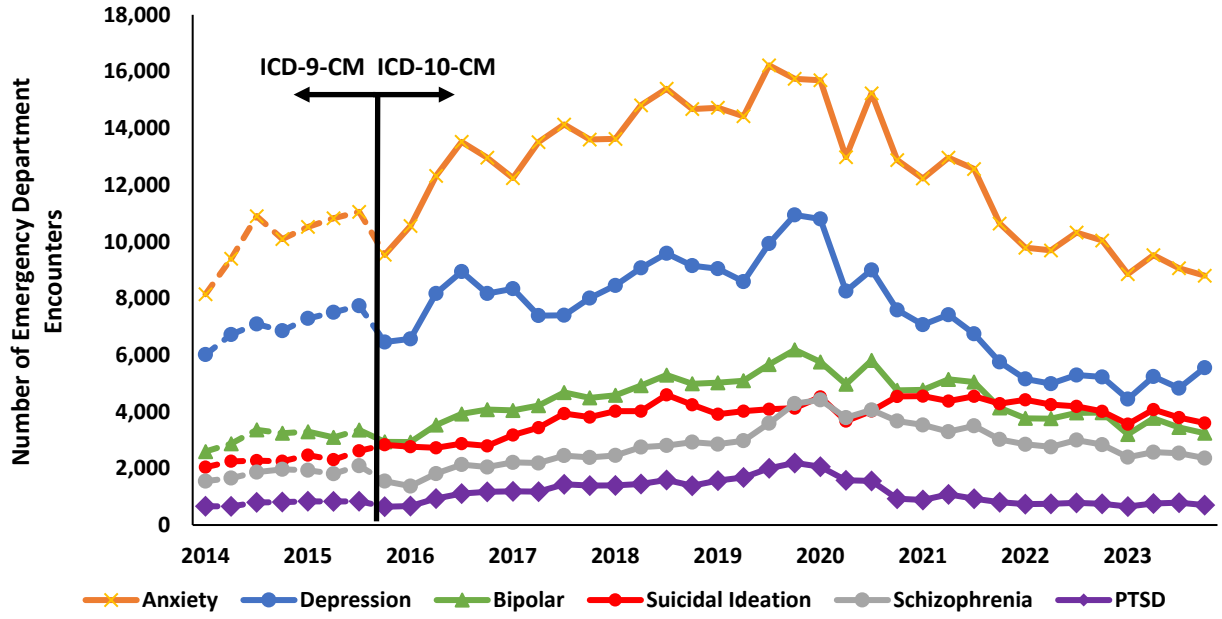
Hospital Emergency Department Encounters

The hospital emergency department billing data includes data for emergency room patients of all ages for Nevada's non-federal hospitals. There were 97,721 visits related to mental health disorders among Nevada residents in 2023. Since an individual can have more than one diagnosis during a single emergency department encounter, 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.

Anxiety has been the most common mental health-related diagnosis in emergency department encounters, followed by depression, with an average of 9,058 and 5,014 encounters per quarter in 2023, respectively. Both have decreased since 2020 to below pre-pandemic levels.

For 2023, males had a higher prevalence of visits for schizophrenia (69.3%) and suicidal ideation (61.0%), whereas females had a higher prevalence of visits for anxiety (62.4%), depression (60.8%), and PTSD (54.1%)

Figure 6. Mental Health-Related Emergency Department Encounters by Quarter and Year, 2014-2023.



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

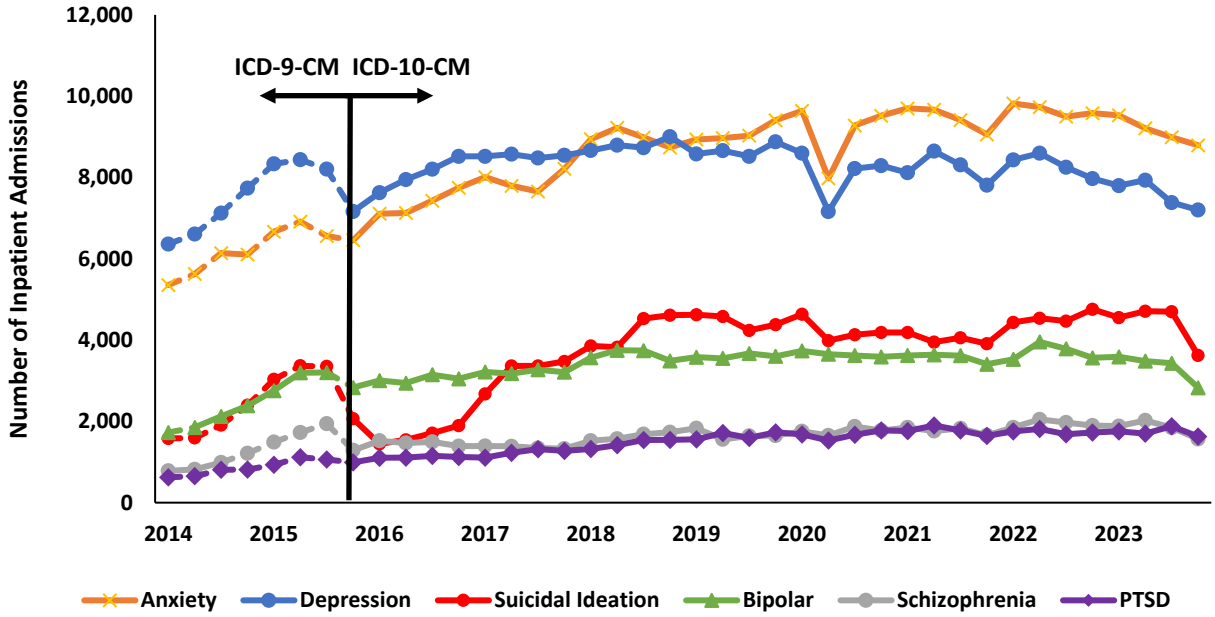
Hospital Inpatient Admissions

Hospital Inpatient Billing data includes data for patients of all ages discharged from Nevada's non-federal hospitals. There were 112,016 inpatient admissions related to mental health disorders among Nevada residents in 2023. 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 and do not represent unique visits.

Anxiety and depression are the top two diagnoses for mental health-related inpatient admissions from 2014 to 2023. For 2023, males had a higher prevalence of visits for schizophrenia (64.0%) and suicidal ideation (59.8%), whereas females had a higher prevalence of visits for anxiety (58.9%) and depression (59.3%).

It should be noted that in 2016, inpatient admissions statewide dropped and then increased in 2017. This may be due to ICD-9-CM conversion to ICD-10-CM or other changes in medical billing.

Figure 7. Mental Health-Related Inpatient Admissions, by Quarter and Year, 2014-2023.



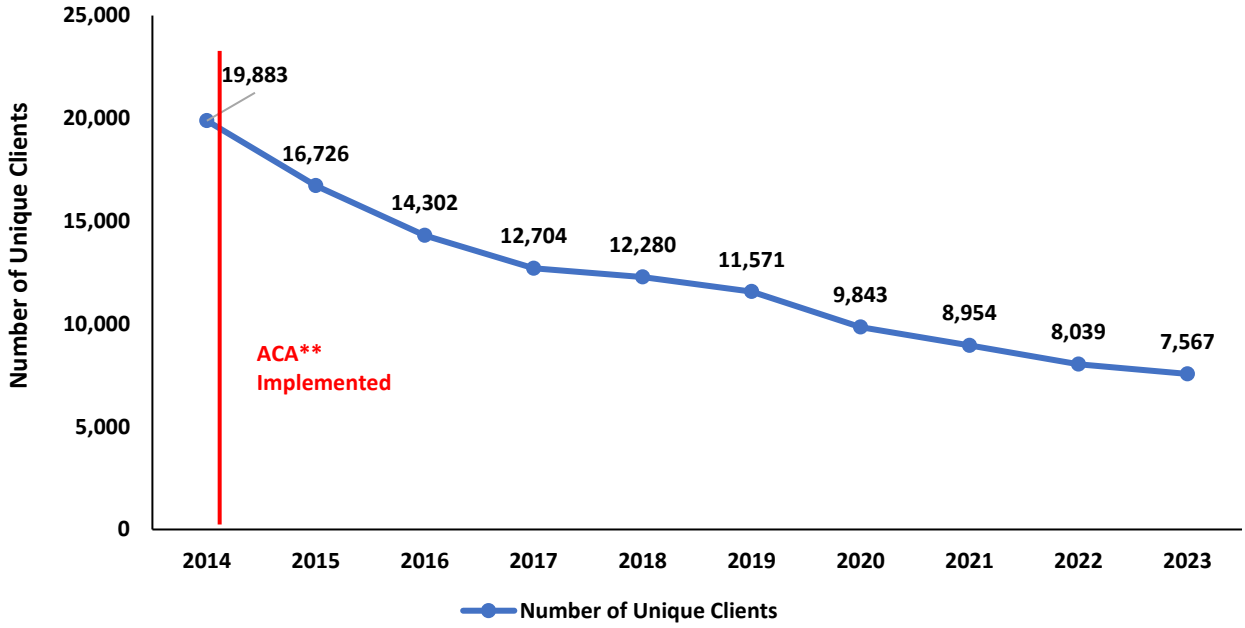
Source: Hospital Inpatient Billing.
Categories are not mutually exclusive.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

State-Funded Adult Mental Health Services

State-funded mental health facilities, those funded by Department of Health and Human Services Division of Public and Behavioral Health, are divided into Northern Nevada Adult Mental Health Services (NNAMHS), Southern Nevada Adult Mental Health Services (SNAMHS), and Rural Clinic and Community Health Services. Services that state-funded mental health facilities provide include inpatient acute psychiatric, mobile crisis, outpatient counseling, service coordination, and case management. Services are not denied if an individual does not have the ability to pay.

The number of unique adult clients served by state-funded mental health facilities has declined since the implementation of the affordable care act (ACA). The ACA helped insure a much larger proportion of Nevada's population creating more avenues for the population to seek alternative mental health services covered through private insurance.

Figure 8. Unique Adult Clients Aged 18+* Served at State-Funded Mental Health Clinics, 2014-2023.



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

Of the Nevada residents accessing Nevada Department of Health and Human Services, Division of Public and Behavioral Health-funded adult mental health services in 2023, 54.6% lived in Clark County and 9.7% lived in Washoe County. Mineral County had the highest rate of adults accessing state mental health services at 280.3 per 10,000 population. Note that this differs from the standard rate presented in this report which is per 100,000.

Figure 9 below shows the percent of Nevada state-funded adult mental health utilization each county represents, the rate of utilization (per 10,000 population), the behavioral health regions, and the locations of mental health and substance abuse facilities.

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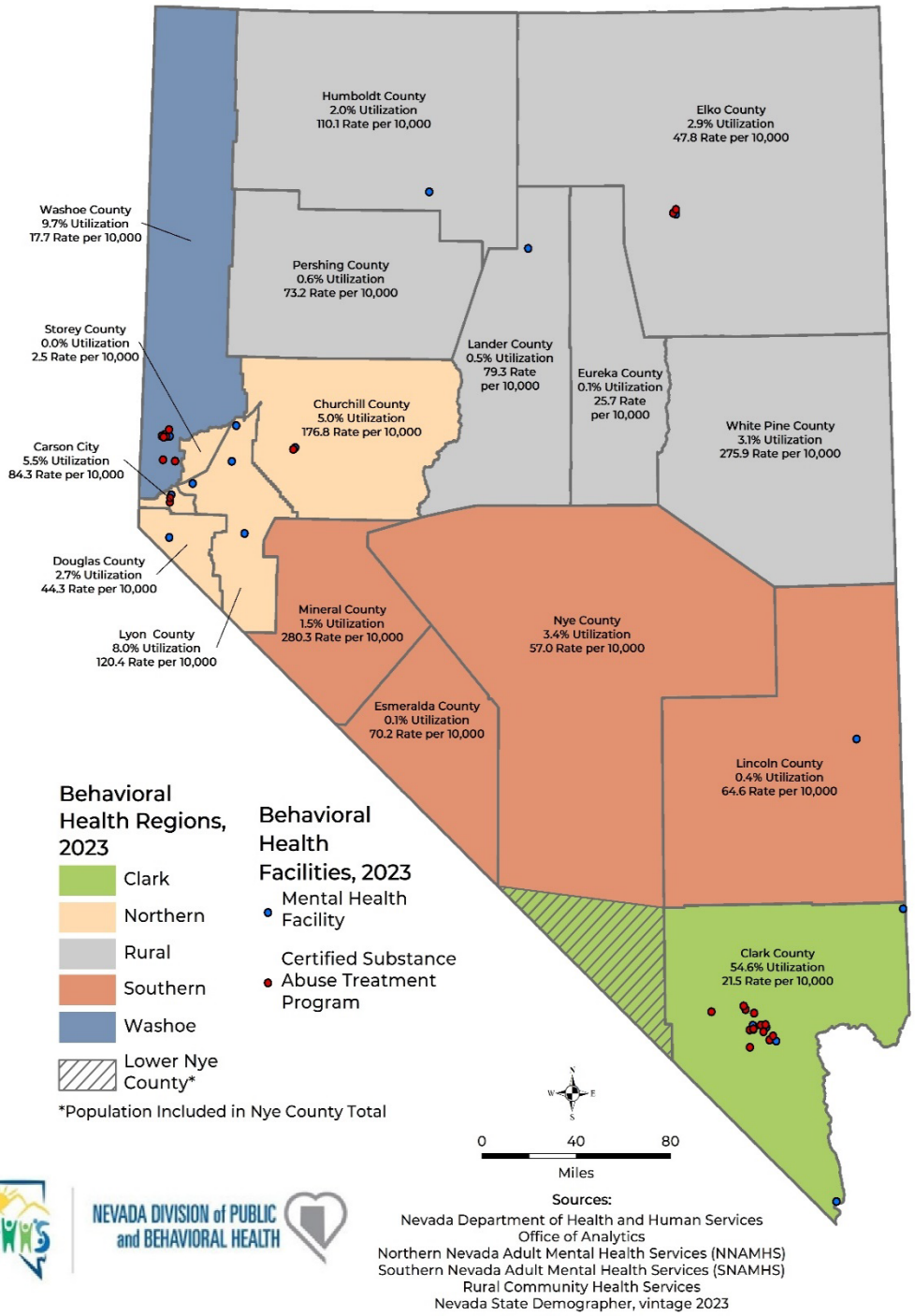
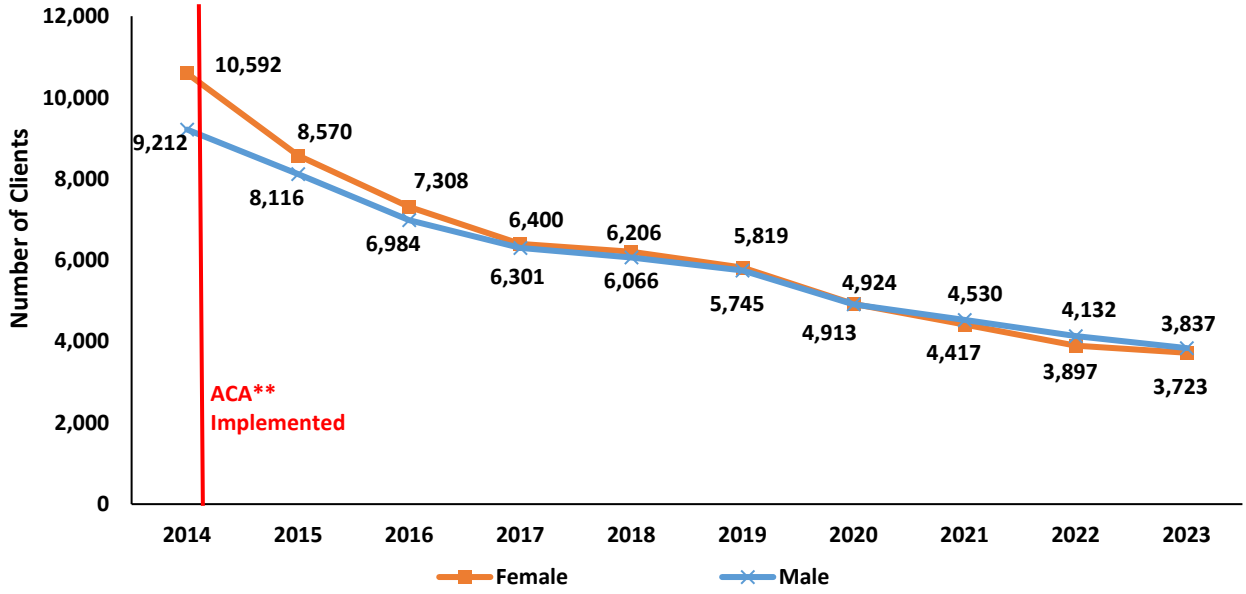
Figure 9. State-Funded Adult (Aged 18+*) Mental Health Clinic Utilization by County, 2023.



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 10,000 population.*

Since 2017, the number of male clients and female clients have been comparable. In 2023, 295.0 per 100,000 of the adult female population utilized the state-funded mental health clinics, compared to adult males at 311.0 per 100,000 of the adult male population.

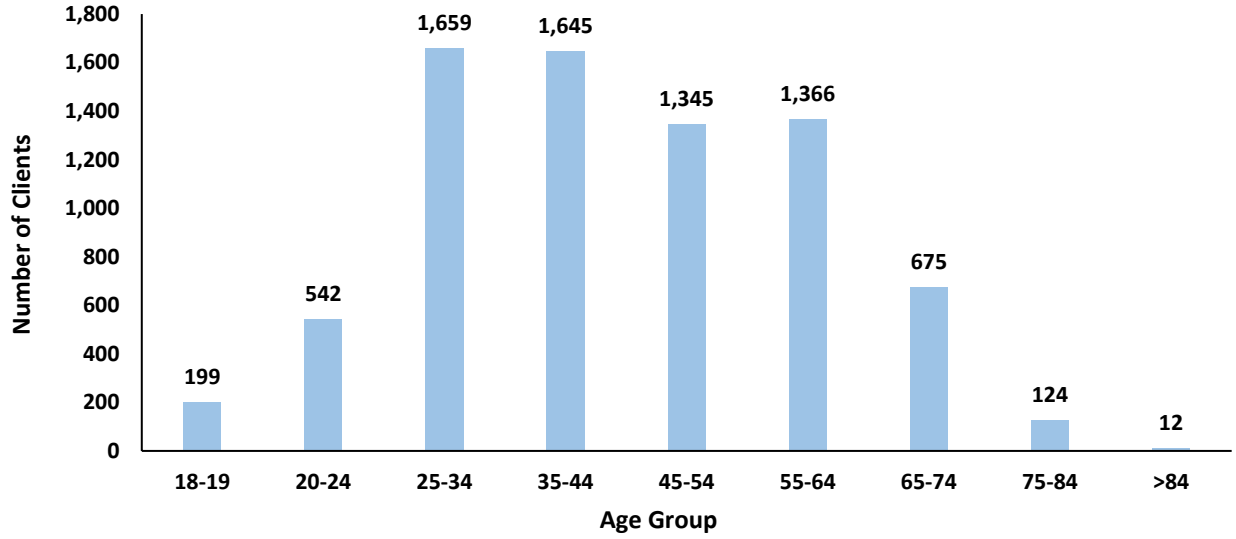
Figure 10. State-Funded Adult (Aged 18+*) Mental Health Clinic Utilization* by Gender, 2014-2023.



Source: Avatar.
**A client is counted only once per year. Clients may be counted more than once across years.*
***Affordable Care Act Implemented in 2014.*

In 2023, 43.7% of adult clients were in the combined 25-44 age group. Most clients were between the ages of 26 and 65, a range that reflects the transition from losing coverage under a parent's insurance to qualifying for Medicaid.

Figure 11. State-Funded Adult (Aged 18+*) Mental Health Clinic Utilization* by Age Group, 2023.



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

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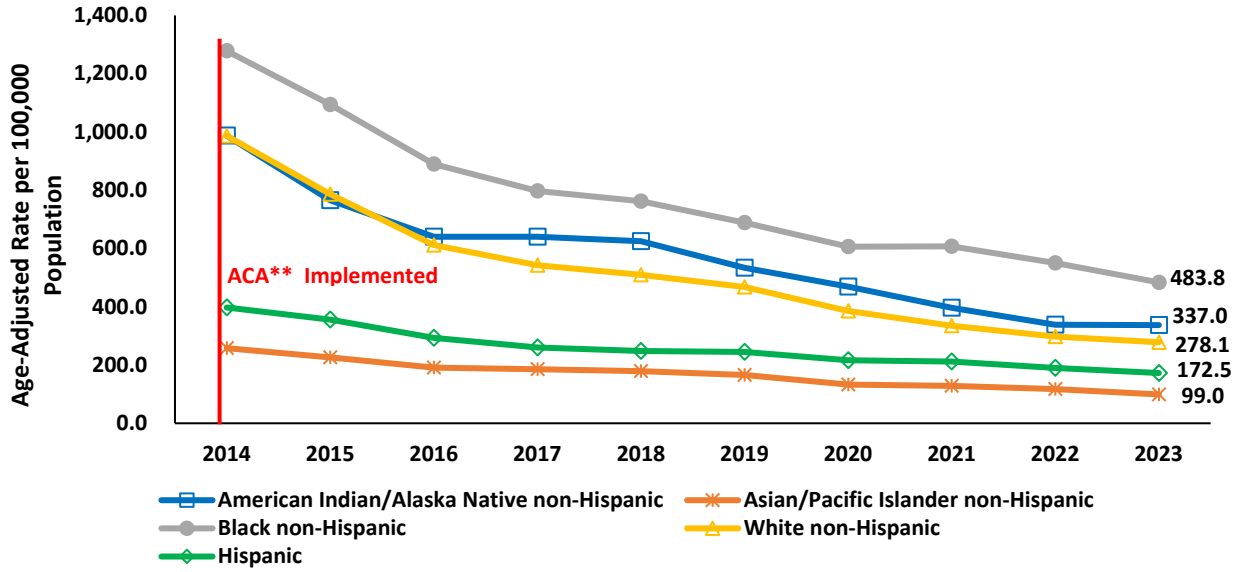
Since 2017, the distribution of all racial and ethnic groups has remained relatively consistent. In 2023, Black non-Hispanics (483.8 per 100,000) and American Indian/Alaska Native non-Hispanics (337.0 per 100,000) had the highest age-adjusted rates.

Figure 12. State-Funded Adult (Aged 18+*) Mental Health Clinic Utilization* by Race/Ethnicity, 2014-2023.



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.*
***Affordable Care Act Implemented in 2014*

Table 2 below illustrates mental health services received from 2014-2023. In 2023, NNAMHS medication clinic and ambulatory service increased by 291 and 106 people, respectively, compared to 2022 despite most other services decreasing. Increases like this may be due staff increases, such is the case with NNAMHS ambulatory services.

Table 2. Top Adult Mental Health Clinic Services by Number of Patients Served*, 2014-2023.

Program	Year									
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
SNAMHS Medication Clinic - Adult	11,014	7,616	5,355	4,711	3,993	3,827	3,607	3,396	3,114	2,915
NNAMHS Medication Clinic - Adult	4,937	4,296	3,310	2,489	2,325	2,103	1,365	653	499	790
SNAMHS Inpatient Hospital - Adult	2,585	2,681	1,984	2,011	1,848	1,754	1,315	1,407	1,056	785
SNAMHS Ambulatory Service - Adult	5,149	3,913	2,897	2,047	1,918	1,904	1,599	1,594	1,409	1,403
NNAMHS Ambulatory Service - Adult	2,489	2,101	1,882	1,410	1,405	1,305	604	332	243	349
SNAMHS Service Coordination - Adult	1,110	895	658	528	639	563	480	322	253	230
SNAMHS Outpatient Counseling - Adult	971	729	707	702	579	573	530	399	329	228

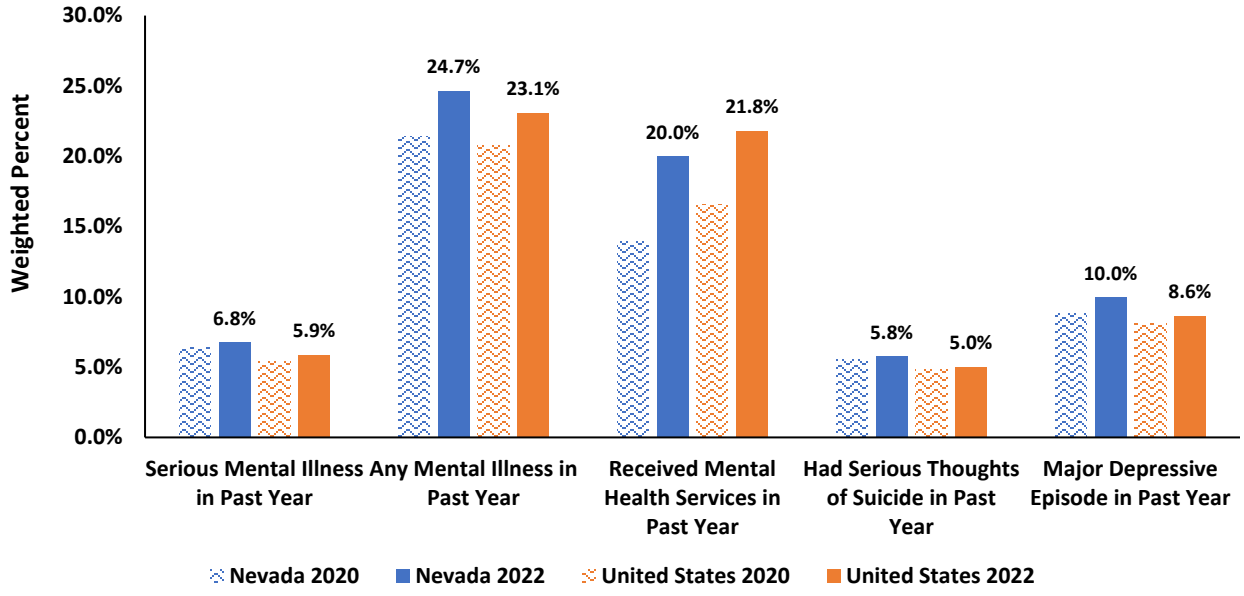
Source: Avatar.
**A client is counted only once per year. Clients may be counted more than once across years.*

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. According to SAMHSA, "because of methodological changes in 2021, estimates from this year should not be compared with previous years". Therefore, 2021 data has been excluded from this report. Please see SAMHSA NSDUH 2021 Survey Release for more information.

Nevada has remained within two percent of the Nation for most mental health issues. Nevada was slightly higher than the nation for the measure with "serious mental illness in the past year," "any mental illness in the past year," "had serious thoughts of suicide in the past year," and "major depressive episode in the past year".

Figure 13. Percent of Mental Health Measures, Nevada and United States, 2020 and 2022, Ages 18+.



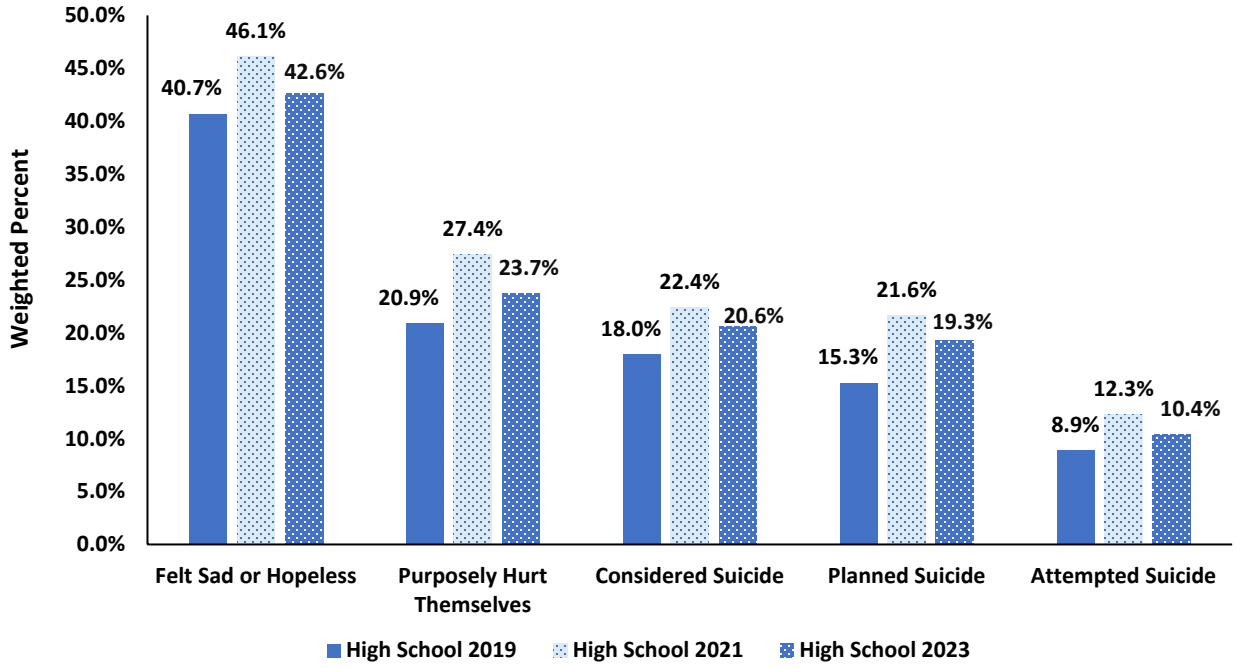
Youth Risk Behavior Survey

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 2023, 5,122 high school students from 99 schools and 6,915 middle school students from 121 schools participated in the YRBS in Nevada. All data are self-reported. The University of Nevada, Reno maintains the YRBS data and publishes data on each survey. For more information on the YRBS survey, please refer to: UNR YRBS.

The prevalence of all reported mental health outcomes for high school students was highest in 2021, with notable declines in 2023. The largest decrease from 2021 to 2023 was the prevalence of those who reported purposely hurting themselves (3.7% decrease), closely followed by those who felt sad or hopeless (3.5% decrease). Despite these decreases, 2023 percents are higher than 2019 percents. This may indicate that the declines may be part of the broader trend recovery from elevated worse mental health outcomes during the COVID-19 pandemic.

In 2023, students who identified as Other/Multiple races had the highest prevalence (51.4%) of feeling sad or hopeless compared to students who identified as White (40.3%).

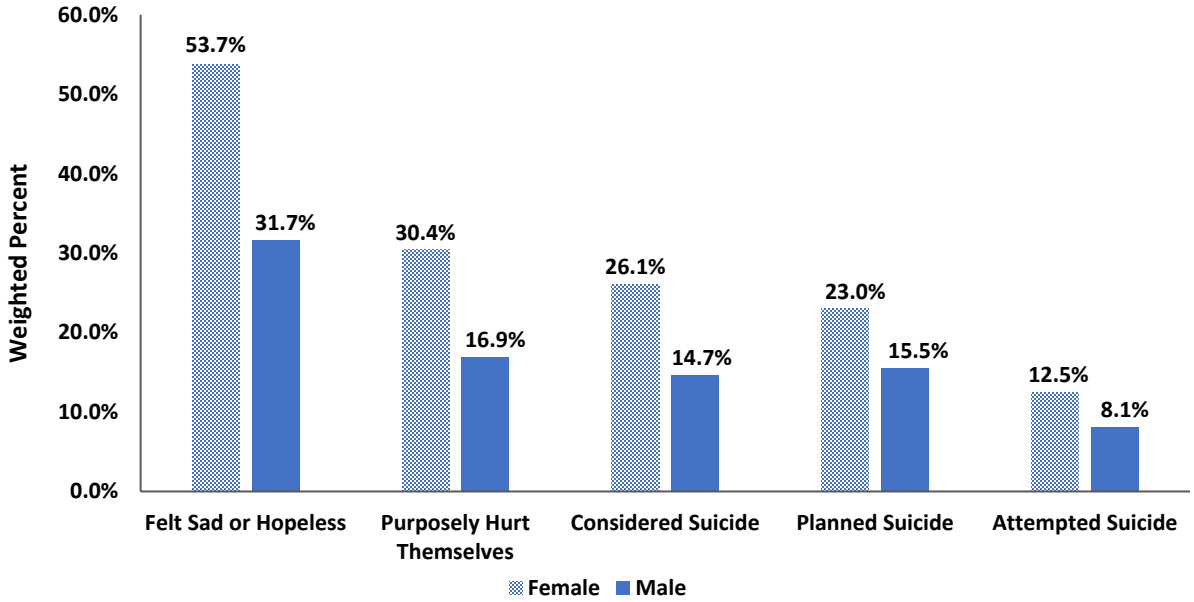
Figure 14a. Mental Health Behaviors, Nevada High School Students, 2019, 2021, and 2023.



Source: Nevada Youth Risk Behavior Survey (YRBS).
Chart scaled to 50.0% to display differences among groups.

In 2023, students who identified as female reported a higher prevalence of all mental health behaviors compared to males. The largest difference was the prevalence of female students who felt sad or hopeless (53.7%) compared to male students (31.7%).

Figure 14b. Mental Health Behaviors by Sex, Nevada High School Students, 2023.

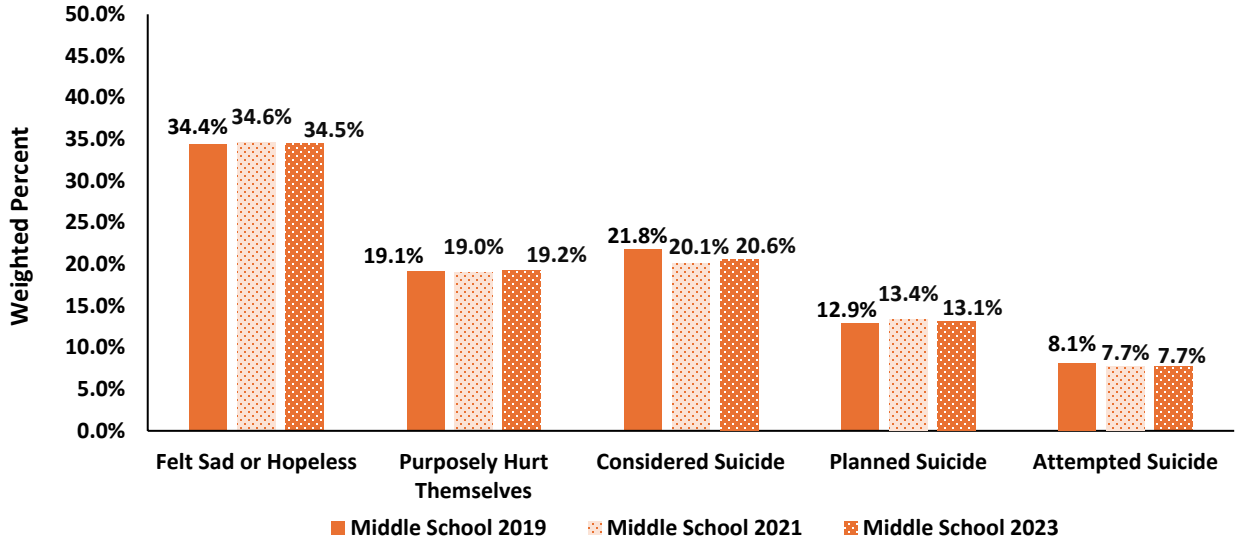


Source: Nevada Youth Risk Behavior Survey (YRBS).
Chart scaled to 60.0% to display differences among groups.

Mental health behaviors for middle school students have remained relatively consistent between 2019 and 2023 with the largest change being from 2019 to 2021 where there was a 1.7% decrease for students who reported considering suicide.

Middle school students had lower outcome percentages than high school students in all measures except for those who considered suicide, where middle school students reported a higher percent (21.8% vs. 18.0%) in 2019 and equal percents (20.6%) in 2023.

Figure 15. Mental Health Behaviors, Nevada Middle School Students, 2019, 2021, and 2023.



Source: Nevada Youth Risk Behavior Survey (YRBS).
Chart scaled to 50.0% to display differences among groups.

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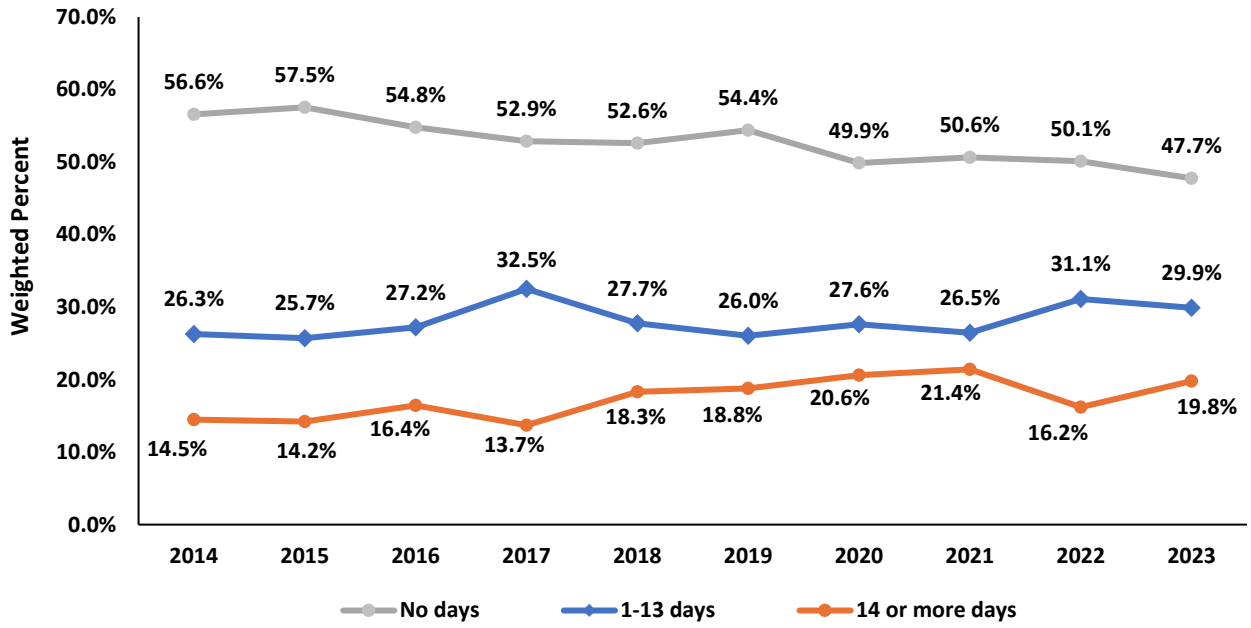
Behavioral Risk Factor Surveillance System

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

Generally, adults who experience "no days" in which poor mental health or physical health prevented them from doing usual activities have decreased since 2014 while "1-13 days" and "14 or more" days have increased. Adults who reported "14 or more days" have increased by 3.6% in 2023 compared to 2022 with a high of 21.4% in 2021.

Figure 16. Percent of Adult BRFSS Respondents Who Experienced Poor Mental or Physical Health that Prevented Them from Doing Usual Activities by Days Affected in Past Month, Nevada Residents, 2014-2023.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 70.0% to display differences among groups.
Frequent physical or mental distress is defined as feeling emotionally unhealthy, very sad, anxious, or troubled for 14 or more days out of the past 30 days.
Specific 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?"

Generally, adults who reported any number of days in which their mental health was considered "not good" has increased while "no days" has decreased since 2014. The prevalence of adults who experienced "14 or more days" reached its peak in 2023 at 19.8%, an increase of 5.4% since 2022.

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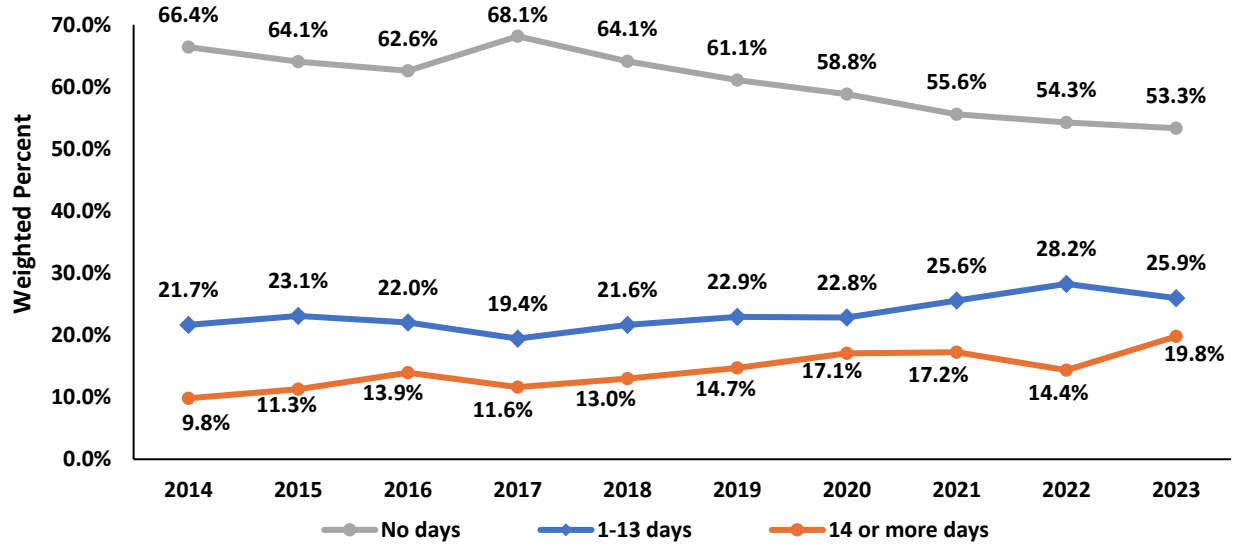
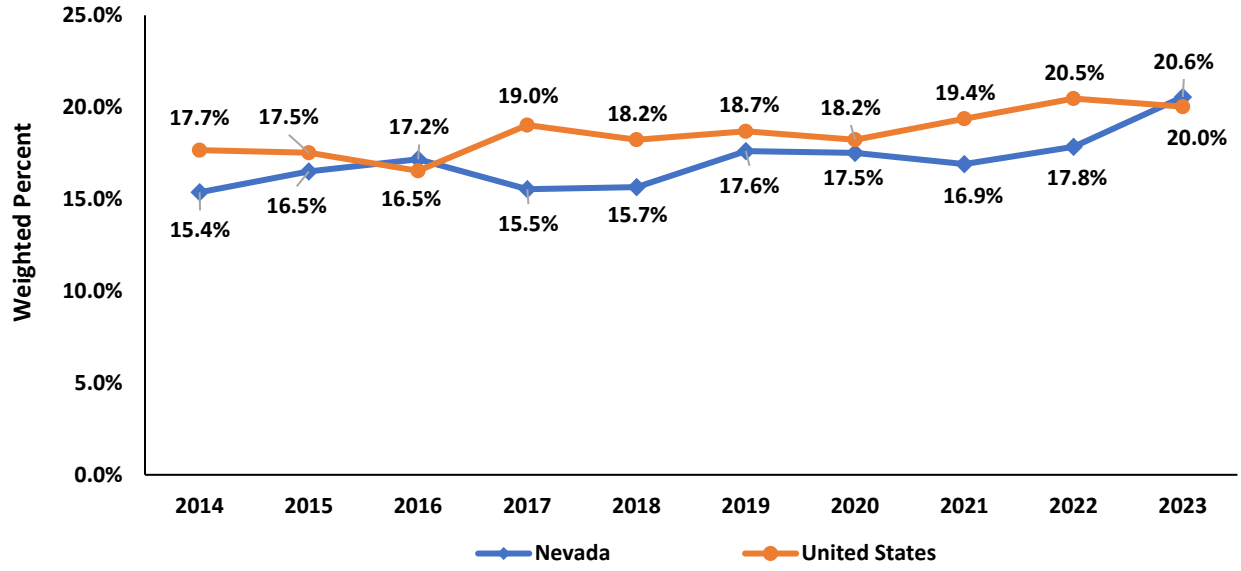
Figure 17. Percent of Adult BRFSS Respondents Whose Mental Health was Not Good by Number of Days Experienced in the Past Month, Nevada Residents, 2014-2023.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 70.0% to display differences among groups.
Frequent mental distress is defined as feeling emotionally unhealthy, very sad, anxious, or troubled for 14 or more days out of the past 30 days.
Specific 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 2023, the prevalence of those who reported having ever been told they have a depressive disorder by a doctor, nurse, or other health professional in Nevada (20.6%) surpassed the United States average (20.0%) for the first time since 2016.

Figure 18. Percent of Adult BRFSS Respondents Who Have Ever Been Told They Have a Depressive Disorder, Including Depression, Major/Minor Depression, or Dysthymia, Nevada Residents, 2014-2023.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 25.0% to display differences among groups.
Specific question asked in survey: "(Ever told) you have a depressive disorder (including depression, major depression, dysthymia, or minor depression)?"

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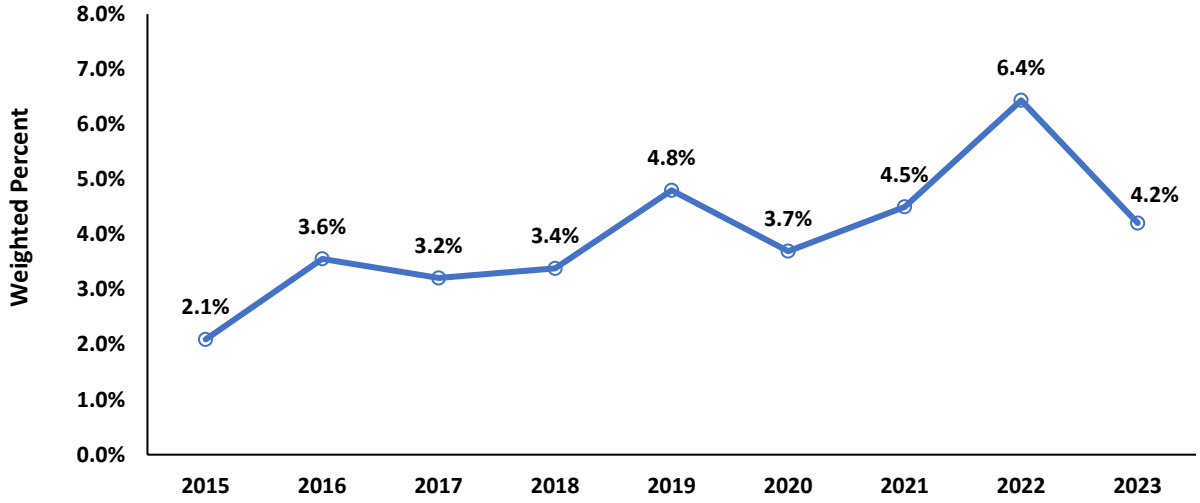
Suicide

Mental health issues, along with factors such as adverse childhood experiences and substance use disorders, may disproportionally affect those who die by suicide.

The 988 Lifeline is available 24/7/365 for anyone dealing with mental health struggles, emotional distress, substance use concerns or thoughts of suicide. Call or text 988 or visit 988lifeline.org to speak to a trained counsellor who can help to provide resources. During the 2024 fiscal year (July 1, 2023 – June 30, 2024), 988 services answered 28,509 calls in Nevada (per Vibrant reporting).

When asked "Have you seriously considered attempting suicide during the past 12 months," 4.2% of adult Nevada resident BRFSS respondents responded "yes" in 2023, a drop of 2.2% from the previous year. In 2022 there was a high of 6.4%, three times more than what was seen in 2015 (2.1%).

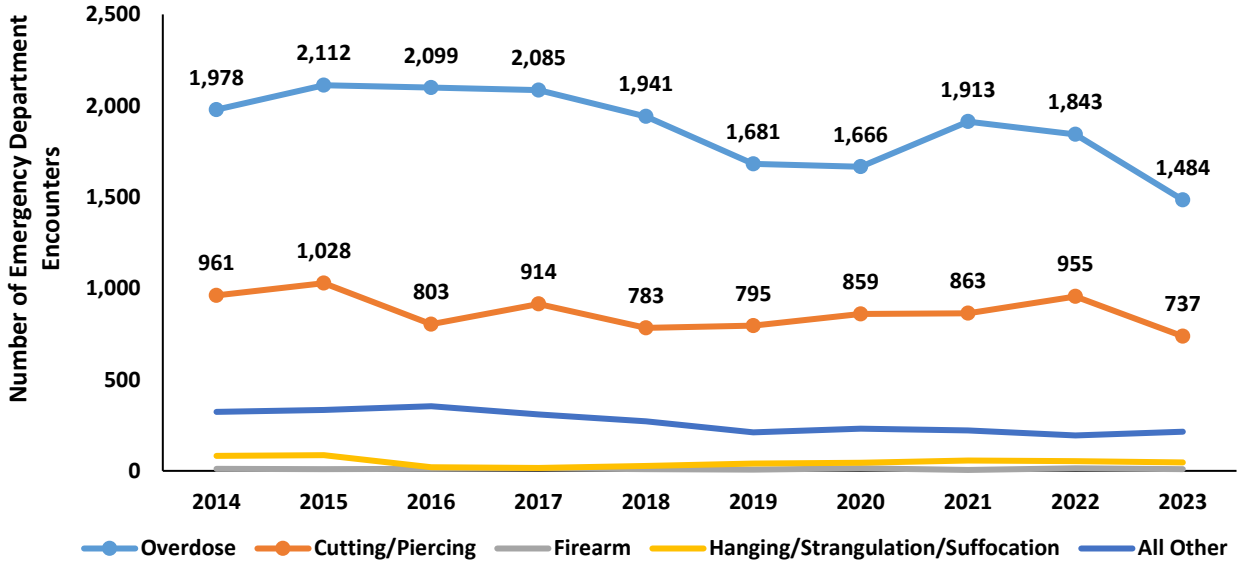
Figure 19. Percent of Adult BRFSS Respondents Who Have Seriously Considered Attempting Suicide, Nevada Residents, 2015-2023.



Source: Behavioral Risk Factor Surveillance System (BRFSS).
Chart scaled to 8.0% to display differences among groups.
Specific question asked in survey: "During the past 12 months have you ever seriously considered attempting suicide?"

Emergency department encounters related to suicide attempt, where the patient did not expire at the hospital, have decreased slightly from 2014 to 2023. The most common method for attempted suicide is overdose (substance or drug poisoning), followed by cutting/piercing. This is the case for both attempts ending in an emergency department encounter as well as those leading to an inpatient admission.

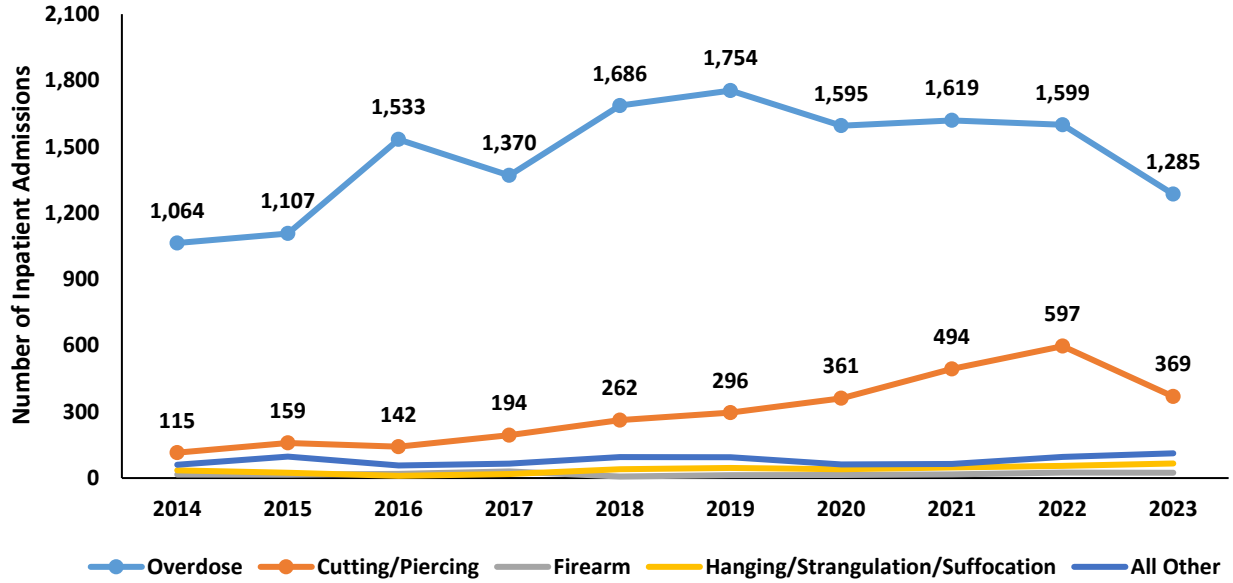
Figure 20. Suicide Attempt Emergency Department Encounters by Method, All Ages, Nevada Residents, 2014-2023.



Source: Hospital Emergency Department Billing.
ICD-9-CM codes were replaced by ICD-10-CM 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.

Inpatient admissions for non-fatal suicide attempts involving substances or drugs increased between 2014 and 2019, followed by a decline through 2023. Admissions for non-fatal suicide attempts by cutting/piercing was the highest in 2022 followed by a decline in 2023.

Figure 21. Suicide Attempt Inpatient Admissions by Method, All Ages, Nevada Residents, 2014-2023.



Source: Hospital Inpatient Billing.
ICD-9-CM codes were replaced by ICD-10-CM 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.

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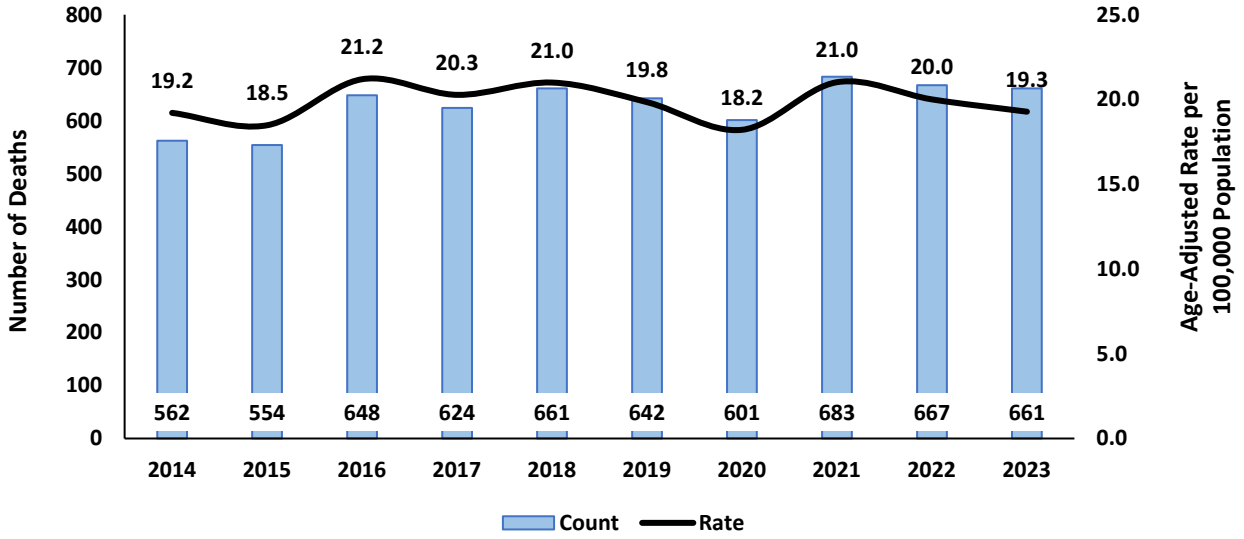
The age-adjusted suicide rate for Nevada in 2023 was 19.3 per 100,000 population. The highest rate was in 2016, at 21.2 per 100,000 population, while the lowest rate was in 2020, at 18.2 per 100,000 population. The national age-adjusted rate in 2022, the most recent year with complete CDC data, was 14.2 per 100,000 population, compared to 20.0 per 100,000 among Nevada residents.

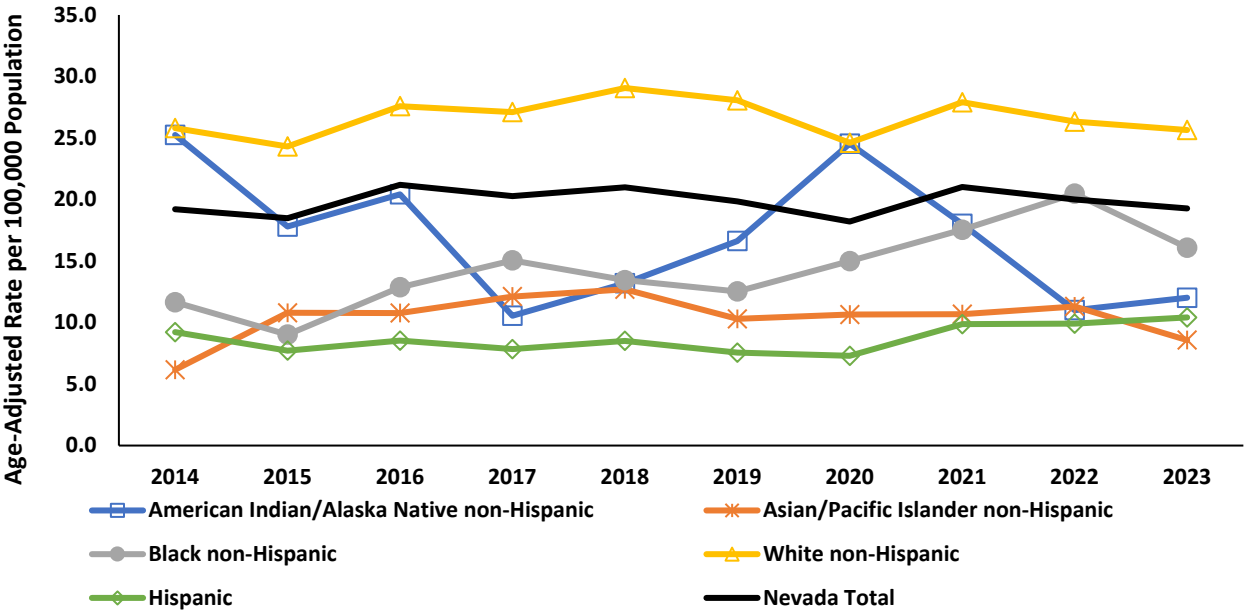
Figure 22. Number of Suicides and Rates, All Ages, Nevada Residents, 2014-2023.



Source: Nevada Electronic Death Registry System.

The age-adjusted suicide rates for White non-Hispanics were significantly higher (based on a 95% confidence interval) than the Nevada overall rate for each year from 2014 to 2023 with a rate of 25.6 per 100,000 population in 2023.

Figure 23. Suicide Rates by Race/Ethnicity, Nevada Residents, 2014-2023.



Source: Nevada Electronic Death Registry System.

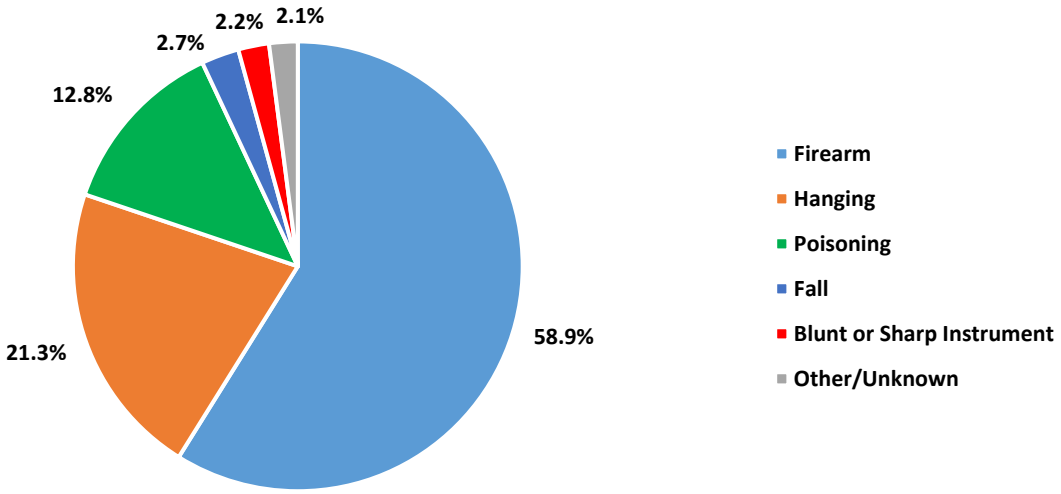
National Violent Death Reporting System (NVDRS)

NVDRS is a CDC-funded program that collects information about violent deaths including homicides, suicides, and deaths caused by law enforcement acting in the line of duty (legal interventions). Data are collected from death certificates, coroner/medical examiner reports (including toxicology), and law enforcement reports. Data elements collected provide valuable context about violent deaths, such as relationship problems, mental health conditions and treatment, toxicology results, and life stressors, including recent money- or work-related or physical health problems.

From 2018-2022, there were 4,329 deaths reported in the Nevada Violent Death Reporting System (NVVDRS). Of those deaths, 69.8% (n=3,023) were suicides, 23.0% were homicides, 1.8% were legal interventions, and the remainder were categorized as unintentional involving firearms or undetermined.

Among the 3,014 suicides, the method was firearms in 58.9% of cases (n=1,780), 21.3% hanging/strangulation/suffocation, 12.8% overdose, 2.7% fall, 2.2% blunt/sharp instrument, and 2.1% other/unknown. About 77% of persons were male and 23% were female.

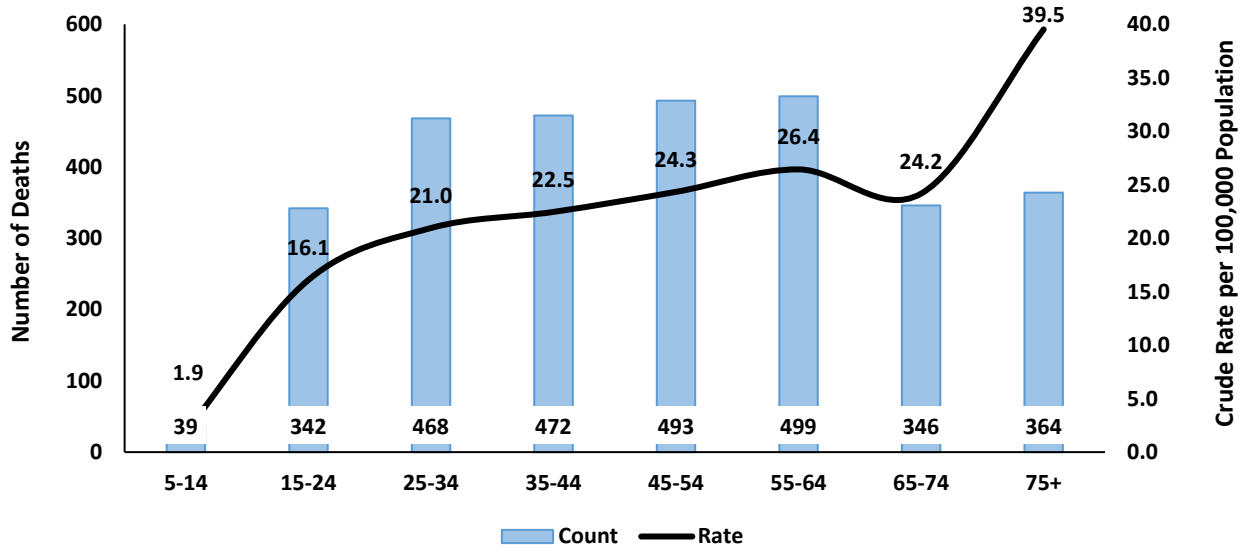
Figure 24. Method of Suicide Deaths, Nevada Residents, 2018-2022.



Source: Nevada Violent Death Reporting System.

The rates of deaths by suicide are fairly consistent from ages 25 to 74, then significantly increased in the 75+ age group.

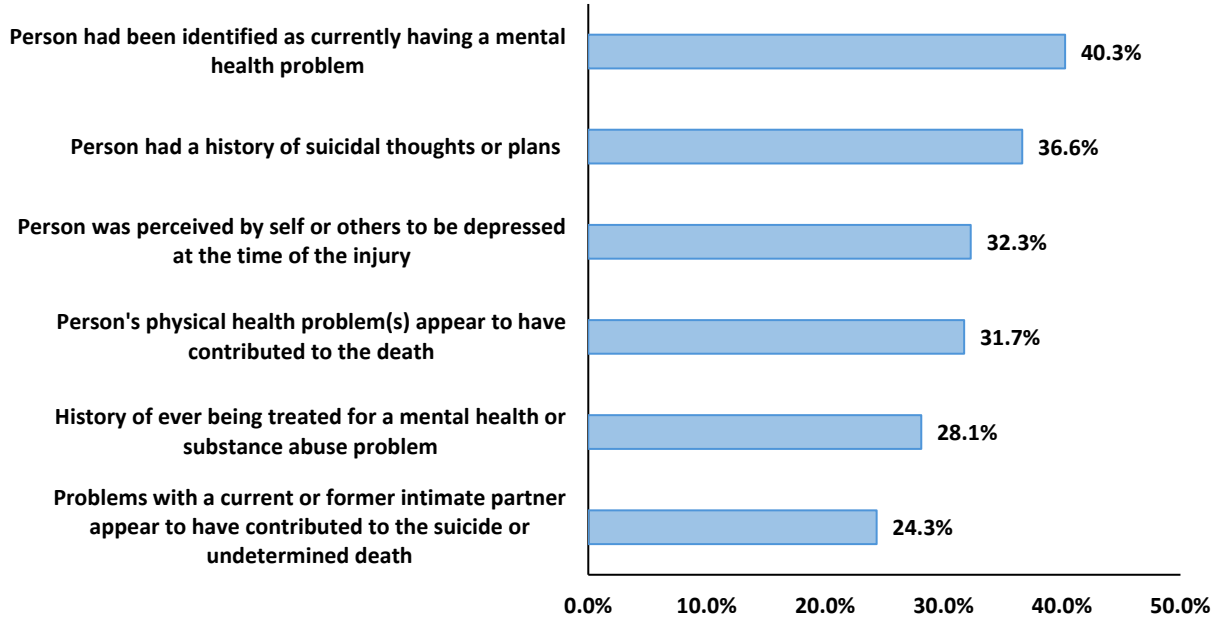
Figure 25. Number of Suicide Deaths and Rates by Age Group, Nevada Residents, 2018-2022.



Source: Nevada Violent Death Reporting System.

Of the 3,023 suicides among Nevada residents from 2018-2022 that were entered into NVDRS, 94.9% (n=2,871) had circumstantial information available. Over 40% of those suicides involved persons reported to have a mental health problem, 36.6% had a history of suicidal thoughts or plans, 32.3% were perceived by self or others to be depressed at the time of injury, 31.7% had a physical health problem(s) that appeared to contribute to the death, 28.1% had a history of ever being treated for a mental health or substance abuse problem, and 24.3% had problems with a current or former intimate partner that appeared to contribute to the death.

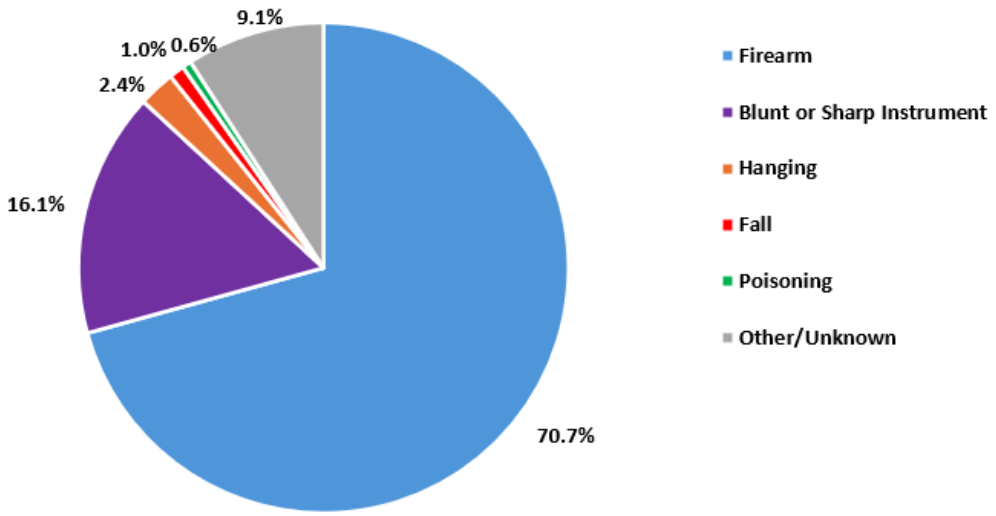
Figure 26. Circumstances Among Suicide Deaths, Nevada Residents, 2018-2022.



Source: Nevada Violent Death Registry System.
Chart scaled to 50.0% to display differences among groups.

Among the 997 homicides, the method was firearms in 70.7% of cases, 16.1% blunt/sharp instrument, 2.4% hanging, 1.0% fall, 0.6% overdose, and 9.1% other/unknown. Males accounted for 77.7% of homicide victims, and 22.3% were females.

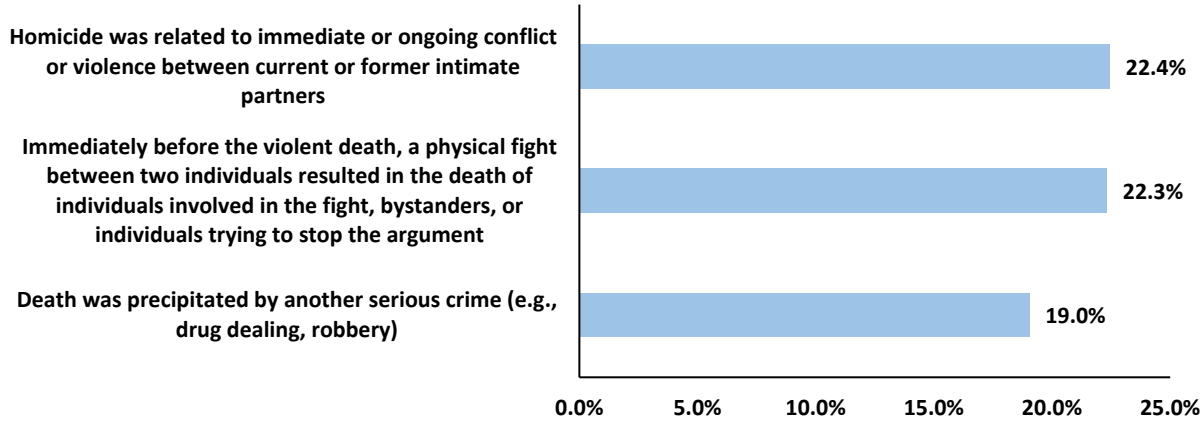
Figure 27. Method of Homicide Deaths, Nevada Residents, 2018-2022.



Source: Nevada Violent Death Reporting System.

Of the 997 homicides among Nevada residents from 2018-2022 that were entered into NVDRS, 79.5% (n=793) had circumstantial information available. Of those homicides, 22.4% were related to ongoing conflict or violence between current or former intimate partners, 22.3% involved a physical fight immediately before the homicide, and 19.0% were precipitated by another serious crime, such as drug dealing or robbery.

Figure 28. Circumstances Among Homicide Deaths, Nevada Residents, 2018-2022.



Source: Nevada Violent Death Reporting System.
Chart scaled to 25.0% to display differences among groups.

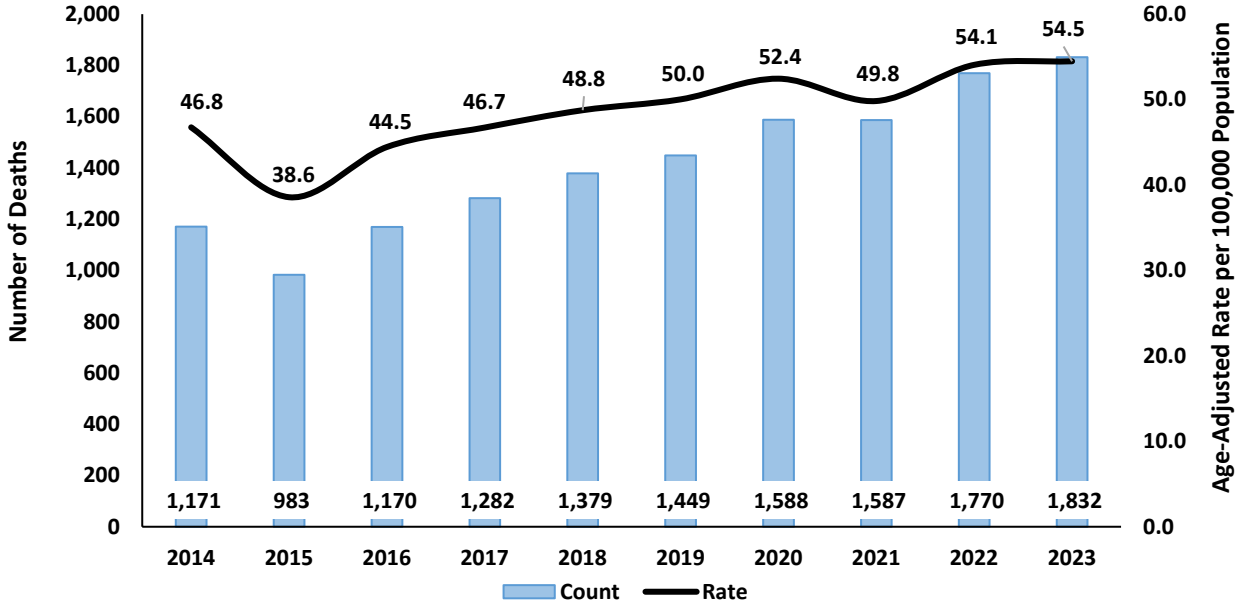
Mental Health-Related Deaths

Mental health-related deaths are deaths with the following ICD-10 code 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
- Intellectual disabilities
- Disorders of psychological development
- Behavioral and emotional disorders with onset usually occurring in childhood and adolescence
- Unspecified mental disorder

Mental health-related deaths in Nevada for 2023 occurred at an age-adjusted rate of 54.5 per 100,000 population, with a death count of 1,832 persons.

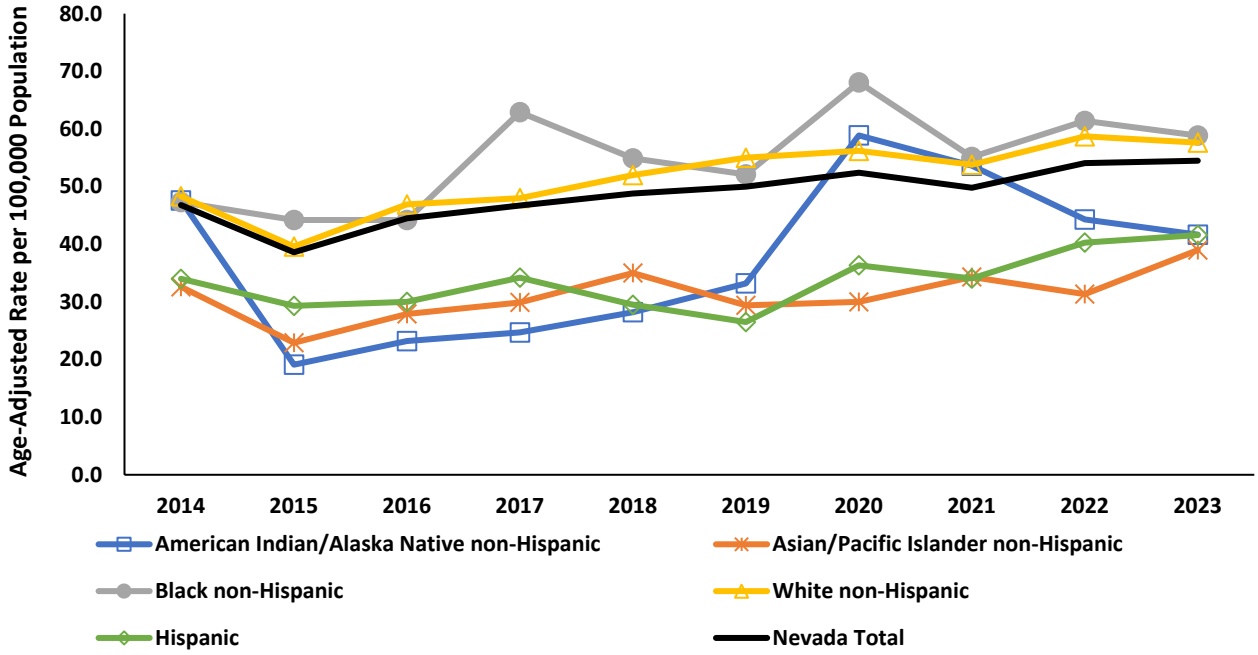
Figure 29. Mental Health-Related Deaths and Rates, Nevada Residents, 2014-2023.



Source: Nevada Electronic Death Registry System.

From 2014 to 2023, there were no statistically significant differences in age-adjusted mental health-related death rates among race/ethnicities. Rates for the state in total have shown an upward trend over this period.

Figure 30. Mental Health-Related Death Rates by Race/Ethnicity, Nevada Residents, 2014-2023.



Source: Nevada Electronic Death Registry System.

Substance Use

Opioids

Opioids are a class of drugs that act on the nervous system to relieve pain. They work by binding to opioid receptors in the brain, spinal cord, and other areas of the body, reducing the intensity of pain signals and affecting areas of the brain that control emotion. This release of endorphins lessens in intensity the longer they are taken, as the body builds a tolerance.

Throughout the 1990s, overdose deaths nationwide shifted from being primarily driven by illegal street drugs like heroin to prescription opioids. This was, at least partially, caused by the over-prescription of opioids for pain management.

In response to increased government oversight of these prescriptions, a second wave of overdose deaths emerged in 2010, mainly involving heroin. This was followed by another surge in overdose deaths, this time involving synthetic opioids including fentanyl and fentanyl analogs (IMFs). Synthetic opioids became the leading cause of overdose deaths in the United States starting 2016.[1]

In 2017, the U.S. Department of Health and Human Services (HHS) officially declared the opioid crisis a public health emergency. In response to this crisis, Nevada introduced Assembly Bill 474, which went into effect on January 1, 2018. This bill placed stricter requirements on the prescription of controlled substances. Additionally, the Nevada Board of Health adopted regulations requiring the reporting of drug overdoses by physicians, physician assistants, nurses, and veterinarians to the State's Chief Medical Officer.[2] Nevada AB 474 has led to measurable outcomes. Figures 31 and 32 below show the sharp decline in the number and rate of both opioid and controlled substance prescriptions in the state since 2017. These Nevada trends reflect the broader national picture of decreased prescription and utilization of opioids.

Per NRS 453.226 (as revised by AB474) prescribers with a controlled substance prescribing license are required to register with the Prescription Drug Monitoring Program (PDMP). The PDMP is a state-operated, CDC-supervised electronic database that monitors the prescribing and dispensing of controlled substances. It serves as a tool to identify and prevent drug misuse while equipping healthcare providers and public health authorities with timely insights into patient prescription behaviors.

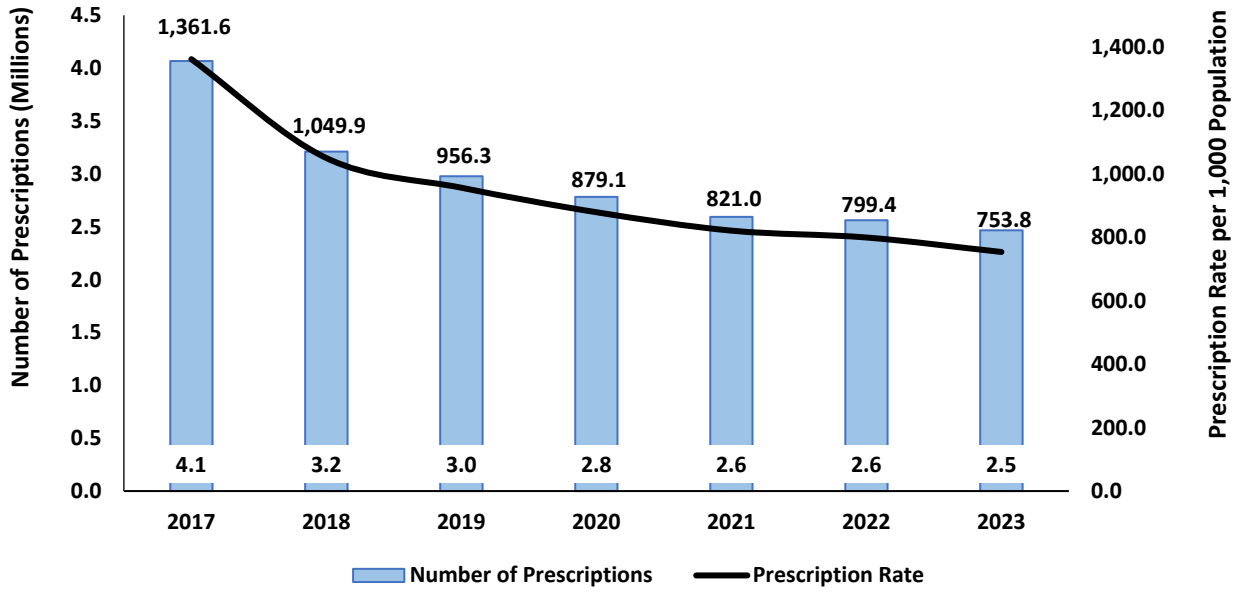
In addition to opioids, Nevada's Prescription Drug Monitoring Program tracks information about all Schedule II–V prescriptions dispensed to patients in the state. These drugs are classified as having accepted medical use and, at minimum, a low potential for abuse and risk of dependence. Schedule I drugs, such as ecstasy, heroin, lysergic acid diethylamide (LSD), and marijuana, are not included in the PDMP because they are defined as having no accepted medical use and a high potential for abuse.

Note that PDMP rates are presented per 1,000 population, which is the standard for this measure, unlike most rates in this report, which are calculated per 100,000 population.

[1] The Opioid Crisis | NIH HEAL Initiative
[2] Prescription Drug Abuse Prevention (nv.gov)

PDMP total prescriptions among Nevada residents have decreased markedly from a rate of 1,361.6 per 1,000 population in 2017 to 753.8 per 1,000 population in 2023.

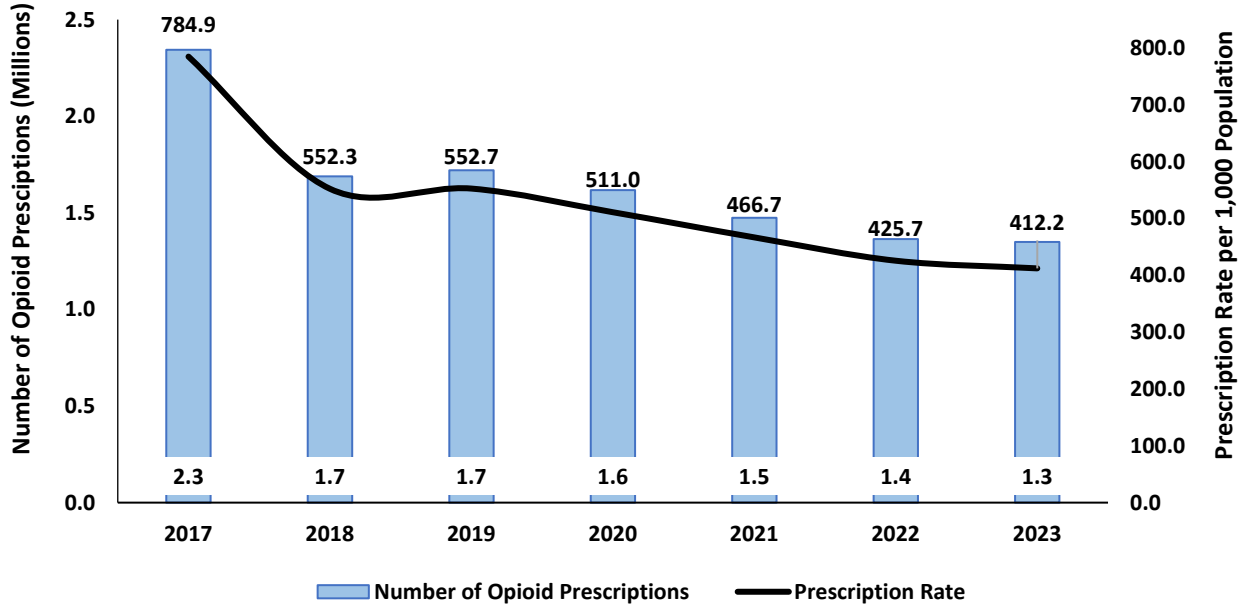
Figure 31. Total Prescriptions and Rates, Nevada Residents 2017-2023.



Source: Prescription Drug Monitoring Program.

Mirroring total prescription trends, total opioid prescriptions have decreased from a rate of 784.9 per 1,000 population in 2017 to 412.2 per 1,000 population in 2023.

Figure 32. Total Opioid Prescriptions and Rates, Nevada Residents 2017-2023.

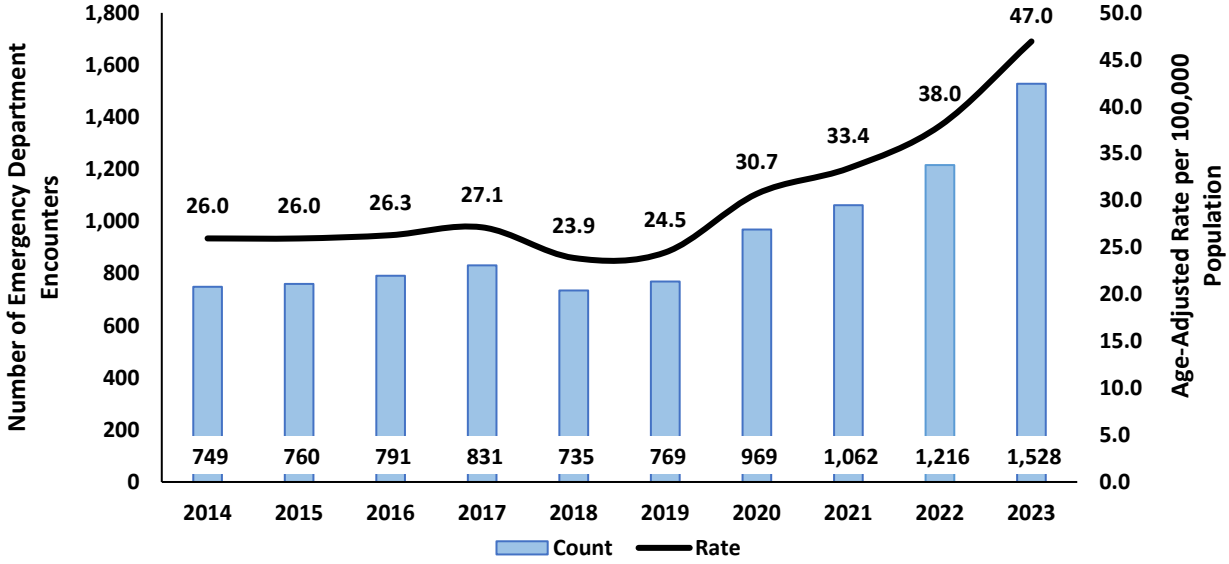


Source: Prescription Drug Monitoring Program.

Hospital Emergency Department Encounters

While total opioid prescriptions among Nevada residents decreased since 2017, opioid overdose emergency department encounters have notably increased since 2018, with the highest rate in 2023, at 47.0 per 100,000 population. This trend may suggest that there are other factors driving opioid misuse.

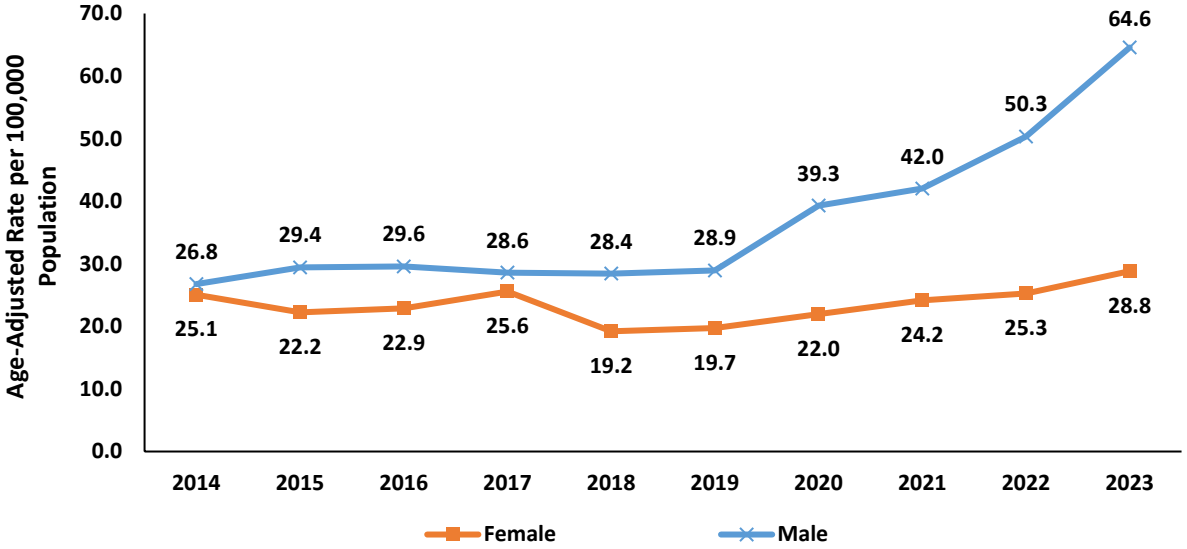
Figure 33. Opioid Overdose Emergency Department Encounters and Rates by Year, 2014-2023.



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

Opioid overdose emergency department encounter rates for both females and males remained relatively close and stable until 2019. Starting in 2020 there is a significant increase in the rate for males ending with a high of 64.6 per 100,000 in 2023.

Figure 34. Opioid Overdose Emergency Department Encounter Rates by Year and Sex, 2014-2023.



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

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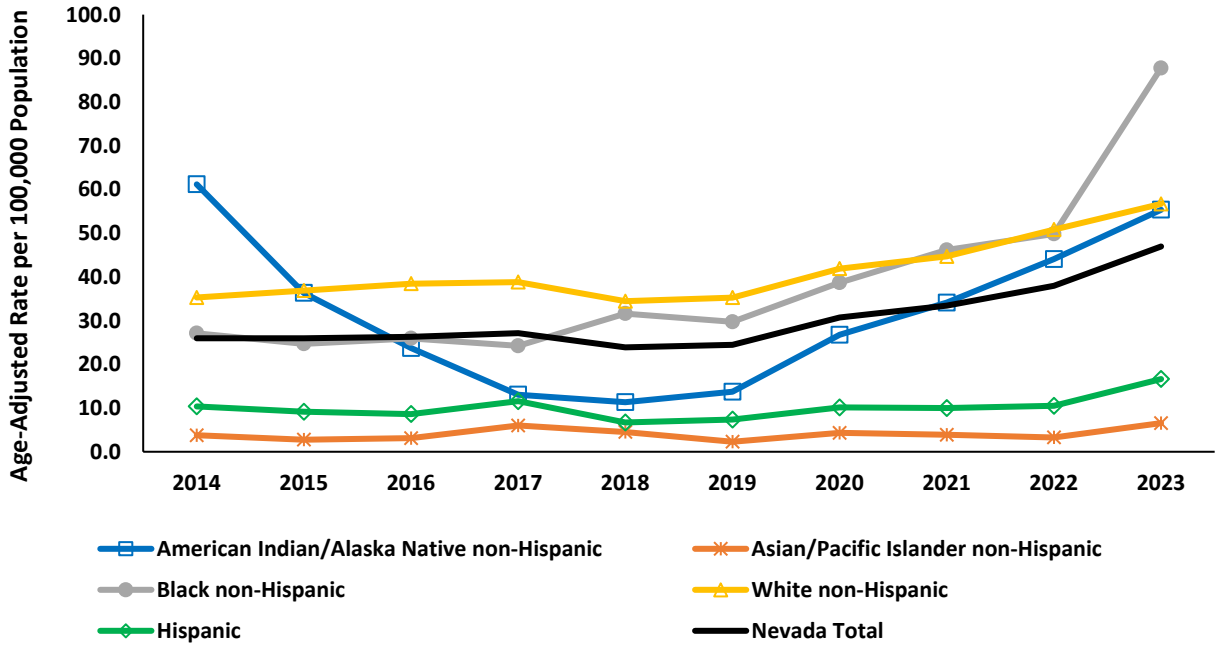
Opioid overdose emergency department encounter rates among White non-Hispanics have been consistently higher than the overall Nevada rate. The rates among Black non-Hispanics saw a statistically significant increase from 2022 to 2023. Note that the rate fluctuations among the American Indian/Alaska Native non-Hispanic population is a result of high volatility due to the relatively low population of this demographic in the state and should not be taken as a significant change from the other years in the reporting period.

Figure 35. Opioid Overdose Emergency Department Encounter Rates by Year and Race/Ethnicity, 2014-2023.

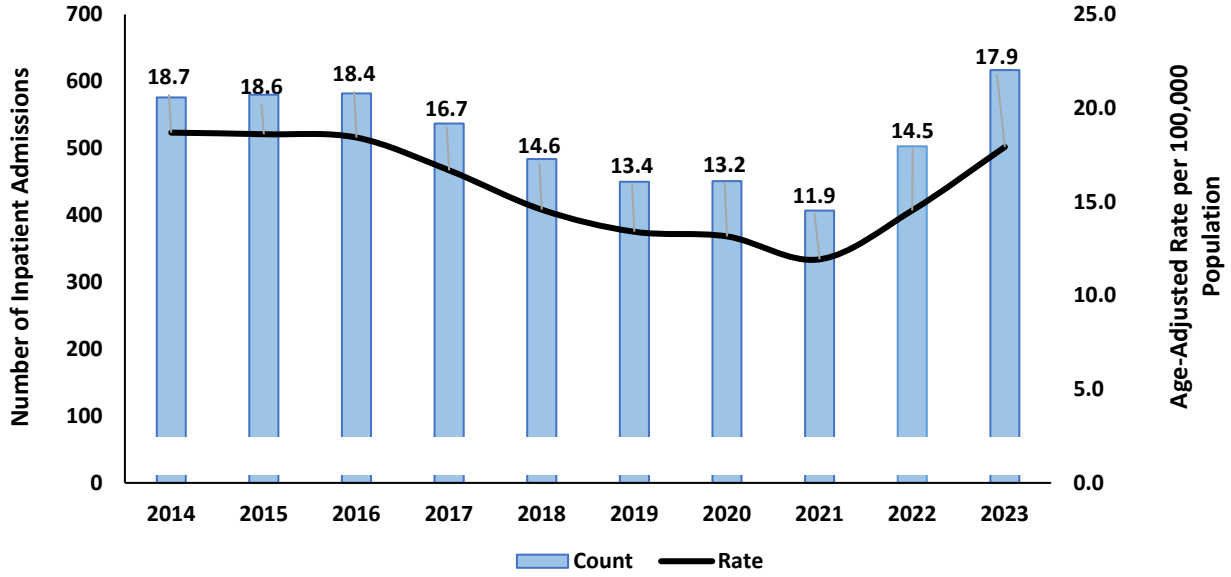


Source: Hospital Emergency Department Billing.
Categories are not mutually exclusive.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Hospital Inpatient Admissions

Opioid-related inpatient admission rates decreased from 2014 to 2021 before increasing beginning in 2022. This is indicative of an increase in cases involving complications requiring extended care.

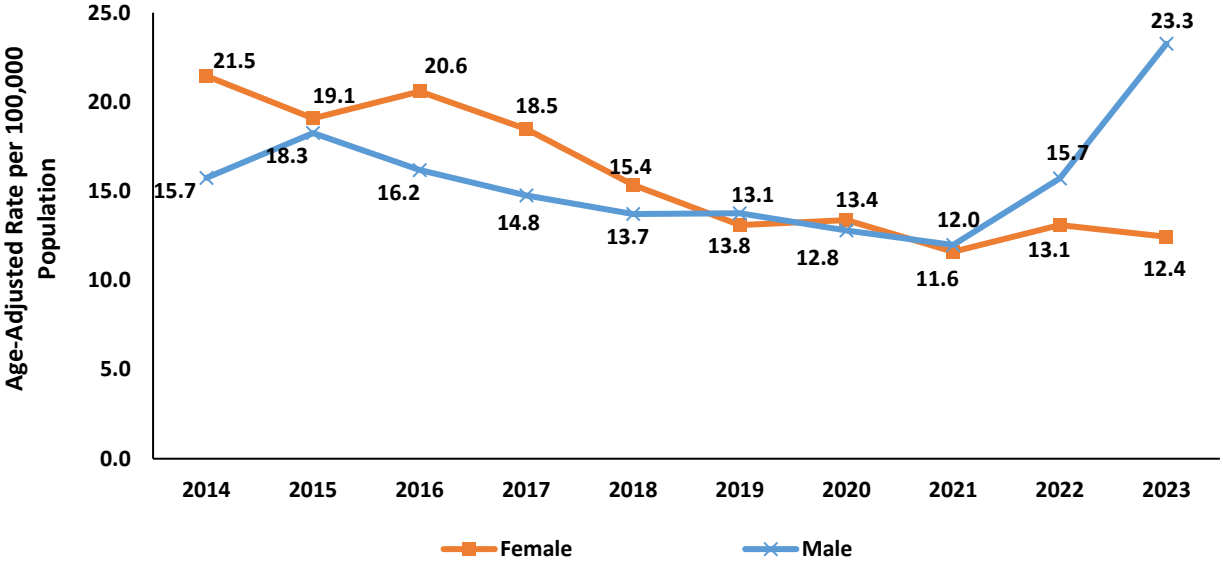
Figure 36. Opioid Overdose Inpatient Admissions and Rates by Year, 2014-2023.



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

From 2016 to 2023, the inpatient admission rate for opioid overdoses among females has decreased, while the rate among males has increased considerably between 2021 and 2023.

Figure 37. Opioid Overdose Inpatient Admission Rates by Year and Sex, 2014-2023.



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

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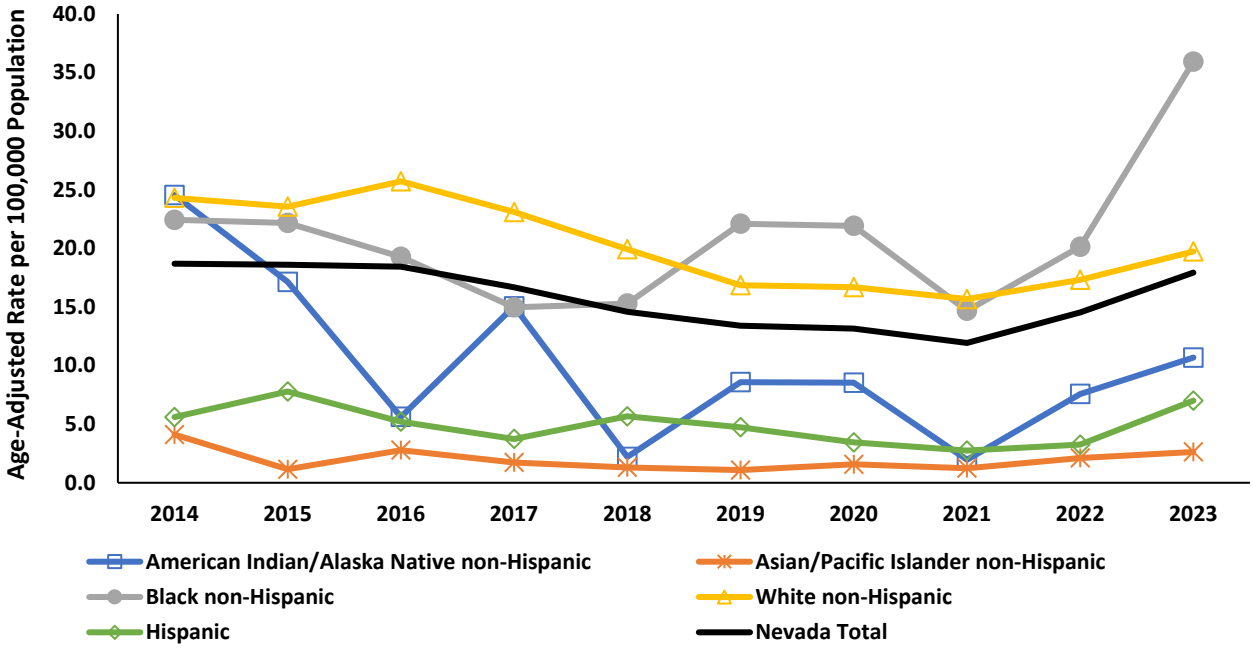
Consistent with opioid overdose emergency room encounters, the rates among White non-Hispanics have been consistently higher than the overall Nevada rate. The rates among Black non-Hispanics saw a statistically significant increase from 2022 to 2023. Note that the rate fluctuations among the American Indian/Alaska Native non-Hispanic population is a result of high volatility due to the relatively low population of this demographic in the state and should not be taken as a significant change from the other years in the reporting period.

Figure 38. Opioid Overdose Inpatient Admission Rates by Year and Race/Ethnicity, 2014-2023.

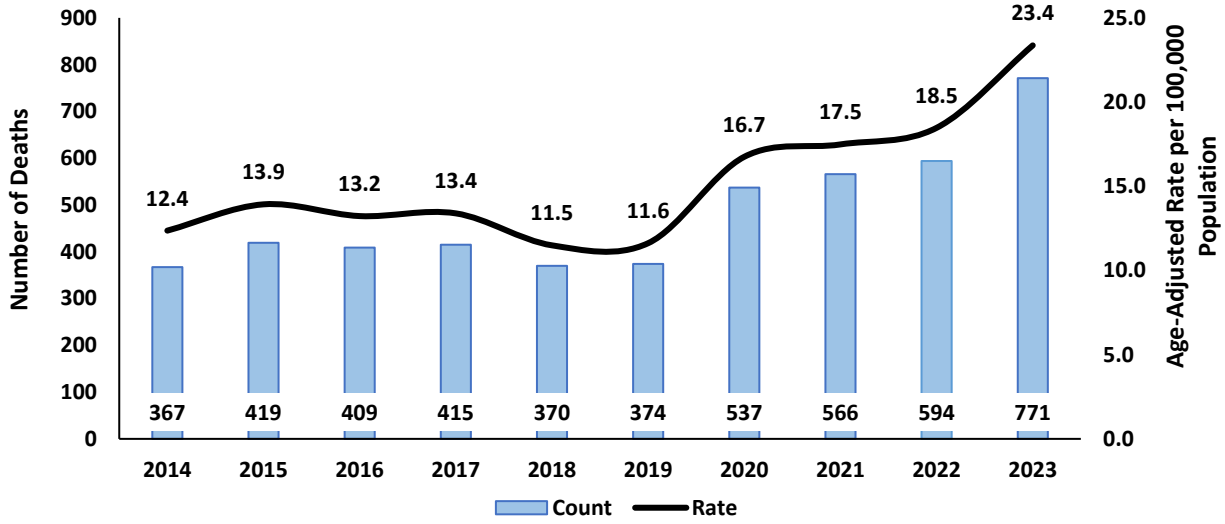


Source: Hospital Inpatient Billing.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Opioid Overdose Deaths

Opioid overdose deaths have significantly increased from 2019 to 2023, mirroring the rise in emergency room encounters starting in 2019 and inpatient admissions starting in 2022. This sharp increase may reflect a worsening opioid epidemic, with the rise of emergency room encounters providing an early indicator of overdose trends.

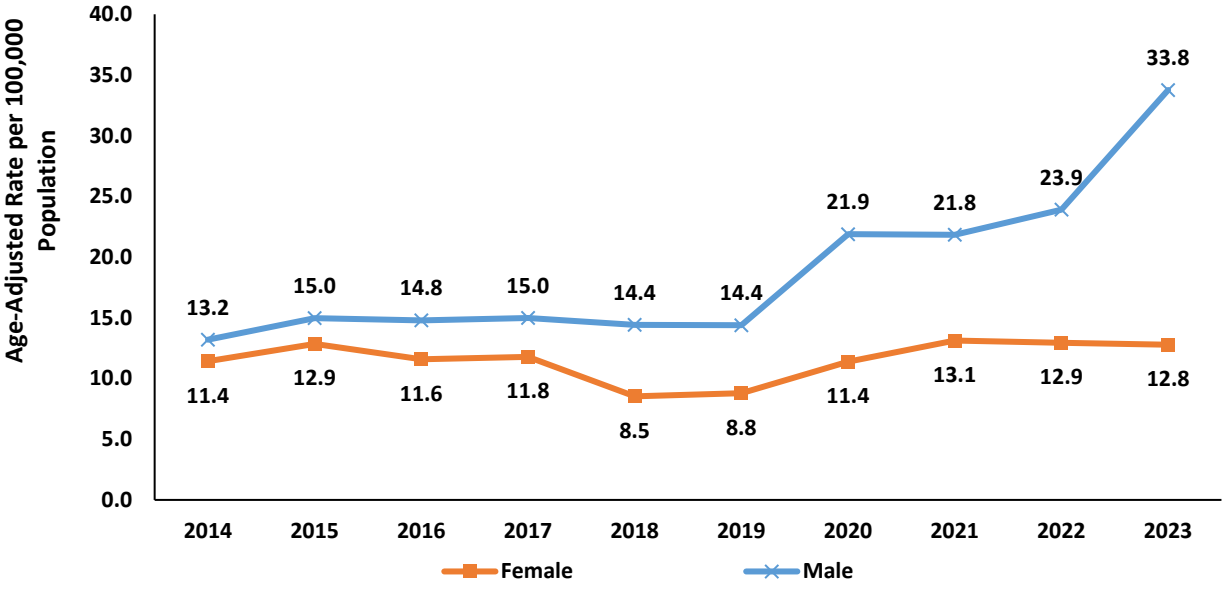
Figure 39. Opioid Overdose Deaths and Rates, Nevada Residents 2014-2023.



Source: Nevada Electronic Death Registry System.

Opioid overdoses by sex also reflect trends in emergency department encounters, with relatively steady rates among females and a notable increase among males starting in 2020. This suggests that the opioid crisis among females has not worsened, and that males have been disproportionately affected.

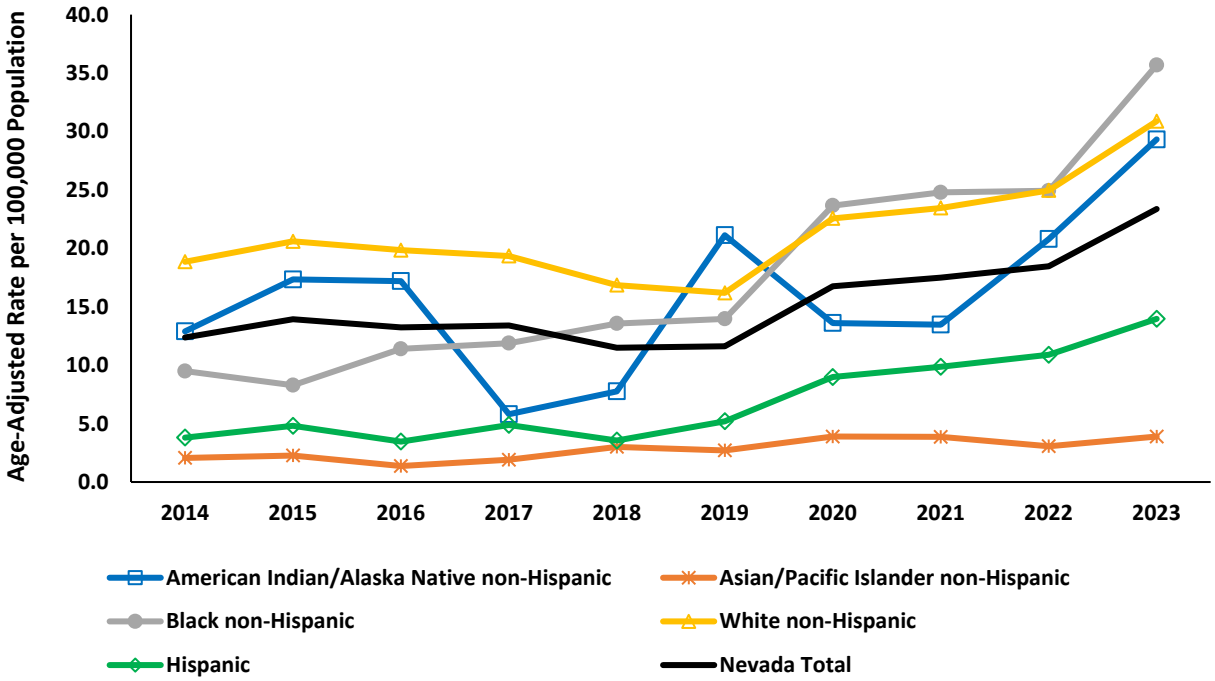
Figure 40. Opioid Overdose Death Rates by Sex, Nevada Residents 2014-2023.



Source: Nevada Electronic Death Registry System.

Opioid overdose deaths by race/ethnicity are also consistent with opioid overdose emergency room encounters; the rates among White non-Hispanics have been consistently higher than the overall Nevada rates, and among Black non-Hispanics since 2018; both groups had a significant increase from 2019 to 2023. Note that the rate fluctuations among the American Indian/Alaska Native non-Hispanic population is a result of high volatility due to the relatively low population of this demographic in the state and should not be taken as a significant change from the other years in the reporting period.

Figure 41. Opioid Overdose Death Rates by Race/Ethnicity, Nevada Residents 2014-2023.



Source: Nevada Electronic Death Registry System.

Stimulants

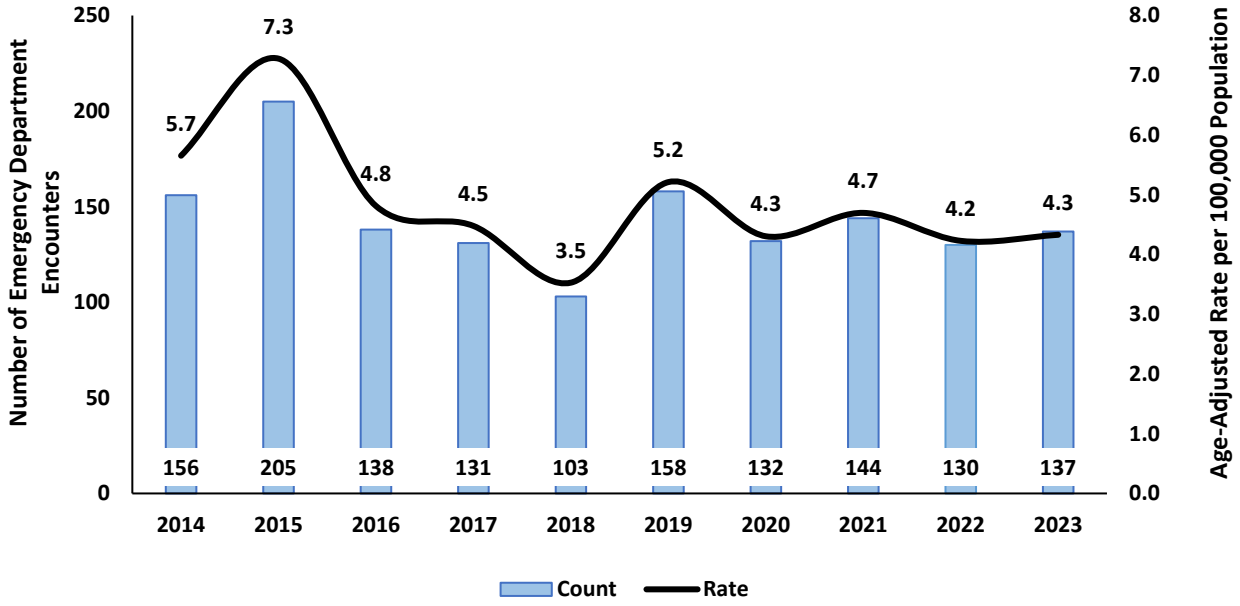
Stimulants are a class of drugs that accelerate communication between the brain and body, often making individuals feel more awake, alert, confident, or energetic. They include legal substances like caffeine and prescription medications such as dexamphetamines, Adderall, and methylphenidate (Ritalin), as well as illicit substances like methamphetamines, speed, and cocaine.

In addition to the risk of death from overdose, long term misuse of stimulants can lead to a variety of health effects including permanent damage to the heart and brain, high blood pressure, and damage to internal organs.[3]

Hospital Emergency Department Encounters

The rate of stimulant overdose emergency department encounters has remained fairly steady after a decrease in 2015. The number of stimulant overdoses is relatively small compared to opioids.

Figure 42. Stimulant Overdose Emergency Department Encounters and Rates by Year, 2014-2023.

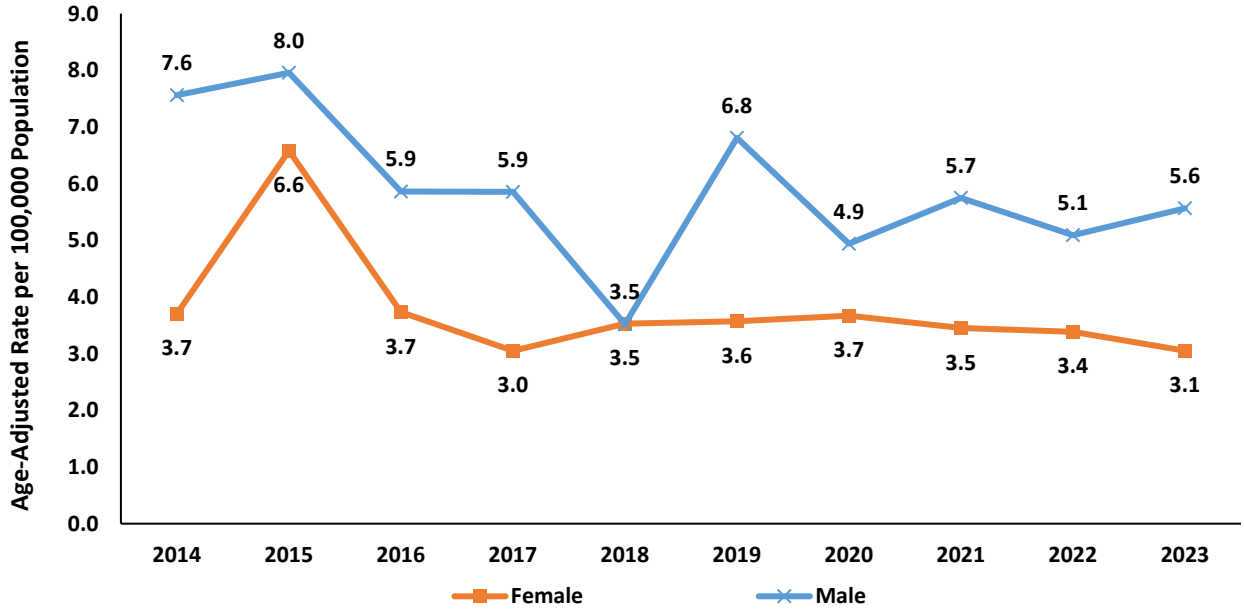


Source: Hospital Emergency Department Billing.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Males have had a higher rate of stimulant overdose emergency department encounters compared to females for all years from 2014-2023, with the exception of equal rates in 2018.

[3] What are Stimulants? Side Effects, Short and Long Term Risks | SAMHSA

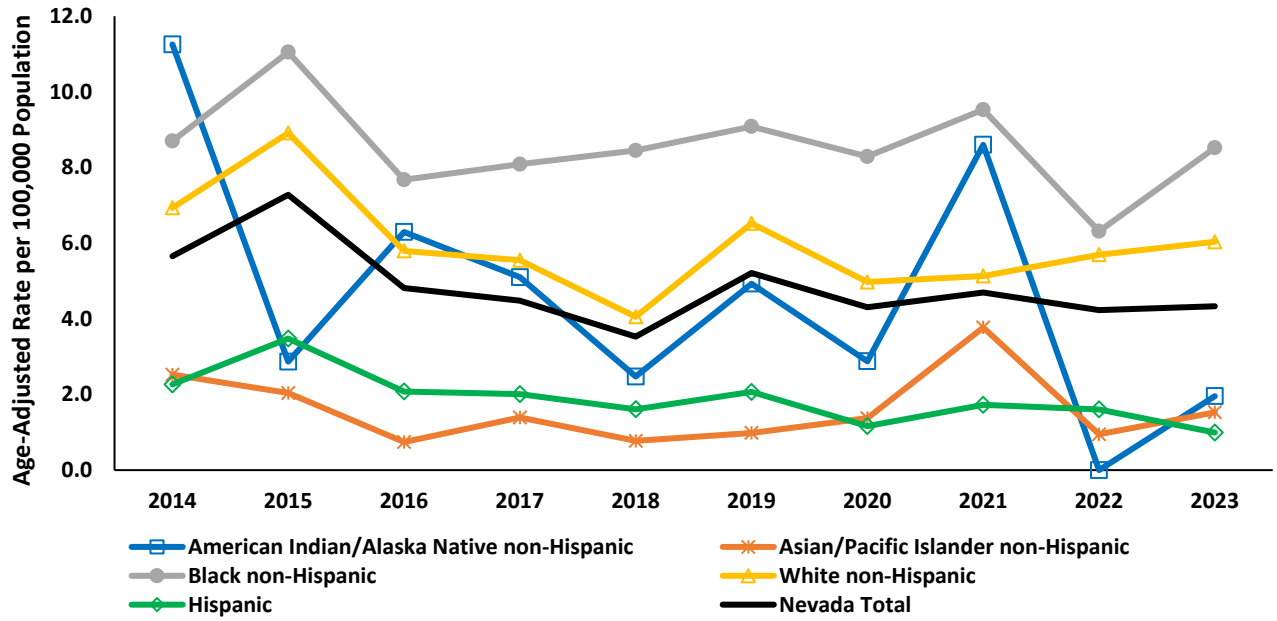
Figure 43. Stimulant Overdose Emergency Department Encounter Rates by Year and Sex, 2014-2023.



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

Similar to opioids, White non-Hispanics and Black non-Hispanics experience higher rates of stimulant overdose-related emergency room encounters compared to the overall Nevada rates. However, unlike opioids, Black non-Hispanics have a higher rate of these encounters than White non-Hispanics.

Figure 44. Stimulant Overdose Emergency Department Encounter Rates by Year and Race/Ethnicity, 2014-2023.



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

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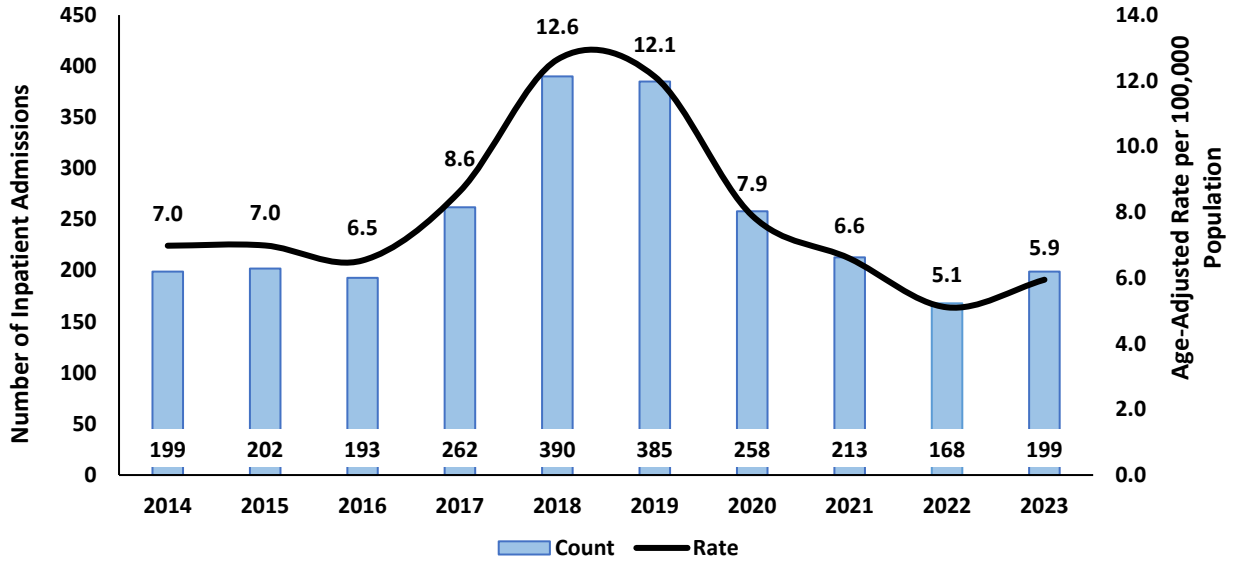
Hospital Inpatient Admissions

Unlike opioid- or alcohol-related overdoses, which result in higher counts and rates of emergency department encounters, stimulant overdoses are more associated with higher inpatient admission rates. The rates peaked in 2018 and 2019, followed by a steady decline through 2022.

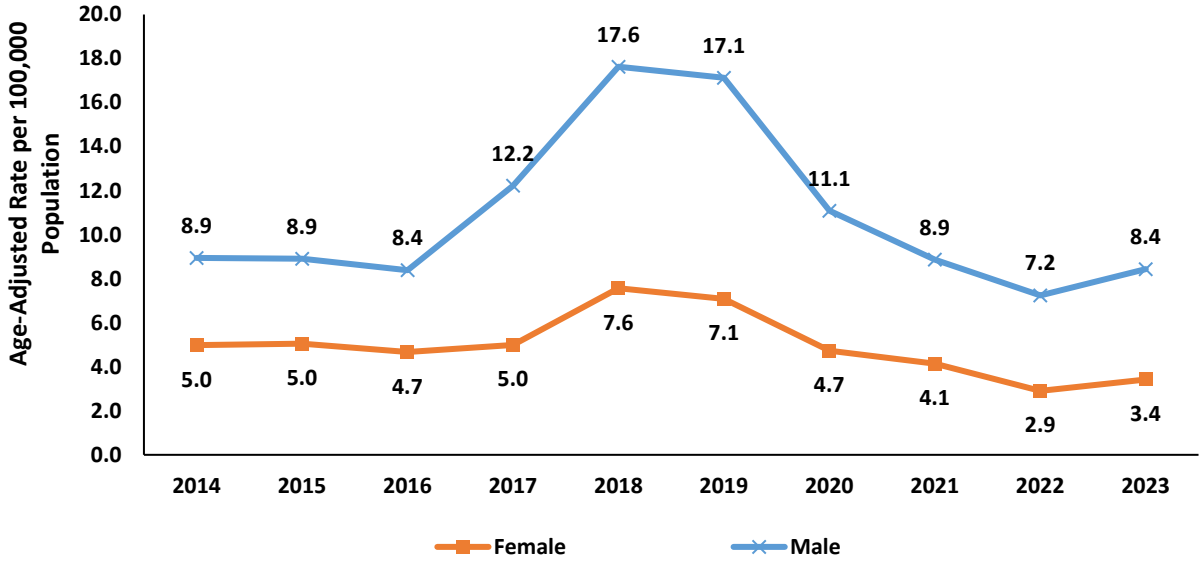
Figure 45. Stimulant Overdose Inpatient Admissions and Rates by Year, 2014-2023.



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

From 2014 to 2023, males consistently had significantly higher stimulant overdose inpatient admission rates compared to females. Rates for both sexes experienced an increase in 2018, followed by a decrease to rates below the 2014 level.

Figure 46. Stimulant Overdose Inpatient Admission Rates by Year and Sex, 2014-2023.



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

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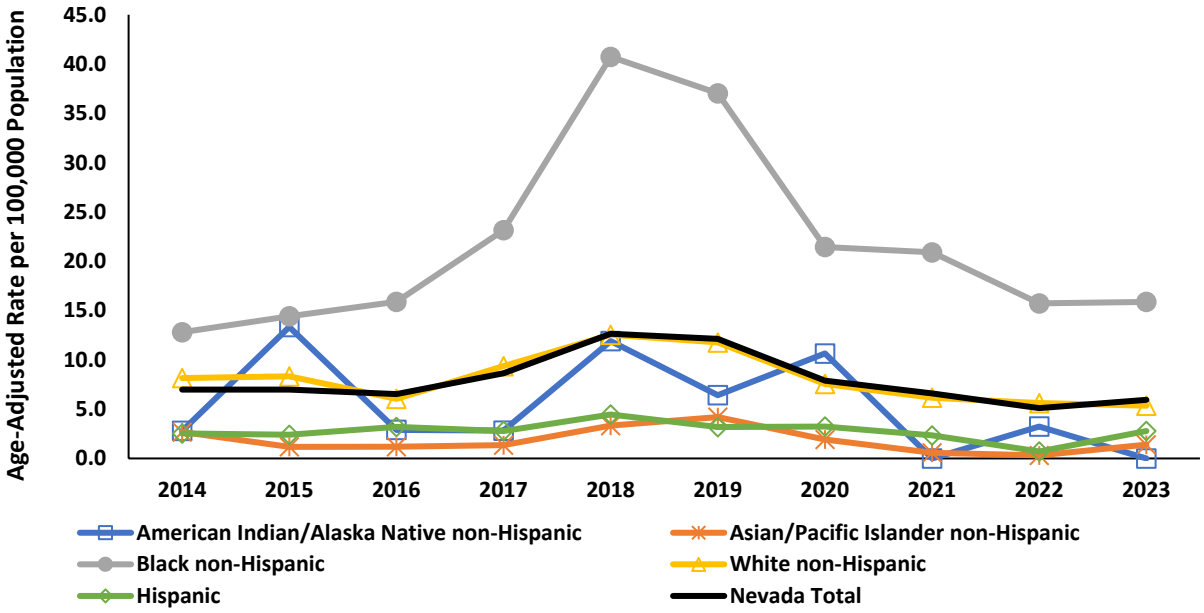
The rates of stimulant overdose inpatient admissions among Black non-Hispanics are significantly higher than the rates of both White non-Hispanics and Nevada totals for all years 2014-2023.

Figure 47. Stimulant Overdose Inpatient Admission Rates by Year and Race/Ethnicity, 2014-2023.

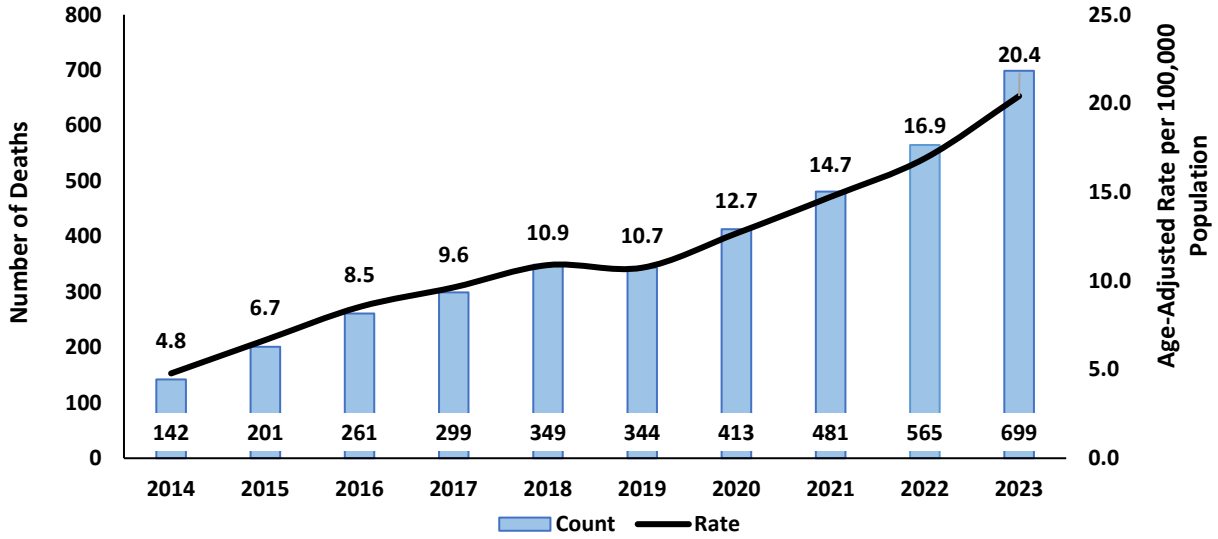


Source: Hospital Inpatient Billing.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Stimulant Overdose Deaths

The rates of stimulant-related overdose deaths have steadily increased since 2014, resulting in a 327% overall increase from 2014 to 2023. Methamphetamine toxicity was a contributing factor in the majority of deaths.

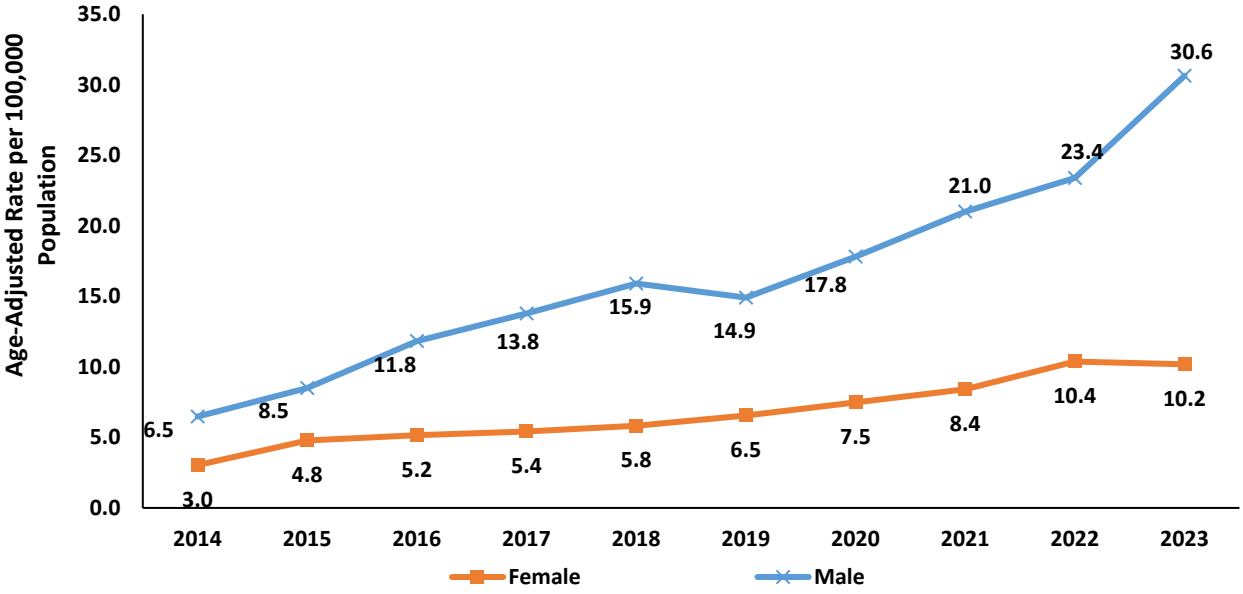
Figure 48. Stimulant Overdose Deaths and Rates, Nevada Residents 2014-2023.



Source: Nevada Electronic Death Registry System.

Since 2014, stimulant overdose death rates have increased among both males and females, with a slight decrease in male rates observed in 2019. Throughout this period, male rates remained consistently and considerably higher than female rates. The male death rate increased 371% from 2014 to 2023, and 240% for females.

Figure 49. Stimulant Overdose Death Rates by Sex, Nevada Residents 2014-2023.



Source: Nevada Electronic Death Registry System.

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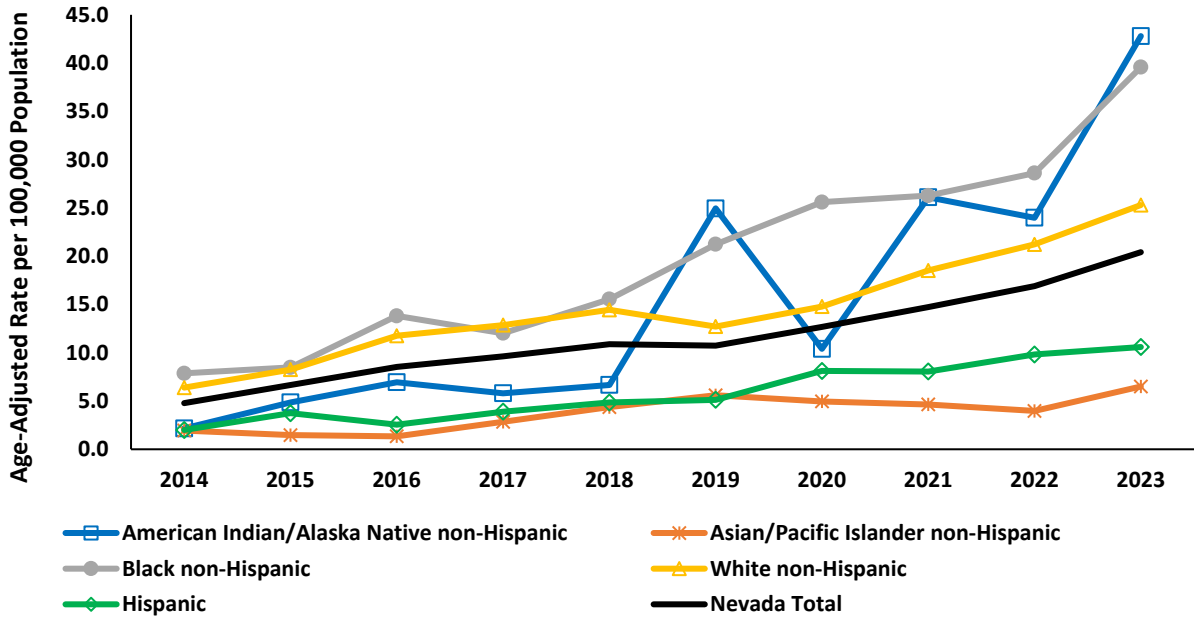
The stimulant overdose death rate among White non-Hispanic and Black non-Hispanics has been consistently higher than the Nevada total rates for all years. Note that the rate fluctuations among the American Indian/Alaska Native non-Hispanic population is a result of high volatility due to the relatively low population of this demographic in the state and should not be taken as a significant change from the other years in the reporting period.

Figure 50. Stimulant Overdose Death Rates by Race/Ethnicity, Nevada Residents 2014-2023.



Source: Nevada Electronic Death Registry System.

Alcohol

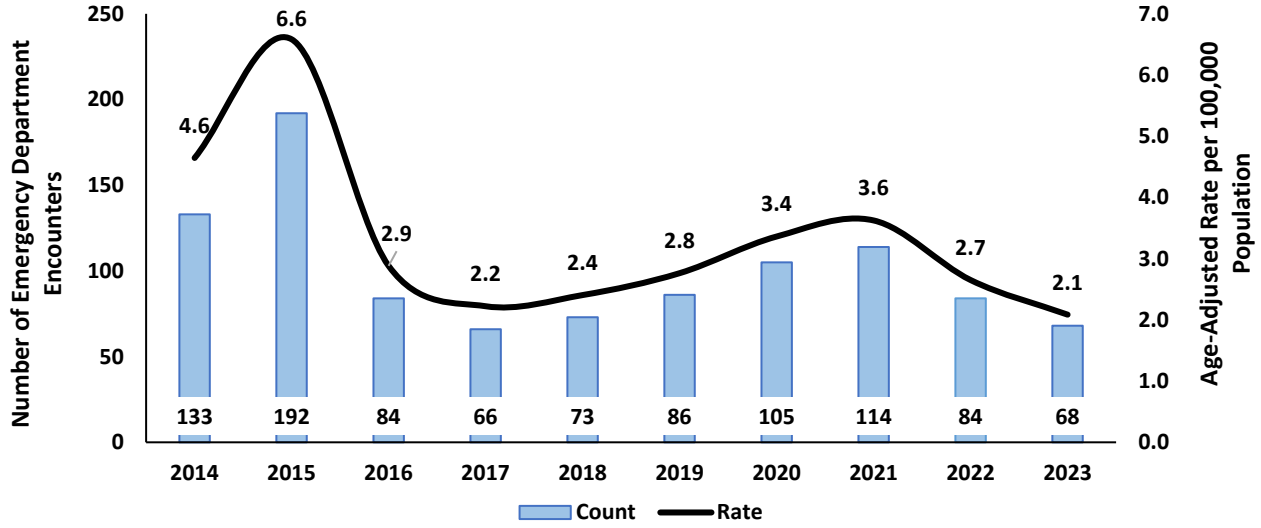
According to research from the CDC[4], alcohol misuse causes roughly 178,000 deaths each year in the United States and shortens the lives of those who die by 24 years on average. About two-thirds of those deaths are from chronic conditions developed from long-term alcohol use, while the other one-third result from binge drinking or a single instance of over-consumption. Those chronic conditions include cancers, heart disease, liver disease and other complications from alcohol use disorder. The latter category of deaths includes motor vehicle crashes, alcohol poisoning, alcohol-involved drug overdoses and deaths by suicide. Both nationally, per the CDC[5], and for Nevada residents (as illustrated in this section) alcohol-related deaths and hospital visits, particularly for chronic alcohol use, disproportionately affect men.

There are several potential causes for the notable increase in deaths and hospitalizations (for chronic conditions) related to alcohol use and misuse. Due to its legality and social acceptability, alcohol is easily accessible and available to most Americans. While the effects of the COVID-19 pandemic are still yet to be fully understood, "stress, loneliness, and social isolation; and mental health conditions"[6] can all lead to a rise in excessive alcohol consumption and may help explain the increases in negative health outcomes in the years immediately following lockdowns.

Overdoses

In contrast to the stark increase in emergency department encounters for opioids, alcohol overdose hospitalizations have been trending down. While there was an increase in emergency department encounters during and immediately following COVID-19 lockdowns, the rate has dropped substantially post-pandemic. Hospital visits for alcohol overdoses have been decreasing, but it should be noted that there has been an increase in alcohol related deaths in Nevada in the past several years.

Figure 51. Alcohol Overdose Emergency Department Encounters and Rates by Year, 2014-2023.

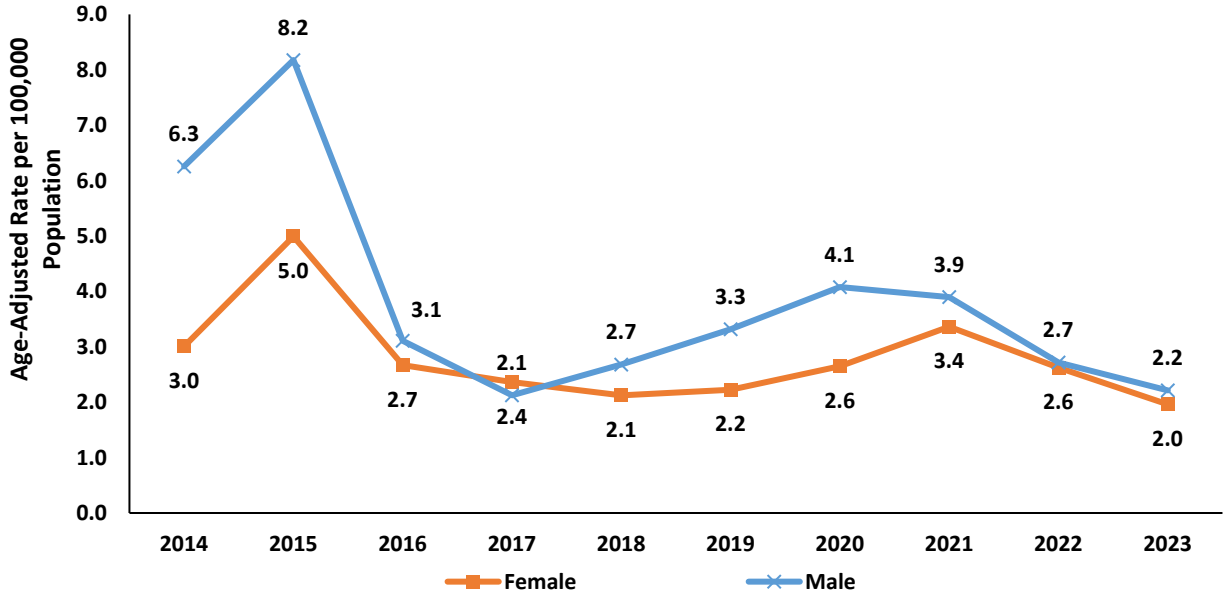


Source: Hospital Emergency Department Billing.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

[4] Facts About U.S. Deaths from Excessive Alcohol Use | Alcohol Use | CDC
[5] Sex and Gender Considerations on Alcohol Use and Health | Alcohol Use | CDC
[6] Deaths from Excessive Alcohol Use — United States, 2016–2021 | MMWR

The rates of emergency department encounters for alcohol overdose have been largely comparable between female and male since 2016 and both reflect the overall trend for the reporting period.

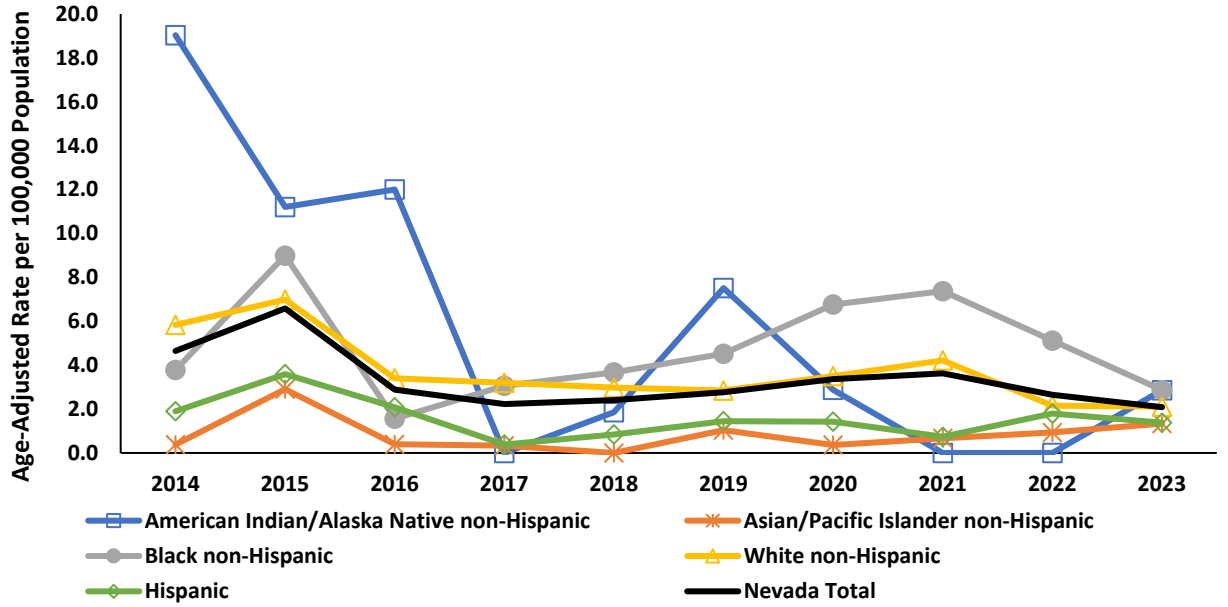
Figure 52. Alcohol Overdose Emergency Department Encounter Rates by Year and Sex, 2014-2023.



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

The variance in the rate of encounters for American Indian/Alaska Native non-Hispanics is a result of high volatility due to the relatively low population of this demographic in the state and should not be taken as a significant. Other race/ethnicity demographics do not differ significantly from the overall trend for Nevada.

Figure 53. Alcohol Overdose Emergency Department Encounter Rates by Year and Race/Ethnicity, 2014-2023.



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

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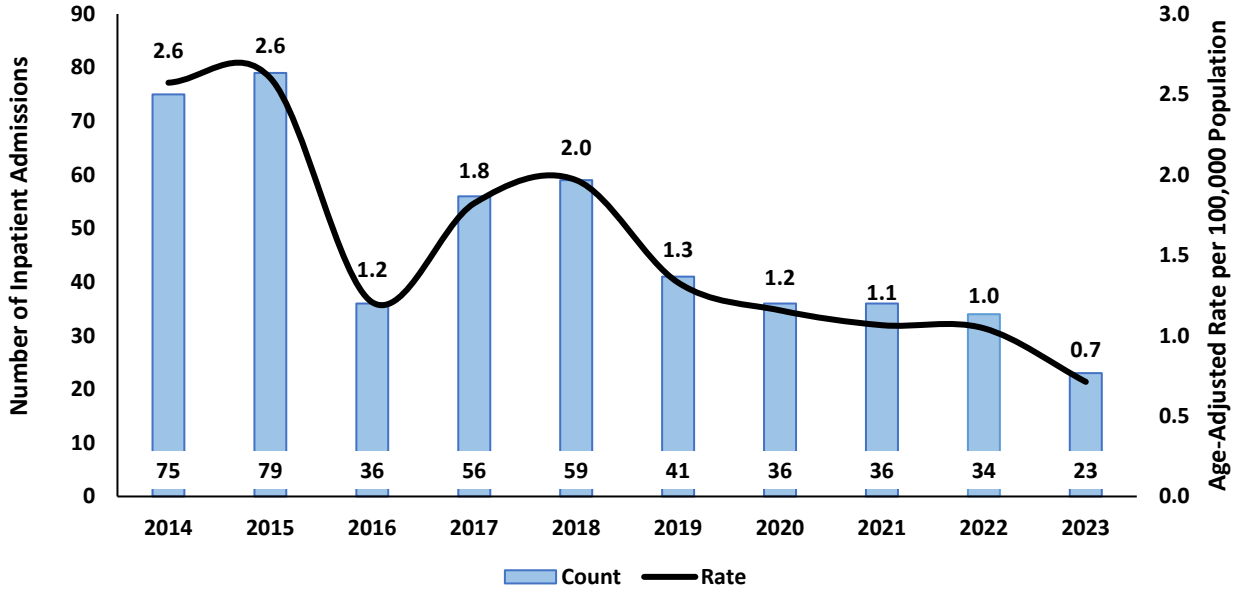
Hospital inpatient admissions due to alcohol overdoses have been decreasing steadily over the past decade, including in the years immediately following the COVID-19 pandemic. The rate per 100,000 in 2023 was the lowest in the reporting period. While this number may adjust slightly due to lag in hospital billing claims data, the rate has stayed consistently below 1.5 per 100,000 population since 2019.

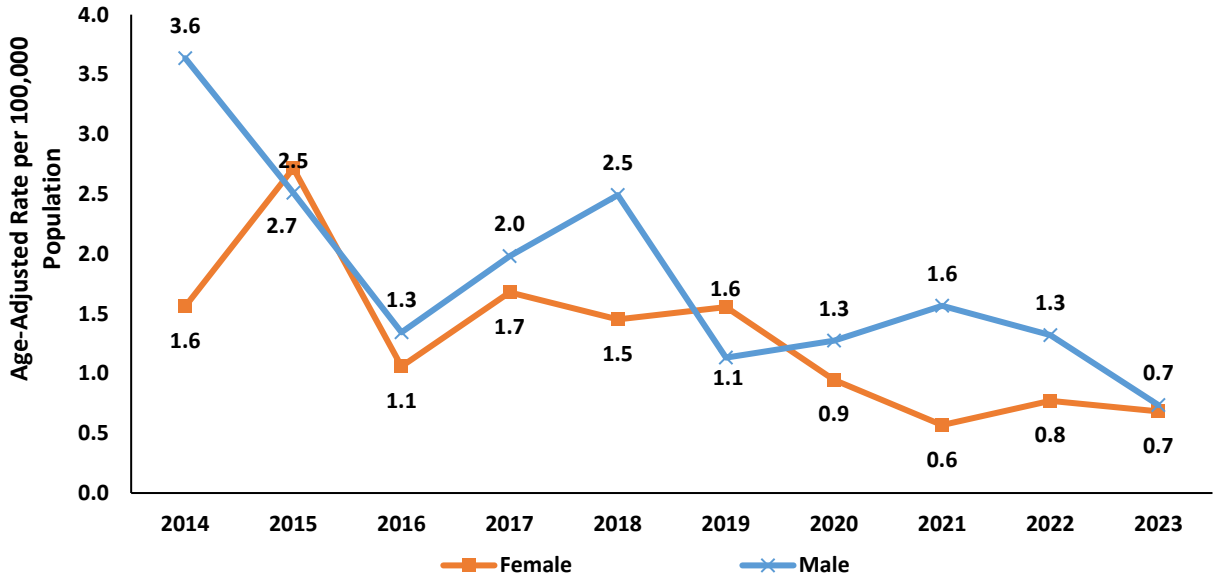
Figure 54. Alcohol Overdose Inpatient Admissions and Rates by Year, 2014-2023.



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

The inpatient admissions are generally comparable between female and male and the rate for both demographics have been decreasing concurrently.

Figure 55. Alcohol Overdose Inpatient Admission Rates by Year and Sex, 2014-2023.



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

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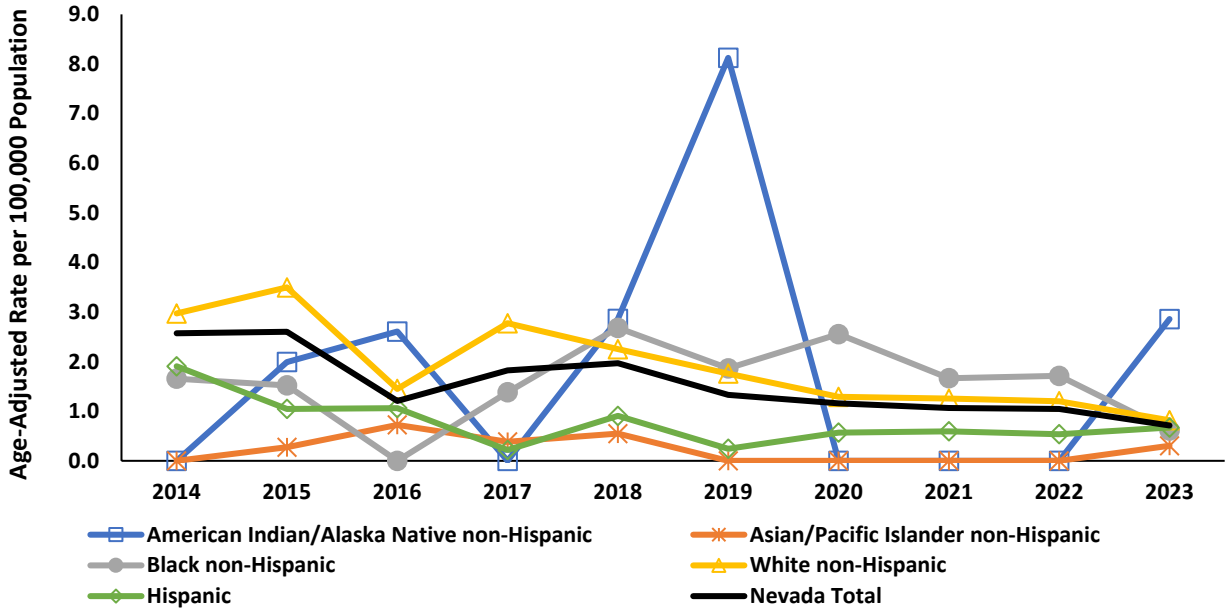
The rate for White non-Hispanics has consistently been slightly higher than the overall Nevada rate. The 2019 spike in the rate of admissions for American Indian/Alaska Native non-Hispanics is a result of high volatility due to the relatively low population of this demographic in the state and should not be taken as a significant change from the other years in the reporting period.

Figure 56. Alcohol Overdose Inpatient Admission Rates by Year and Race/Ethnicity, 2014-2023.



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

Chronic Alcohol Conditions

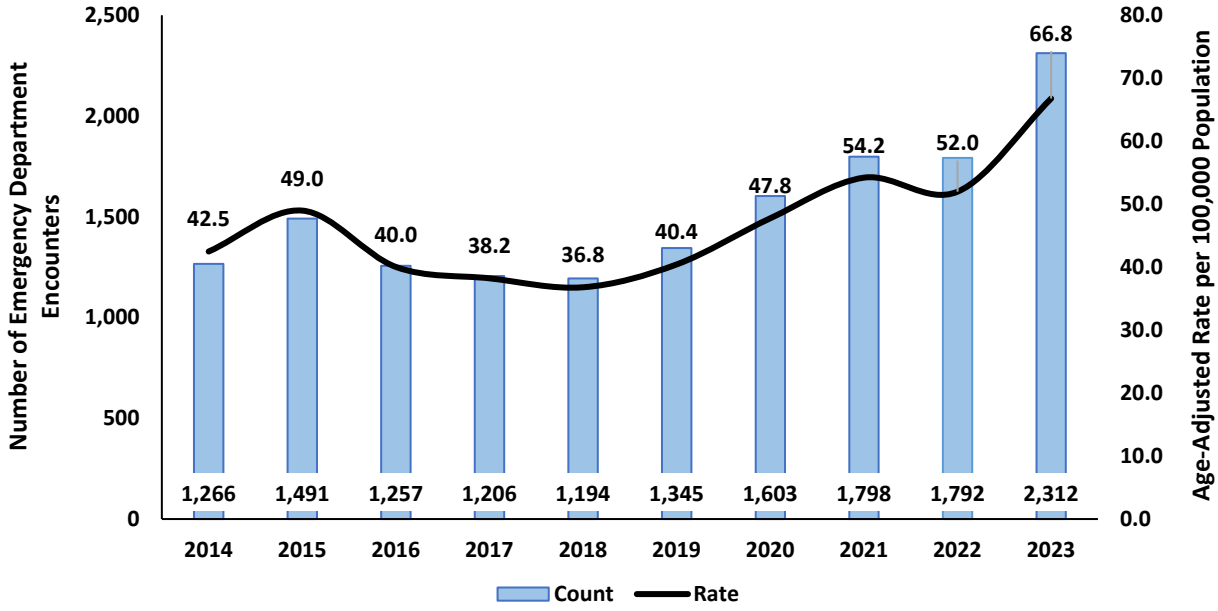
There are many chronic conditions and diseases that can occur from long-term misuse of alcohol and contribute to an increased mortality rate for those users. These include multiple types of cancer (throat, colon, liver, and breast cancer), heart disease, liver disease, high blood pressure, and strokes.

In contrast to the trends for alcohol overdoses, hospital encounters for chronic conditions related to alcohol use have consistently increased since 2016 with some notable high points in the years following the COVID-19 pandemic. Deaths attributable to diseases of chronic alcohol misuse also increased throughout the pandemic.

Hospital Emergency Department Encounters

Emergency department encounters for alcohol-related diseases have increased every year since 2018 with the rate increasing by nearly 80 percent in that time frame.

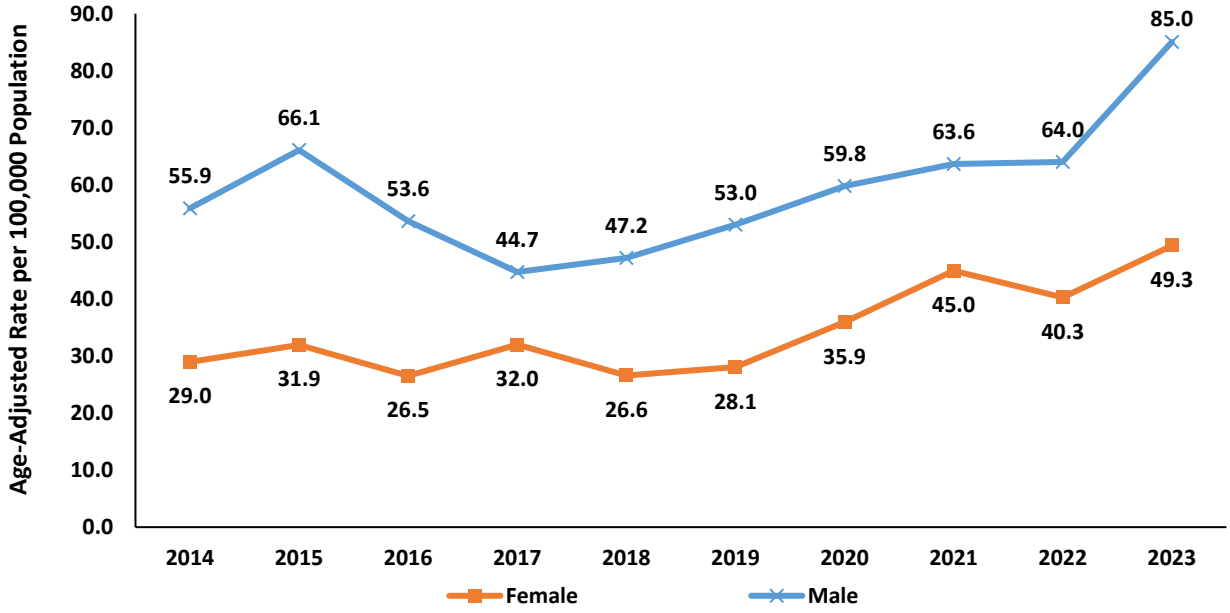
Figure 57. Chronic Alcohol Diseases Emergency Department Encounters and Rates by Year, 2014-2023.



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

The rates for both females and males have been increasing since 2018 and are consistently higher for men than for women. The rate of emergency department encounters for men was 85.0 per 100,000 population in 2023 which 70% higher than for women and over double the lowest rate for men (44.7 per 100,000 population in 2017).

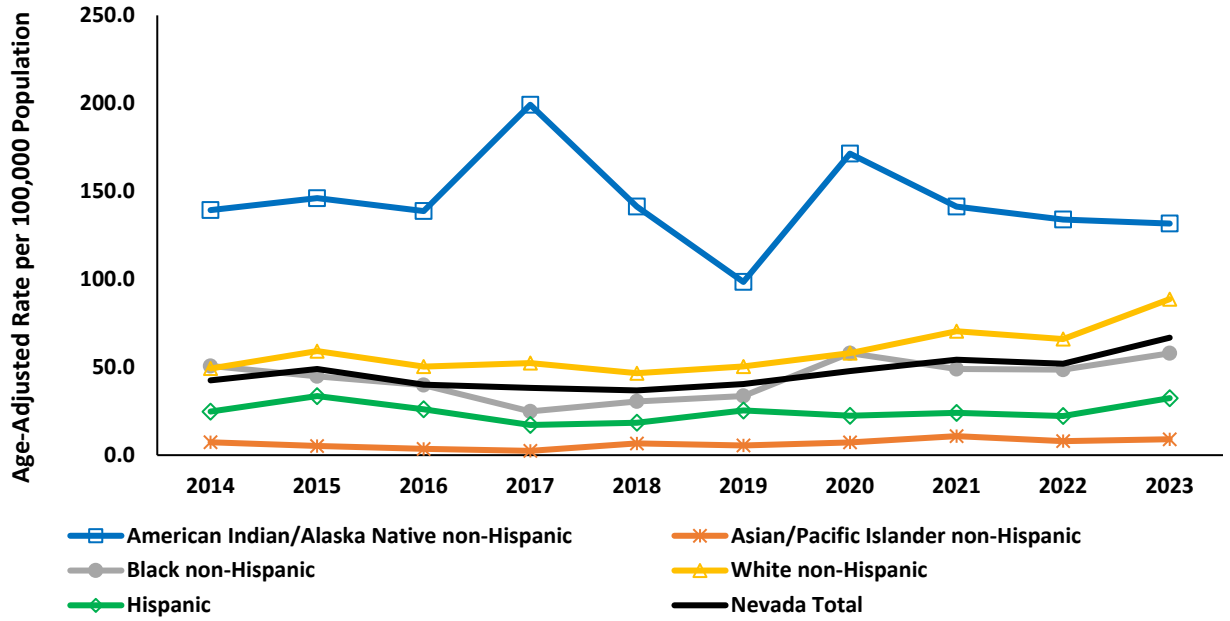
Figure 58. Chronic Alcohol Diseases Emergency Department Encounter Rates by Year and Sex, 2014-2023.



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

The rate of chronic alcohol diseases is significantly higher for American Indian/Alaska Native non-Hispanics than for any other racial/ethnic group in Nevada or the overall rate for the State. Indigenous people are disproportionately likely to be seen in the ER or admitted inpatient for treatment for these conditions compared to other groups. In 2017 the rate reached nearly 200 per 100,000 population, over 5 times higher than the Nevada total at the time.

Figure 59. Chronic Alcohol Diseases Emergency Department Encounter Rates by Year and Race/Ethnicity, 2014-2023.



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

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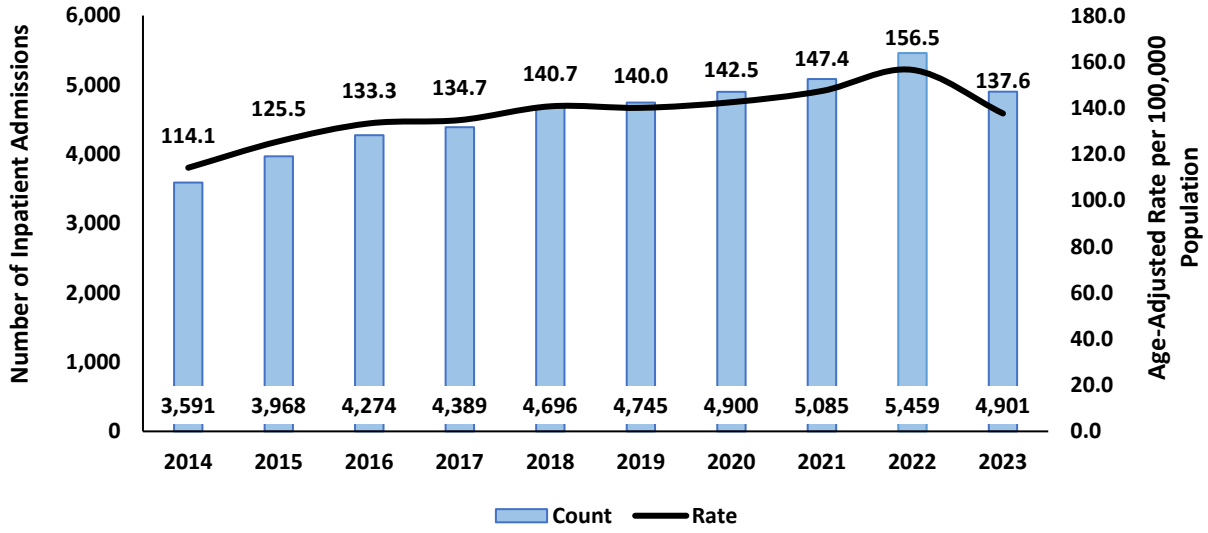
Hospital Inpatient Admissions

Following the trend seen in emergency departments, there has also been an increase over the reporting period in inpatient admissions for chronic conditions due to alcohol use. While the rate did drop noticeably in 2023, it should be noted that due to lag in hospital billing data, this number may change in future reporting.

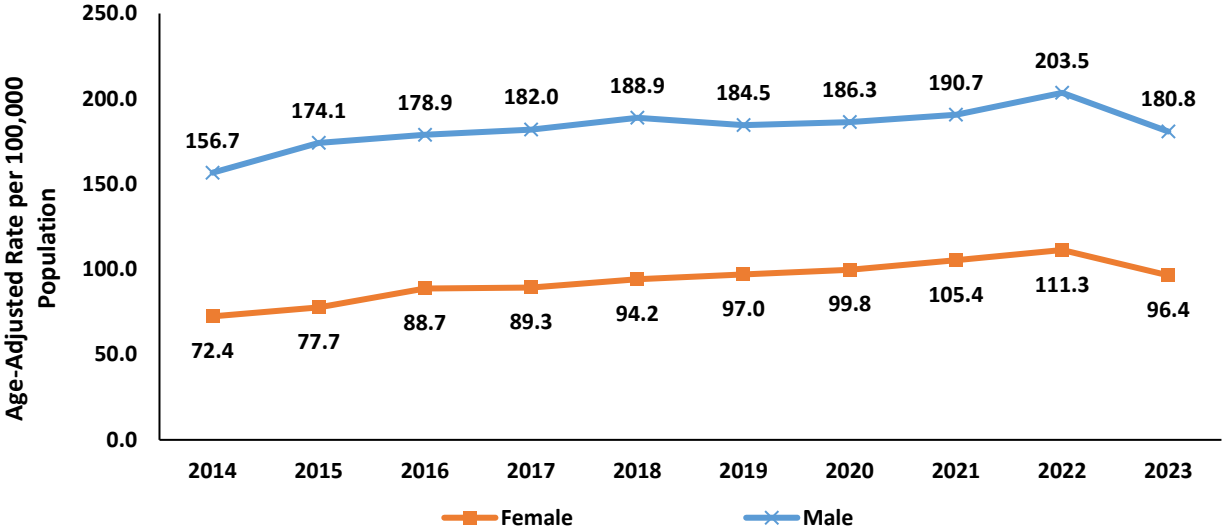
Figure 60. Chronic Alcohol Diseases Inpatient Admissions and Rates by Year, 2014-2023.



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

The rate for men has remained significantly higher than that of women for the duration of the reporting period, with admits being roughly twice as likely to be men.

Figure 61. Chronic Alcohol Diseases Inpatient Admission Rates by Year and Sex, 2014-2023.



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

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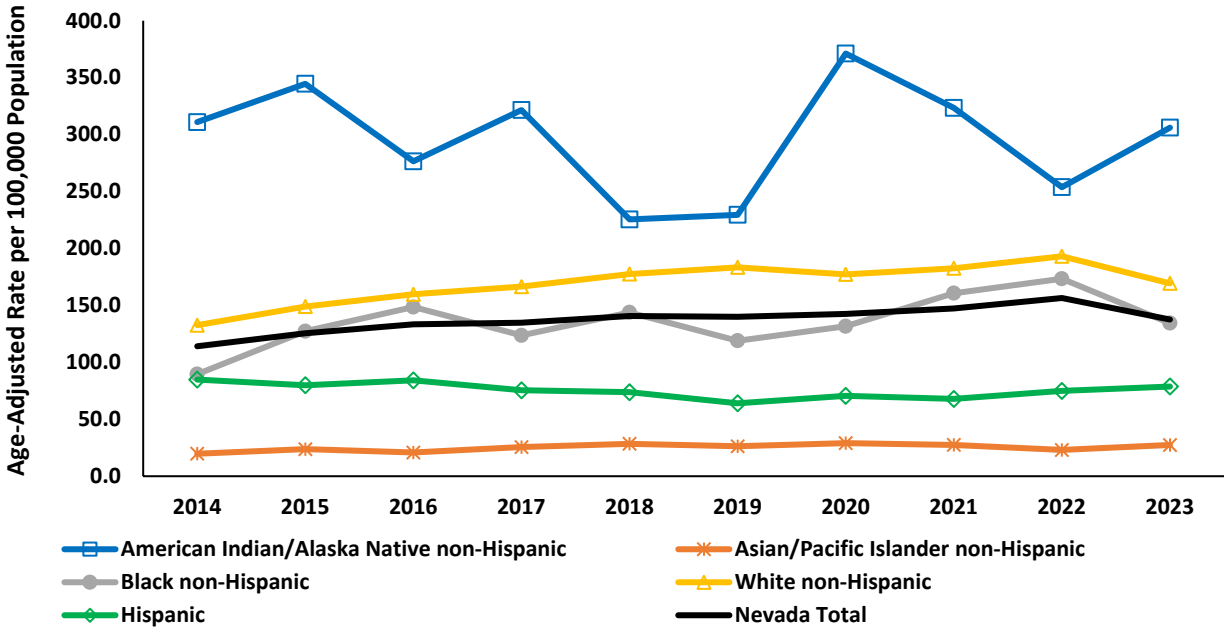
As with emergency department encounters, American Indian/Alaska Native non-Hispanics had a rate of inpatient admissions that was significantly higher than the total rate for Nevada in all years of the reporting period. The rate is also significantly higher than that of any other race/ethnicity demographic in all years except 2018 and 2019.

Figure 62. Chronic Alcohol Diseases Inpatient Admission Rates by Year and Race/Ethnicity, 2014-2023.

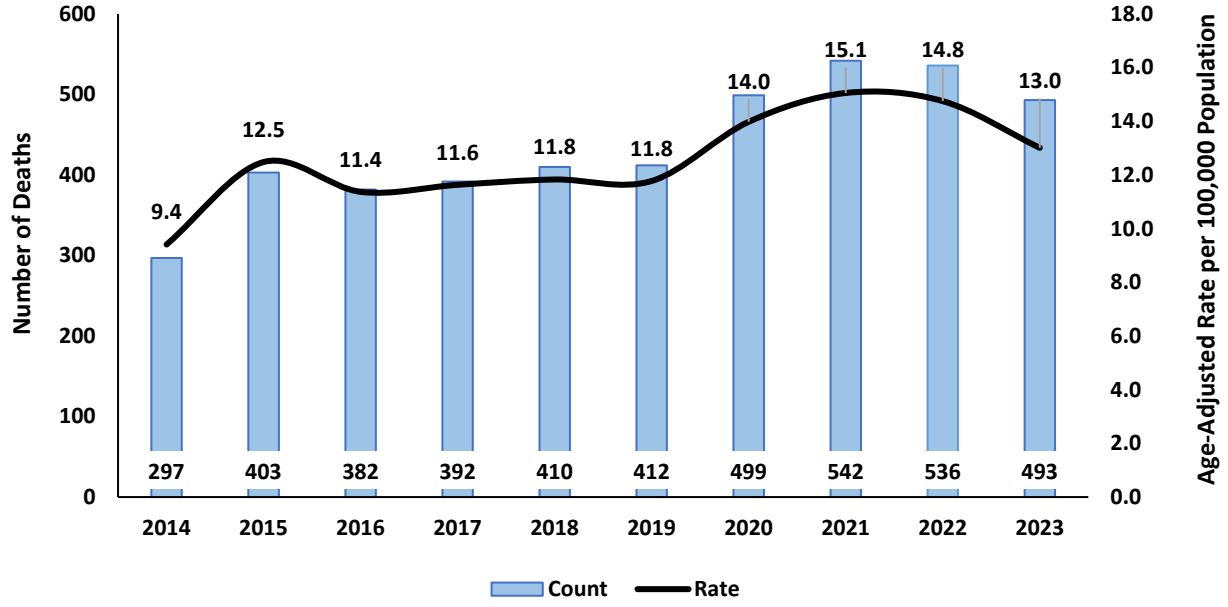


Source: Hospital Inpatient Billing.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Chronic Alcohol Diseases Deaths

Deaths related to chronic diseases from alcohol increased markedly in 2020 and the two years following the height of the COVID-19 pandemic.

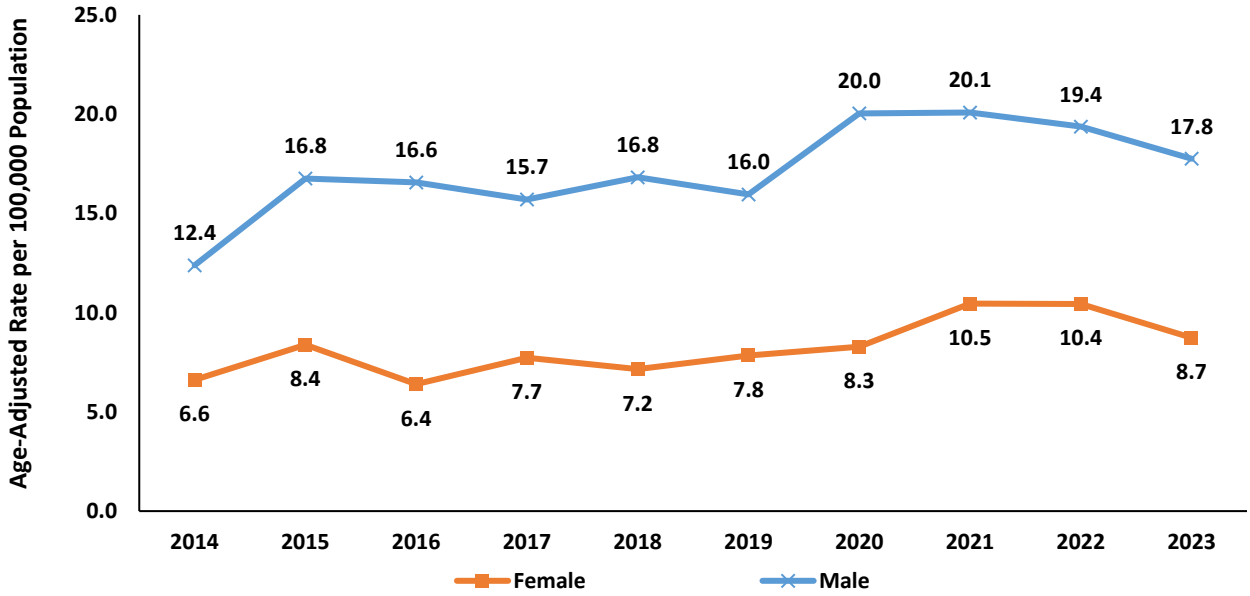
Figure 63. Chronic Alcohol Diseases Deaths and Rates, All Ages, Nevada Residents 2014-2023.



Source: Nevada Electronic Death Registry System.

As with hospital visits, the rate of deaths from these conditions is significantly higher for men than it is for women. In all years of the reporting period the rate for men was roughly double that of women.

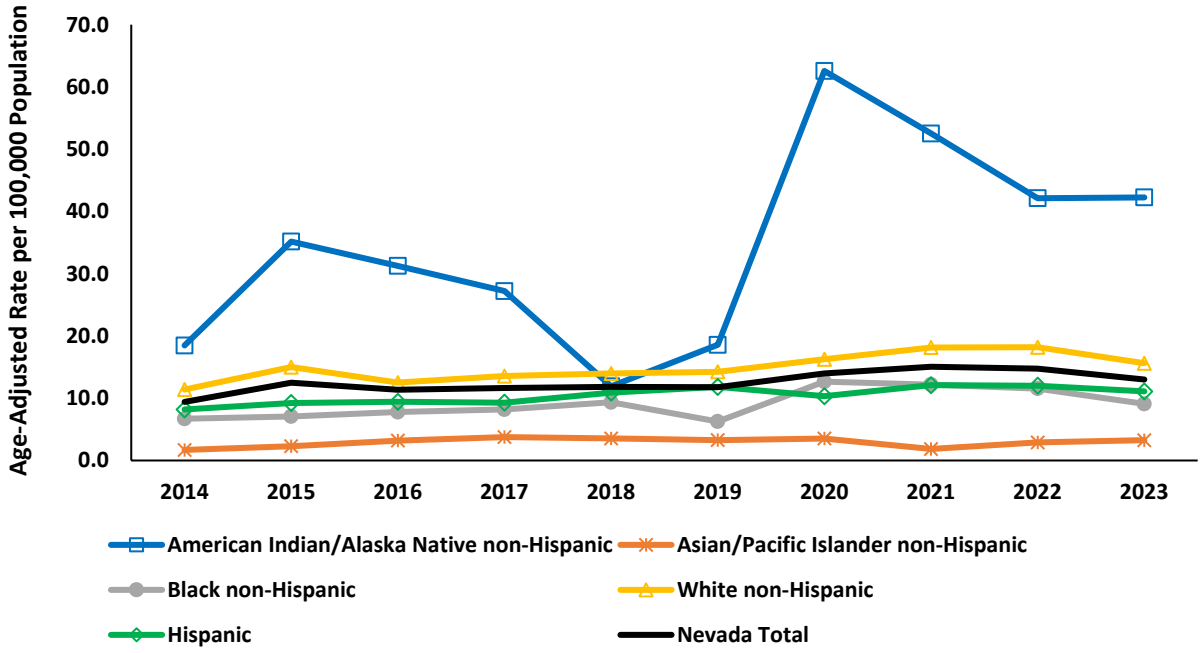
Figure 64. Chronic Alcohol Diseases Death Rates by Sex, Nevada Residents 2014-2023.



Source: Nevada Electronic Death Registry System.

While it should again be noted that the relatively small population of indigenous people in the Nevada population can lead to volatility in rates per 100,000, the rate of death for this demographic due to these chronic conditions is significantly higher than any other demographic or Nevada as a whole for the years 2020-20203.

Figure 65. Chronic Alcohol Diseases Death Rates by Race/Ethnicity, Nevada Residents 2014-2023.



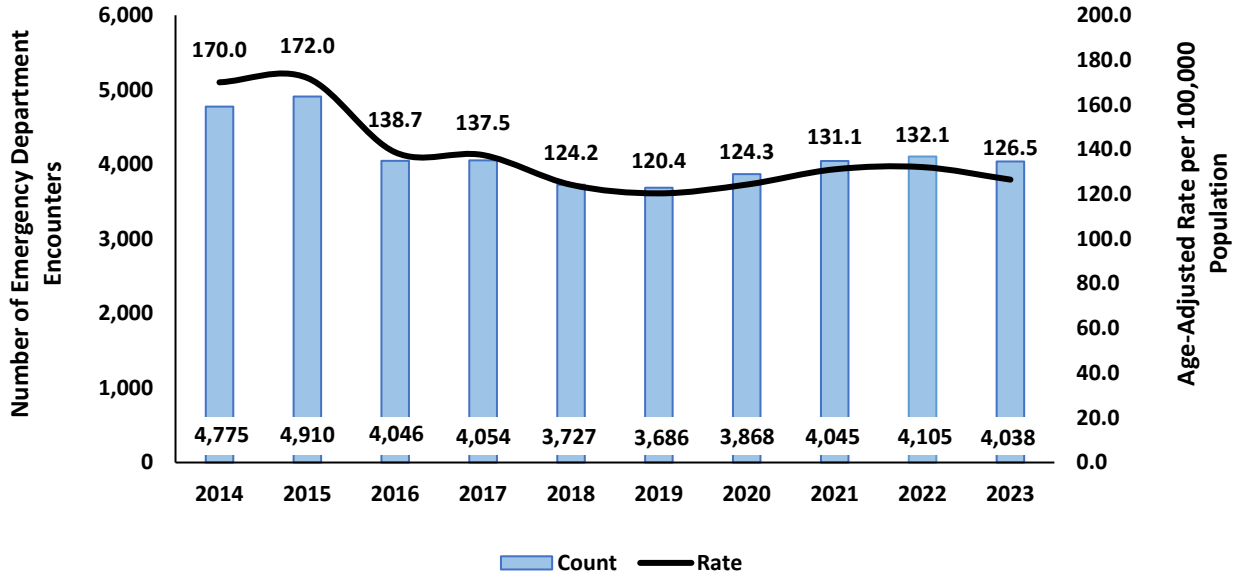
Source: Electronic Death Registry System.

Alcohol- and/or Drug-Related Overdoses

This section combines alcohol with all other substances including opioids, stimulants, hallucinogens, and other prescription medications to present a broader picture of overdose-related hospitalizations and deaths across Nevada. Much like the data presented above, there is an overall decreasing trend in in the rate of emergency department encounters and inpatient admissions while associated deaths have increased.

Hospital Emergency Department Encounters

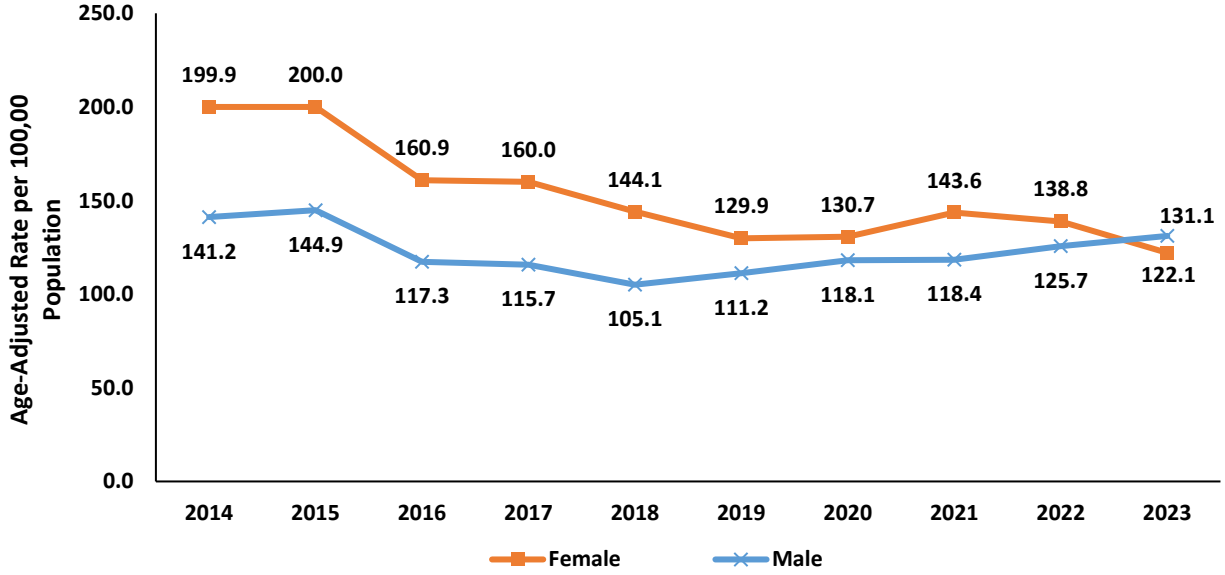
Figure 66. Alcohol- and/or Drug-Related Overdose Emergency Department Encounters and Rates by Year, 2014-2023.



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

From 2014 to 2022, females consistently had higher rates of alcohol- and drug-related overdose emergency department encounters compared to males. However, in 2023, males surpassed females with rates of 131.1 and 122.1 per 100,000 population, respectively.

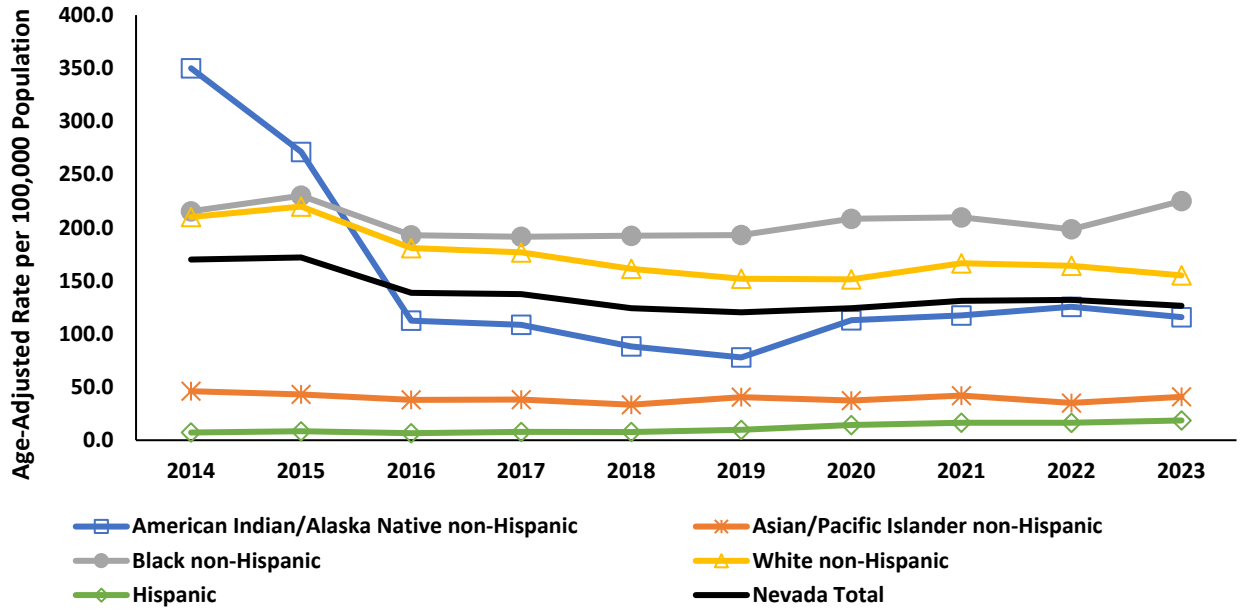
Figure 67. Alcohol- and/or Drug-Related Overdose Emergency Department Encounter Rates by Year and Sex, 2014-2023.



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

Black non-Hispanic and White non-Hispanic populations consistently had higher rates of alcohol- and drug-related overdose emergency department encounters compared to other race/ethnicities with the exception of 2014 and 2015, when American Indian/Alaska Native non-Hispanics had the highest rates.

Figure 68. Alcohol- and/or Drug-Related Overdose Emergency Department Encounter Rates by Year and Race/Ethnicity, 2014-2023.



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

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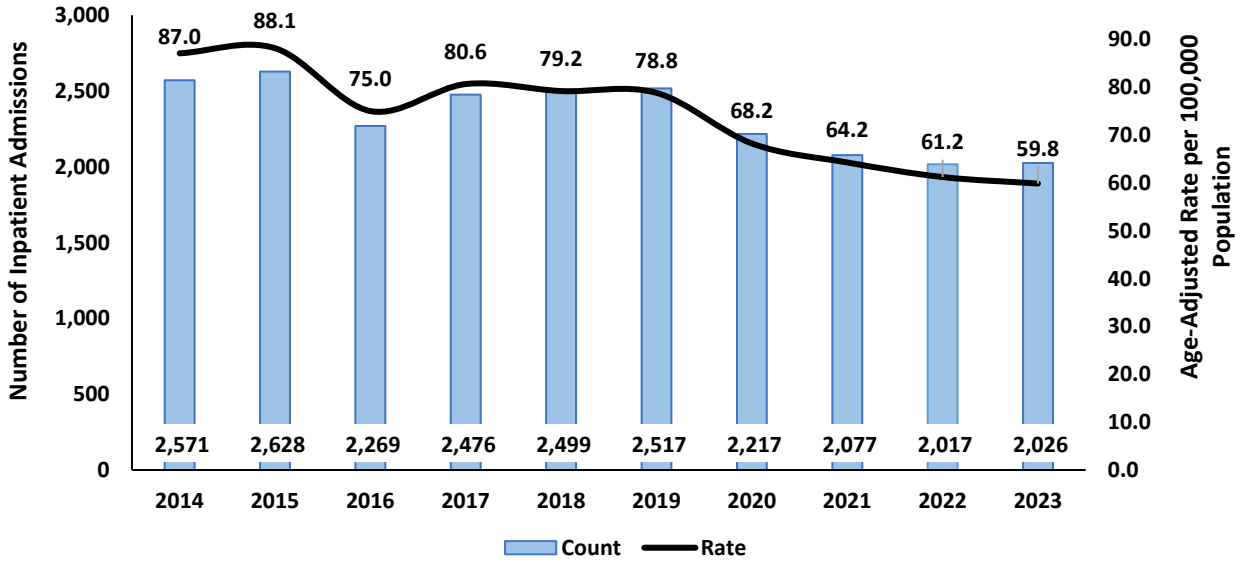
Hospital Inpatient Admissions

The rate of alcohol- and drug-related overdose inpatient admissions had experienced a downward trend since 2017, with the lowest rate occurring in 2023, at 59.8 per 100,000 population.

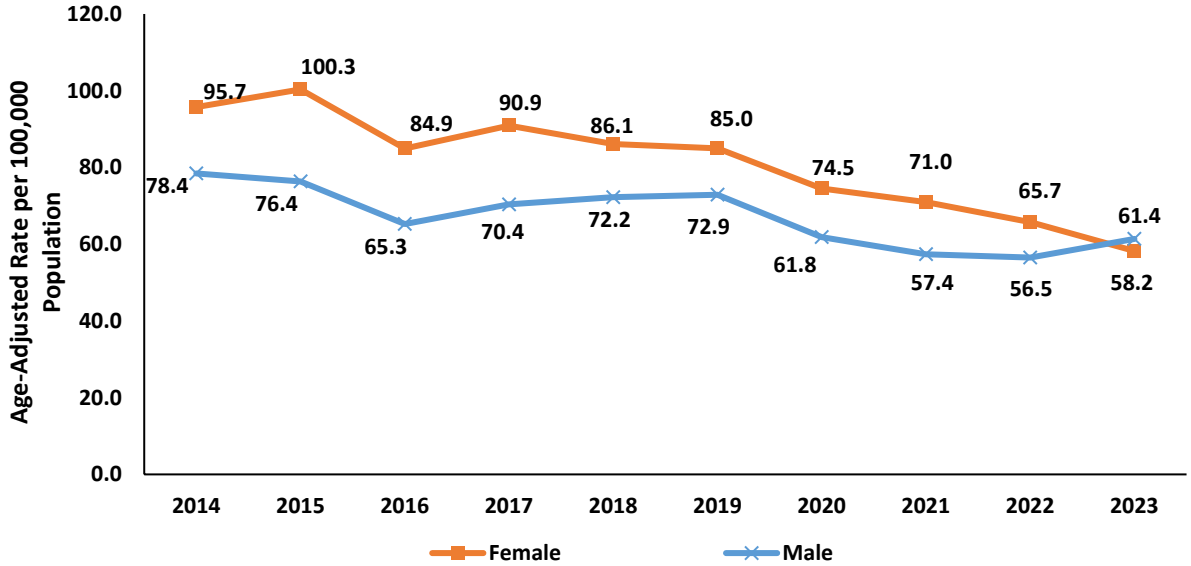
Figure 69. Alcohol- and/or Drug-Related Overdose Inpatient Admissions and Rates by Year, 2014-2023.



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

Following the same trend as emergency department encounters, females consistently had higher rates of alcohol- and drug-related inpatient admissions compared to males, with males surpassing females in 2023 (61.4 and 58.2 per 100,000 population, respectively).

Figure 70. Alcohol- and/or Drug-Related Overdose Inpatient Admission Rates by Year and Sex, 2014-2023.



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

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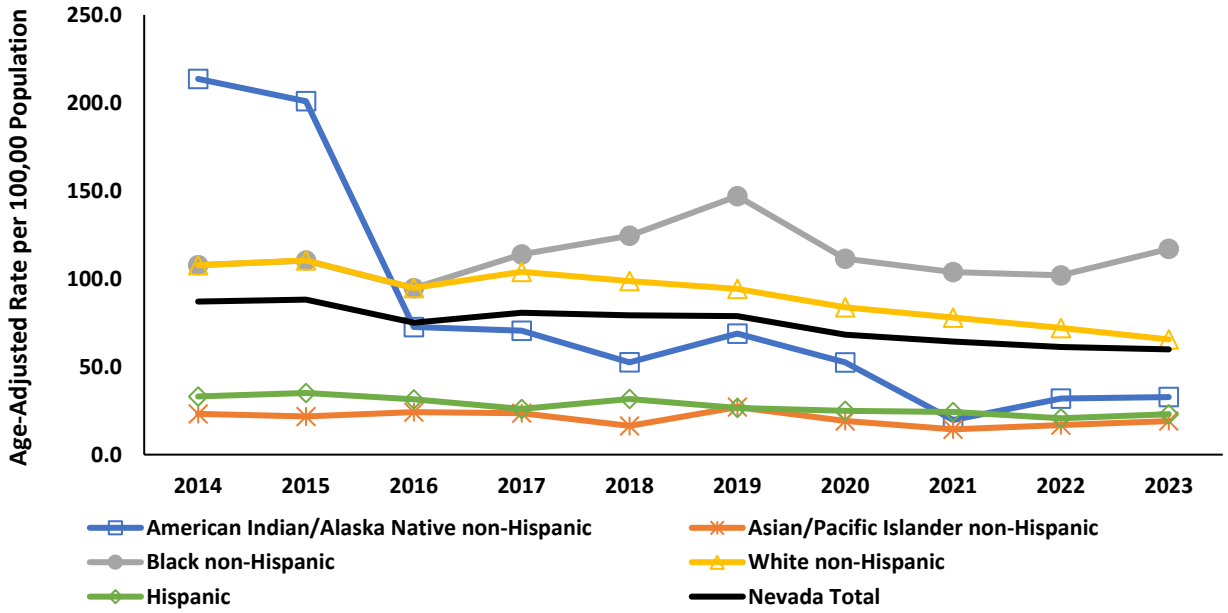
Following the same trend as emergency department encounters, Black non-Hispanic and White non-Hispanic populations consistently had higher rates of alcohol- and drug-related overdose inpatient admissions compared to other race/ethnicities with the exception of 2014 and 2015, when American Indian/Alaska Native non-Hispanics had the highest rates.

Figure 71. Alcohol- and/or Drug-Related Overdose Inpatient Admission Rates by Year and Race/Ethnicity, 2014-2023.

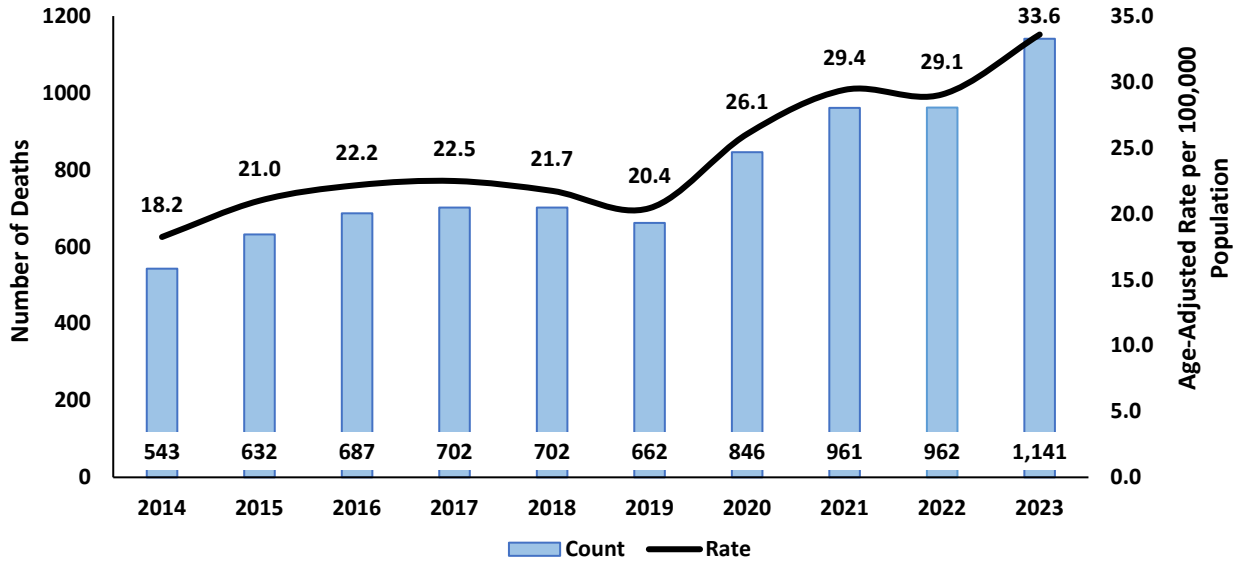


Source: Hospital Inpatient Billing.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Alcohol- and/or Drug-Related Overdose Deaths

This section includes deaths of all ages where alcohol overdose or drug overdose is listed as the primary cause of death. In 2023, there were 1,141 such deaths in Nevada. Both the number of these deaths and the age-adjusted rate have been increasing since 2019.

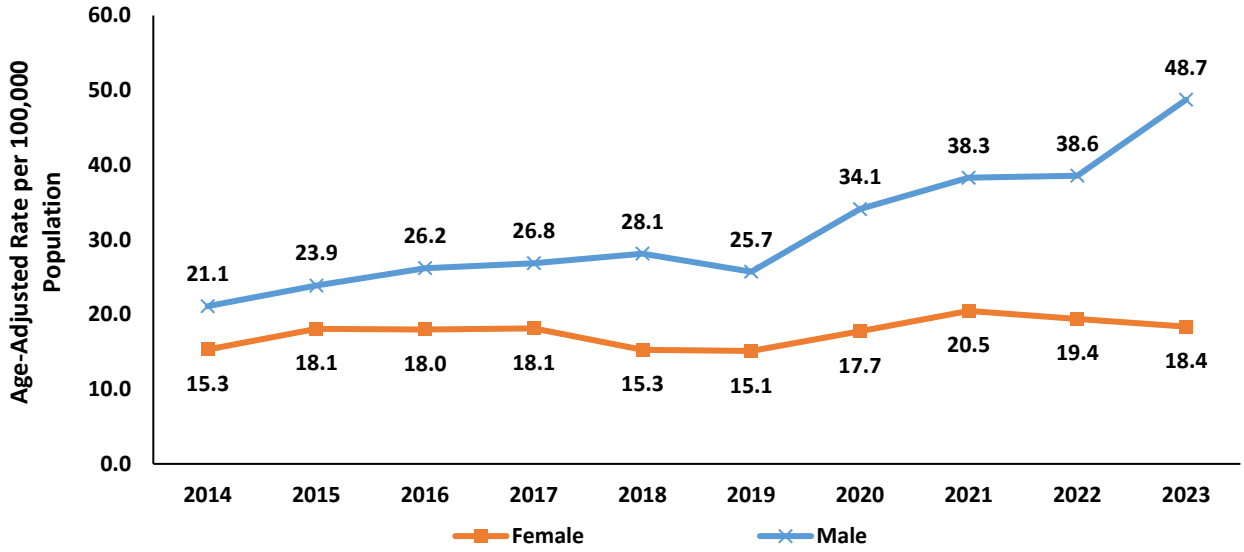
Figure 72. Alcohol- and/or Drug-Related Overdose Deaths and Rates, Nevada Residents 2014-2023.



Source: Electronic Death Registry System.

A notable disparity in overdose death rates has emerged between males and females. Historically, males have experienced higher overdose death rates compared to females. Between 2019 and 2023 the increase in the rate for males has outpaced that of females.

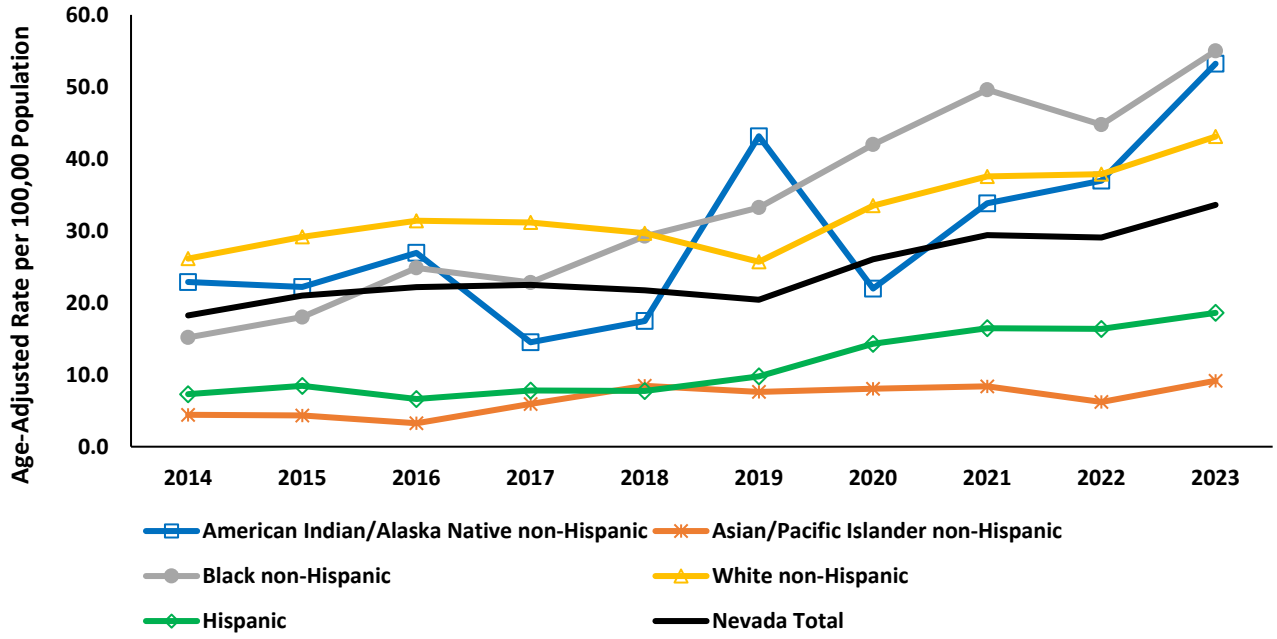
Figure 73. Overdose Death Rates by Sex, Nevada Residents 2014-2023.



Source: Electronic Death Registry System.

All race/ethnicities experienced an overdose death rate increase from 2019-2023, with the exception of the Asian/Pacific Islander non-Hispanic population. The rates among White non-Hispanics have been higher than the Nevada total rates for all years and for Black non-Hispanics since 2016.

Figure 74. Overdose Death Rates by Race/Ethnicity, Nevada Residents 2014-2023.



Source: Electronic Death Registry System.

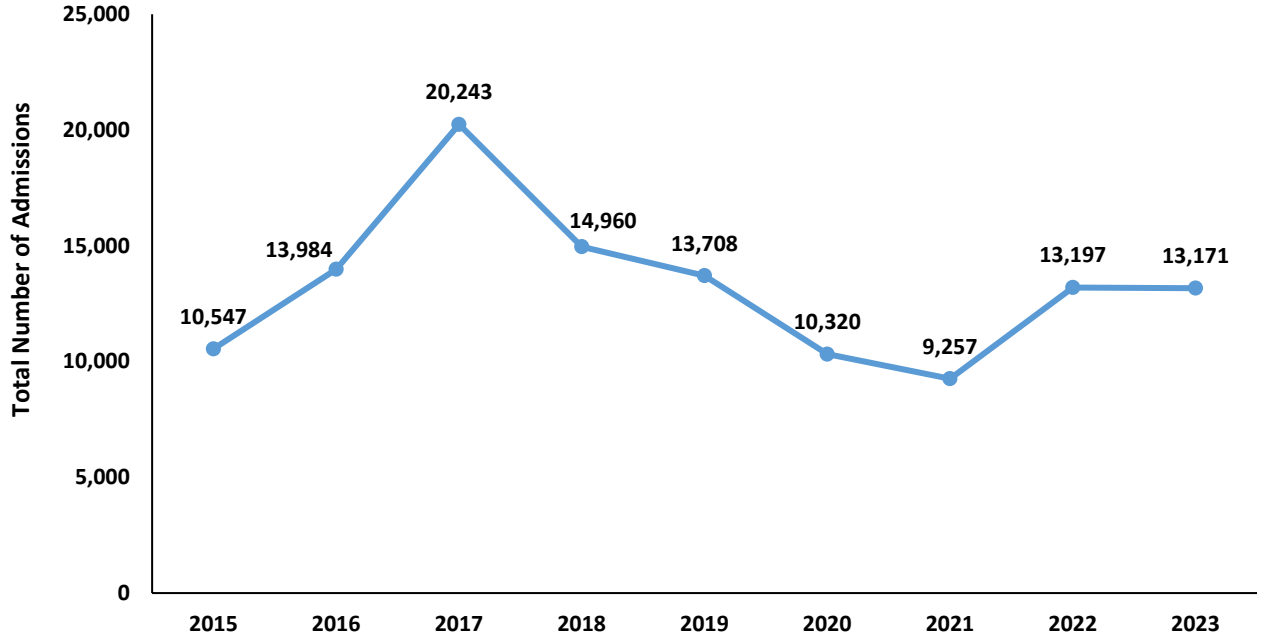
Substance Use Treatment Centers

Treatment Episode Data Sets (TEDS) are a compilation of demographic and drug history information on adult 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.

The number of admissions to Nevada state-funded substance use treatment facilities peaked in 2017, decreased through 2021, and increased through 2022.

In 2021, Medicaid reduced copayment requirements for opioid use disorder (OUD) medications and expanded coverage to include all states covering buprenorphine, oral naltrexone, and injectable naltrexone. Additionally, utilization management policies, such as quantity limits and prior authorizations, were decreased. These changes from 2017 through 2021, along with policies from the Affordable Care Act, the Obama administration, and the 2018 SUPPORT Act, have significantly expanded Medicaid's role in substance use disorder (SUD) care[7]. Due to the prevalence of Medicaid utilization at these facilities there was a notable increase in admissions in 2022 and 2023.

Figure 75. Total Number of Admissions in Nevada State-Funded Substance Abuse Treatment Facilities, 2015-2023.



Data Source: Treatment Episode Data Sets.

Among all insured individuals admitted to state-funded substance use treatment facilities, 67% are covered by Medicaid or Medicare. Of this group, Medicaid accounts for 96% of the total Medicaid/Medicare coverage. This utilization rate is in line with expectations as TEDS data represents state-funded safety-net services.

[7] SAMHSA - Medicaid Coverage of Medications, OUD)

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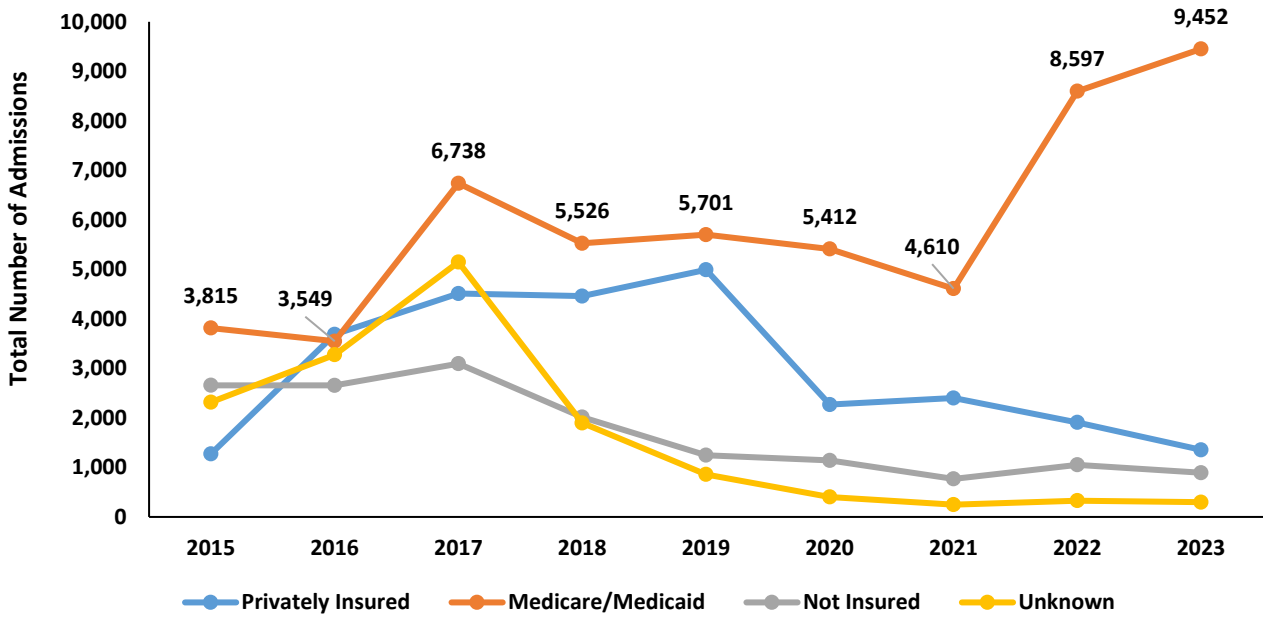
Figure 76. Insurance Coverage for Individuals Admitted in a Nevada State-Funded Substance Use Treatment Facility, 2015-2023.

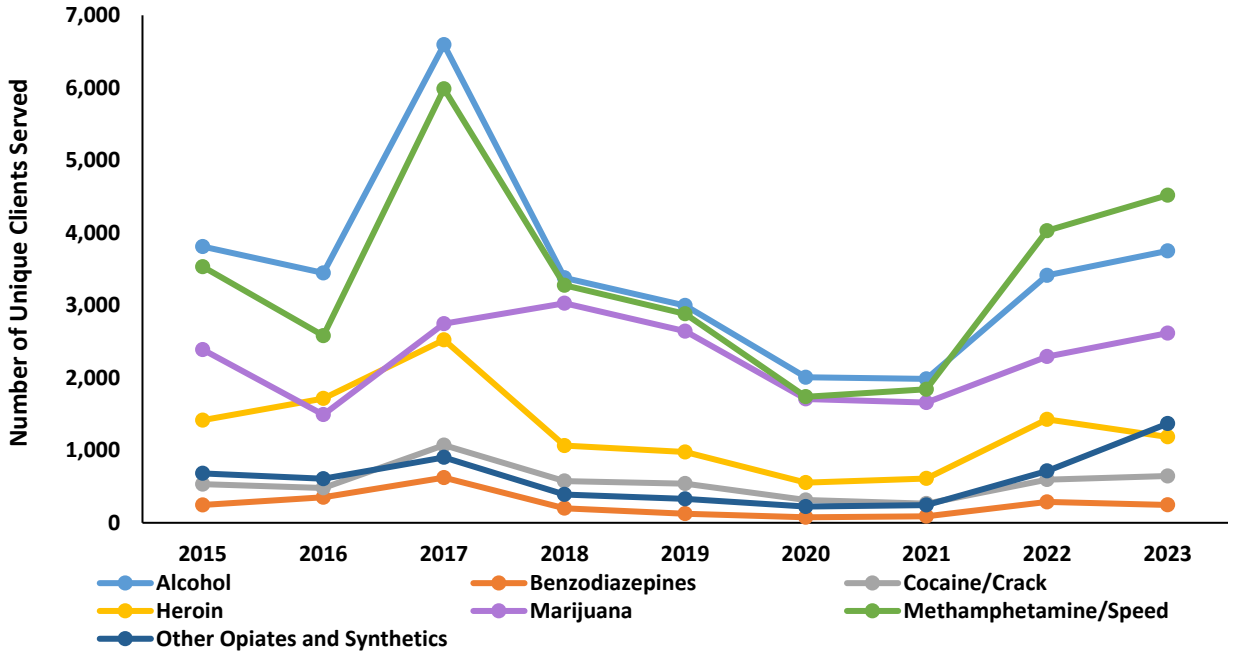


Data Source: Treatment Episode Data Sets.

Alcohol and methamphetamine/speed were the most frequently reported primary substances among individuals admitted to a Nevada state-funded substance use treatment facility from 2015-2023, followed by marijuana.

These counts of primary substance at admission are not mutually exclusive as clients could be admitted with current use of multiple substances.

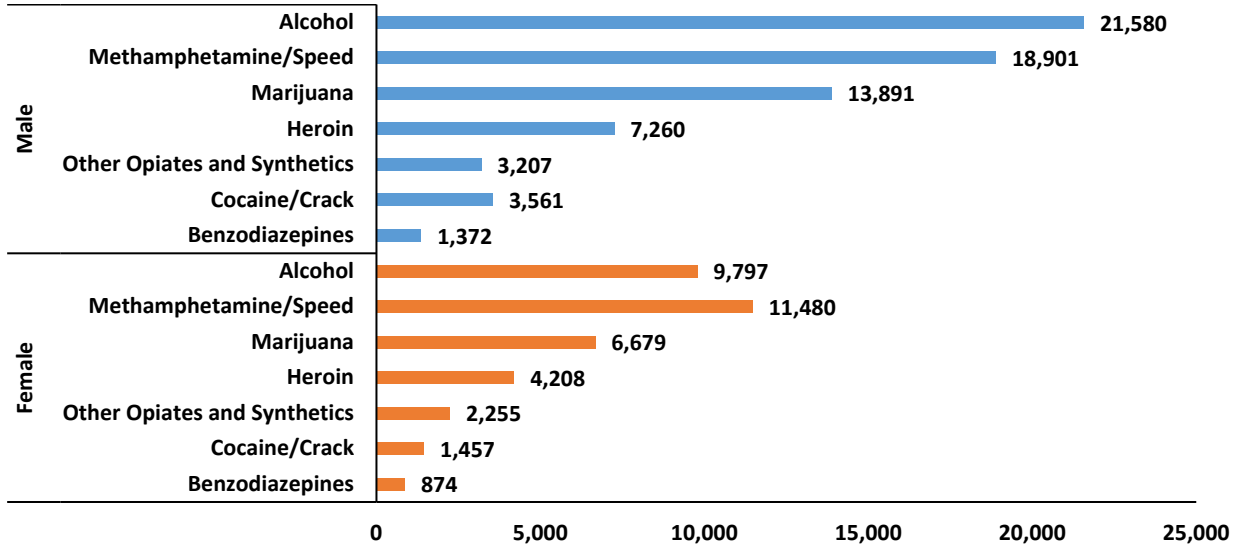
Figure 77. Primary Substance Used for Clients at Nevada State-Funded Adult Substance Abuse Treatment Centers, 2015-2023.



Data Source: Treatment Episode Data Sets.

Alcohol was the primary substance reported for males admitted from 2015-2023. For females methamphetamine/speed were the primary substances reported in the same timeframe. This is in comparison to national TEDS data from 2018-2022 where the primary substances were alcohol followed by heroin. This indicates that methamphetamines have a higher utilization in Nevada compared to the U.S.

Figure 78. Primary Substance Used for Clients at Nevada State-Funded Adult Substance Abuse Treatment Centers by Gender, 2015-2023.

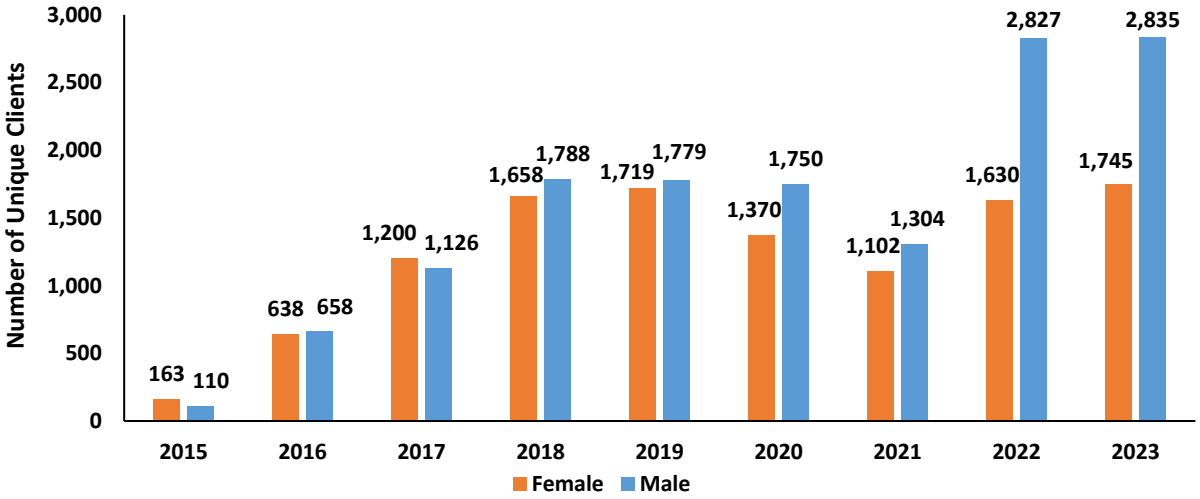


Data Source: Treatment Episode Data Sets.

Co-occurring mental health disorders are frequently observed among individuals admitted to substance use treatment facilities. As illustrated in the figure below, there has been a notable increase in the number

of admissions involving individuals with co-occurring disorders, particularly among males. The number of male admissions with co-occurring mental health disorders has more than doubled, increasing from 1,126 in 2017 to 2,835 in 2023.

Figure 79. Individuals Admitted to a Nevada State-Funded Substance Use Treatment Facility with a Co-occurring Mental Health Disorder by Sex, 2015-2023.



Data Source: Treatment Episode Data Sets.

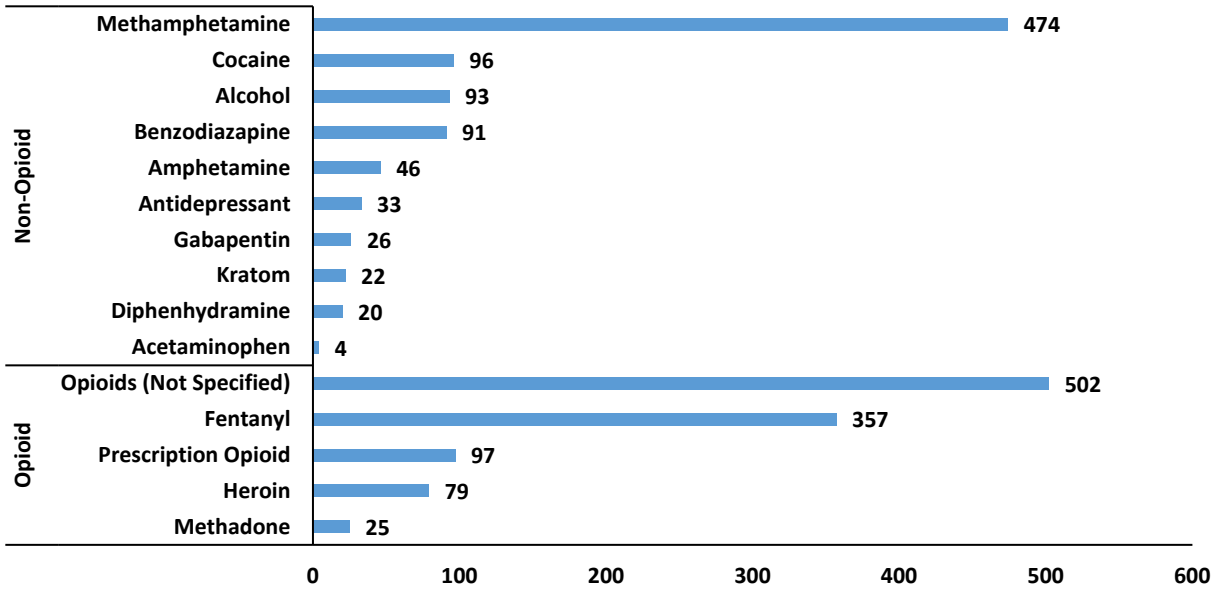
SUDORS

The State Unintentional Drug Overdose Reporting System (SUDORS) tracks data related to fatal drug-involved overdoses in Nevada. SUDORS uses death certificates and coroner/medical examiner reports (including post-mortem toxicology testing results) to capture detailed information on toxicology, death scene investigations, route of drug administration, and other risk factors that may be associated with a fatal overdose.

Of the 836 total drug overdose deaths of unintentional/undetermined intent among Nevada residents in 2022, decedents were mostly male, white, and were a high school graduate or had a completed GED.

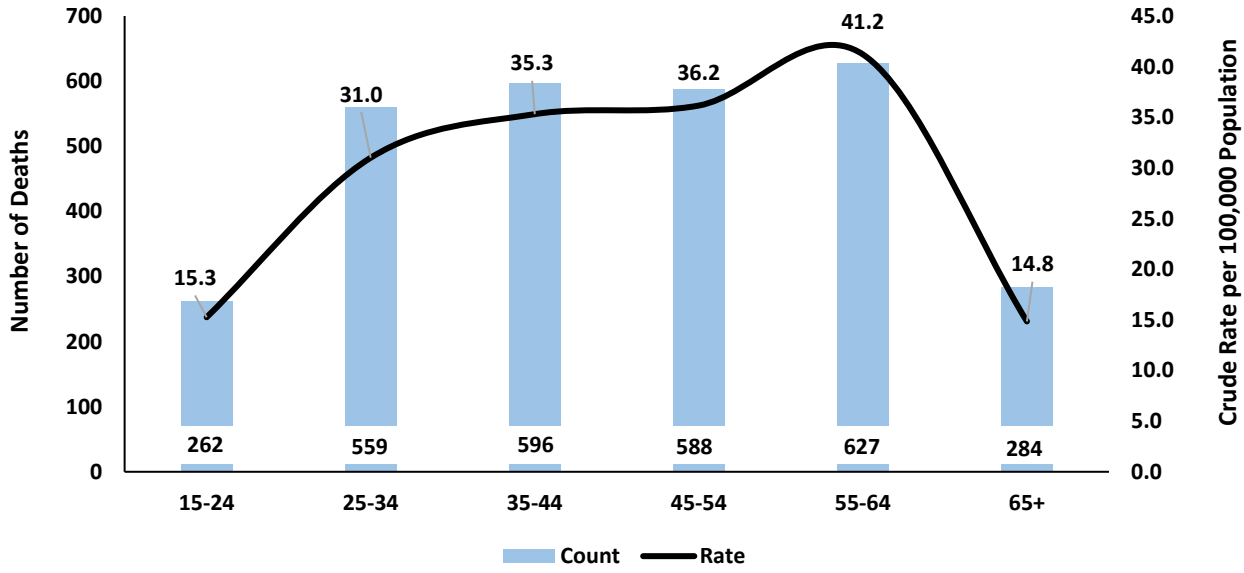
Overdose deaths have risen from 510 in 2019 to 836 in 2022. Opioids were listed in the cause of death for over half of cases (type not specified, 60%). Fentanyl was listed in about 43% of cases, prescription opioids were listed in the cause of death in 11.6% of cases, heroin was listed in about 9% of cases. Methamphetamine was also listed as one of the substances in the cause of death in over half of cases reported.

Figure 80. Substances Listed in the Cause of Death Among Unintentional/Undetermined Overdose Deaths, Nevada Residents, 2022.



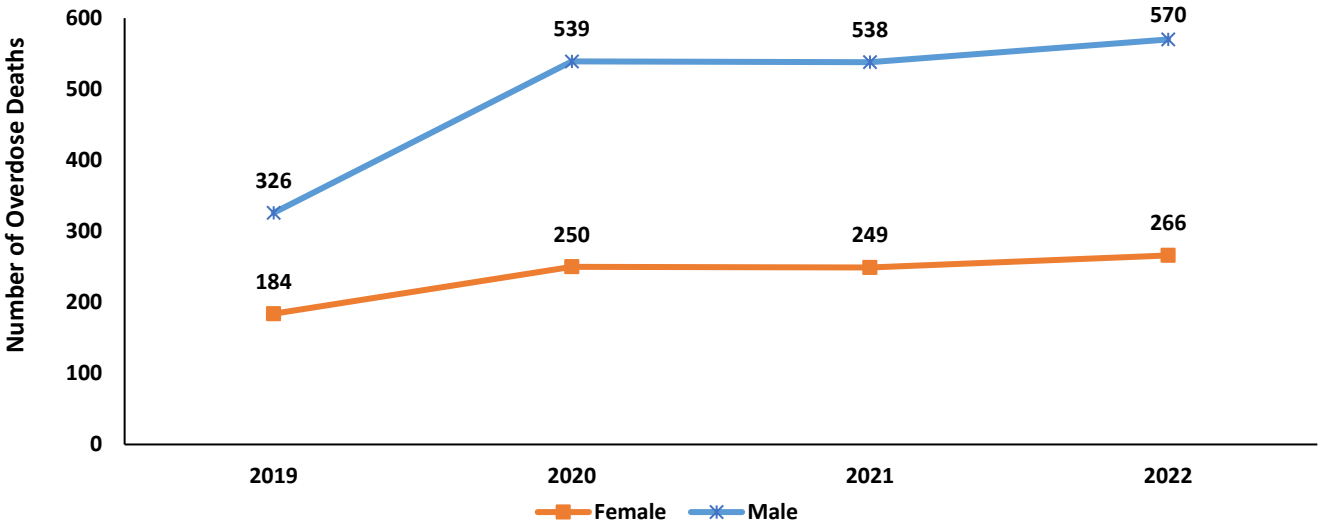
Source: SUDORS.

Figure 81. Total Number of Unintentional/Undetermined Overdose Deaths and Rates by Age Group, Nevada Residents, 2019-2022.



Source: SUDORS.

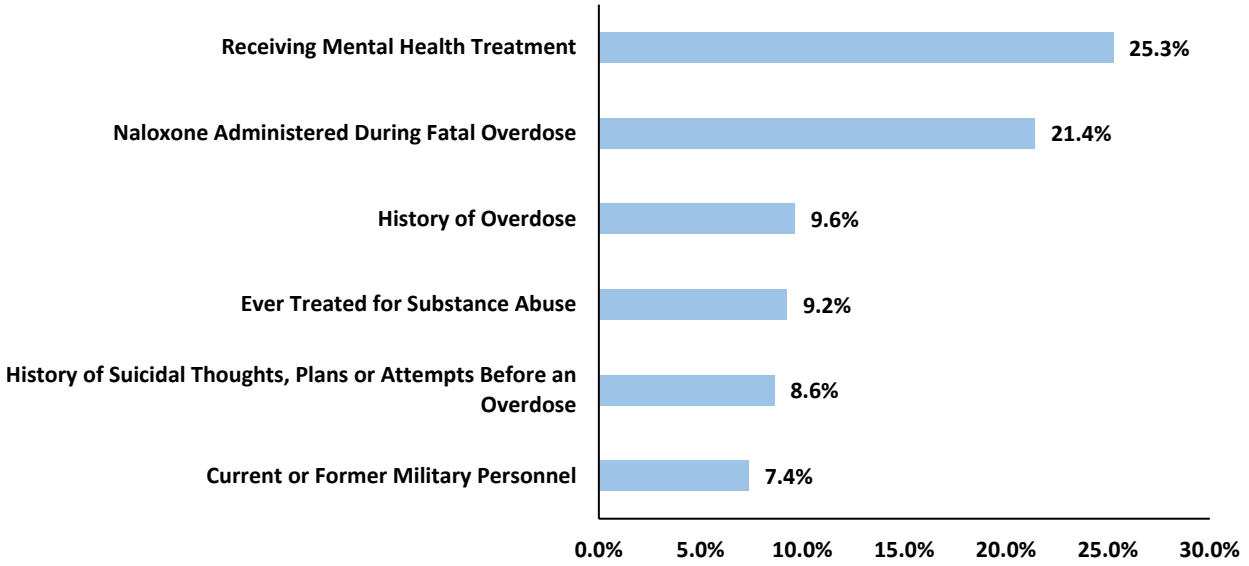
Figure 82. Total Number of Unintentional/Undetermined Overdose Deaths by Sex, Nevada Residents, 2019-2022.



Source: SUDORS.

Over 25% of persons in the SUDORS dataset had been receiving mental health treatment services, and 21% had naloxone administered during the fatal overdose. About 9% of cases had a documented prior history of overdose.

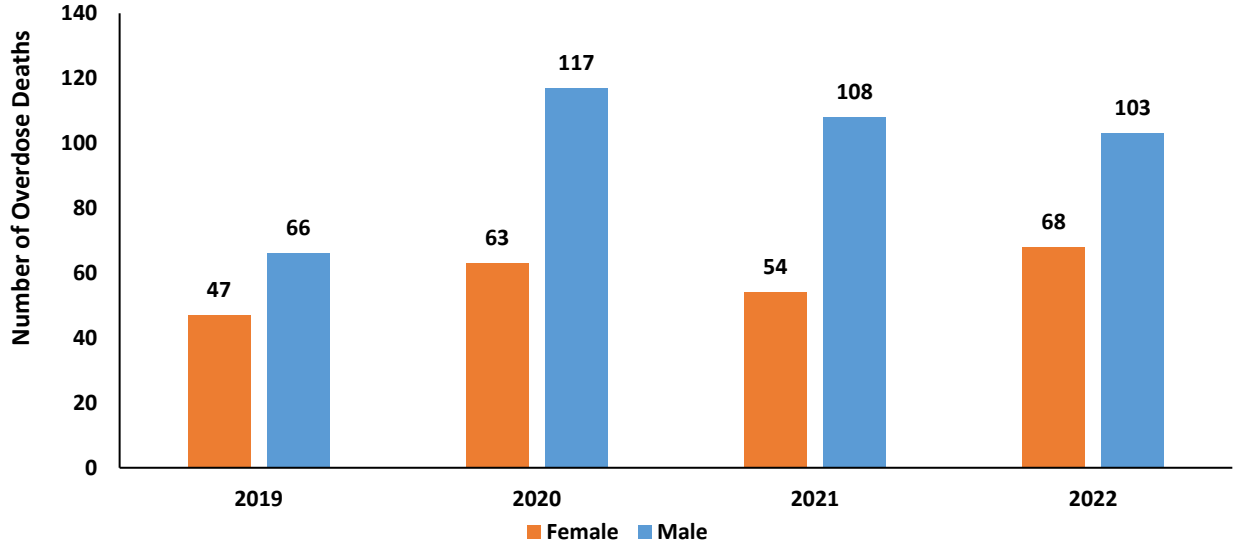
Figure 83. Circumstances Preceding Unintentional/Undetermined Overdose Deaths, Nevada Residents, 2019-2022.



Source: SUDORS.
Chart scaled to 30.0% to display differences among groups.

Narcan is a brand name for naloxone, a medication designed to quickly reverse the effects of an opioid overdose. It works by attaching to the same brain receptors that opioids, such as heroin, fentanyl, or prescription painkillers, target, thereby reversing life-threatening symptoms like slowed or halted breathing. Narcan can be administered via injection or nasal spray, and it is commonly used by first responders, healthcare professionals, and even bystanders during emergencies. By counteracting the dangerous respiratory depression caused by opioids, Narcan can help save lives. Males were about 1.5 times more likely have naloxone administered at the scene before dying from an unintentional/undetermined overdose compared to females from 2019-2022.

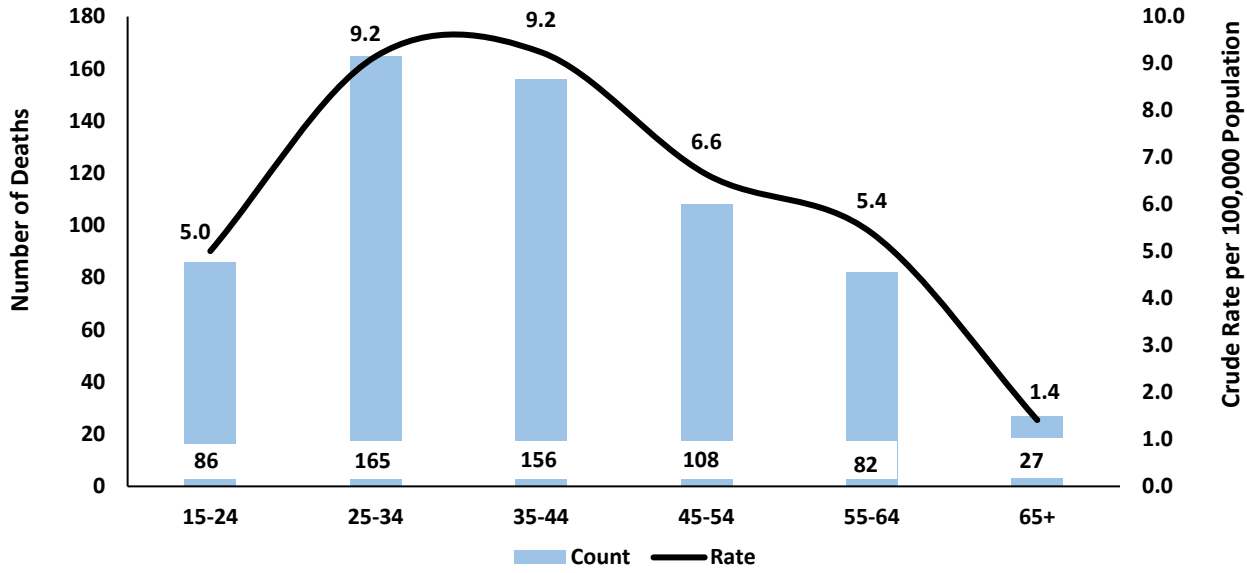
Figure 84. Naloxone Administered at the Scene Among Unintentional/Undetermined Overdoses Deaths by Sex, Nevada Residents, 2019-2022.



Source: SUDORS.

The combined 25-44 age groups comprise the highest number of deaths and the highest rate of naloxone administered.

Figure 85. Naloxone Administered Among Unintentional/Undetermined Overdose Deaths by Rate and Age Group, Nevada Residents, 2019-2022.



Source: SUDORS.

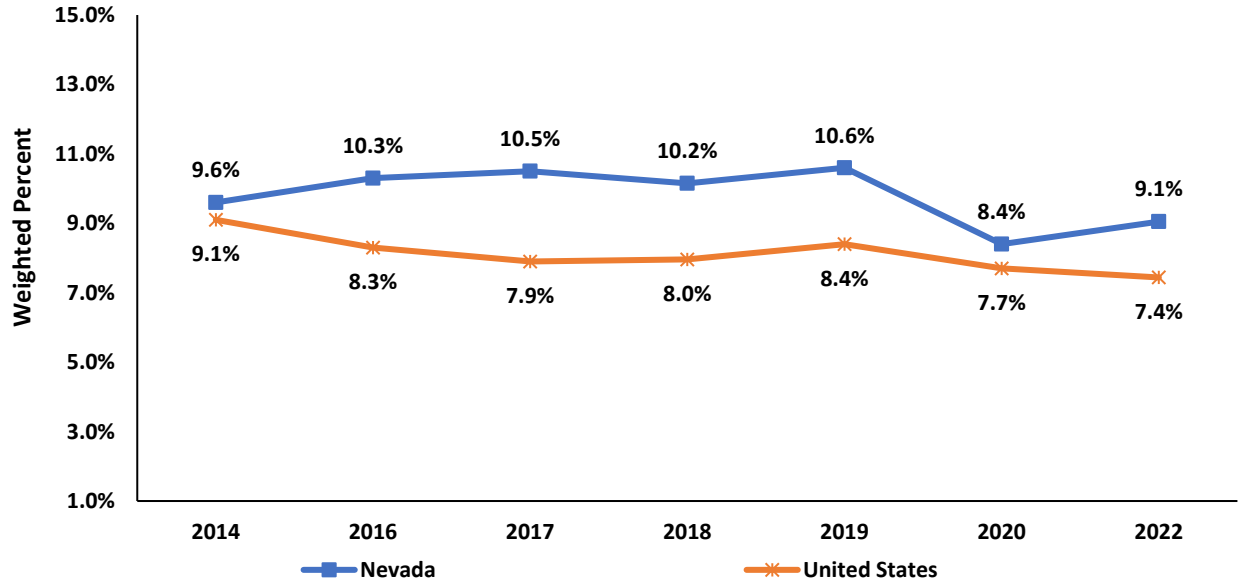
National Survey on Drug Use and Health

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. For more information about the national survey, please go to the following website: SAMHSA NSDUH.

According to SAMHSA, "because of methodological changes in 2021, estimates from this year should not be compared with previous years". Therefore, 2021 data have been excluded from this report. Please see SAMHSA NSDUH 2021 Survey Release for more information.

Illicit drug use rates by adolescents in Nevada have remained steady throughout the reporting period with 9.1% of adolescents reporting illicit drug use in 2022. This is higher than the illicit drug use rate among adolescents in the United States in 2020 (7.4%).

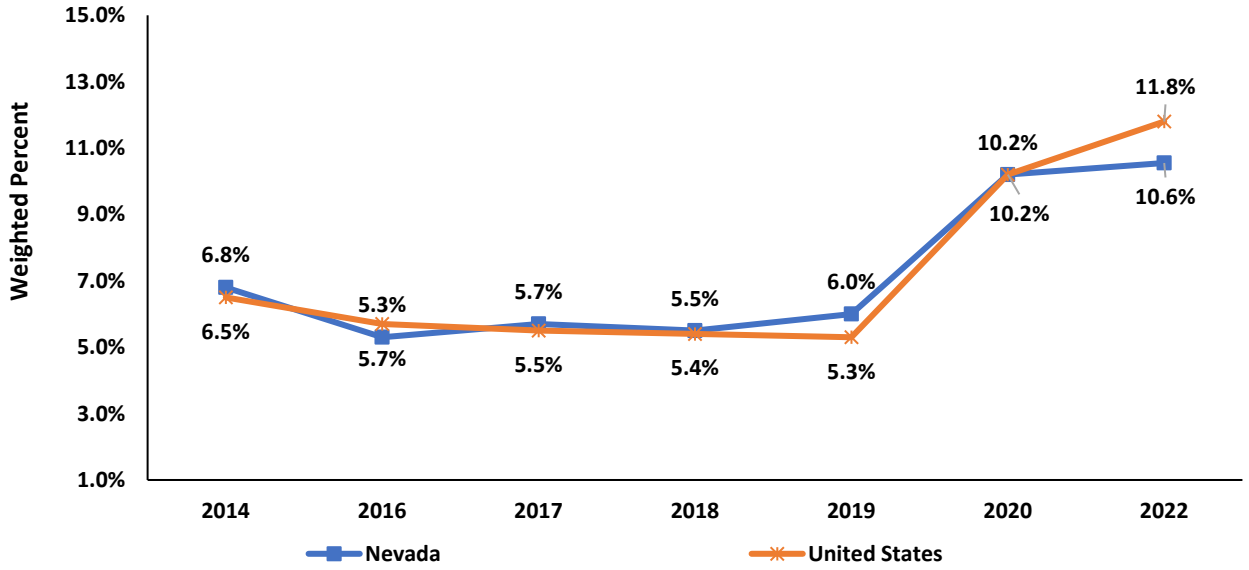
Figure 86. Illicit Drug Use Among Adolescents in the Past Month, Aged 12-17, Nevada and the United States, 2014-2022.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health.
Chart scaled to 15.0% to display differences among groups.

Alcohol use disorder among adolescents and adults in the past year increased from 10.2% in 2020 to 10.6% in 2022 for Nevada. This increase is also seen in the United States from 10.2% in 2020 to 11.8% in 2022. For both Nevada and the nation, the percents in 2022 are the highest in the reporting period.

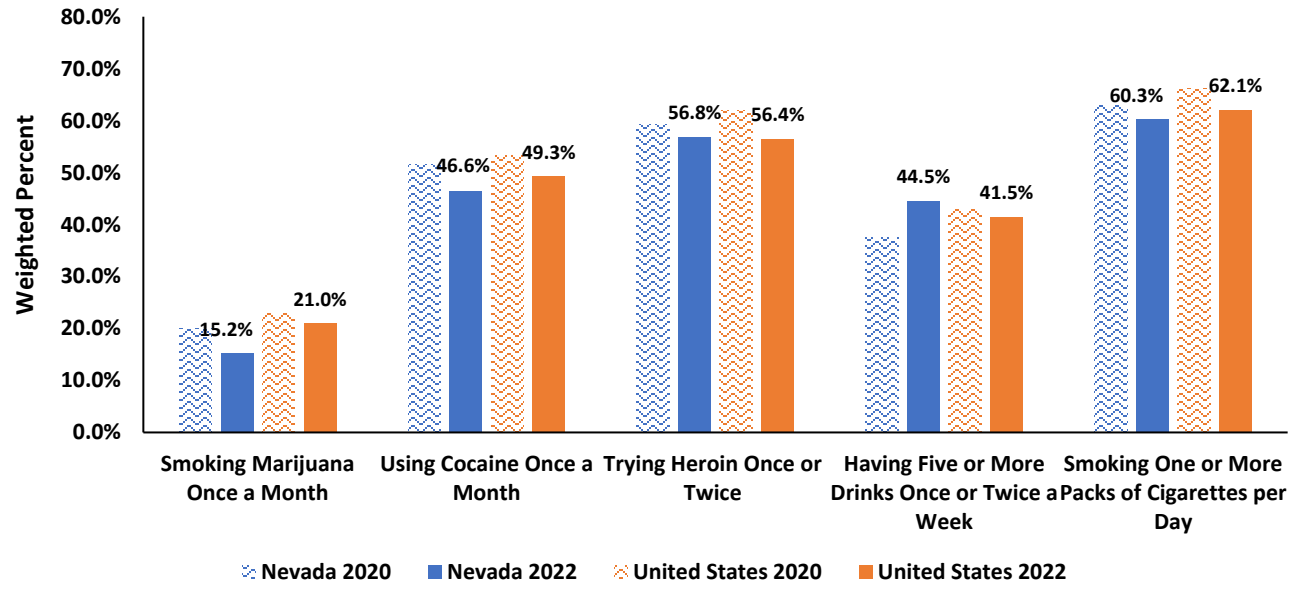
Figure 87. Alcohol Use Disorder in the Past Year, Aged 12 and Above, Nevada and the United States, 2014-2022.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health.
Chart scaled to 15.0% to display differences among groups.

For perceived risks, the higher the percent, the more the person perceives there is a risk from it. Nevadans' perceived risk among adolescents aged 12-17 is lower than the nation in using cocaine once a month, smoking marijuana once a month, and smoking one or more packs of cigarettes per day.

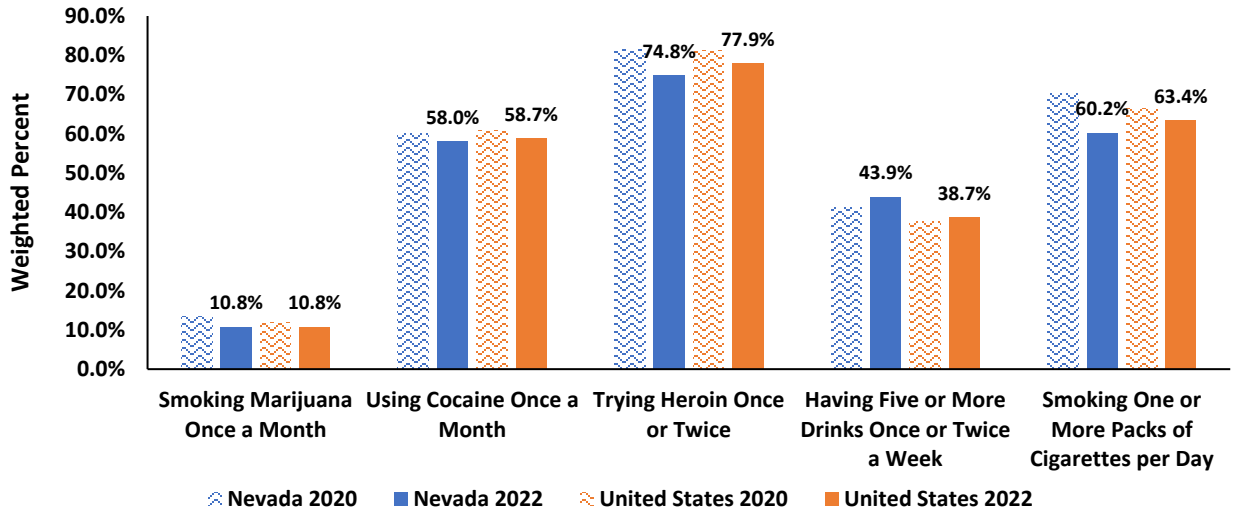
Figure 88. Perceptions of Great Risk from Alcohol or Substance Use, Adolescents Aged 12-17, Nevada and the United States, 2020-2022.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health.
Chart scaled to 80.0% to display differences among groups.

Nevadans' perceived risk among persons aged 18-25 is lower than the nation for all alcohol or substance use except for using having five or more drinks once or twice a week, with Nevada at 43.9% and the US at 38.7%.

Figure 89. Perceptions of Great Risk from Alcohol or Substance Use Among Young Adults Aged 18-25, Nevada and the United States, 2020-2022.



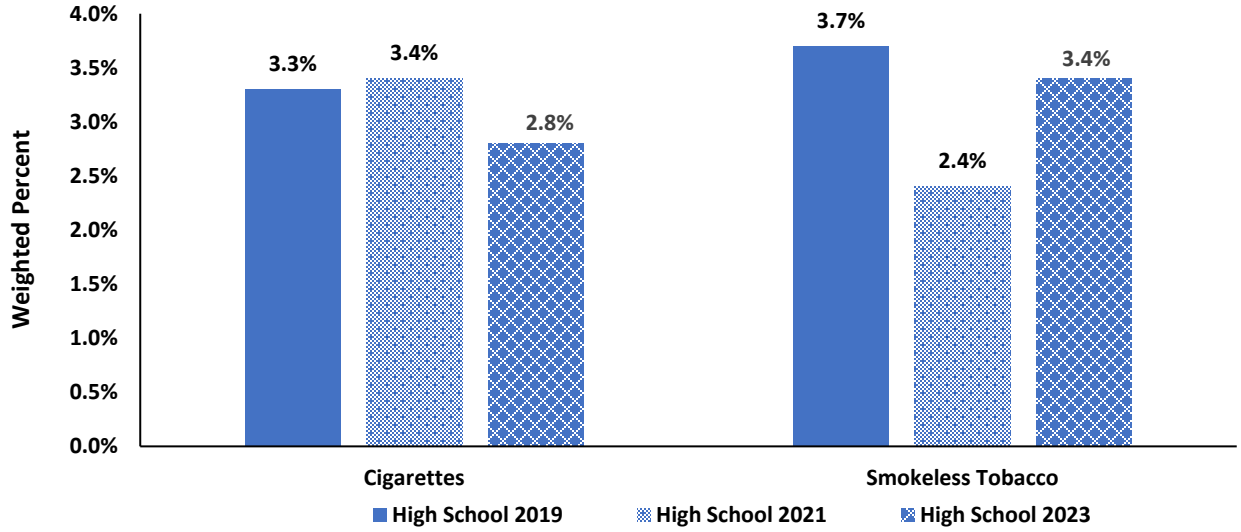
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health.
Chart scaled to 90.0% to display differences among groups.

Youth Risk Behavior Survey

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 2023, 5,122 high school students from 99 schools and 6,915 middle school students from 121 schools participated in the YRBS in Nevada. All data are self-reported. 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.

Among Nevada high school students in 2023, 2.8% currently smoke cigarettes, which is not significantly lower than 2021 at 3.4%. The percent of Nevada high school students who currently use smokeless tobacco has Increased since 2021, but not significantly.

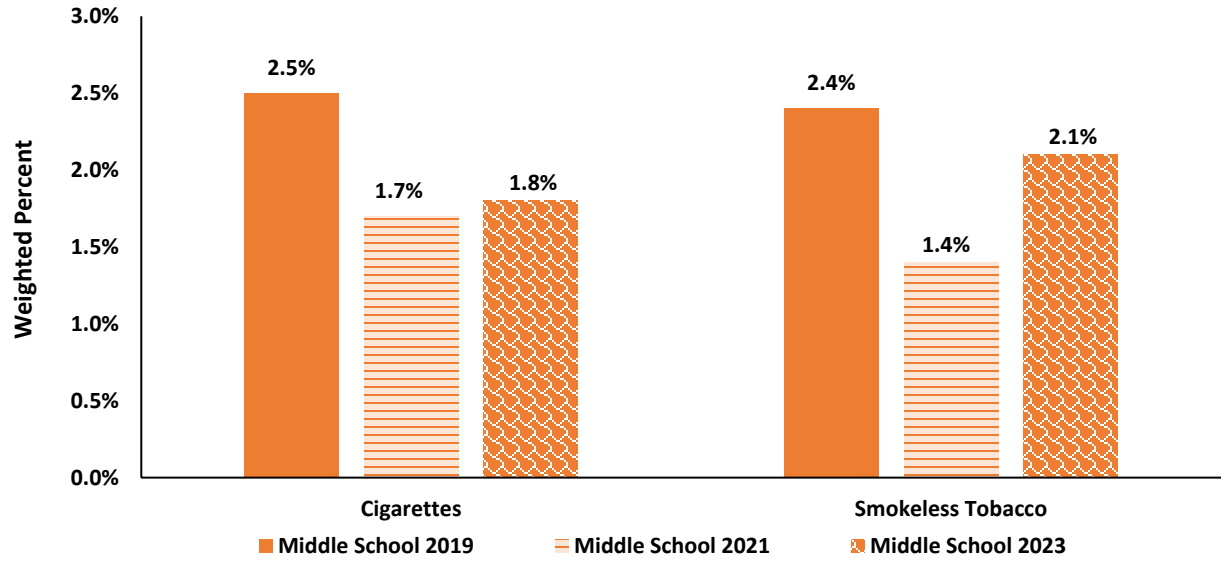
Figure 90a. Current Tobacco Use (On at Least One Day During the Past 30 Days), Nevada High School Students, 2019, 2021, and 2023.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 4.0% to display differences among groups.

The percent of middle school students who currently smoke cigarettes or use smokeless tobacco has increased but not significantly from 2021 to 2023.

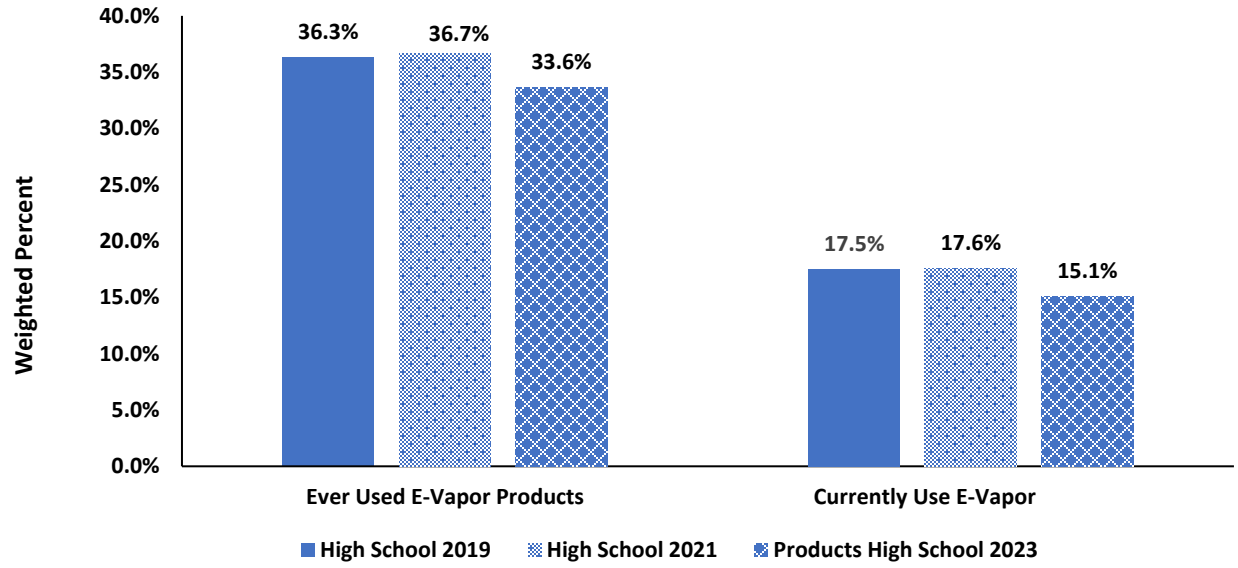
Figure 90b. Current Tobacco Use (On at Least One Day During the Past 30 Days), Nevada Middle School Students, 2019, 2021, and 2023.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 3.0% to display differences among groups.

Among Nevada high school students in 2023, 15.1% currently use electronic vapor (E-vapor) products, which is a notable decrease from 2021 at 17.6%.

Figure 91a. Electronic Vapor Product* Use, Nevada High School Students, 2019, 2021, and 2023.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 40.0% to display differences among groups.
**Includes e-cigarettes, vapes, vape pens, e-cigars, e-hookahs, hookah pens, and mods such as 'JUUL', 'SMOK', 'Suorin', 'Vuse', and 'blu'.*

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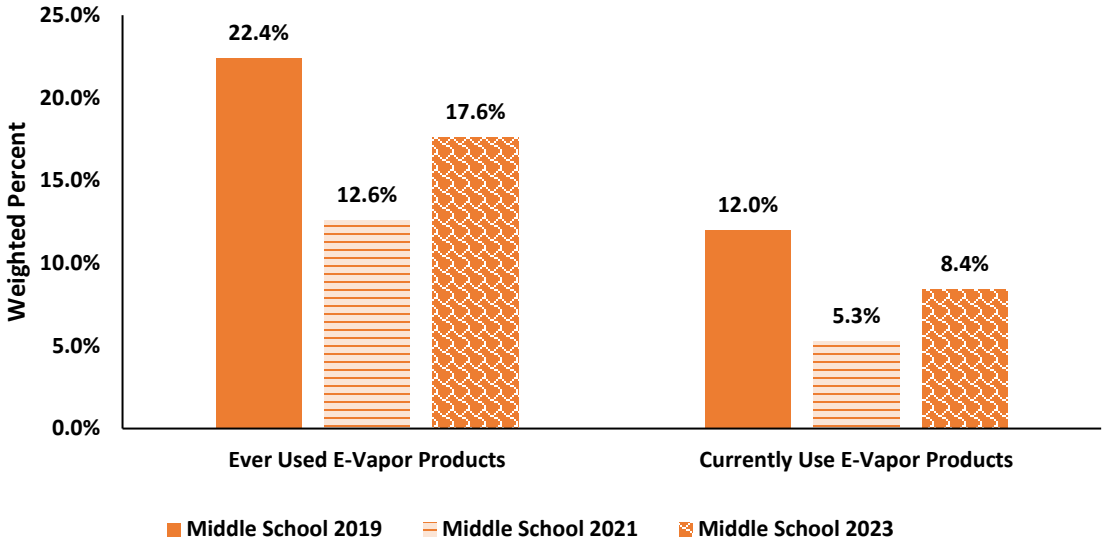
The percent of middle school students who have either ever used E-vapor products or currently use E-vapor products decreased from 2019 to 2021 but has increased from 2021 to 2023.

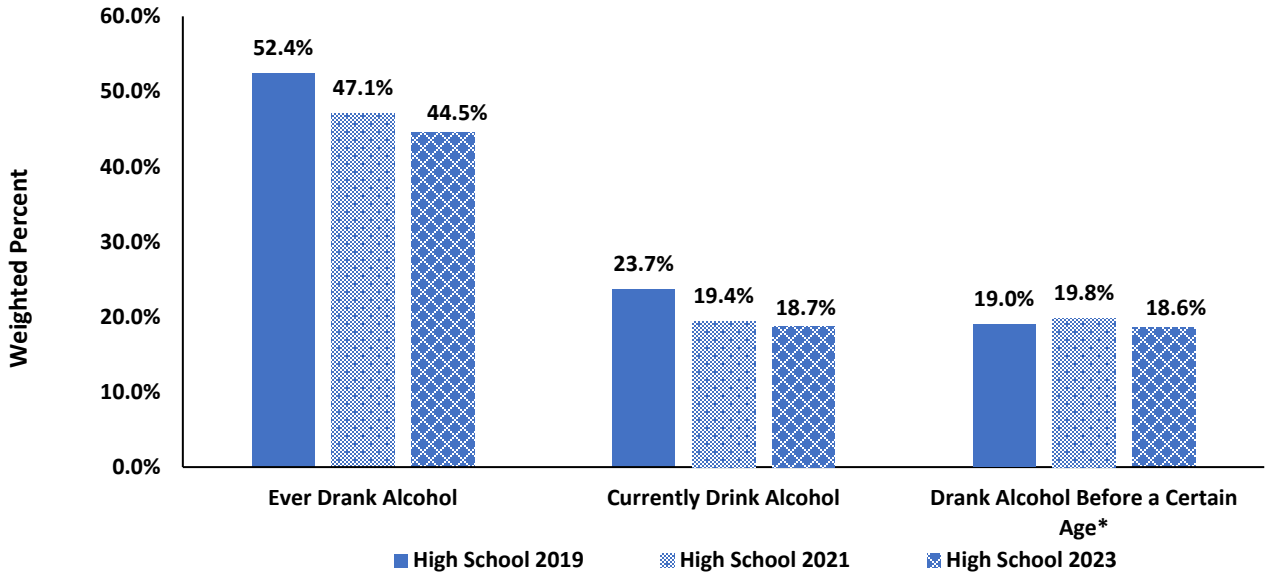
Figure 91b. Electronic Vapor Product* Use, Nevada Middle School Students, 2019, 2021, and 2023.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 25.0% to display differences among groups.
**Includes e-cigarettes, vapes, vape pens, e-cigars, e-hookahs, hookah pens, and mods such as 'JUUL', 'SMOK', 'Suorin', 'Vuse', and 'blu'.*

Among Nevada high school students in 2023, there was a decrease in the percentage of students who reported ever drinking alcohol compared to 2021 (47.1% and 44.5%, respectively).

Figure 92a. Alcohol Use, Nevada High School Students, 2019, 2021, and 2023.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 60.0% to display differences among groups.
**Among high school students, if they ever drank before age 13.*

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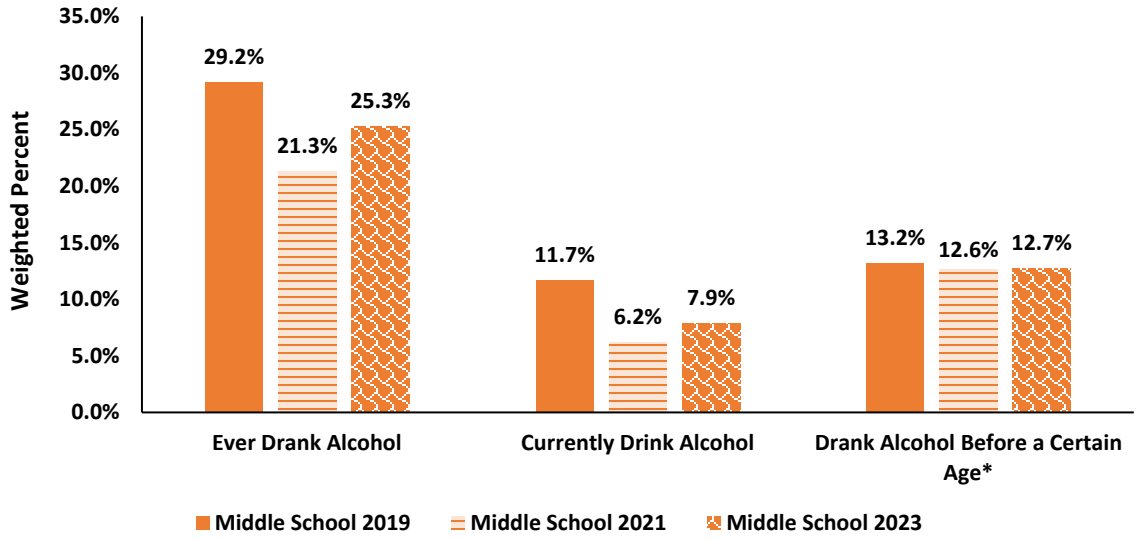
Among Nevada middle school students, there was a decrease between 2019 to 2021 (29.2% and 21.3%, respectively) and 2019 to 2023 (29.2% and 25.3%, respectively) in the percent of students that had reported ever drinking alcohol.

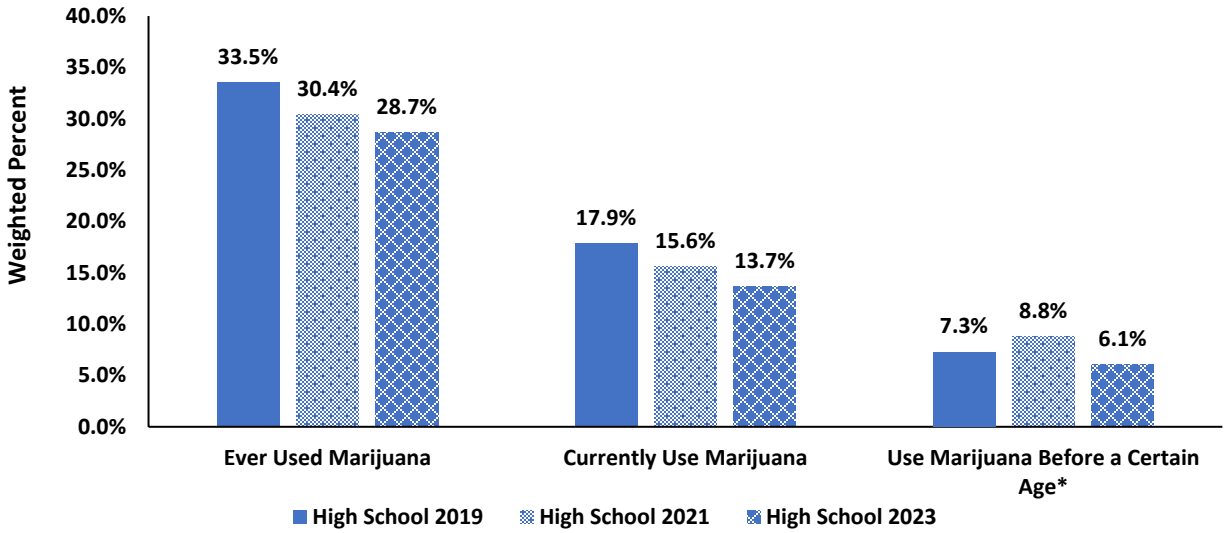
Figure 92b. Alcohol Use, Nevada Middle School Students, 2019, 2021, and 2023.



Source: **Nevada** *Youth Risk Behavior Survey.*
Chart scaled to 35.0% to display differences among groups.
**Among middle school students, if they ever drank before age 11.*

Among Nevada high school students there has been a decrease in the percentage of students that reported ever using marijuana (30.4% and 28.7%, respectively), current use of marijuana (15.6% and 13.7%, respectively), and the use of marijuana before the age of 13 (8.8% and 6.1%, respectively).

Figure 93a. Marijuana Use, Nevada High School Students, 2019, 2021, and 2023.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 40.0% to display differences among groups.
**Among high school students, if they ever used marijuana before age 13.*

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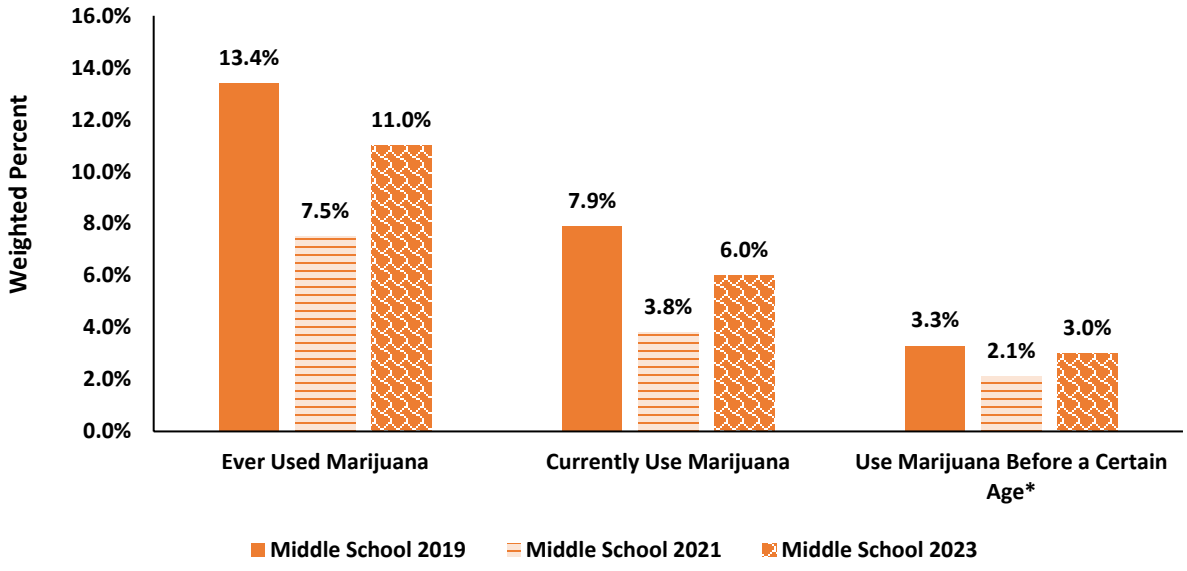
Among Nevada middle school students, the percent who reported ever using marijuana, currently using marijuana, or used marijuana before a certain age all decreased from 2019 to 2021 then increased in 2023.

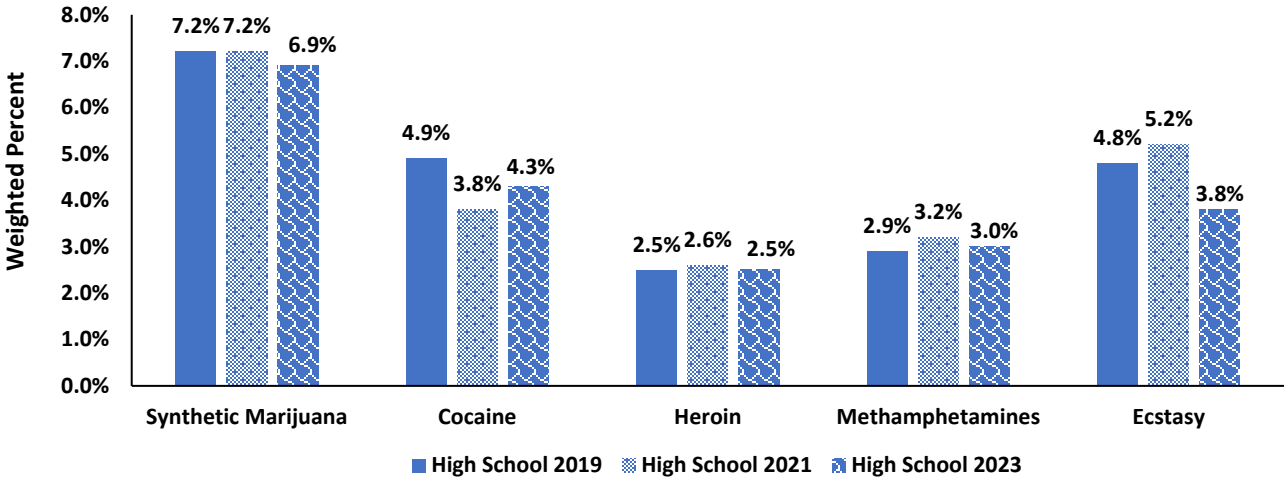
Figure 93b. Marijuana Use, Nevada Middle School Students, 2019, 2021, and 2023.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 16.0% to display differences among groups.
**Among middle school students, if they ever used marijuana before age 11.*

Among Nevada high school students, lifetime drug use decreased from 2021 to 2023 for all drugs except cocaine. The largest decrease from 2021 to 2023 is in ecstasy use, which was at 5.2% in 2021 and at 3.8% in 2023. In contrast, lifetime drug use among Nevada middle school students has increased from 2021 to 2023 in all drug categories.

Figure 94a. Lifetime Drug Use, Nevada High School Students, 2019, 2021, and 2023.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 8.0% to display differences among groups.

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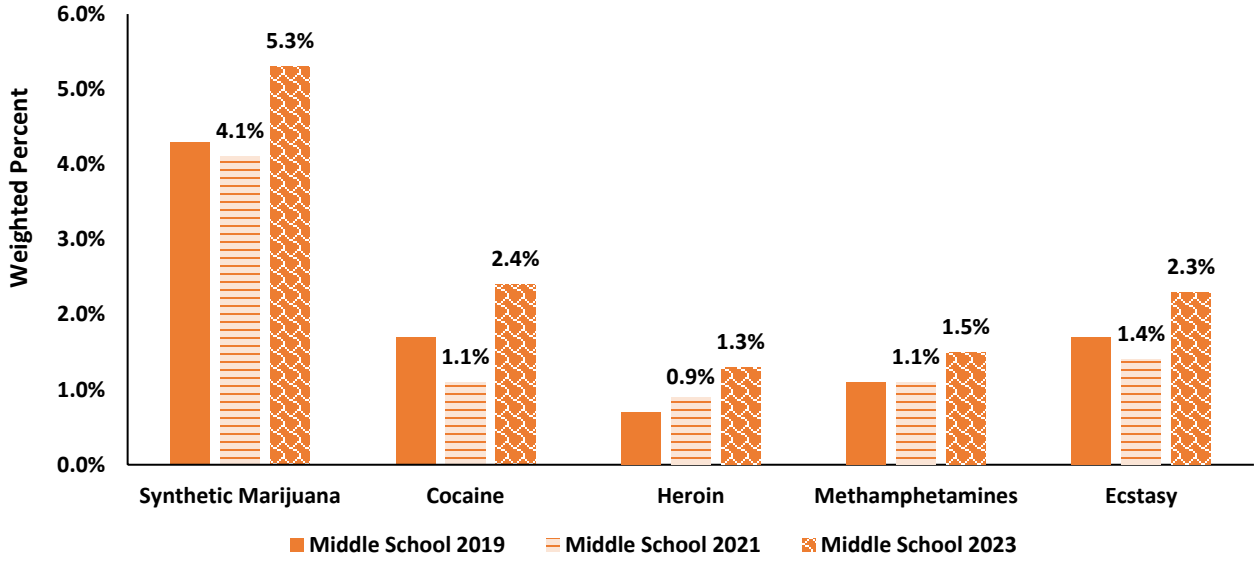
Figure 94b. Lifetime Drug Use, Nevada Middle School Students, 2019, 2021, and 2023.



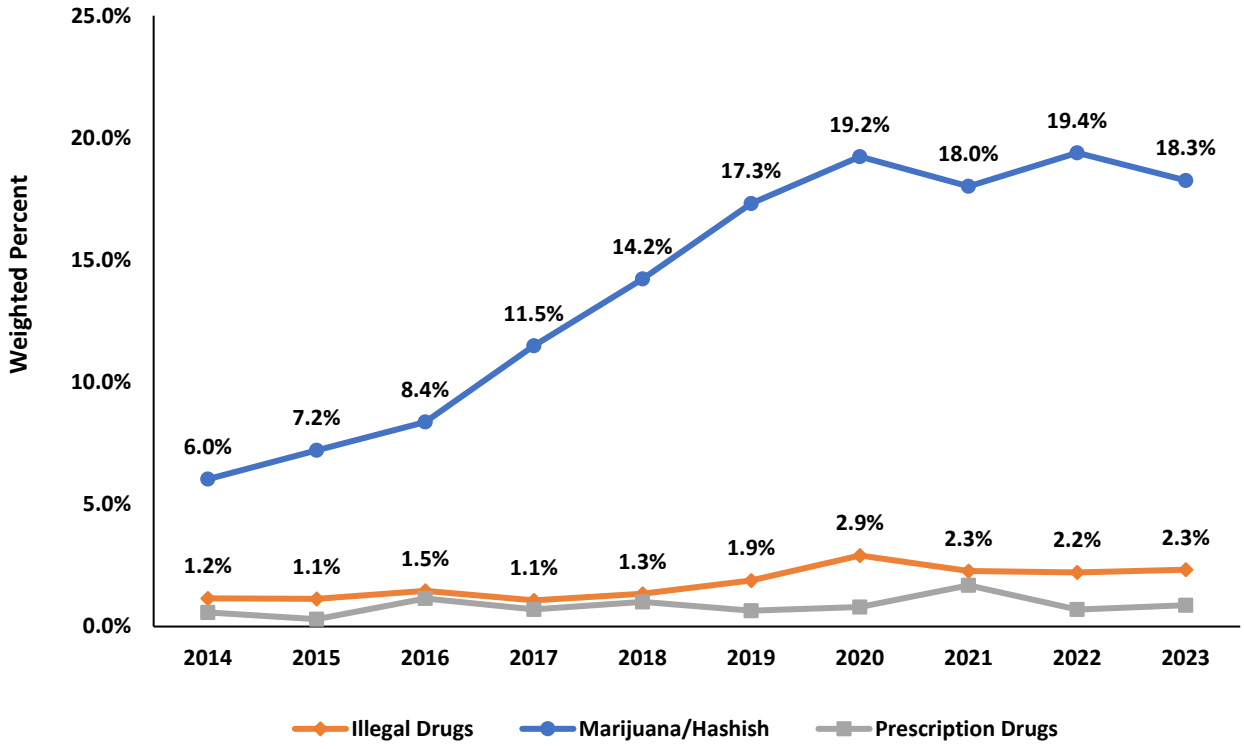
Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 6.0% to display differences among groups.

Behavioral Risk Factor Surveillance System (BRFSS)

BRFSS collects information on adult self-reported 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.

Marijuana use has more than tripled since 2014. In 2023, 18.3% of respondents reported to have used marijuana in the past 30 days, up from 6.0% in 2014 and a high of 19.4% in 2022. Self-reported use of marijuana has increased, as expected, since recreational marijuana use was legalized in Nevada in 2017. Of Nevadans surveyed in 2023, 2.3% (on average) used illegal drugs to get high in the last 30 days and 0.9% used prescription drugs to get high in the last 30 days.

Figure 95. Percent of Adult BRFSS Respondents Who Used Marijuana/Hashish, Illegal Substances, or Painkillers to Get High in the Last 30 Days, Nevada Residents, 2014-2023.



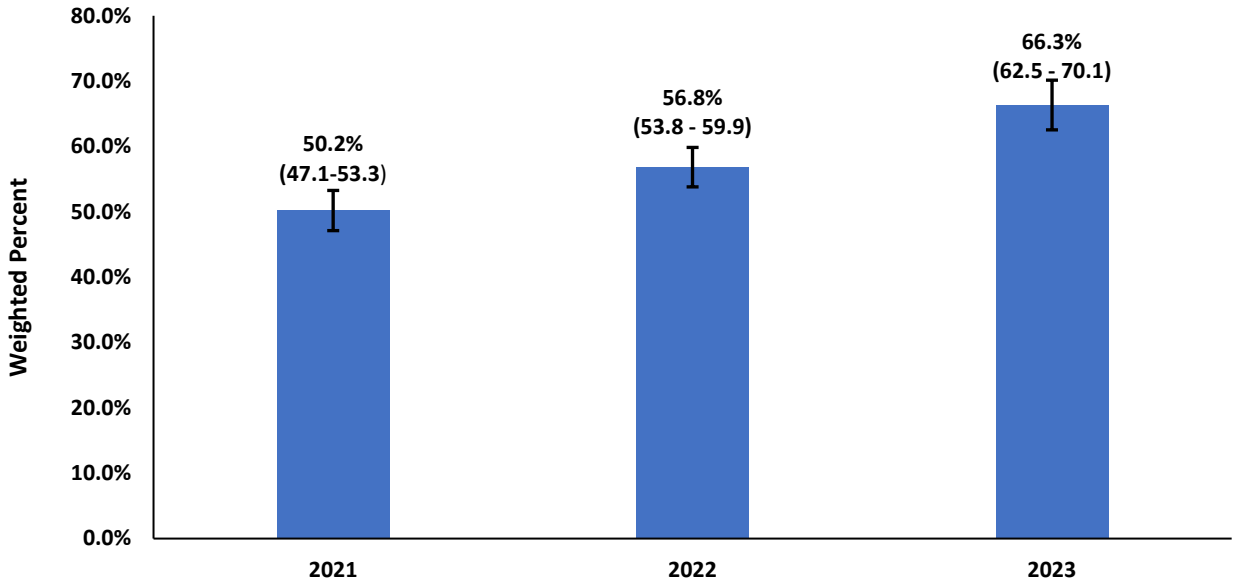
Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 25.0% to display differences among groups.
Specific question asked in survey: "During the past 30 days, on how many days did you use marijuana or hashish/any other illegal drug/ prescription drugs without a doctor's order, just to "feel good," or to "get high"?"

An array of efforts have been put in place to tackle the opioid epidemic in Nevada. With the help of the State Opioid Response funding (DPBH SOR) and other community partners including the University of Nevada, Reno Center for the Application of Substance Abuse Technologies (CASAT), and the Nevada Opioid Center of Excellence, Nevada has launched an educational initiative to address opioid overdoses and promote harm reduction. This program offers free online training on opioid overdose recognition and naloxone (Narcan) administration, allowing students, faculty, and staff to earn a certificate and anonymously access harm reduction kits containing naloxone, test strips, CPR tools, and resource

information. Additionally, the Overdose Data to Action Program (OD2A) is working to improve opioid-related data collection to guide prevention and intervention efforts, managed by the Division of Public and Behavioral Health with partnerships from organizations like the Nevada Board of Pharmacy and the University of Nevada, Reno School of Public Health.

In Nevada, reported Narcan knowledge has increased by 16.1% since 2021 (the first year the question was added to BRFSS).

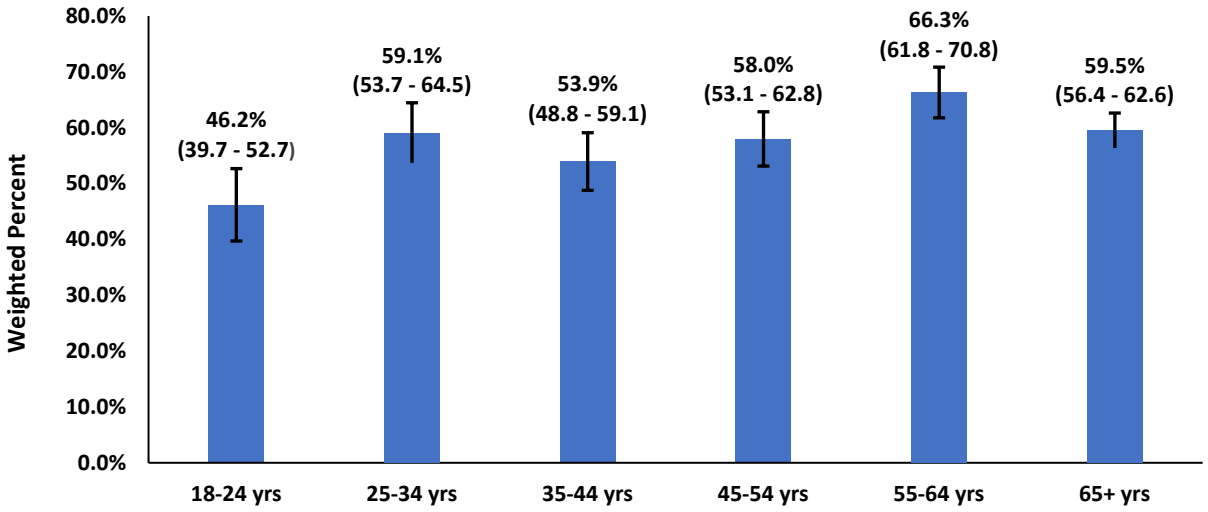
Figure 96. Percentage of BRFSS Respondents who Reported Knowing what Narcan is, Nevada Residents, 2021-2023.



Source: Behavioral Risk Factor Surveillance System.
Question added to BRFSS beginning in 2021.
Chart scaled to 80.0% to display differences among groups.

Adults aged 25-34 years are at risk for opioid overdose (seen in Figure 81) and had the third highest prevalence (59.1%) for knowing what Narcan is after the 55-64 age group (66.3%) and the 65+ age group (59.5%). Adults aged 18-24 years had the lowest prevalence for knowing what Narcan is (46.2%). There is a significant difference of reported Narcan knowledge between at least one age group.

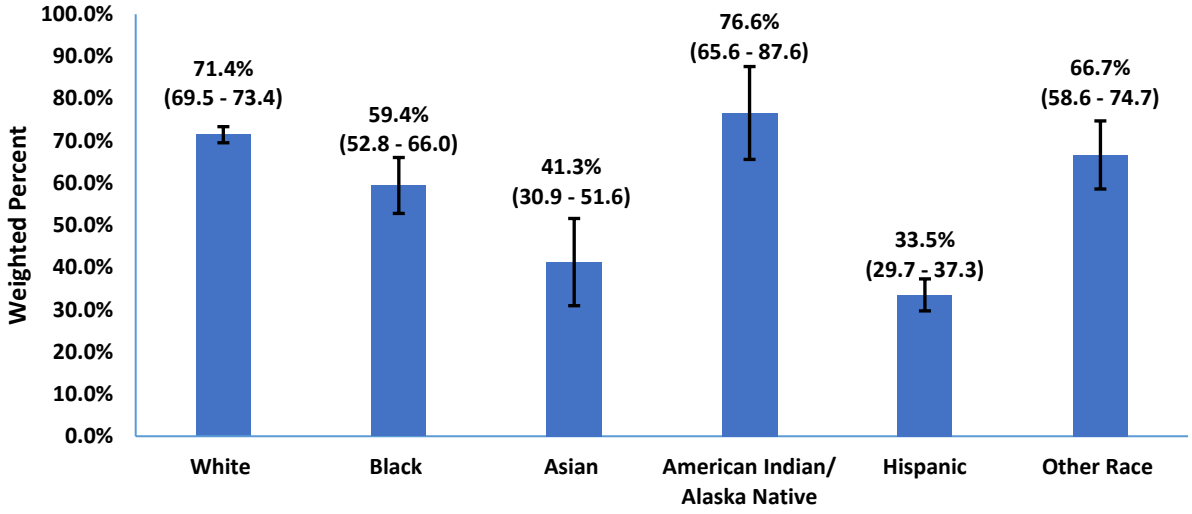
Figure 97. Percentage of BRFSS Respondents who Reported Knowing what Narcan is, by Age, Nevada Residents, 2021-2023.



Source: Behavioral Risk Factor Surveillance System.
Question added to survey beginning in 2021.
Chart scaled to 80.0% to display differences among groups.
0.05 test of significance.
P<0.0001

Narcan knowledge is significantly different among race/ethnicity groups for at least one group. Adults who identified as AI/AN non-Hispanic had the highest prevalence of knowing what Narcan is (76.6%) with those who identified as Hispanic having the lowest prevalence (33.5%).

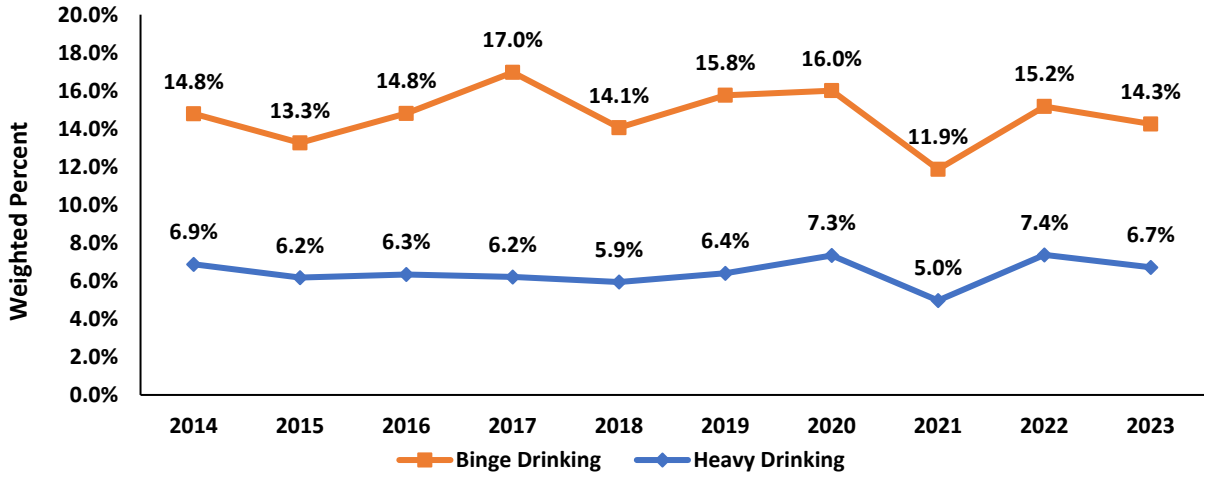
Figure 98. Percentage of BRFSS Respondents who Reported Knowing what Narcan is, by Race/ Ethnicity, Nevada Residents, 2021-2023.



Source: Behavioral Risk Factor Surveillance System.
Question added to survey beginning in 2021.
Figure includes aggregate data from 2021-2023.
Chart scaled to 80% to display differences among groups.
Non-Hispanic unless otherwise noted.
0.05 test of significance
P<0.0001

Binge drinking is defined in men as having five or more alcoholic beverages and woman having four or more alcoholic beverages on the same occasion. Heavy drinking is defined in men as consuming more than two alcoholic beverages, and in women as consuming more than one alcoholic beverage per a day. Both men and women who reported heavy drinking and binge drinking was lowest in 2021.

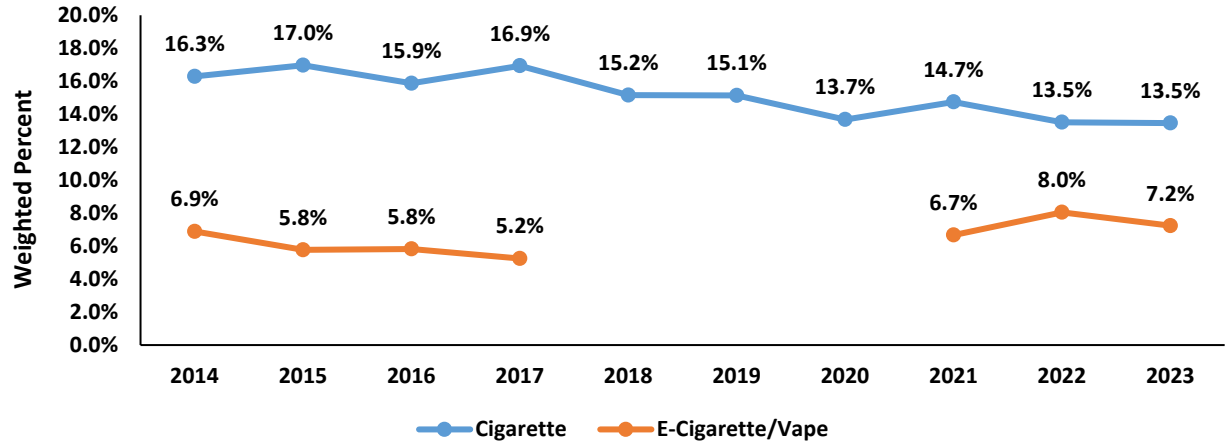
Figure 99. Percent of Adult BRFSS Respondents Who are Considered Binge Drinkers or Heavy Drinkers, Nevada Residents, 2014-2023.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 20.0% to display differences among groups.

In 2023, 13.5% of adults were current cigarette smokers, which has decreased since 2014, at 16.3%. E-cigarette use reached a high of 8.0% in 2022, before decreasing to 7.2% in 2023. In 2018 through 2020, the e-cigarette use question was asked differently compared to years prior, thus had to be excluded from the graph.

Figure 100. Percent of Adult BRFSS Respondents Who are Current Cigarette or E-Cigarette Smokers, Nevada Residents, 2014-2023.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 20.0% to display differences among groups.
E-cigarette use was not collected in 2018-2020.
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.

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Youth

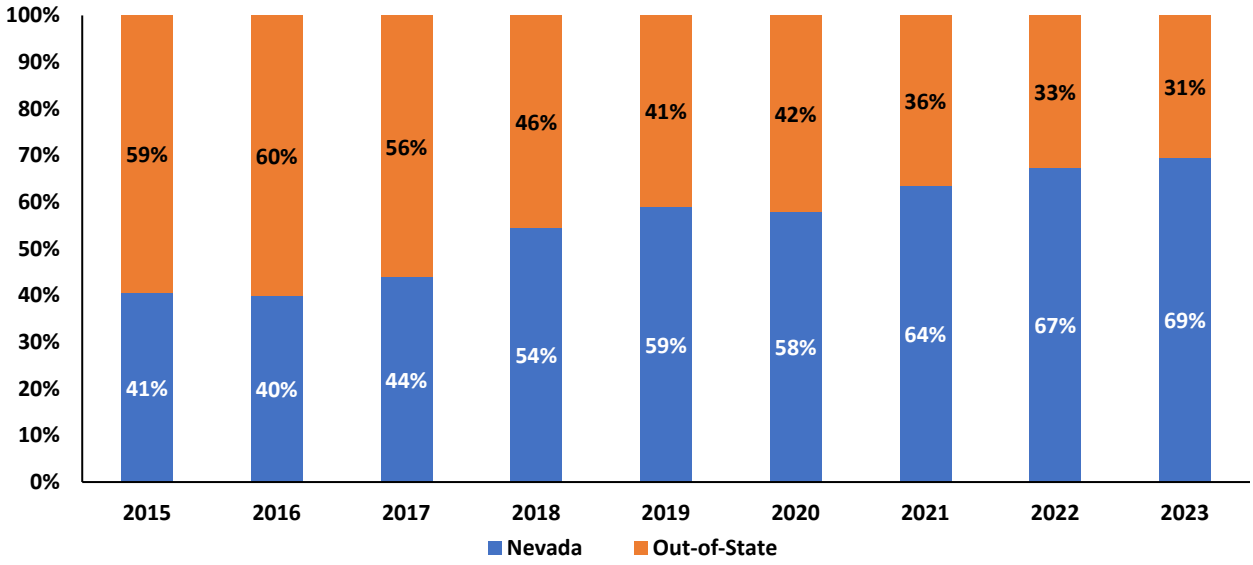
This section focuses on other factors that affect youth not directly related to substance use or mental health.

Medicaid: Residential Treatment Centers

Residential treatment centers provide intensive behavioral, mental, and emotional health services for youth. These are typically 24-hour, inpatient facilities and may provide psychiatric oversight, medication management, and behavioral therapy among other services. The centers reported in this section include both state-run facilities and private centers that accept Medicaid reimbursement.

Since 2015 the percent of Nevada children admitted to facilities in the state of Nevada (rather than out-of-state facilities) has increased by nearly thirty percent. This reflects statewide efforts to keep the treatment of Nevada youth in-state.

Figure 101. Medicaid-Funded Residential Treatment Center Placement for Children, In Nevada and Out-of-State, 2015-2023.



Source: Nevada Medicaid Data Warehouse.
Children refers to those under the age of 18.

Table 3. Medicaid Nevada and Out-of-State Residential Treatment Center Placement for Children, 2015-2023.

Year	Provider State			
	Nevada	Out of State	Nevada %	Out of State %
2015	320	468	40.6%	59.4%
2016	319	481	39.9%	60.1%
2017	332	425	43.9%	56.1%
2018	364	305	54.4%	45.6%
2019	349	243	59.0%	41.0%
2020	330	239	58.0%	42.0%
2021	404	232	63.5%	36.5%
2022	365	177	67.3%	32.7%
2023	367	162	69.4%	30.6%

Source: Nevada Medicaid Data Warehouse.
Children refers to those under the age of 18.

For additional information, please see the State of Nevada Youth Behavioral Health Services Dashboard or DCFS Residential Services.

Juvenile Justice System

The Nevada Juvenile Justice system is bifurcated and administered at both the state and county level. The Division of Child and Family Services Juvenile Justice (DCFS JJ – state-level Juvenile Justice) operates three state juvenile detention facilities: Caliente Youth Center (CYC), Nevada Youth Training Center (NYTC), and Summit View Youth Center (SVYC). Additionally, DCFS operates a Youth Parole program for youth who have been released from a detention facility but are still legally committed to DCFS JJ. Note that these data only include information about children committed to state juvenile justice. State agencies are actively working with county agencies to access county-level juvenile justice data to provide a more comprehensive picture of juvenile justice services statewide in the future.

DCFS detention facilities serve youth 12-19 years old, while children can be on youth parole up to their 21st birthday with limited exceptions. During a given calendar year, committed youth may be served by one or all of these facilities/programs. "Any Facility Including CYC, NYTC, or SVYC" provides a distinct count of youth served by any facility during the calendar year, which is less than the sum of each facility's populations. Those youth may be counted in the Youth Parole column as well if they were served by youth parole at any point during the calendar year.

Table 4. Youth Served by Each Juvenile Justice Facility and Youth Parole 2019-2023.

Year	Caliente Youth Center (CYC)	Nevada Youth Training Center (NYTC)	Summit View Youth Center (SVYC)	Any Facility (Including CYC, NYTC, or SVYC)	Youth Parole
2019	230	118	110	435	584
2020	182	108	109	385	533
2021	126	92	101	305	493
2022	118	92	90	288	452
2023	134	120	107	333	457

Source: Enterprise Supervision.

Caliente Youth Center serves both male and female youth. Summit View Youth Center and Nevada Youth Training Center historically and currently only serve male youth; however, NYTC had some female residents in 2022 and 2023. The Youth Parole program serves both male and female youth. Table 5 shows the percent of distinct youth who are male and female by program and calendar year.

Table 5. Youth Served by Each Juvenile Justice Facility and Youth Parole by Sex, 2019-2023.

Year	Any Facility		Youth Parole	
	Female	Male	Female	Male
2019	21.8%	78.2%	20.9%	79.1%
2020	16.4%	83.6%	18.9%	81.1%
2021	15.4%	84.6%	16.6%	83.4%
2022	19.1%	80.9%	18.8%	81.2%
2023	18.9%	81.1%	21.2%	78.8%

Source: Enterprise Supervision.

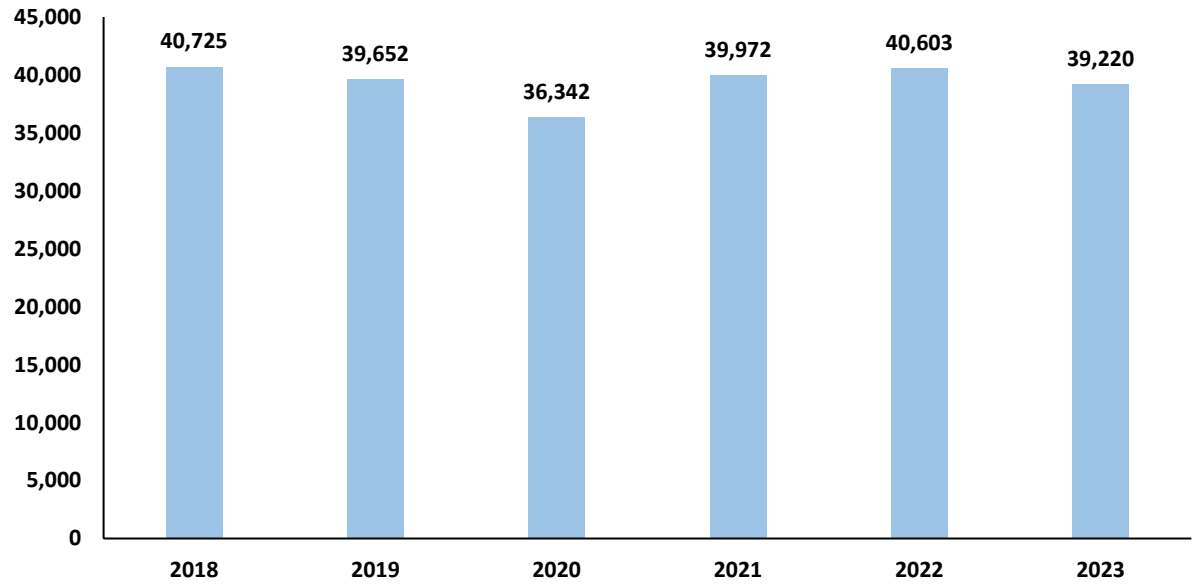
Child Protective Services

Child Protective Services (CPS) exists to ensure the safety, well-being, and stability of children by investigating reports of abuse, neglect, or exploitation. CPS responds to reports of abuse or neglect involving children under the age of eighteen[8].

Children exposed to abuse or neglect are at a higher risk of developing mental health conditions, such as anxiety, depression, PTSD, or behavioral disorders. Parental mental health challenges can contribute to situations of neglect or abuse as well. CPS workers can connect families with interventions such as therapy, parenting support, and substance abuse treatment to help parents provide safe homes.

In the reporting period 2018-2023, CPS in Nevada responded to 236,514 reports. Aside from a notable decrease in 2020 due to the COVID pandemic, the prevalence of CPS reports is fairly consistent year over year.

Figure 102. Child Protective Services Reports Received, 2018-2023.



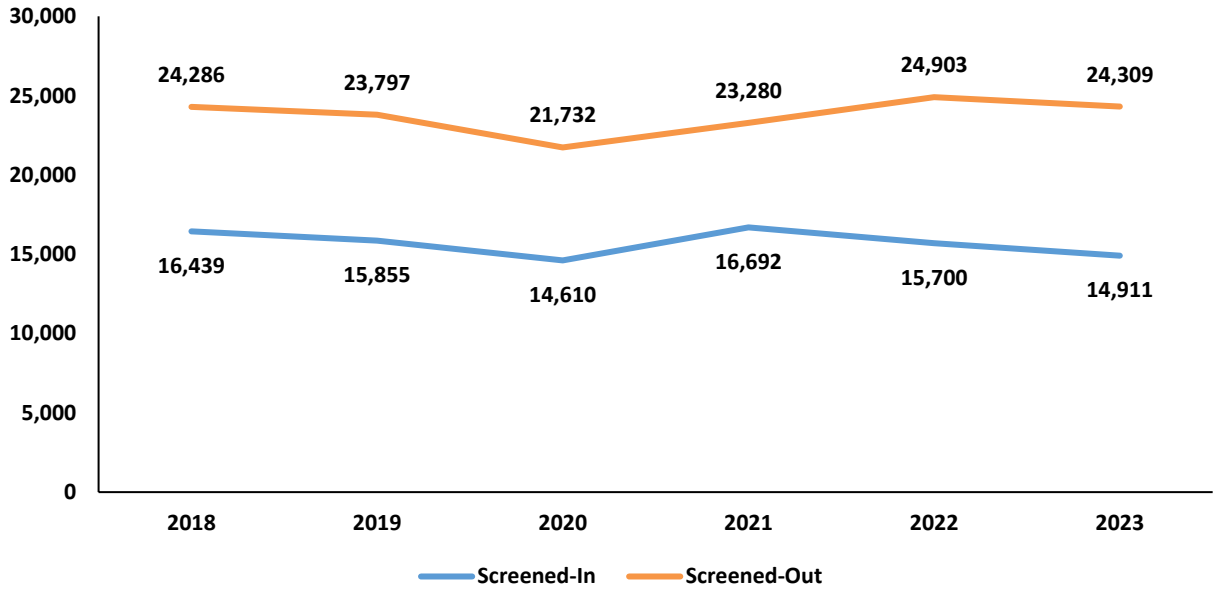
Source: UNITY Database.

For each report, a screening decision is made determining whether an agency response (making contact with the family, assessing child safety, and providing child welfare agency services) is necessary. These "screened-in" reports reflect those where agency personnel responded and attempted to make face-to-face contact with the children and families to assess child safety and family functioning.

Of the 236,514 reports made between 2018 and 2023 roughly 40% (n=94,207) were screened-in resulting in agency response. This percent of screened-in reports is consistent by year over the reporting period. Most reports received by CPS are screened-out.

[8] Nevada's Child Welfare and Child Protective Services

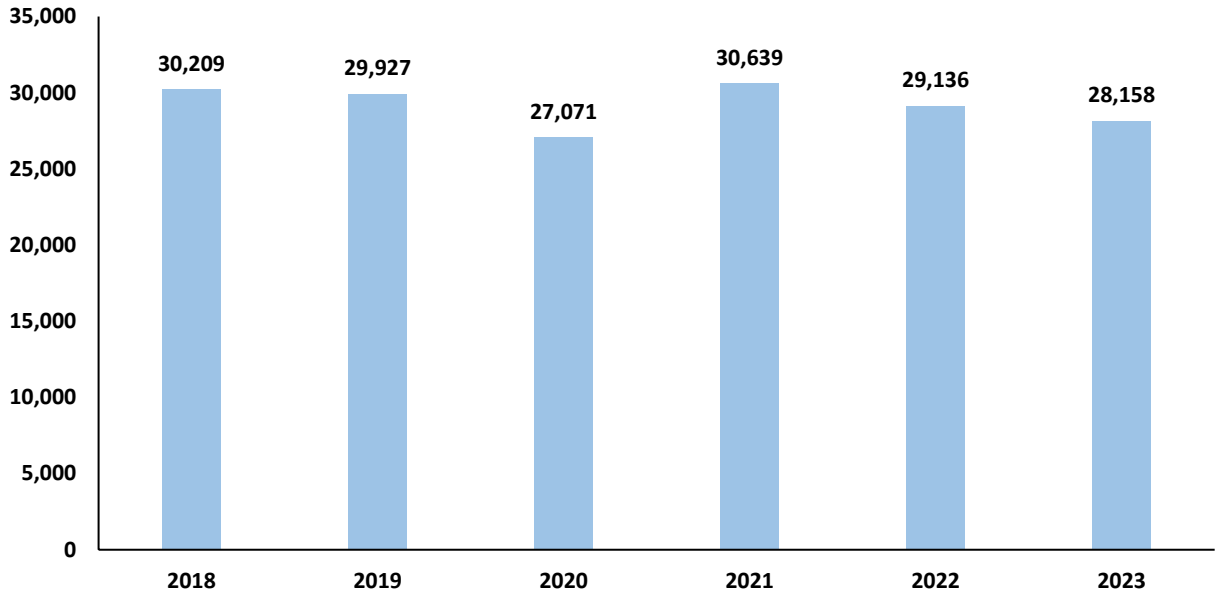
Figure 103. Child Protective Services Reports Received by Screening Decision, 2018-2023.



Source: UNITY Database.

During the reporting period, more than 94,000 screened-in reports involved 175,140 Nevada youth—an average of about 29,000 per year participating in a CPS investigation, assessment, or response. These counts are distinct by year; some youth may be counted more than once in the reporting period (2018-2023) if they appeared on screened-in reports in more than one year.

Figure 104. Unique Nevada Youth Screened-In, 2018-2023.



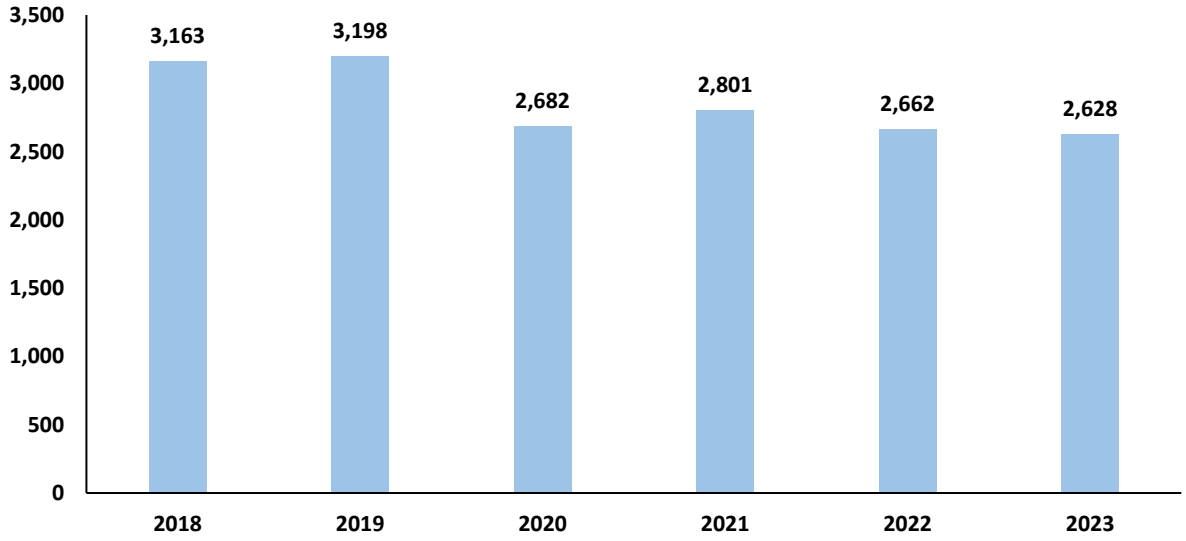
Source: UNITY Database.

Foster Care

Some investigations reveal that a child cannot safely remain in the home and must be removed to foster care. This is a last resort option and part of the overall continuum of services provided by child welfare agencies.

From 2018 to 2023, a total of 16,151 unique youth were served in the foster care system, accounting for 17,134 entries. Some youth entered, exited, and later re-entered the foster care system, with each entry counted separately. Since 2018, the number of entries has slightly decreased, averaging 2,856 per year.

Figure 105. Foster Care Entries, Nevada, 2018-2023.



Source: UNITY Database.

Neglect is the primary driver of Nevada youth being placed into foster care followed by parental substance use.

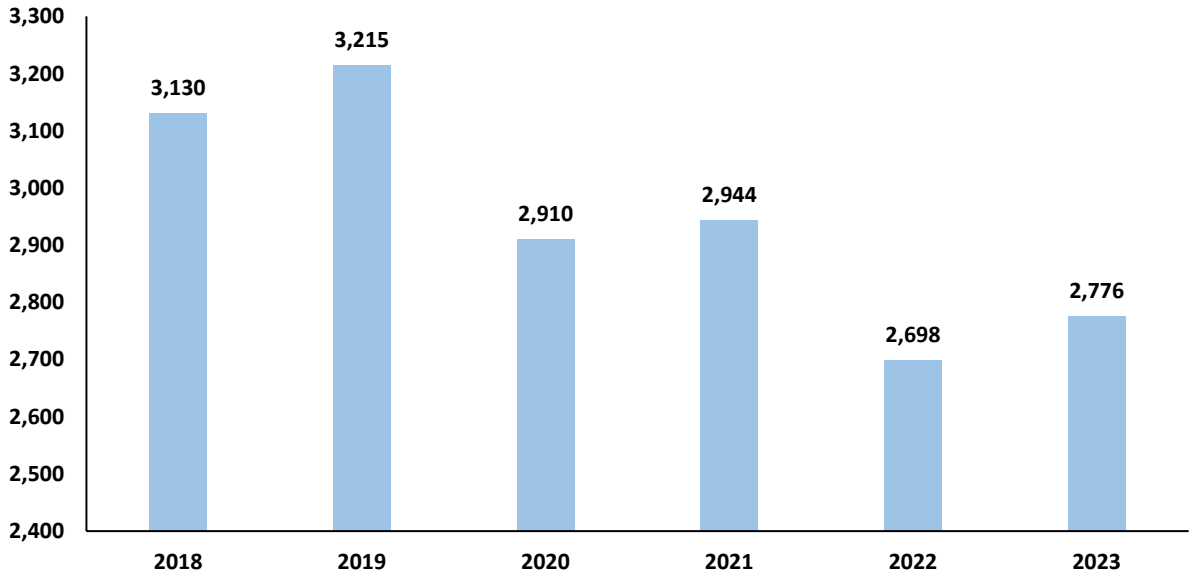
Table 6. Top Reasons for Foster Care Entries, Nevada, 2018-2023.

Entry Reason	2018	2019	2020	2021	2022	2023
NEGLECT	2,686	2,736	2,281	2,331	2,147	2,118
PARENTAL SUBSTANCE ABUSE	364	383	512	746	941	896
ABUSE	348	402	387	409	484	394
DOMESTIC VIOLENCE	230	266	315	379	393	432
INCARCERATION OF PARENT(S)	339	337	288	327	287	320
INADEQUATE HOUSING	216	211	149	320	434	436
ALL OTHER	347	397	411	609	534	508

Source: UNITY Database.

In each year of the reporting period, there were substantially fewer exits from the foster care system than entries. The number of exits has, however, decreased notably since 2019.

Figure 106. Foster Care Exits, Nevada, 2018-2023.



Source: UNITY Database.

Reunification with family is the most common outcome for youth leaving foster care, accounting for nearly 60% of exits.

Table 7. Reason for Foster Care Exits, Nevada, 2018-2023.

Exit Reason	2018	2019	2020	2021	2022	2023
REUNIFICATION	1,874	1,892	1,684	1,645	1,493	1,595
ADOPTION	794	853	705	736	714	688
GUARDIANSHIP	236	231	223	293	232	271
AGED OUT	149	169	189	178	158	164
TRANSFER TO OTHER AGENCY	44	45	71	65	73	43
ALL OTHER	29	21	34	22	26	14
TOTAL	3,130	3,215	2,910	2,944	2,698	2,776

Source: UNITY Database.

Youth Suicide

Suicide was the leading cause of death for Nevadans aged 10-24, accounting for more than 1 in every five youth and young adult deaths from 2014 to 2023. Youth ages 10-17 had an average of 18 suicide deaths each year, and young adults 18-24 had 55 per year on average during this same period.

Emergency department encounters and inpatient admissions for attempted suicides both saw pronounced increases in 2021 and 2022, the years immediately following the COVID-19 pandemic. Emergency department encounters had a maximum rate of 144.0 per 100,000 population in 2021. That same year and the following year showed the highest rates of inpatient admissions for attempts at 97.9 and 100.1 per 100,000 population. The rate of attempts for 2021 and 2022 are substantially higher than for any other year in the reporting period.

Table 8. Suicide and Suicide Attempts and Rates by Year, 18 Years of Age and Younger, Nevada Residents 2014-2023.

Year	Suicide Attempts				Suicides	
	Emergency Department Encounters		Inpatient Admissions			
	N	Rate	N	Rate	N	Rate
2014	724	101.0	145	20.2	16	2.2
2015	820	111.2	211	28.6	24	3.3
2016	775	103.7	236	31.6	21	2.8
2017	802	106.7	257	34.2	21	2.8
2018	780	102.1	410	53.7	32	4.2
2019	743	96.1	491	63.5	23	3.0
2020	829	106.1	572	73.2	32	4.1
2021	1,091	144.0	742	97.9	29	3.8
2022	1,020	134.6	759	100.1	25	3.3
2023	876	114.7	528	69.1	28	3.7

Source: Hospital Emergency Department Billing and Inpatient Billing, and Electronic Death Registry System.
Crude rate per 100,000 age-specific population.

Table 9. Top Causes of Death, Ages 10-17 and 18-24, Nevada Residents 2014-2023.

Youth Deaths Age 10 17				
Rank	Leading Cause of Death	N.	% of Total Deaths	Crude Rate
1	Intentional self-harm (suicide)	186	23.5%	5.6
2	Transport accidents	138	17.4%	4.2
3	Assault (homicide)	100	12.6%	3.0
4	Non-transport accidents	92	11.6%	2.8
5	Malignant neoplasms	63	7.9%	1.9
	Total	**789**		

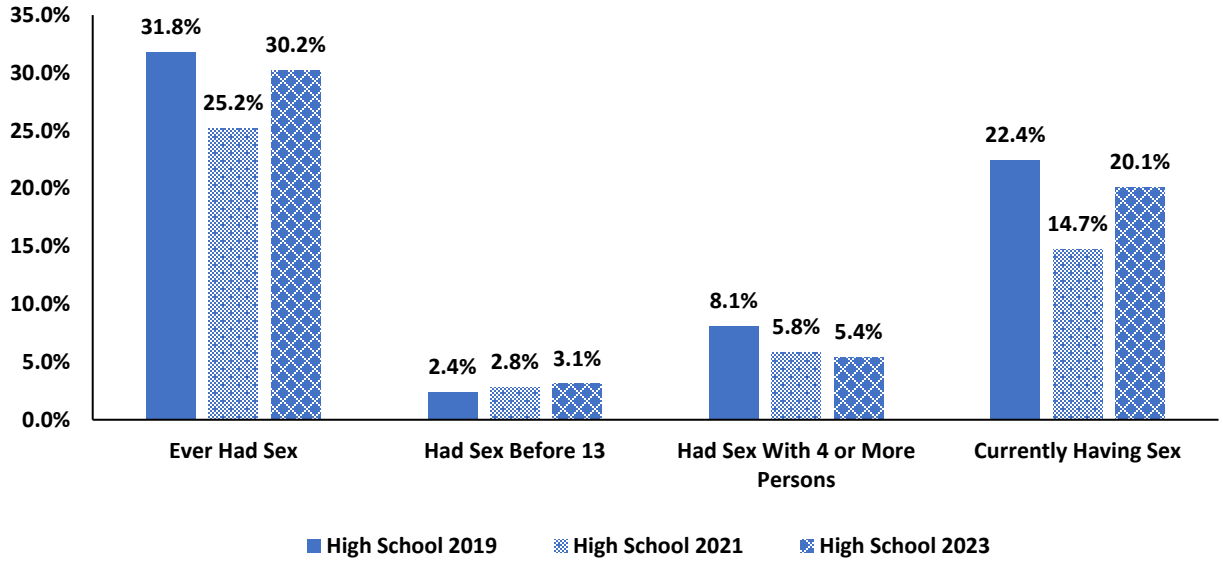
Rank	Leading Cause of Death	N.	% of Total Deaths	Crude Rate
1	Intentional self-harm (suicide)	551	21.7%	19.1
2	Non-transport accidents	529	20.8%	18.3
3	Transport accidents	475	18.7%	16.4
4	Assault (homicide)	354	13.9%	12.2
5	Malignant neoplasms	114	4.5%	3.9
	Total	**2,536**		

Source Electronic Death Registry System.
Crude rate 100,000 age-specific population.

Youth Risk Behavior Survey (YRBS)

There were decreases in the rates for all categories for sexual behaviors among Nevada high school students from 2019 to 2023 with the exception of those who had sex before the age of 13 (2.4% and 3.1%, respectively).

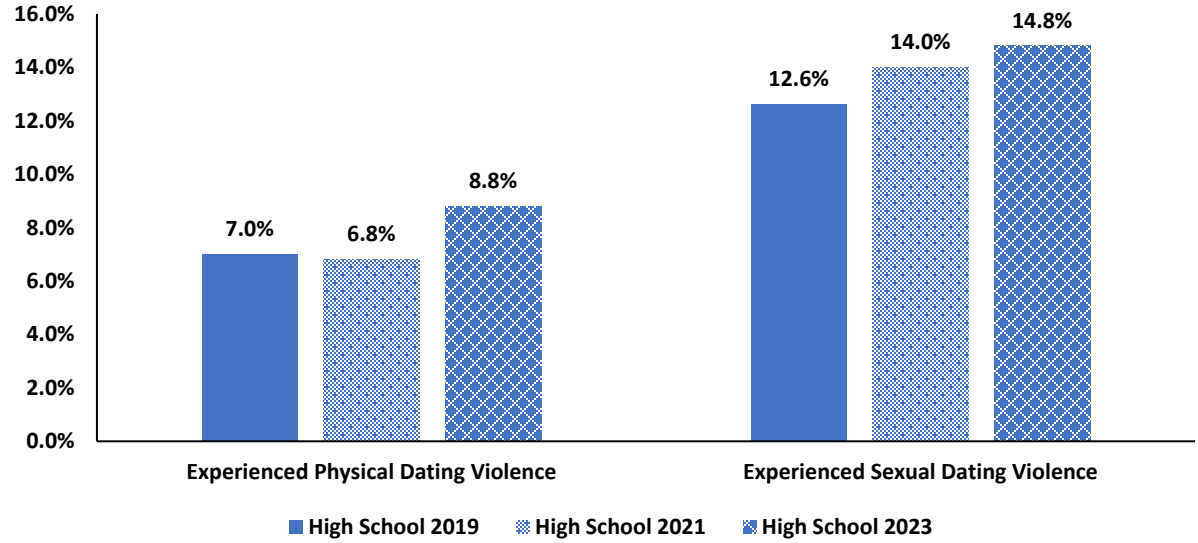
Figure 107. Sexual Behaviors Among Nevada High School Students, 2019, 2021 and 2023.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 35.0% to display differences among groups.

The rate at which Nevada high school students reported both physical and sexual dating violence has increased from 2019 to 2023.

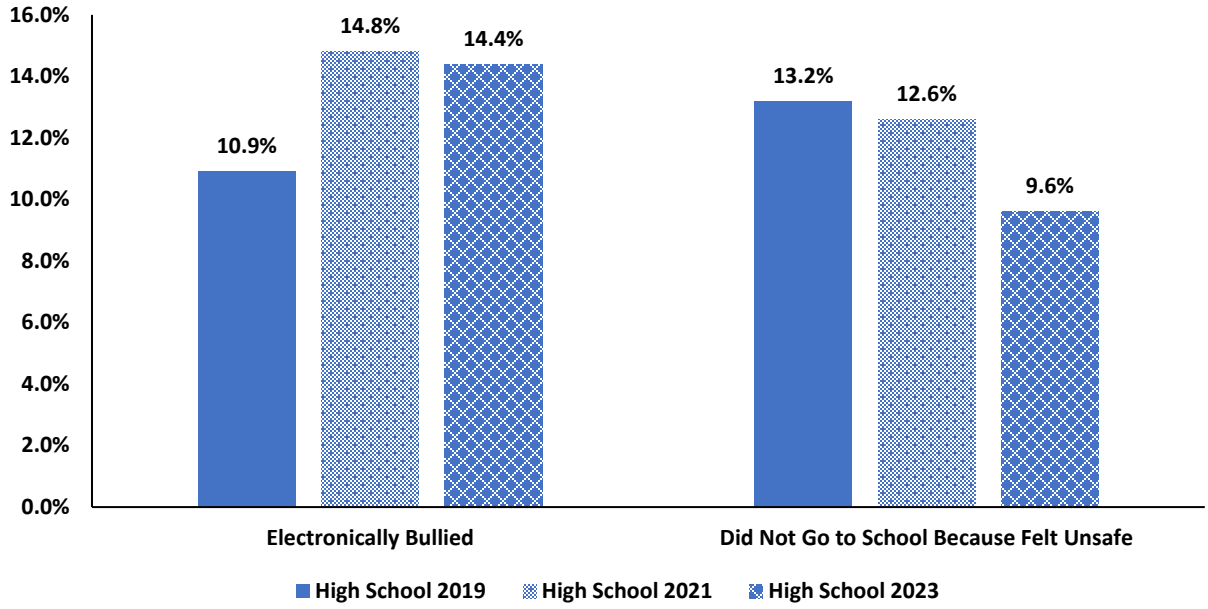
Figure 108. Sexual Violence Among Nevada High School Students, 2019, 2021, and 2023.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 16.0% to display differences among groups.

Between 2019 and 2023 the percent of students who reported being electronically bullied increased from 10.9% to 14.4% while the percent who reported not going to school because they felt unsafe decreased by roughly 4%.

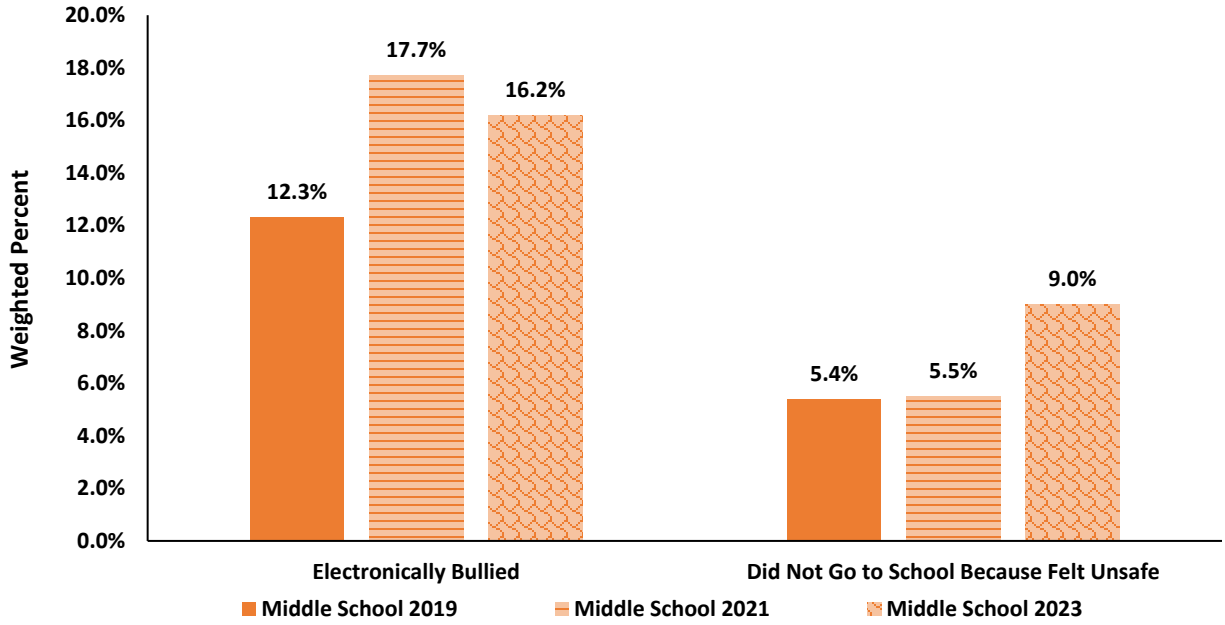
Figure 109a. Violence Among Nevada High School Students, 2019, 2021, and 2023.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 16.0% to display differences among groups.

In contrast to high school students, middle school students reported at an increased rate both electronic bullying and not going to school because they felt unsafe between 2019 and 2023.

Figure 109b. Violence Among Students, Nevada Middle School Students, 2019, 2021, and 2023.



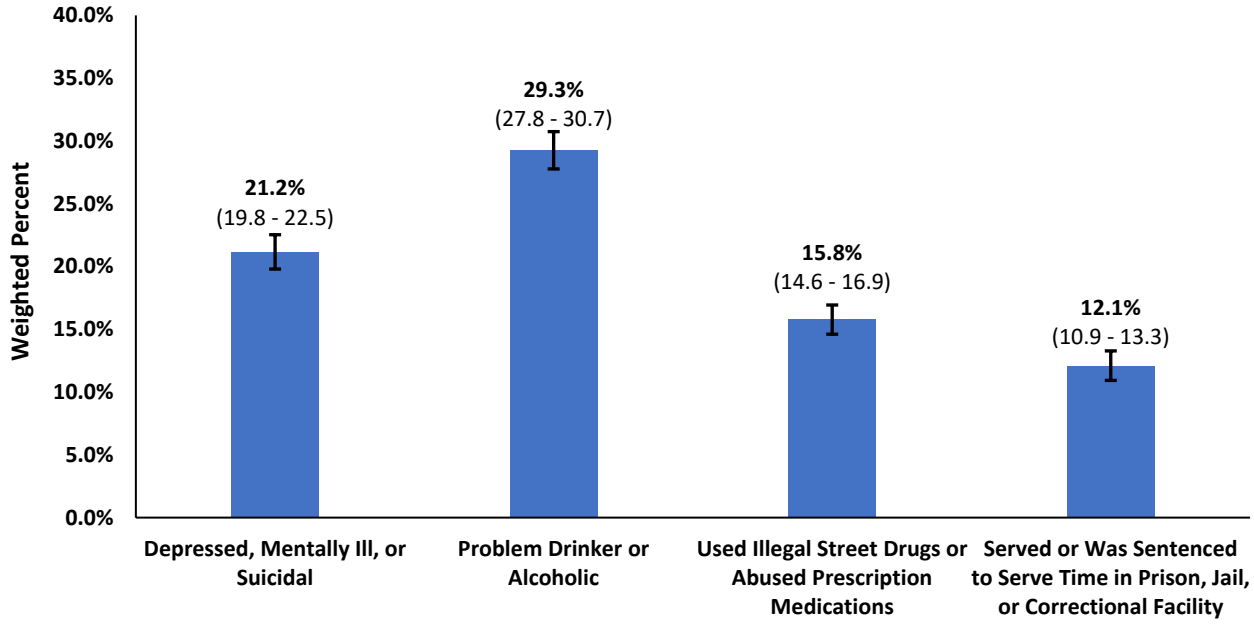
Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 20.0% to display differences among groups.

Behavioral Risk Factor Surveillance System

The following charts are from state-added BRFSS questions about adverse events that happened during childhood. This information is to better understand issues that may occur early in life. The question refers to living with a person and not to the actual person being interviewed. The CDC states that adverse childhood experiences (ACEs) are linked to multiple worse health outcomes in adulthood such as mental illness, substance misuse, and other chronic health problems[9]. Prevention of ACEs is vital to preventing worse health outcomes in the community.

Between 2019-2023, 29.3% of adults, before the age of 18, lived with someone who was a problem drinker or alcoholic, and 21.2% reported to living with someone who was depressed, mentally ill, or suicidal. These early exposures (ACEs) may be associated with increased adverse health outcomes later in life.

Figure 110. Adult BRFSS Respondents Who, During Childhood, Lived with Others Who Had Certain Conditions, Nevada Residents, 2019-2023.

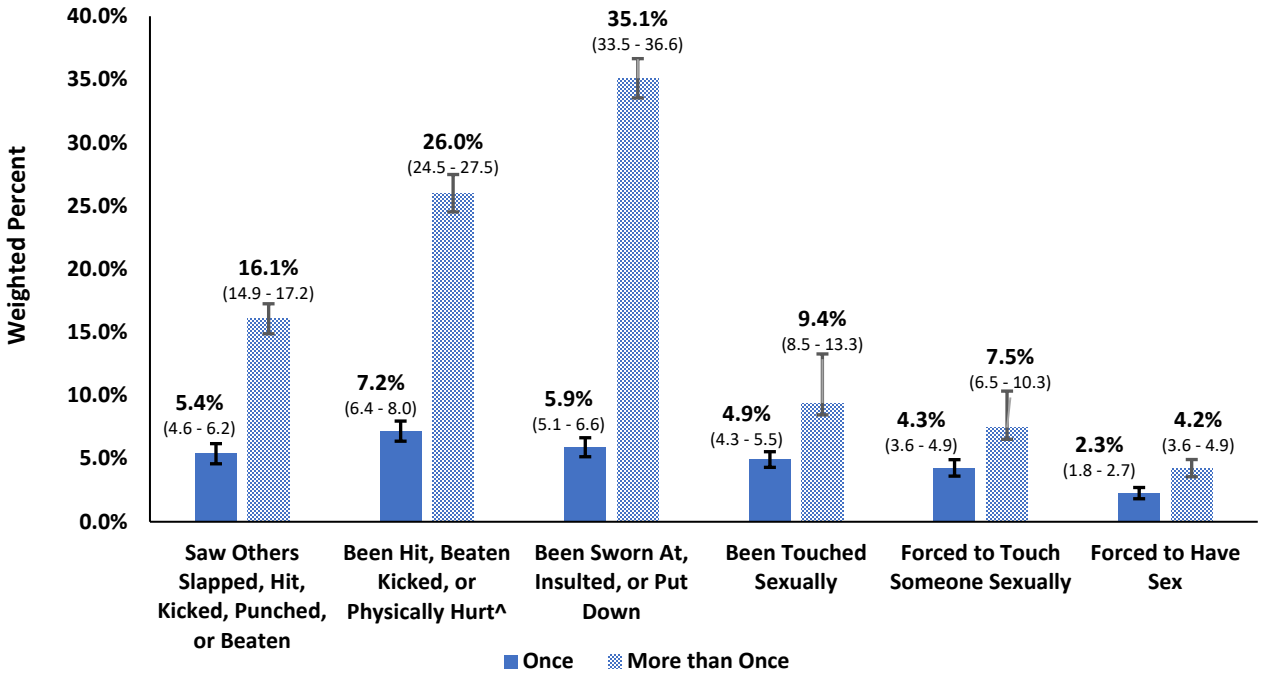


Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 40.0% to display differences among groups.
Childhood refers to before the age of 18.
Questions: "Did you live with anyone who was depressed, mentally ill, or suicidal?"
"Did you live with anyone who was a problem drinker or alcoholic?"
"Did you live with anyone who used illegal street drugs or who abused prescription medications?"
"Did you live with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility?"
95% Confidence Intervals.

[9] About Adverse Childhood Experiences | Adverse Childhood Experiences (ACEs) | CDC

Using combined data from 2019-2023, 41.0% of adults reported that, before the age of 18, they had been sworn at, insulted, or put down at least once, 33.2% were "hit, beaten, kicked, or physically hurt" (not including spanking) at least once, and 14.3% of adults had been touched sexually at least once.

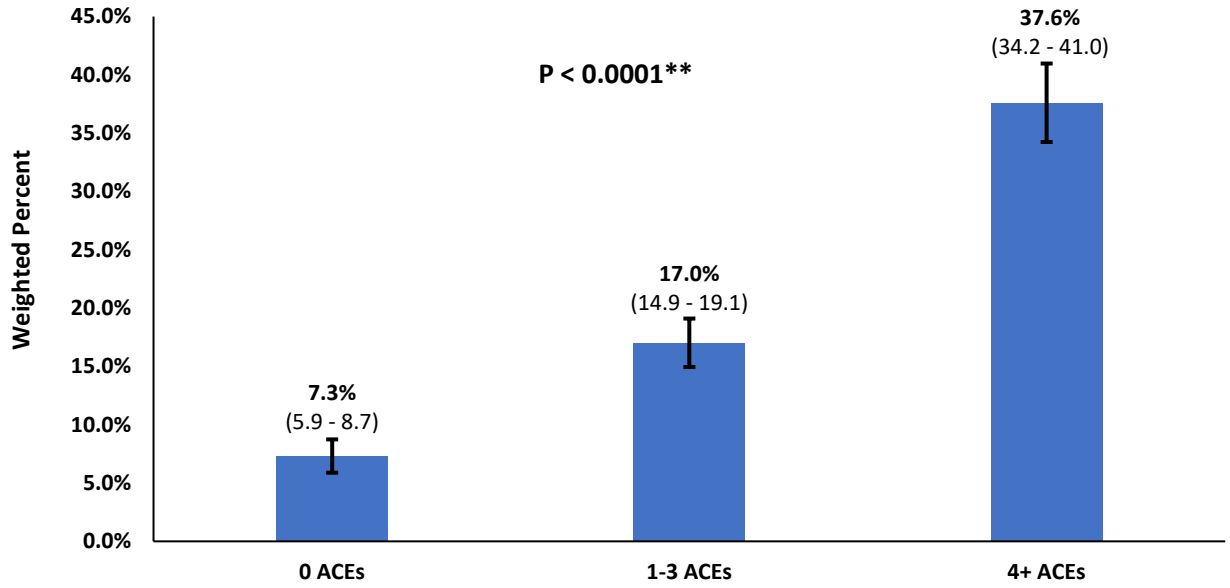
Figure 111. Adult BRFSS Respondents with Adverse Childhood Experiences, Nevada Residents, 2019-2023.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 40.0% to display differences among groups.
Childhood refers to before the age of 18.
Questions: "How often did your parents or adults in your home ever slap, hit, kick, punch or beat each other up?"
"Before age 18, how often did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?"
"How often did a parent or adult in your home ever swear at you, insult you, or put you down?"
"How often did anyone at least 5 years older than you or an adult, touch you sexually?"
"How often did anyone at least 5 years older than you or an adult, try to make you touch them sexually?"
"How often did anyone at least 5 years older than you or an adult, force you to have sex?"
^Does not include spanking.
**Someone at least 5 years older than you or an adult.*
95% Confidence Intervals.

Higher exposure to ACEs is significantly associated with a greater prevalence of depression among adults. Among adults who reported experiencing at least four ACEs, 37.6% also reported having depression, compared to just 7.3% of those reporting depression who experienced no ACEs.

Figure 112. Percentage of BRFSS Respondents who Reported Having Depression, by Number of Adverse Childhood Events, Nevada Residents, 2019-2023.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 45.0% to display differences among groups.
Childhood refers to before the age of 18.
Questions for ACE score:

"How often did your parents or adults in your home ever slap, hit, kick, punch or beat each other up?"
"Before age 18, how often did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?"
"How often did a parent or adult in your home ever swear at you, insult you, or put you down?"
"How often did anyone at least 5 years older than you or an adult, touch you sexually?"
"How often did anyone at least 5 years older than you or an adult, try to make you touch them sexually?"
"How often did anyone at least 5 years older than you or an adult, force you to have sex?"

**Someone at least 5 years older than you or an adult.*
0.05 test of significance.
***Significant P-value.*

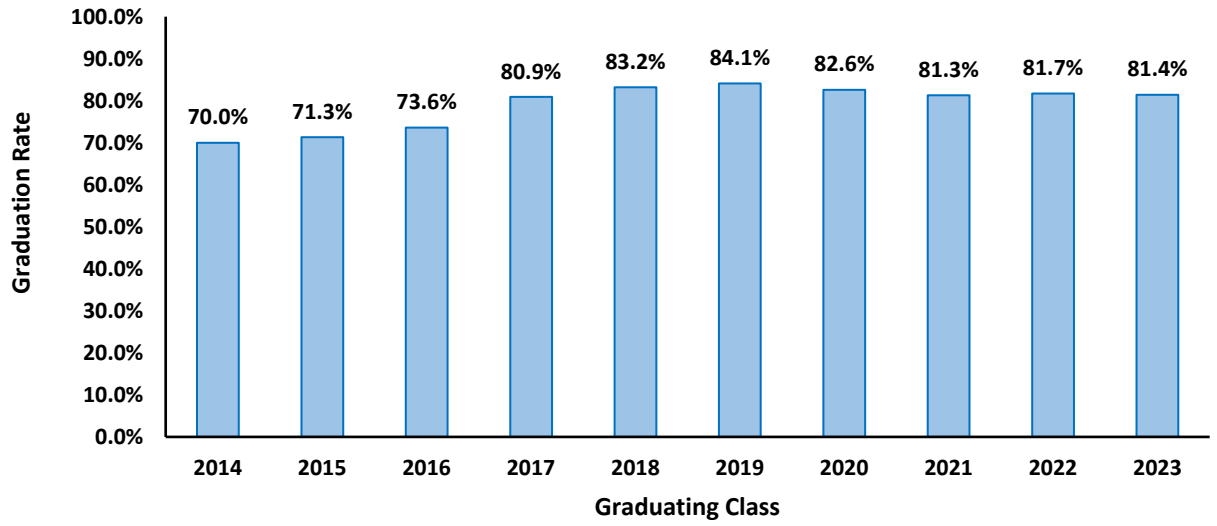
Nevada Report Card

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. This can lead to higher dropout rates, as well as legal and social difficulties in adulthood.[10]

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). The class of 2019 had the highest graduation rate of 84.1%.

Figure 113. High School Graduation Rate, Nevada, Class Cohorts 2014-2023.



Source: Nevada Department of Education, Report Card.

[10] Mental Health in Schools | NAMI

There were 10,195 reports of bullying and 1,140 incidents of cyber bullying during the 2022-2023 school year. Roughly 80% of these incidents involved students who were economically disadvantaged. Most of the bullying involved males (65.8% for males versus 34.2% for females), whereas cyber bullying involved a higher percent of females (57.4% for females versus 42.6% for males).

Table 10. Bullying and Cyber Bullying by Demographics, Nevada Schools, 2022-2023.

	Bullying		Cyber Bullying	
	N	%	N	%
Total	10,195		1,140	
Race/Ethnicity				
American Indian	78	0.8%	9	0.8%
Asian	307	3.0%	52	4.6%
Black	3,058	30.0%	307	26.9%
Pacific Islander	182	1.8%	24	2.1%
Two or More	1,120	11.0%	124	10.9%
White	2,410	23.6%	284	24.9%
Hispanic	3,923	38.5%	443	38.9%
Sex				
Female	3,490	34.2%	654	57.4%
Male	6,705	65.8%	486	42.6%
Other				
Economically Disadvantaged	8,060	79.1%	849	74.5%
English Learners	1,279	12.5%	123	10.8%
Homeless	545	5.3%	36	3.2%
In Foster Care	134	1.3%	5	0.4%
Individuals with Disabilities	2,112	20.7%	161	14.1%
Migratory Children	1	0.0%	0	0.0%
Parents in the Military	90	0.9%	18	1.6%

Source: Nevada Department of Education, Report Card.

Incidents among students are highest among those in economically disadvantaged situations, accounting for more than 65% of incidents of every category. Incidents including weapons or violence occur more among males than females (66.6% and 70.4% for males versus 33.4% and 29.6% for females). Female students were, however, more likely to be involved in incidents involving alcoholic beverages (62.4%).

Table 11. Incidents by Demographics, Nevada Schools, 2022-2023.

	Incidents Including Weapons		Incidents Including Violence		Incidents Including Use of Alcoholic Beverages		Incidents Including Use of Controlled Substances	
Total	1,771		16,844		670		5,052	
Race/Ethnicity								
American Indian	61	3.4%	203	1.2%	29	4.3%	59	1.2%
Asian	28	1.6%	275	1.6%	13	1.9%	80	1.6%
Black	258	14.6%	5,151	30.6%	56	8.4%	1,127	22.3%
Pacific Islander	17	1.0%	239	1.4%	12	1.8%	83	1.6%
Two or More	96	5.4%	1,772	10.5%	50	7.5%	403	8.0%
White	527	29.8%	4,353	25.8%	163	24.3%	979	19.4%
Hispanic	794	44.8%	7,067	42.0%	371	55.4%	2,550	50.5%
Sex								
Female	591	33.4%	4,982	29.6%	418	62.4%	2,041	40.4%
Male	1,180	66.6%	11,862	70.4%	252	37.6%	3,011	59.6%
Other								
Economically Disadvantaged	1,153	65.1%	13,298	78.9%	495	73.9%	4,308	85.3%
English Learners	224	12.6%	2,445	14.5%	119	17.8%	853	16.9%
Homeless	68	3.8%	1,256	7.5%	30	4.5%	267	5.3%
In Foster Care	10	0.6%	350	2.1%	4	0.6%	65	1.3%
Individuals with Disabilities	384	21.7%	5,107	30.3%	495	73.9%	4,308	85.3%
Migratory Children	0	0.0%	0	0.0%	0	0.0%	1	0.0%
Parents in the Military	7	0.4%	125	0.7%	5	0.7%	21	0.4%

Source: Nevada Department of Education, Report Card.

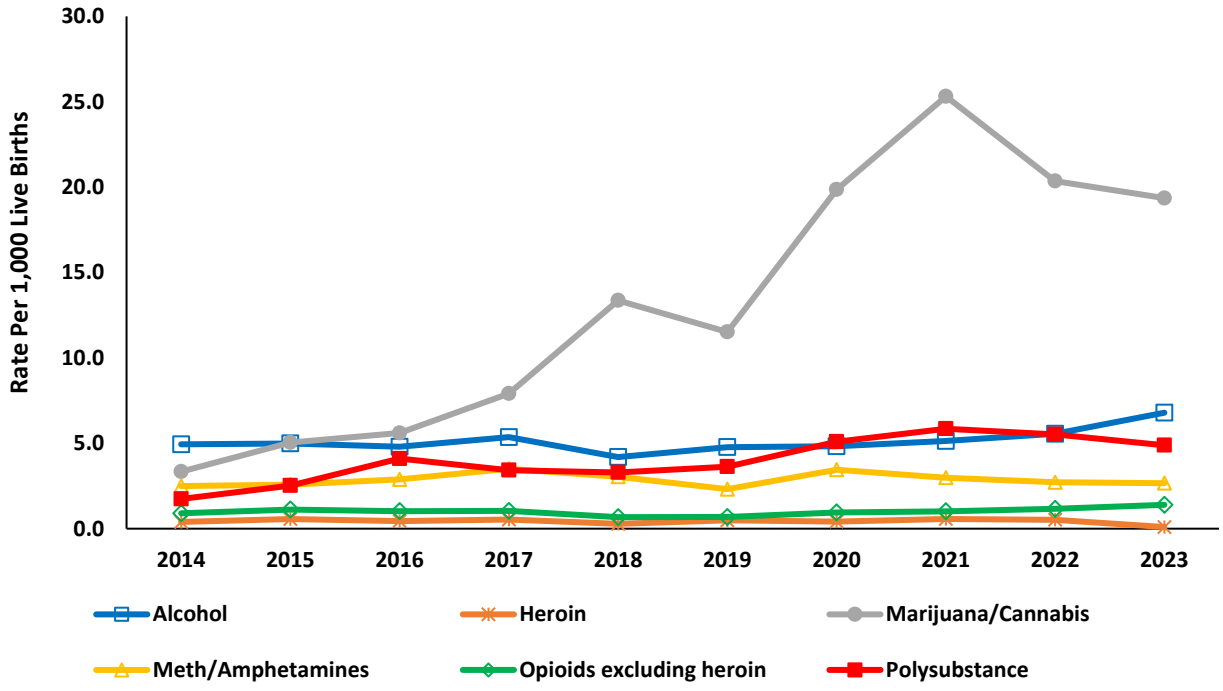
Maternal and Child Health

Substance Use Among Pregnant Nevadans (Births)

The data in this section is reflective of self-reported information provided by the mother on the birth record. Because alcohol and substance use during pregnancy is self-reported, rates are likely lower than actual rates due to underreporting, and pregnant Nevadans may be reluctant to be forthcoming on the birth record for a variety of reasons. On average, there were 34,491 live births per year to Nevada residents between 2014 and 2023. In 2023, 610 birth certificates indicated marijuana use, 154 indicated polysubstance (more than one substance) use, 84 indicated meth/amphetamine use, 44 indicated opiate use, and 3 indicated heroin use during pregnancy.

Of the self-reported substance use during pregnancy among Nevadans who gave birth between 2014 and 2023, the highest rate was with marijuana use in 2021, at 25.3 per 1,000 live births. Polysubstance use (more than one substance) has increased from 1.7 per 1,000 live births in 2014 to a high of 5.9 per 1,000 live births in 2021. The rate of self-reported meth/amphetamine and opioids excluding heroin use has remained fairly steady over the 10-year period. The substance categories are mutually exclusive, with any instance of multiple substance classified as polysubstance use.

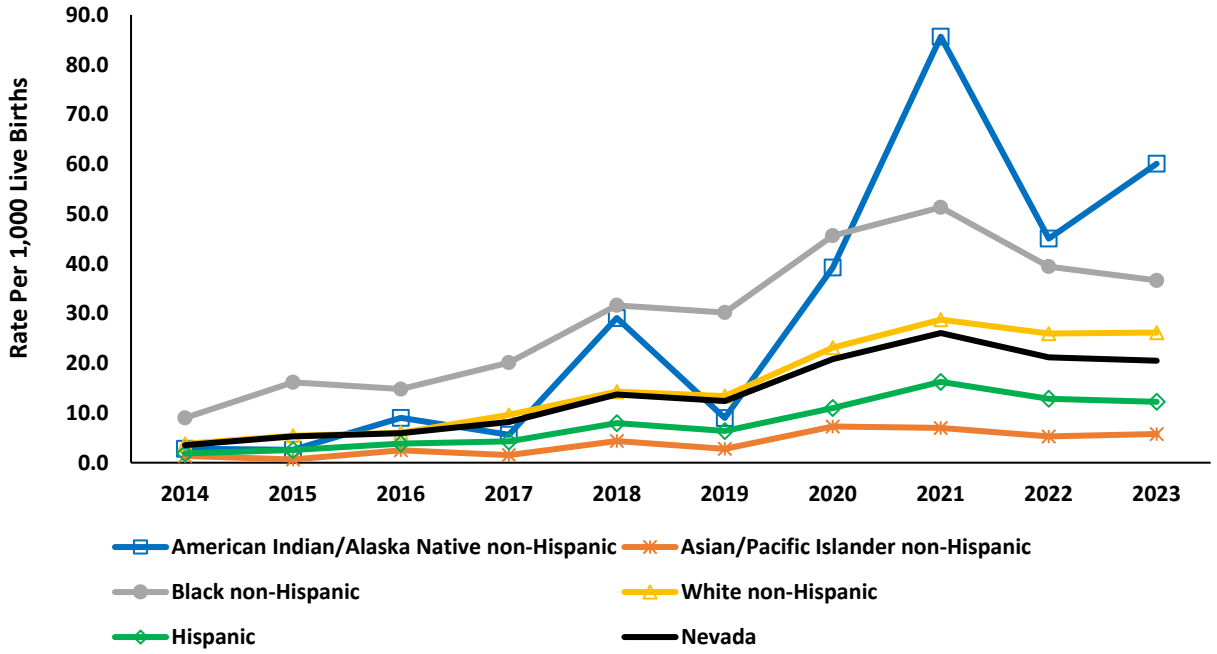
Figure 114. Self-Reported Prenatal Substance Use Birth Rates for Select Substances, Nevada Residents, 2014-2023.



Source: Nevada Electronic Birth Registry System.

The rates of self-reported prenatal marijuana use among Black non-Hispanic and White non-Hispanic are higher than the Nevada overall rates. The rates among the American Indian/Alaska Native non-Hispanic population fluctuate greatly due to small populations and are not statistically significant.

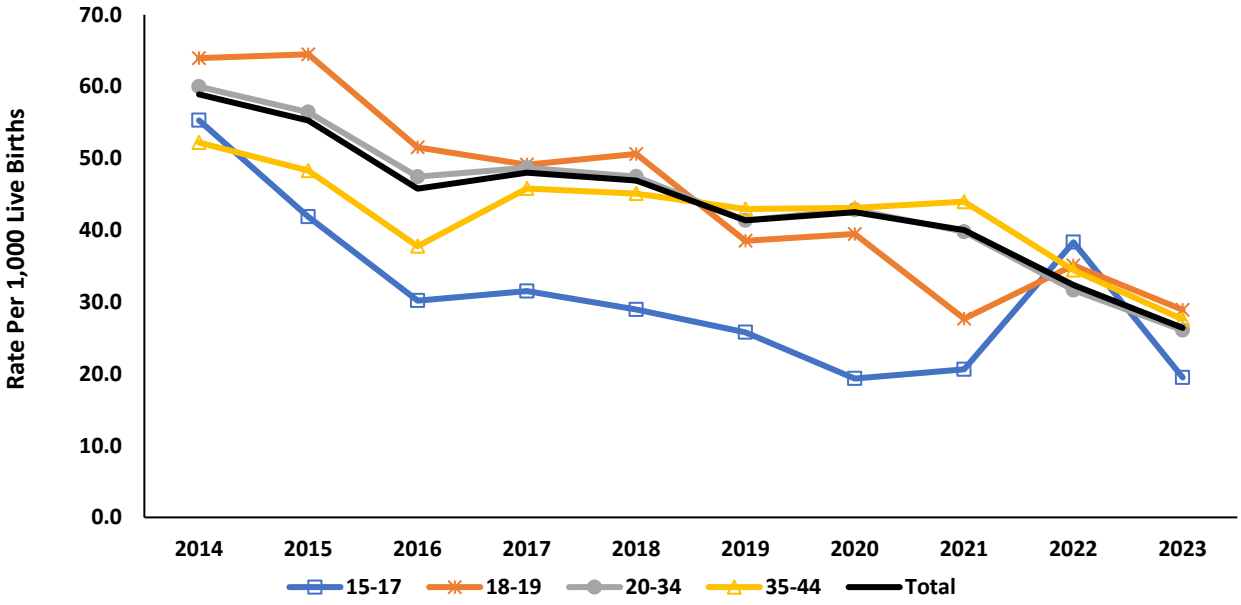
Figure 115. Self-Reported Prenatal Marijuana Use Birth Rates by Race/Ethnicity, Nevada Residents, 2014-2023.



Source: Nevada Electronic Birth Registry System.

Self-reported tobacco use during pregnancy has fluctuated over the years but shows an overall decline across all age groups.

Figure 116. Self-Reported Prenatal Tobacco Use Birth Rates by Maternal Age, Nevada Residents, 2014-2023.



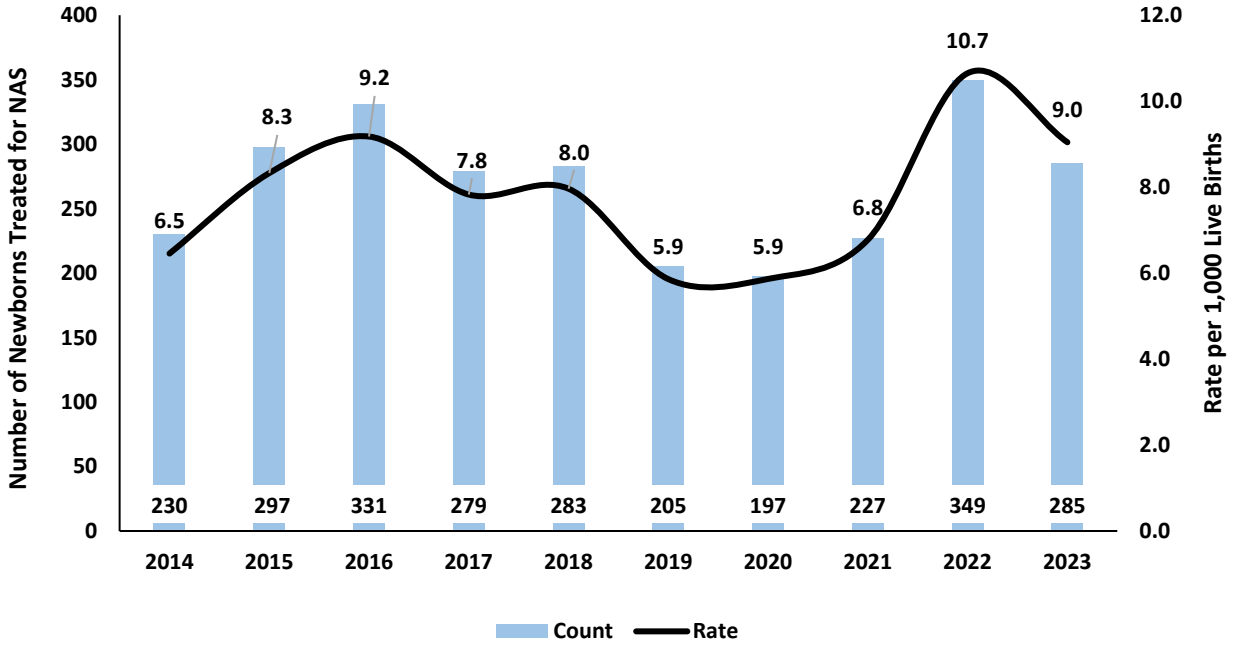
Source: Nevada Electronic Birth Registry System.

Neonatal Abstinence Syndrome

Neonatal abstinence syndrome (NAS) is a group of issues that occur in a newborn who was 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 have fluctuated from 2014 to 2023, peaking in 2022, with 349 admissions and a rate of 10.7 per 1,000 live births.

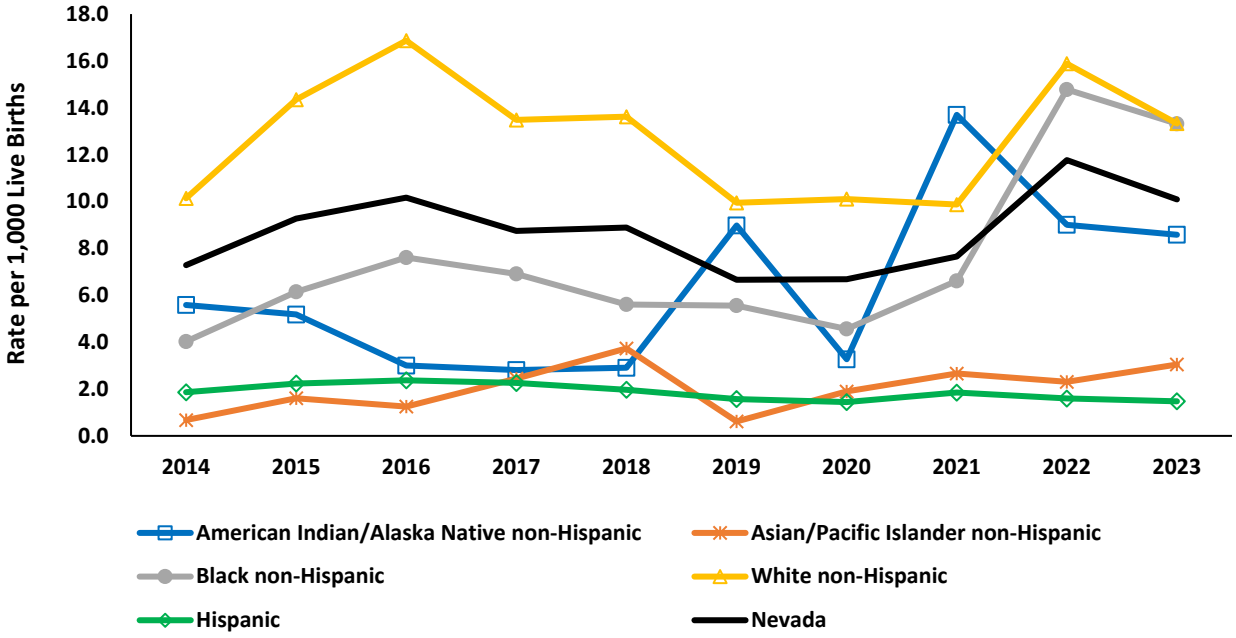
Figure 117. Neonatal Abstinence Syndrome, Nevada Residents, 2014-2023.



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

White non-Hispanic Nevadans have a higher NAS rate compared to all other race/ethnicities for all years except 2023 where the rate was the same for Black non-Hispanic Nevadans.

Figure 118. Neonatal Abstinence Syndrome Rate by Race/Ethnicity, Nevada Residents, 2014-2023.



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

Lesbian, Gay, Bisexual, and Transgender Health

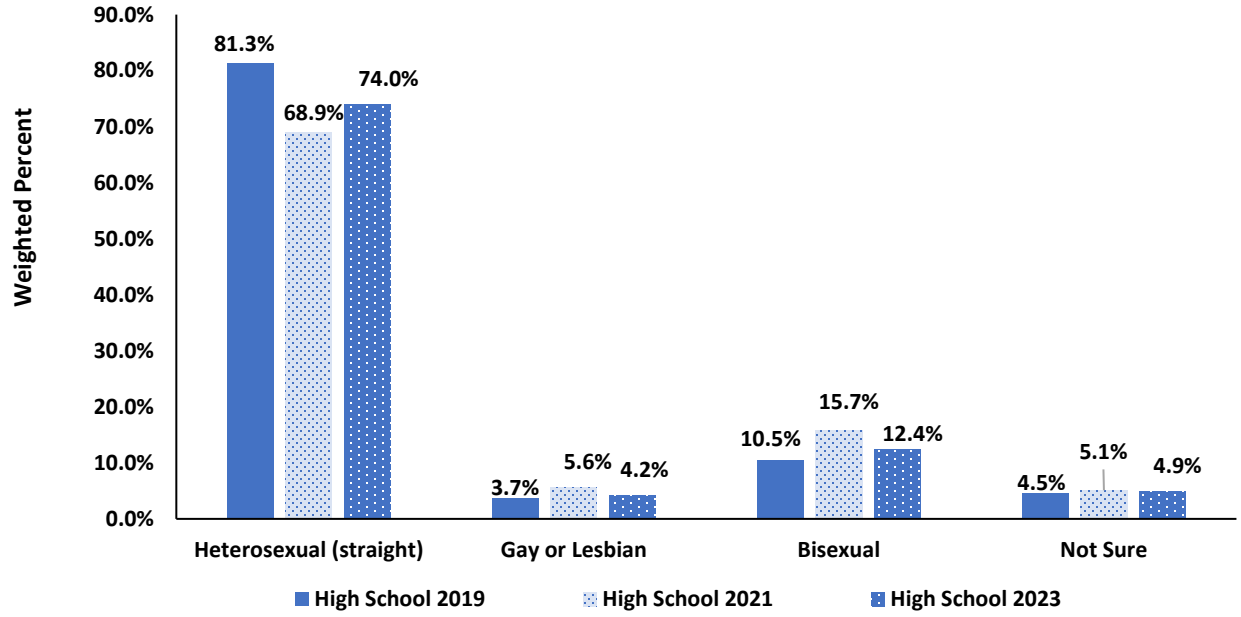
Those who identify as lesbian, gay, bisexual, or transgender (LGBT) are part of a vulnerable community that may face unique or worse health outcomes. This is especially important when considering LGBT youth who may be most at risk for health disparities. This section exists to better understand the unique risk factors that exist for this population.

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. LGB youth included in this report identify as gay or lesbian, bisexual, or not sure. For more detail information about YRBS and sexual orientation and gender identity, the University of Nevada, Reno produced a Sexual and Gender Minority Special Report that was released with 2021 data.

Among Nevada high school students, the percent of persons identifying as heterosexual decreased notably from 2019 to 2021 (81.3% and 68.9%, respectively), and the percent of persons identifying as gay/lesbian or bisexual both increased from 2019 to 2021.

Figure 119. Sexual Orientation, Nevada High School Population, 2019, 2021, and 2023.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 90.0% to display differences among groups.

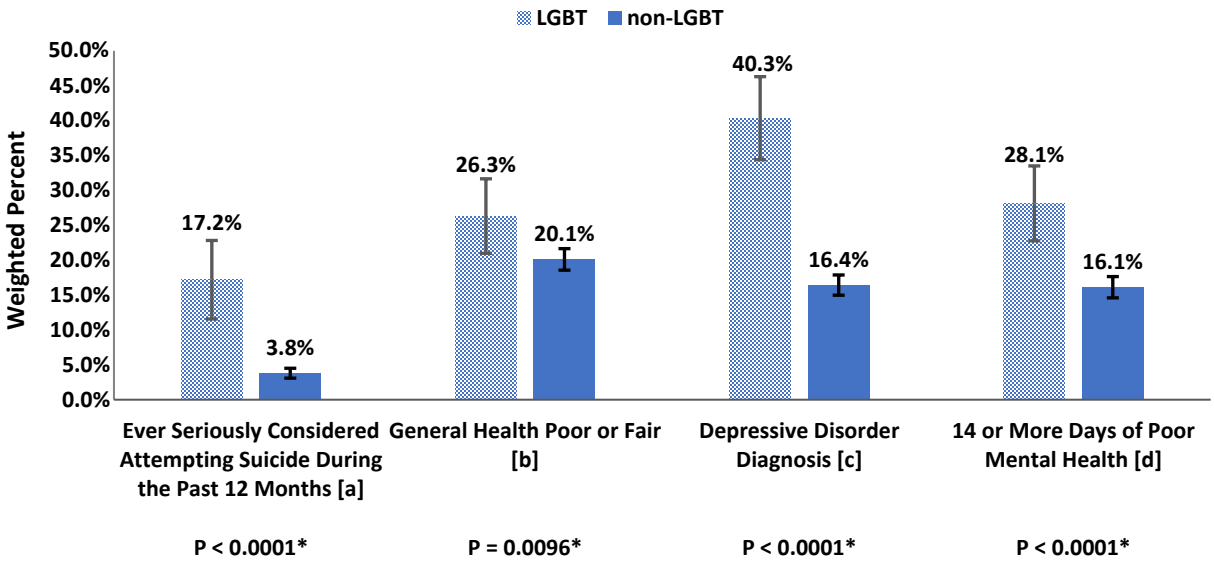
Behavioral Risk Factor Surveillance System

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, alcohol use, and e-cigarette use.

Those in the LGBT community are considered a vulnerable community and may have worse health outcomes when compared to the non-LGBT population. A more in depth look at health outcomes is vital to ensure these health disparities are addressed and analyzed. LGBT data includes those that reported being Lesbian, Gay, Bisexual, Other, and/or Transgender (n=617). The non-LGBT comparison group consists of 6,927 adults.

Adults that are part of the LGBT community were significantly more likely to report having any mental health behavior compared to non-LGBT adults from 2021-2023. LGBT adults were 5 times as likely to report seriously considering attempting suicide within the past 12 months and 2.5 times as likely to have a depressive disorder compared to non-LGBT adults.

Figure 120. Mental Health Behaviors, by LGBT and non-LGBT Nevada Adult BRFSS Respondents, 2021-2023.

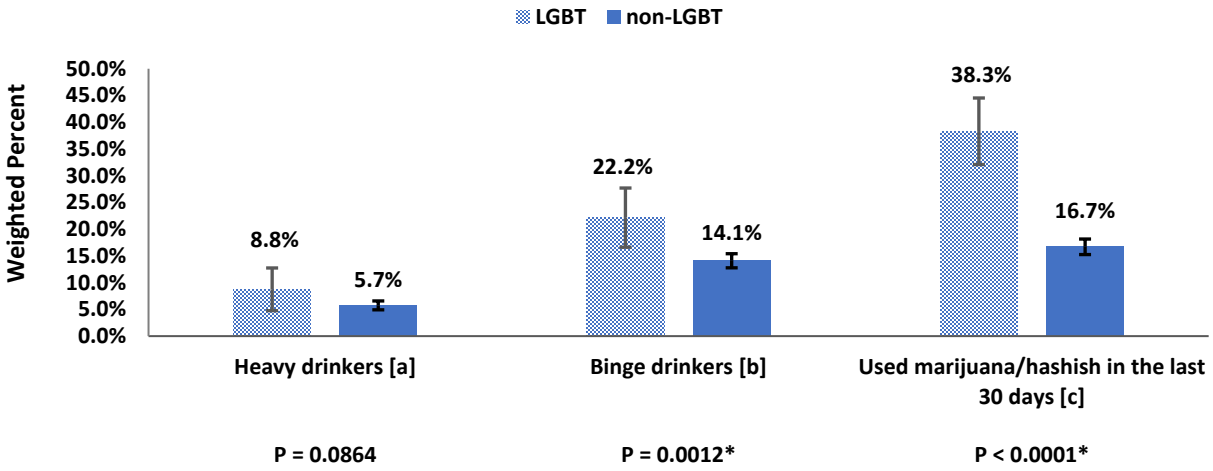


Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 50.0% to display differences among groups.
** Significant (P < 0.05).*
95% Confidence Intervals

a. LGBT (11.6 - 22.8), non-LGBT (3.1 - 4.5)
b. LGBT (21.0 - 31.7), non-LGBT (18.6 - 21.6)
c. LGBT (34.4 - 46.3), non-LGBT (15.0 - 17.9)
d. LGBT (22.8 - 33.5), non-LGBT (14.6 - 17.6)

Adults who are part of the LGBT community were significantly more likely to binge drink or use marijuana with LGBT adults having over twice the prevalence of marijuana usage than non-LGBT adults.

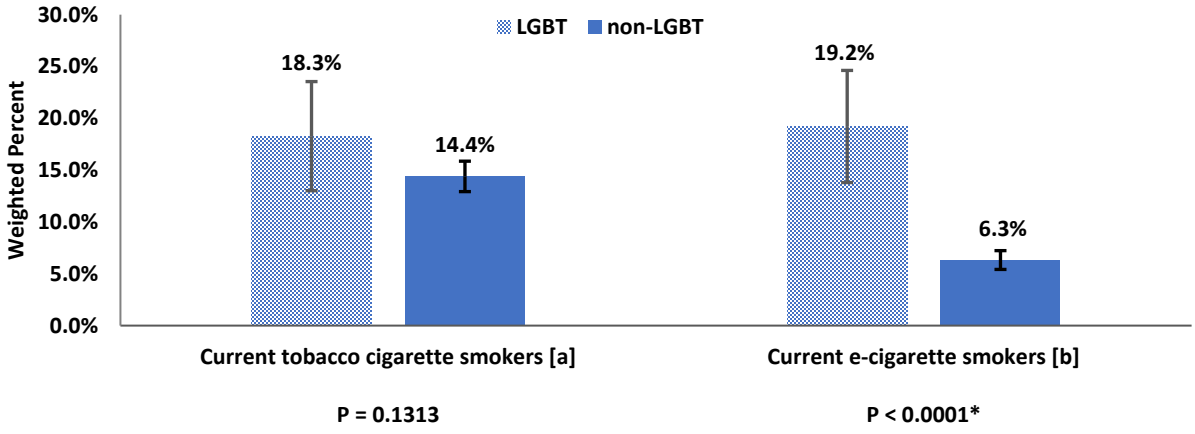
Figure 121. Substance Use-Related Risk Factors, by LGBT and non-LGBT Nevada Adult BRFSS Respondents, 2021-2023.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 50.0% to display differences among groups.
** Significant (P < 0.05).*
95% Confidence Intervals
a. LGBT (4.8 - 12.7), non-LGBT (4.9 - 6.6)
b. LGBT (16.6 - 27.7), non-LGBT (12.8 - 15.4)
c. LGBT (32.1 - 44.5), non-LGBT (15.3 - 18.2)

Adults who are part of the LGBT community were significantly more likely to be current e-cigarette smokers (three times more likely) than non-LGBT adults.

Figure 122. Current Cigarette Smokers, by LGBT and non-LGBT Nevada Adult BRFSS Respondents, 2021-2023.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 30.0% to display differences among groups.
** Significant (P < 0.05).*
95% Confidence Intervals
a. LGBT (13.0 - 23.5), non-LGBT (12.9 - 15.9)
b. LGBT (13.8 - 24.6), non-LGBT (5.4 - 7.2)

Department of Health and Human Services | January 2025

Cannabis

Legal Cannabis in Nevada

Legislation to allow licensed cannabis sales in Nevada was approved in 2013, the first medical cannabis dispensary opened in Nevada in 2017, and cannabis became legal for recreational use in Nevada on January 1, 2017. Figures 123a, 123b, and 123c below display the locations of the State of Nevada licensed cannabis dispensaries. Licensing is managed by the State of Nevada Cannabis Compliance Board (see NV CCB for more information). Note that there are tribal cannabis establishments in Nevada; these establishments are not licensed through the State of Nevada Cannabis Compliance Board and therefore are not shown on the maps.

While cannabis is legal in Nevada, according to the Substance Abuse and Mental Health Services Administration (SAMHSA), its use can have negative and long-term effects on brain health, mental health, and infant and fetal health and development. For more information: SAMHSA - Marijuana Risks

Figure 123a. Prevention Coalitions and Licensed Cannabis Dispensary Locations.

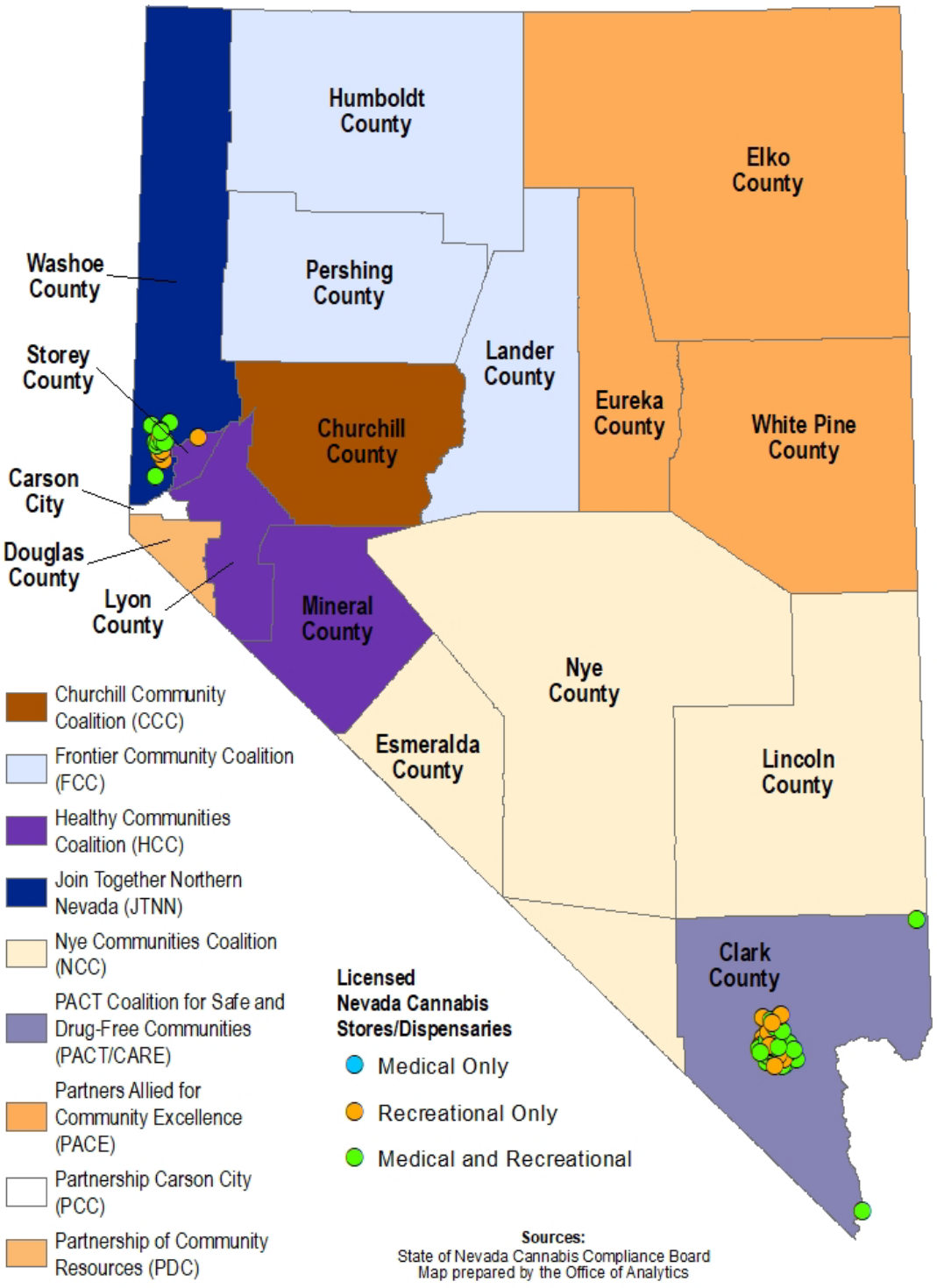


Figure 123b. Las Vegas Area, Nevada Licensed Cannabis Dispensary Locations.

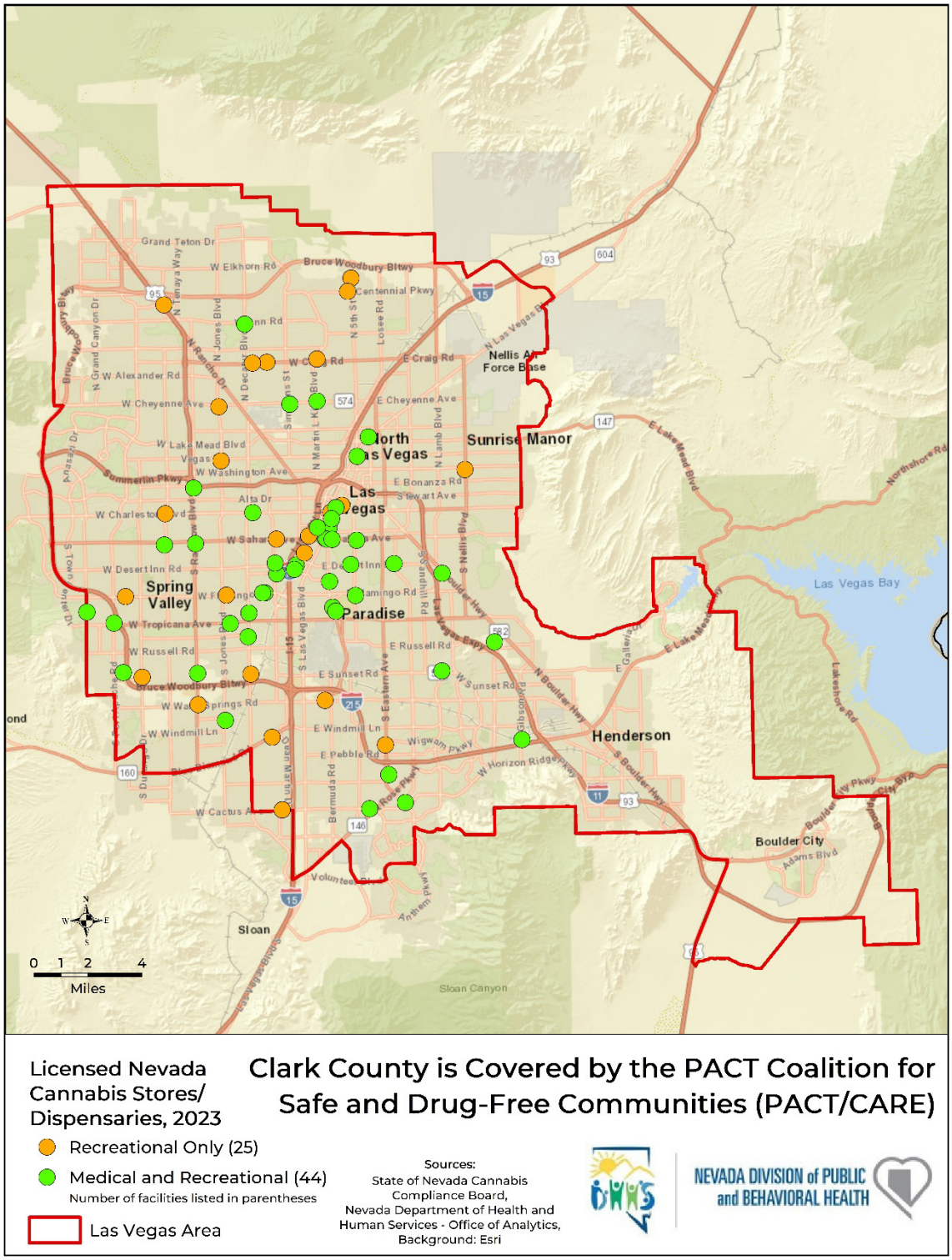
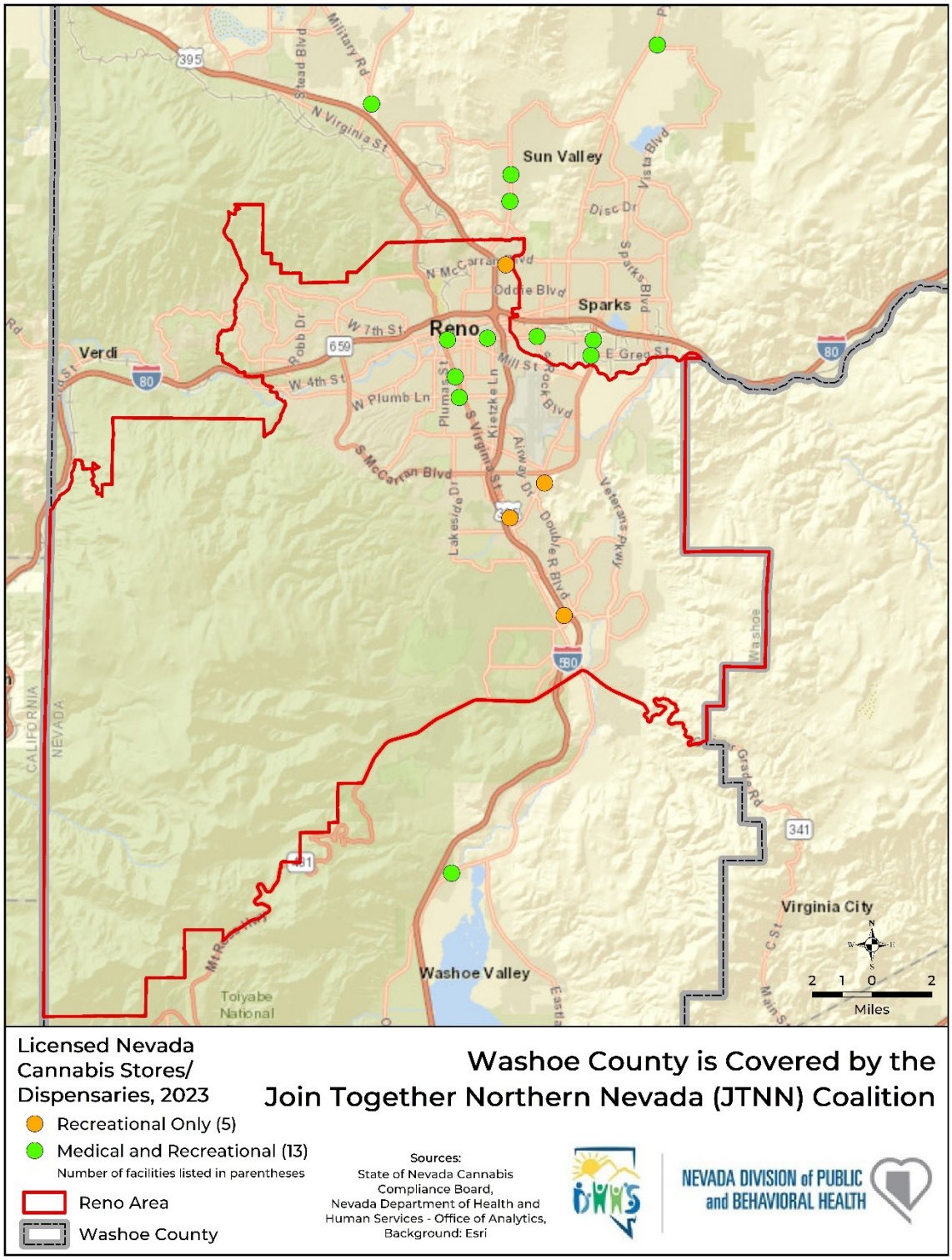


Figure 123c. Washoe County, Nevada Licensed Cannabis Dispensary Locations.



Unhoused Population in Nevada

Projects for Assistance in Transition from Homelessness (PATH)

The PATH program is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency within the US Department of Health and Human Services that focuses on behavioral health. Nationwide, the PATH program enrolls clients in the following services:

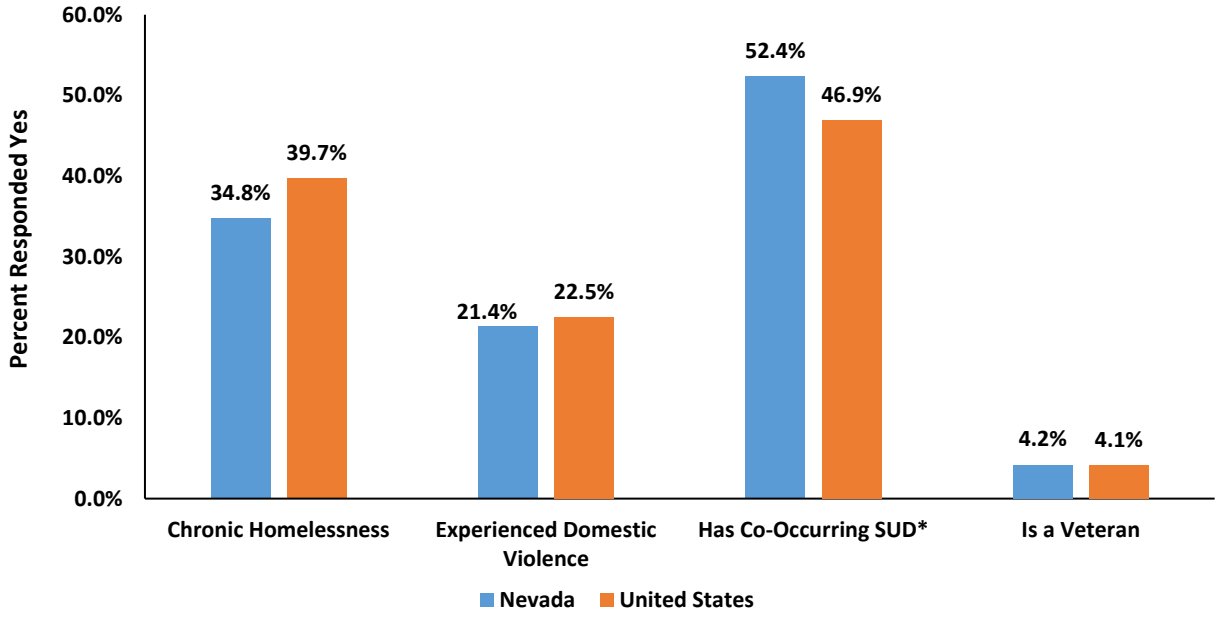
- Outreach
- Screening and diagnostic treatment
- Habilitation and rehabilitation
- Community mental health
- Substance use disorders treatment
- Referrals for primary health care, job training, educational services, and housing
- Housing services as specified in Section 522(b)(10) of the Public Health Service Act

For more information: PATH Program

In Nevada, there were 1,188 active enrolled persons in the PATH program during the Fiscal Year 2023 (FY23) reporting period.

Nevada PATH participants had a higher rate of self-reported co-occurring substance use disorders and lower rates of experiencing chronic homelessness and domestic violence than national reporting.

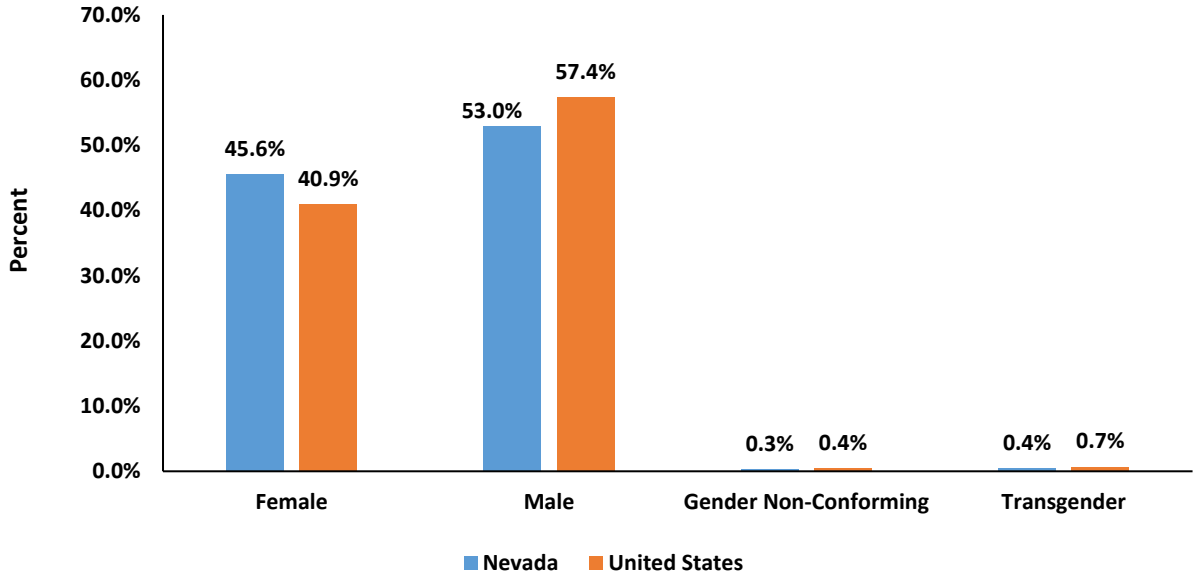
Figure 124. PATH Participants, Nevada and United States, 2023.



Source: Projects for Assistance in Transition from Homelessness (PATH).
Chart scaled to 60.0% to display differences among groups.
**SUD = Substance use disorder.*

Nevada PATH participants were higher percentage female than the gender split seen at the national level.

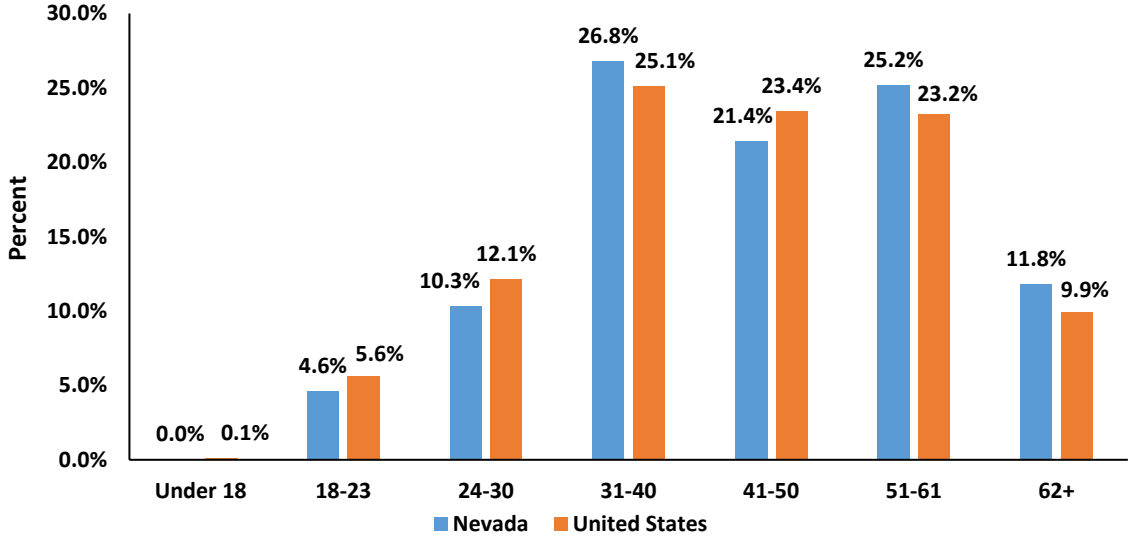
Figure 125. PATH Participants by Gender*, Nevada and United States, 2023.



Source: Projects for Assistance in Transition from Homelessness (PATH).
Chart scaled to 70.0% to display differences among groups.
**Don't know/refused/missing gender not included in analysis.*

The age distribution of Nevada PATH participants is similar to that of programs nation-wide with roughly 50% of participants between age 31 and 50, and nearly 75% age 31-61.

Figure 126. PATH Participants by Age Group*, Nevada and United States, 2023.



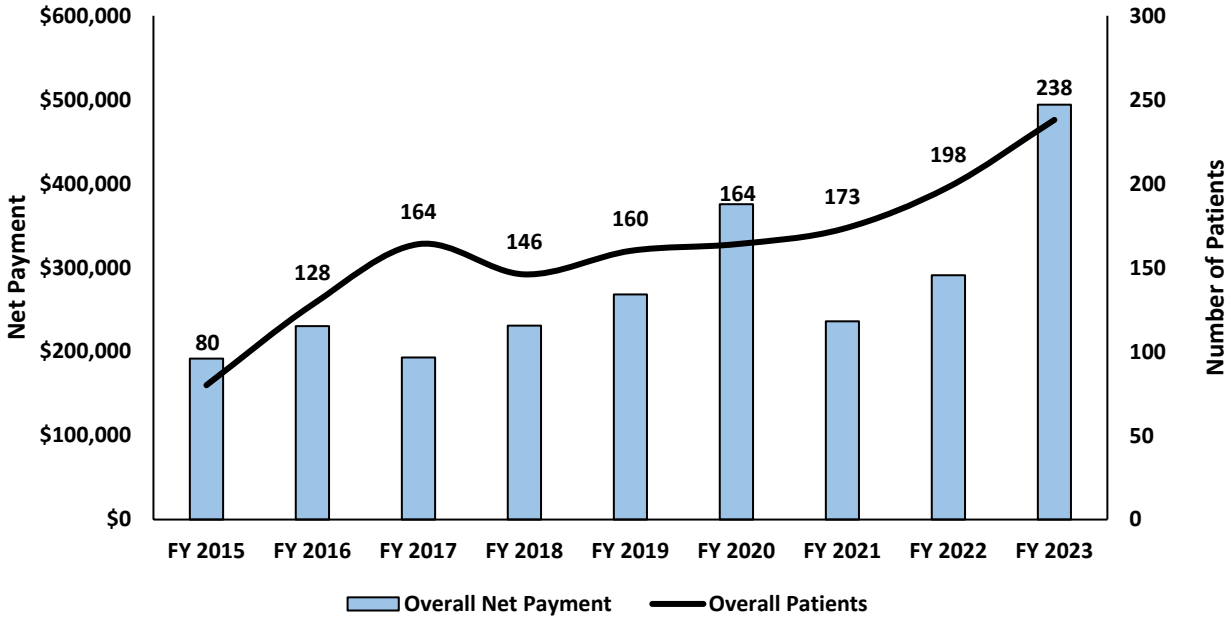
Source: Projects for Assistance in Transition from Homelessness (PATH).
Chart scaled to 30.0% to display differences among groups.
**Don't know/refused/missing age not included in analysis.*

Gambling

Gambling has been legal in Nevada for over 90 years and has long been a cultural and economic cornerstone the of state. Problem gambling (also called gambling addiction or gambling disorder) is a behavioral health issue recognized by the DSM-5 and for which anyone who gambles is at risk. Problem gambling can be disruptive to the lives of those who suffer and can result in financial and legal issues as well as mental health issues like depression and suicidality.[11]

Medicaid patients in Nevada can access services for pathological gambling. Figure 121 below shows the number of Medicaid-insured patients with this diagnosis as well as the total claims costs for associated services. Both have been increasing overall since fiscal year 2015, with the exception of a notable drop in net claims payments in FY 2021 and FY 2022.

Figure 127. Medicaid-Paid Patients with Pathological Gambling Diagnosis and Rates, Clients and Payment, State Fiscal Years 2015-2023.



Sources: DSS and Medicaid Data Warehouse.
This includes the costs for all claims that had a Pathological Gambling Diagnosis. Net Payment represents only paid claims.
Patients were identified using Pathological Gambling diagnosis codes 312.31 (ICD 9) and F63.0 (ICD 10) from paid claims. Patients is a unique count by plan and year. Since patients can have claims in multiple years or move between Fee For Service and MCO, the grand total of patients may be less than the sum by year or by plan.
Net Payment represents paid amount after all pricing guidelines have been applied, and all third party, copayment, coinsurance, and deductible amounts have been subtracted. Due to capitated arrangements, the Managed Care costs included in this analysis are direct costs to the Managed Care Organizations but are not reflective of the direct costs to the State.

[11] https://www.ncpgambling.org/help-treatment/faqs-what-is-problem-gambling/

The following figure is from the University of Nevada, Las Vegas, Nevada Problem Gambling Study, Fiscal Year 2023 (FY23). This report examines the effectiveness of state-funded treatment services for problem gambling.

Table 12. Treatment System Summary.

Total number of people receiving a problem gambling evaluation in FY23	**427**
Outpatient Services	
Number of gamblers entering outpatient treatment	279
Average number of sessions per client treatment episode	20
Average cost per client treatment episode	$1,225
Number of concerned others entering outpatient treatment	28
Average number of sessions per client treatment episode	9
Average cost per client treatment episode	$1,036
Residential Services	
Number of clients entering residential gambling treatment	49
Average length of stay in residential treatment	23 days
Maximum length of stay in residential treatment	31 days
Average cost per client treatment episode	$3,054
Percent change in the number of clients from FY20	-33%
Number of clients receiving assessment only	78
Number of clients receiving court-referred treatment	34
Access	
Average number of days between first contact and first available service	1.5
Average number of days between first contact and treatment entry	3.6
Average number of days between first available date and treatment entry	2.1
Average number of days between treatment entry and treatment exit	63
Successful Completion of Treatment Program	
Total non-adjusted percent of successfully discharged clients	32%
Percent of successfully discharged clients, adjusted for external factors	69%

Source: University of Nevada, Las Vegas, International Gaming Institute.

Appendix

Hospital billing data (emergency department encounters 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 mortality where the ICD codes are 4-digit. In hospital billing data, the ICD codes are provided in the diagnosis fields, while mortality 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.

For more detailed ICD-9-CM codes: Legacy ICD-9-CM billing codes
For more detailed ICD-10-CM codes: ICD-10-CM billing codes
For more detailed ICD-10 mortality codes: ICD-10 mortality codes

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

All Diagnosis:

Anxiety: 300.0 (9); F41 (10)
Bipolar: 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, F32.A (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)

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: F10, K70, Y90, Y91, X45, X65, Y15, T51, G31.2, G62.1, I42.6, K29.2, K86.0, K85.0, R78.0, E24.4, O35.4, Q86.0, and Z72.1 (Initial or contributing cause of death)
Drug-overdose deaths: X40-X44, X60-S64, X85, Y10-Y14 (Initial cause of death)
Other overdose deaths: T36-T65

Data Tables

Table A1. Population Distribution, Nevada, 2014-2023.

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Nevada	2,843,301	2,897,684	2,953,377	2,986,656	3,057,583	3,112,935	3,165,506	3,214,260	3,204,105	3,271,898
Sex										
Female	1,410,857	1,440,920	1,470,250	1,488,221	1,525,385	1,554,484	1,582,048	1,607,496	1,604,926	1,640,562
Male	1,432,444	1,456,765	1,483,127	1,498,435	1,532,198	1,558,451	1,583,458	1,606,764	1,599,179	1,631,336
Age										
<1	35,964	35,453	36,460	37,252	37,719	38,864	39,728	40,549	32,775	34,865
1-4	144,034	145,106	146,339	146,925	151,760	154,870	158,599	161,470	141,471	141,264
5-14	391,533	405,007	407,823	408,426	410,912	411,315	411,014	408,772	401,387	401,823
15-24	379,820	387,182	394,928	395,471	406,901	416,609	425,381	436,095	445,006	459,419
25-34	381,591	396,649	407,260	416,478	430,745	441,557	451,808	458,966	457,842	467,693
35-44	399,542	398,838	403,408	405,872	413,408	417,567	422,029	426,557	425,738	431,964
45-54	385,828	387,647	394,646	396,403	399,657	402,950	406,753	410,681	410,279	420,117
55-64	338,075	344,172	351,960	356,916	366,052	374,473	379,965	384,568	386,633	394,890
65-74	241,857	248,456	254,595	260,147	269,994	277,072	286,230	295,608	303,495	312,533
75-84	108,183	111,916	117,805	123,615	130,587	136,750	141,611	146,423	153,968	160,574
85+	36,876	37,258	38,153	39,151	39,846	40,907	42,387	44,571	45,511	46,756
Race/Ethnicity										
White non-Hispanic	1,528,666	1,530,902	1,539,684	1,541,655	1,554,968	1,564,311	1,570,730	1,575,891	1,574,210	1,585,324
Black non-Hispanic	238,788	247,229	254,921	259,779	268,945	276,025	283,256	290,120	292,121	301,971
Native American/Alaska Native non-Hispanic	32,424	34,075	34,353	34,787	35,291	35,573	35,939	36,119	35,354	35,357
Asian/Pacific Islander non-Hispanic	250,934	265,838	276,711	282,653	296,201	306,212	316,281	325,604	320,719	334,120
Hispanic	792,488	819,641	847,708	867,782	902,178	930,815	959,300	986,526	981,700	1,015,127
Behavioral Health Region										
Clark County	2,069,450	2,118,353	2,166,177	2,193,818	2,251,175	2,293,391	2,337,410	2,378,903	2,338,127	2,392,158
	72.8%	73.1%	73.3%	73.5%	73.6%	73.7%	73.8%	74.0%	73.0%	73.1%
Northern Region	189,527	189,481	191,019	192,540	195,223	197,005	199,193	200,797	202,433	205,296
	6.7%	6.5%	6.5%	6.4%	6.4%	6.3%	6.3%	6.2%	6.3%	6.3%
Rural Region	96,141	95,803	96,130	95,845	96,867	98,020	97,167	96,110	99,667	99,870
	3.4%	3.3%	3.3%	3.2%	3.2%	3.1%	3.1%	3.0%	3.1%	3.1%
Southern Region	51,386	52,101	51,744	52,530	54,080	54,718	55,597	56,304	62,243	62,999
	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.9%	1.9%
Washoe County	436,797	441,946	448,307	451,923	460,237	469,801	476,139	482,146	501,635	511,575
	15.4%	15.3%	15.2%	15.1%	15.1%	15.1%	15.0%	15.0%	15.7%	15.6%

Source: Nevada State Demographer, Vintage 2023.

Table A2. Age-Adjusted Rates per 100,000 Population of Mental Health-Related Emergency Department Encounters by Year, Nevada Residents, 2014-2023.

Year	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicide Ideation
2014	248.3 (242.5-254.1)	1,345.4 (1,332.0-1,358.9)	924.4 (913.3-935.4)	423.9 (416.3-431.4)	102.8 (099.0-106.5)	312.2 (305.7-318.7)
2015	256.3 (250.5-262.2)	1,439.2 (1,425.4-1,453.0)	985.2 (973.9-996.6)	439.1 (431.5-446.8)	108.2 (104.4-112.0)	354.9 (348.0-361.7)
2016	251.7 (246.0-257.5)	1,658.2 (1,643.6-1,672.9)	1,058.1 (1,046.5-1,069.7)	489.7 (481.7-497.7)	132.1 (128.0-136.3)	381.6 (374.5-388.7)
2017	312.0 (305.7-318.4)	1,777.1 (1,762.0-1,792.2)	1,023.3 (1,011.9-1,034.6)	586.8 (578.1-595.5)	176.6 (171.8-181.4)	487.6 (479.7-495.6)
2018	358.4 (351.6-365.1)	1,897.0 (1,881.6-1,912.3)	1,162.5 (1,150.6-1,174.5)	648.4 (639.4-657.5)	192.4 (187.5-197.3)	561.5 (553.0-570.0)
2019	443.6 (436.2-451.0)	1,938.4 (1,923.0-1,953.8)	1,208.3 (1,196.2-1,220.4)	704.8 (695.4-714.1)	242.0 (236.5-247.5)	525.6 (517.5-533.7)
2020	510.6 (502.6-518.5)	1,777.2 (1,762.6-1,791.8)	1,208.3 (1,089.9-1,112.8)	677.7 (668.6-686.8)	196.1 (191.2-201.0)	540.8 (532.6-549.0)
2021	425.6 (418.3-432.8)	1,508.0 (1,494.6-1,521.4)	828.6 (818.7-838.5)	605.5 (596.9-614.1)	117.7 (113.9-121.4)	571.6 (563.2-580.1)
2022	359.2 (352.6-365.8)	1,218.5 (1,206.5-1,230.5)	624.8 (616.2-633.3)	482.9 (475.3-490.5)	117.7 (091.2-098.0)	534.4 (526.4-542.5)
2023	303.0 (297.1-309.0)	1,078.2 (1,067.1-1,089.3)	588.6 (580.4-596.7)	412.4 (405.5-419.3)	88.6 (085.3-091.8)	465.1 (457.7-472.6)

Source: Hospital Emergency Department Billing.
Rates are per 100,000 age-specific population, provided by the state demographer, Vintage 2023.
Categories are not mutually exclusive.

Table A3. Age-Adjusted Rates per 100,000 Population of Mental Health-Related Inpatient Admissions by Year, Nevada Residents, 2014-2023.

Year	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicidal Ideation
2014	127.6 (123.6-131.7)	777.6 (767.6-787.6)	935.3 (924.3-946.3)	270.7 (264.8-276.6)	98.5 (094.9-102.0)	258.6 (252.7-264.5)
2015	219.5 (214.1-224.8)	877.2 (866.7-887.8)	1,065.8 (1,054.1-0,017.0)	404.7 (397.5-411.9)	139.7 (135.4-144.0)	407.0 (399.6-414.3)
2016	196.5 (191.5-201.5)	943.5 (932.7-954.3)	1,043.5 (1,032.1-1,054.8)	401.0 (393.9-408.1)	149.9 (145.6-154.3)	223.0 (217.6-228.4)
2017	177.8 (173.1-182.5)	999.2 (988.2-1,010.2)	1,086.2 (1,074.7-1,097.8)	419.8 (412.6-427.1)	161.8 (157.3-166.4)	431.2 (423.7-438.6)
2018	208.6 (203.5-213.6)	1,109.6 (1,098.1-1,121.1)	1,094.1 (1,082.7-1,105.5)	462.3 (454.8-469.8)	187.9 (183.1-192.8)	551.8 (543.5-560.2)
2019	209.6 (204.6-214.6)	1,100.9 (1,089.6-1,112.2)	1,053.6 (1,042.5-1,064.7)	447.1 (439.8-454.4)	208.2 (203.1-213.2)	573.2 (564.8-581.6)
2020	217.00 (211.9-222.1)	1,089.0 (1,077.9-1,100.2)	960.6 (950.1-971.1)	445.5 (438.2-452.7)	209.4 (204.3-214.4)	537.6 (529.5-545.6)
2021	217.92 (212.8-223.0)	1,118.1 (1,106.8-1,129.4)	970.4 (959.9-980.9)	435.7 (428.6-442.9)	222.3 (217.1-227.4)	511.1 (503.2-519.0)
2022	236.64 (231.4-241.9)	1,122.6 (1,111.4-1,133.8)	965.3 (954.9-975.7)	445.0 (437.8-452.1)	214.7 (209.6-219.7)	569.1 (560.8-577.4)
2023	219.59 (214.6-224.6)	1,045.6 (1,034.8-1,056.3)	861.5 (851.8-871.2)	390.7 (384.0-397.3)	208.8 (203.9-213.7)	538.9 (530.9-546.8)

Source: Hospital Inpatient Billing.
Rates are per 100,000 age-specific population, provided by the Nevada State Demographer, Vintage 2023.
Categories are not mutually exclusive.

Table A4. Age-Adjusted Rates per 100,000 Population Drug-Related Emergency Department Encounters by Drug Type and Year, Nevada Residents, 2014-2023.

Year	Opioids	Heroin	Marijuana/ Hallucinogens	Cocaine	Methamphetamines	Marijuana	Hallucinogens
2014	154.0 (149.5-158.5)	8.8 (7.7-9.9)	230.1 (224.5-235.7)	43.3 (40.9-45.7)	211.1 (205.7-216.5)	- -	- -
2015	190.4 (185.5-195.4)	10.9 (9.7-12.1)	261.8 (255.9-267.8)	57.8 (55.0-60.5)	293.3 (287.0-299.6)	- -	- -
2016	246.4 (240.8-252.0)	12.0 (10.7-13.2)	- -	67.5 (64.5-70.4)	403.4 (396.1-410.7)	451.2 (443.5-458.9)	9.0 (7.9-10.1)
2017	232.2 (226.8-237.6)	12.1 (10.9-13.4)	- -	71.6 (68.5-74.6)	406.3 (399.0-413.6)	431.0 (423.5-438.5)	12.7 (11.4-14.0)
2018	204.6 (199.5-209.6)	12.7 (11.4-14.0)	- -	77.9 (74.8-81.0)	459.0 (451.3-466.7)	397.1 (390.0-404.2)	16.1 (14.7-17.6)
2019	189.3 (184.5-194.1)	12.3 (11.1-13.6)	- -	70.4 (67.5-73.3)	487.0 (479.2-494.9)	381.0 (374.1-387.9)	19.8 (18.2-21.4)
2020	178.2 (173.6-182.9)	11.9 (10.7-13.1)	- -	62.4 (59.6-65.1)	515.4 (507.3-523.4)	390.5 (383.6-397.5)	21.4 (19.7-23.0)
2021	181.1 (176.5-185.8)	12.8 (11.5-14.1)	- -	56.8 (54.2-59.4)	472.9 (465.3-480.6)	338.3 (331.9-344.8)	17.7 (16.2-19.2)
2022	183.1 (178.5-187.8)	8.1 (7.1-9.1)	- -	68.1 (65.2-70.9)	505.3 (497.4-513.1)	720.4 (711.1-729.7)	16.3 (14.9-17.8)
2023	206.5 (201.6-211.4)	3.4 (2.8-4.1)	- -	77.4 (74.4-80.4)	489.4 (481.8-497.1)	714.4 (705.2-723.5)	11.5 (10.4-12.7)

Source: Hospital Emergency Department Billing.
Rates are per 100,000 age-specific population, provided by the Nevada State Demographer, Vintage 2023.
Categories are not mutually exclusive.

Table A5. Age-Adjusted Rates per 100,000 Population Drug-Related Inpatient Admissions by Drug Type and Year, Nevada Residents, 2014-2023.

Year	Opioids	Heroin	Marijuana/ Hallucinogens	Cocaine	Methamphetamines	Marijuana	Hallucinogens
2014	175.0 (170.2-179.7)	2.4 (1.9-3.0)	151.4 (146.9-155.9)	48.4 (45.9-50.8)	140.8 (136.5-145.2)	- -	- -
2015	228.1 (222.7-233.5)	3.6 (2.9-4.3)	175.7 (170.9-180.5)	62.8 (59.9-65.6)	226.5 (221.0-232.0)	- -	- -
2016	289.4 (283.4-295.4)	3.5 (2.8-4.2)	- -	62.1 (59.3-64.9)	277.6 (271.6-283.7)	282.2 (276.2-288.2)	4.8 (4.0-5.6)
2017	285.4 (279.5-291.3)	3.9 (3.2-4.6)	- -	62.1 (59.3-64.9)	316.7 (310.3-323.1)	342.4 (335.8-349.0)	5.5 (4.6-6.3)
2018	303.6 (297.6-309.6)	5.2 (4.4-6.0)	- -	73.0 (70.1-76.0)	390.5 (383.5-397.5)	438.9 (431.6-446.3)	6.7 (5.7-7.6)
2019	291.2 (285.4-297.0)	3.7 (3.0-4.4)	- -	75.7 (72.7-78.7)	400.1 (393.1-407.1)	468.7 (461.2-476.3)	7.2 (6.3-8.2)
2020	260.4 (254.9-265.9)	3.5 (2.9-4.2)	- -	62.0 (59.4-64.7)	405.0 (398.0-412.0)	453.1 (445.7-460.4)	11.4 (10.2-12.6)
2021	241.0 (235.7-246.2)	3.1 (2.5-3.7)	- -	55.2 (52.7-57.7)	395.8 (388.9-402.7)	444.9 (437.6-452.1)	10.3 (9.2-11.5)
2022	253.3 (247.9-258.6)	2.6 (2.1-3.2)	- -	68.2 (65.5-71.0)	418.2 (411.1-425.3)	346.1 (339.8-352.5)	10.5 (9.4-11.7)
2023	227.7 (222.7-232.8)	1.3 (0.9-1.6)	- -	62.6 (60.0-65.2)	409.1 (402.2-416.1)	277.4 (271.8-283.1)	10.6 (9.4-11.7)

Source: Hospital Inpatient Billing.
Rates are per 100,000 age-specific population, provided by the Nevada State Demographer, Vintage 2023.
Categories are not mutually exclusive.