Behavioral Health Epidemiologic Profile 2024: Rural Region, Nevada

Elko, Eureka, Humboldt, Lander, Pershing, and White Pine Counties

April 2025

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Suggested Citation
State of Nevada, Department of Health and Human Services – Office of Analytics. *Behavioral Health Epidemiologic Profile 2024: Rural Region, Nevada.* Carson City, Nevada. April 2025.

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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 (40.7%) and depression (31.6%) are the leading diagnoses for mental health-related emergency department encounters for 2023. These diagnoses have decreased since 2020 to pre-pandemic levels in 2023. (Mental Health - ER).
- Anxiety (35.8%) and depression (32.7%) are the leading diagnoses for mental health-related inpatient encounters for 2023. In 2023, Rural Region females had a higher prevalence of encounters for all mental health diagnoses other than schizophrenia and suicidal ideation. (Mental Health - IP).
- Females in the Rural Region have higher percentages for mental health outcomes such as anxiety and depression compared to statewide trends for emergency department encounters (anxiety 72.7% compared to 62.4% and depression 72.9% compared to 60.8%) (Mental Health - ER).
- The Rural Region accounts for 9.1% of adults accessing state mental health services in Nevada in 2023 (Mental Health - Clinic Utilization).
- In 2023, American Indian or Alaska Native, non-Hispanic (66.8 per 100,000) and White, non-Hispanic (33.7 per 100,000) had the highest age-adjusted rates of utilization of state mental health services. (Avatar - State-Funded Mental Health Services).

National Violent Death Reporting System (NVDRS)

- Firearms were used in 70.3% of suicides and 67.9% of homicides among Nevada residents from 2018-2022 (Firearm Deaths - NVDRS).
- Males accounted for 76.6 of suicide cases and 64.3% of homicide cases from 2018-2022 (Deaths by Sex - NVDRS).
- The rate of suicide deaths among Rural Region residents from 2018-2022 was highest in the 15-24 age group at 37.7 per 100,000 population (Deaths by Age Group - NVDRS).
- Among suicide deaths among Nevada residents from 2018-2022, it was reported that 34.9% had been identified as currently having a mental health problem, and 31.1% had a history of ever being treated for a mental health or substance abuse problem (Circumstances of Deaths - NVDRS).

Substance Use

- The rates of stimulant-related overdose deaths have steadily increased since 2014, with a dramatic increase of 300% from 2021 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).
- 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).
- The rate of opioid-related deaths in the region has been largely comparable between males and females until 2022 when a notable disparity emerged with an increased death rate for males (Opioid-Related Overdose Deaths).
    - A similar pattern exists for stimulant-related deaths (Stimulant-Related Overdose Deaths).

State Unintentional Drug Overdose Reporting System (SUDORS)

- Of the 64 unintentional/ undetermined intent drug overdose deaths among Nevada residents from 2019-2022, 70.3% had non-specified opioids and 51.5% had methamphetamines listed in the cause of death (Toxicology - SUDORS).

Youth – Adverse Childhood Experiences

- Combined data from 2019-2023 shows that 13.9% of Rural Region adults have been touched sexually at least once during childhood (ACEs - BRFSS).
- Rural Region 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

- Of the self-reported marijuana use during pregnancy among Rural Region residents who gave birth between 2014 and 2023, the highest rate was in 2023, at 25.4 per 1,000 live births (Rate of Marijuana Use Among Pregnant Nevadans).

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.

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.

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 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.

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.

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 the Rural Region and Nevada, 2023.

Population, Rural Region, 2023 estimate*	99,870
Population, Rural Region, 2014 estimate*	96,141
Population, Rural Region, percent change*	3.7%
Female persons, Rural Region, 2023 estimate*	47,930 (48.0%)
Male persons, Rural Region, 2023 estimate*	51,940 (52.0%)
Median household income, Rural Region (2023) **	$77,541
Median household income, Nevada (2023) **	$75,561
Per capita income in the past 12 months, Rural Region (2023)**	$34,366
Per capita income in the past 12 months, Nevada (2023)**	$39,963
Percent of persons below poverty level, Rural Region (2023) **	12.2%
Percent of persons below poverty level, Nevada (2023)**	12.6%
Percent uninsured, Rural Region (2023)**	8.2%
Percent uninsured, Nevada (2023)**	11.4%

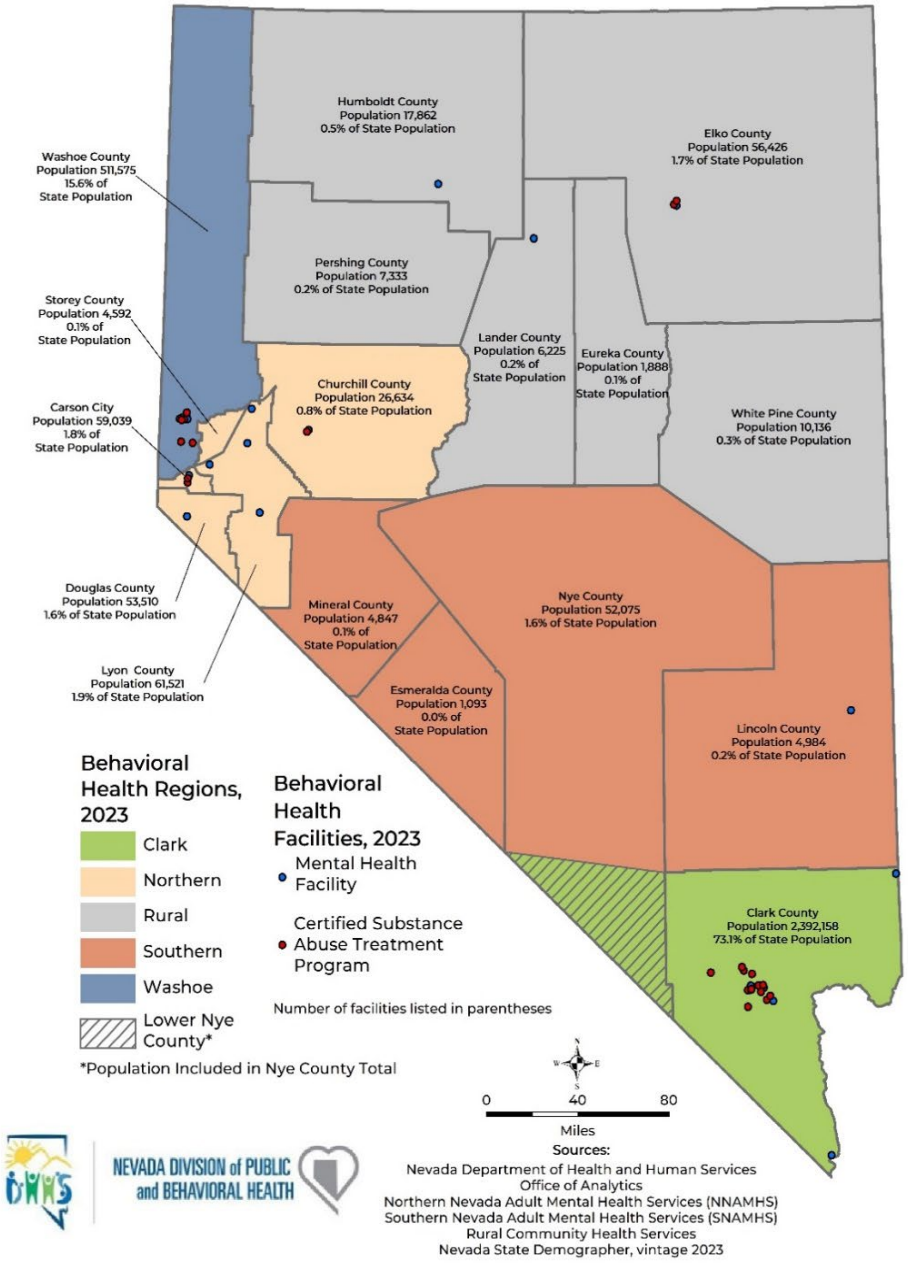
*Source: *Nevada State Demographer, Vintage 2023**U.S. Census Bureau*

In 2023, the estimated population for the Rural Region was 99,870, a 3.7% increase from the 2014 estimated population. The median household income was $77,541, which is higher than the median household income of Nevada ($75,561), but lower than the United States ($78,535). The percent of uninsured Rural Region residents in 2023 was 8.2%, which is lower than Nevada's percent (11.4%) and the national percent (8.6%).

According to the Nevada Behavioral Health Policy Boards: "Nevada is divided into five distinct behavioral health regions that are overseen by Regional Behavioral Health Policy Boards. These boards, composed of community leaders, law enforcement, healthcare and treatment providers, social services, family and peer advocates, and others, bring diverse perspectives to the table, and facilitate collaboration focused on improving the behavioral health system in Nevada." For more information on Behavioral Health Regions please see nvbh.org. The Rural Region comprises Elko, Eureka, Humboldt, Lander, Pershing, and White Pine Counties.

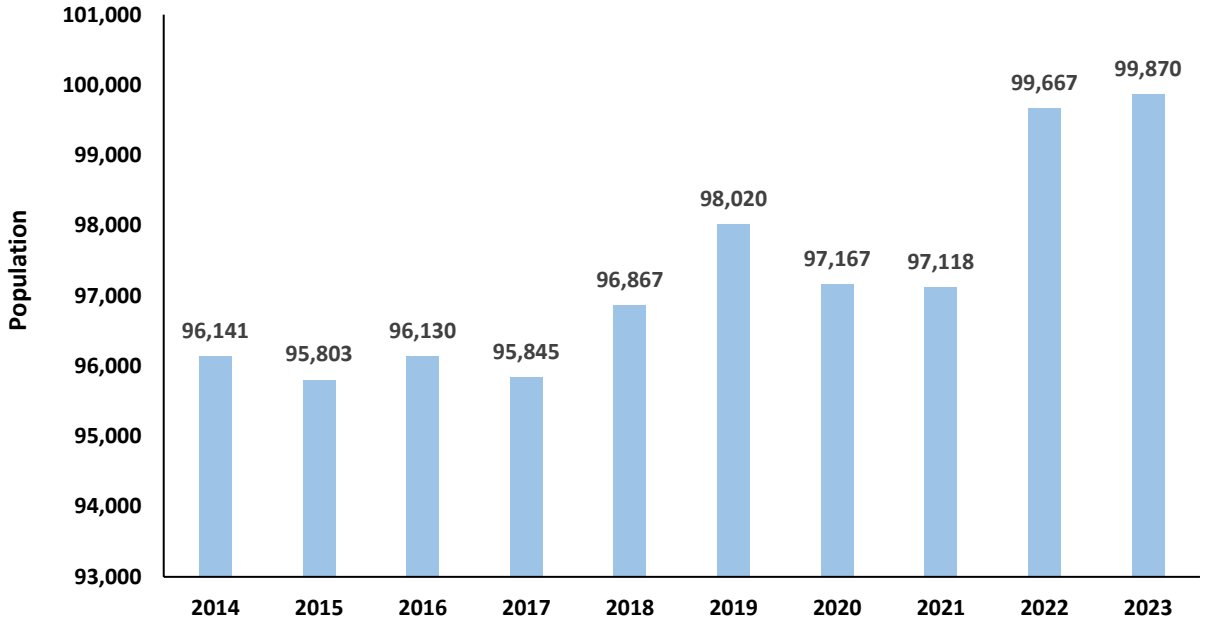
Figure 1 below shows the population for each of Nevada's 17 counties, the percent of Nevada population each county represents, the behavioral health regions, and the locations of mental health and substance abuse facilities.

Figure 1. Nevada Population Distribution by County, 2023.



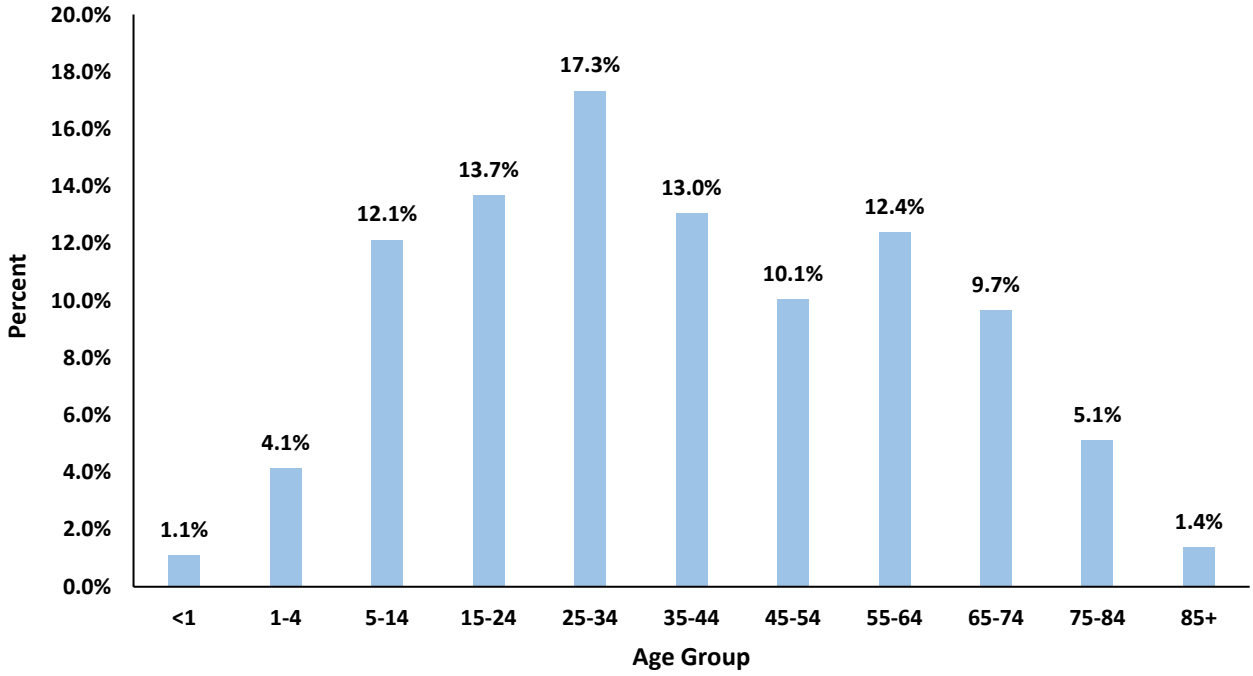
Source: Nevada State Demographer, Vintage 2023.
***Clark Region**: Clark County and southern Nye County.*
***Northern Nevada Region:** Carson City, Churchill, Douglas, Lyon, and Storey Counties.*
***Rural Nevada Region:** Elko, Eureka, Humboldt, Lander, Pershing, and White Pine Counties.*
***Southern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



Source: Nevada State Demographer, Vintage 2023.

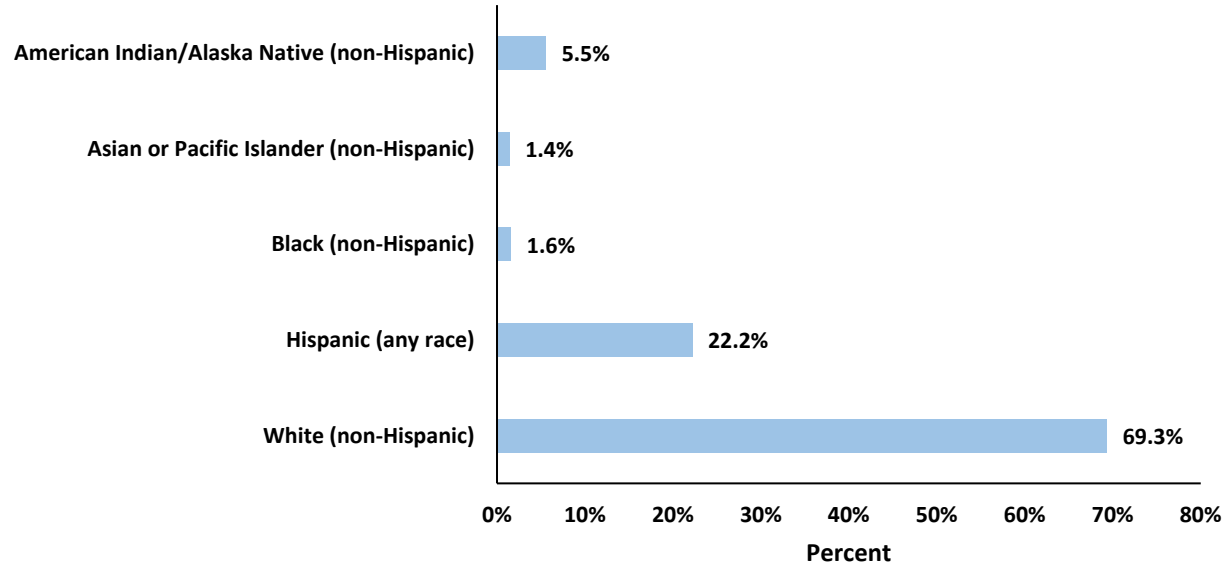
Figure 3. Rural Region Population by Age Group, 2023.



Source: Nevada State Demographer, Vintage 2023.
Chart scaled to 20.0% to display differences among groups.

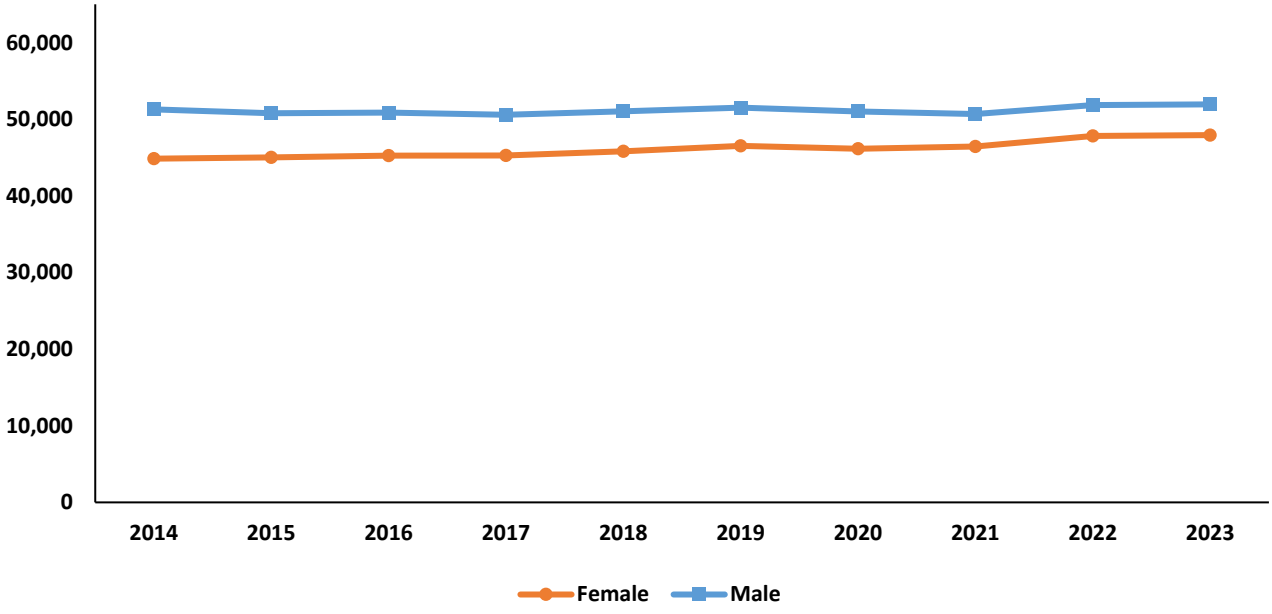
White non-Hispanics comprise 69.3% of the Rural Region population, followed by Hispanics (22.2%), American Indian/Alaska Native non-Hispanics (5.5%), Black non-Hispanics (1.6%), and Asian or Pacific Islanders (1.4%). The population consists of approximately equal percentages of males and females.

Figure 4. Rural Region Population by Race/Ethnicity, 2023.



Source: Nevada State Demographer, Vintage 2023.
Chart scaled to 80.0% to display differences among groups.

Figure 5. Rural Region Population Distribution by Sex, 2014-2023.



Source: Nevada State Demographer, Vintage 2023.

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.

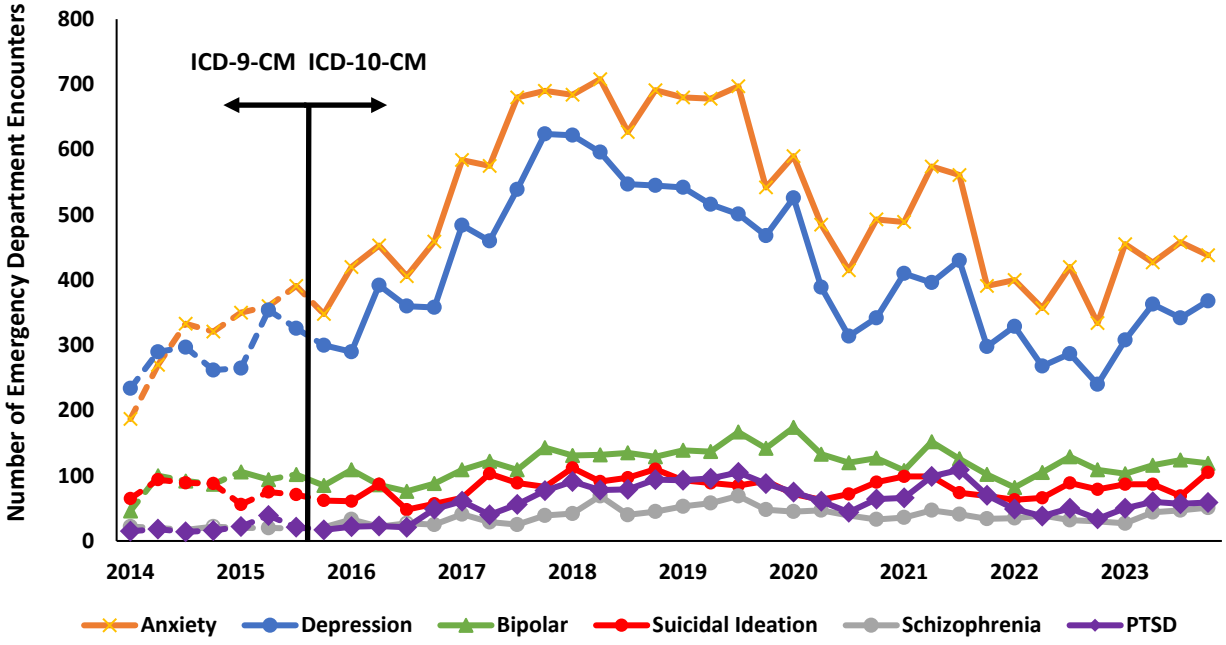
Hospital Emergency Department Encounters

The hospital emergency department billing data includes data for emergency room patients of all ages for Nevada's non-federal hospitals. There were 4,364 visits related to mental health disorders among Rural Region 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 445 and 346 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 (56.2%) and suicidal ideation (61.0%), whereas females had a higher prevalence of visits for anxiety (72.7%), depression (72.9%), bipolar disorder (72.5%) and PTSD (64.2%). Both genders had approximately 50.0% prevalence for suicidal ideation.

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



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

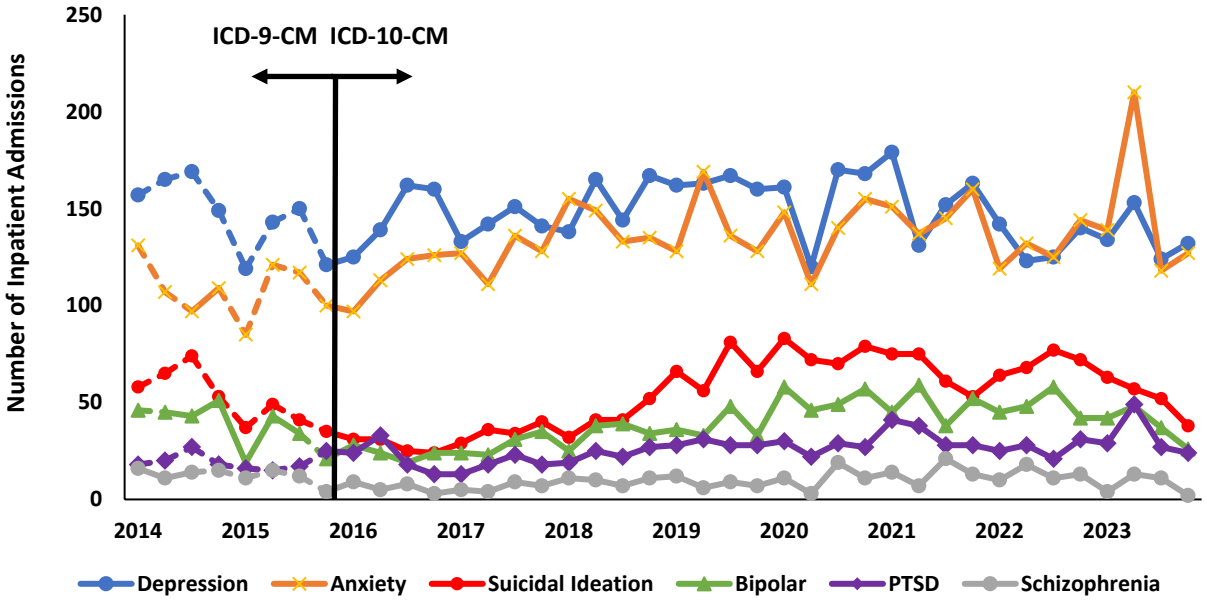
Hospital Inpatient Admissions

Hospital Inpatient Billing data includes data for patients of all ages discharged from Nevada's non-federal hospitals. There were 1,659 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 with an average of 149 and 136 encounters per quarter, respectively.

For 2023, males had a higher prevalence of visits for schizophrenia (53.3%) and suicidal ideation (52.4%), whereas females had a higher prevalence of visits for anxiety (64.3%), depression (65.9%), bipolar disorder (64.7%), and PTSD (60.5%).

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



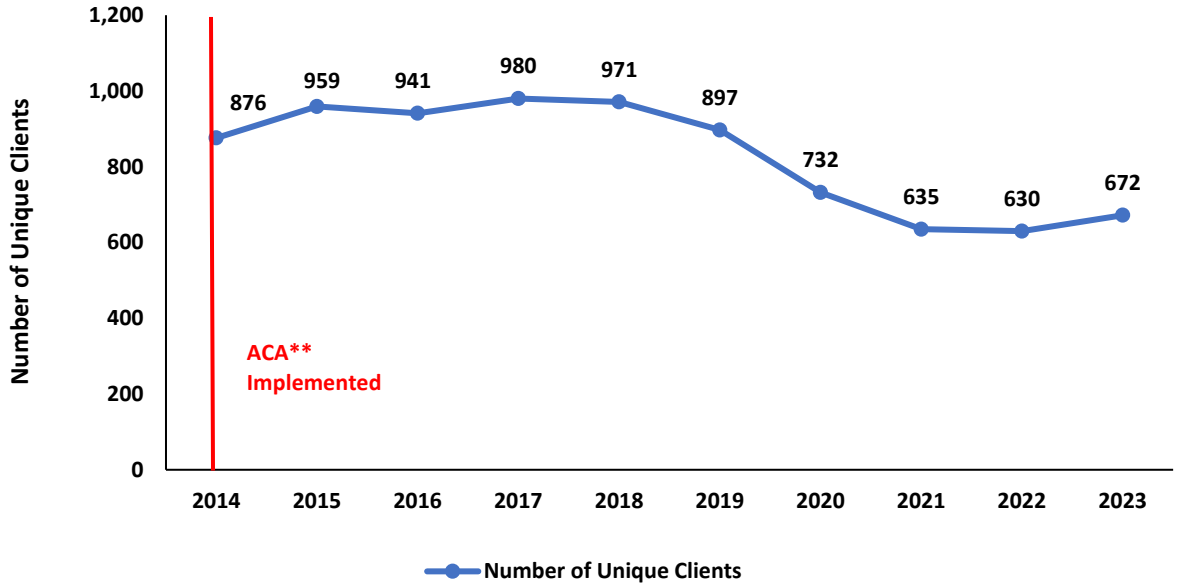
Source: Hospital Inpatient Billing.
Categories are not mutually exclusive.
ICD-9-CM codes were replaced by ICD-10-CM codes in the last quarter of 2015, therefore data prior to that may not be directly comparable.

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 had a slight decline since the implementation of the affordable care act (ACA), much less than what is seen state-wide. 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, Rural Region Residents, 2014-2023.

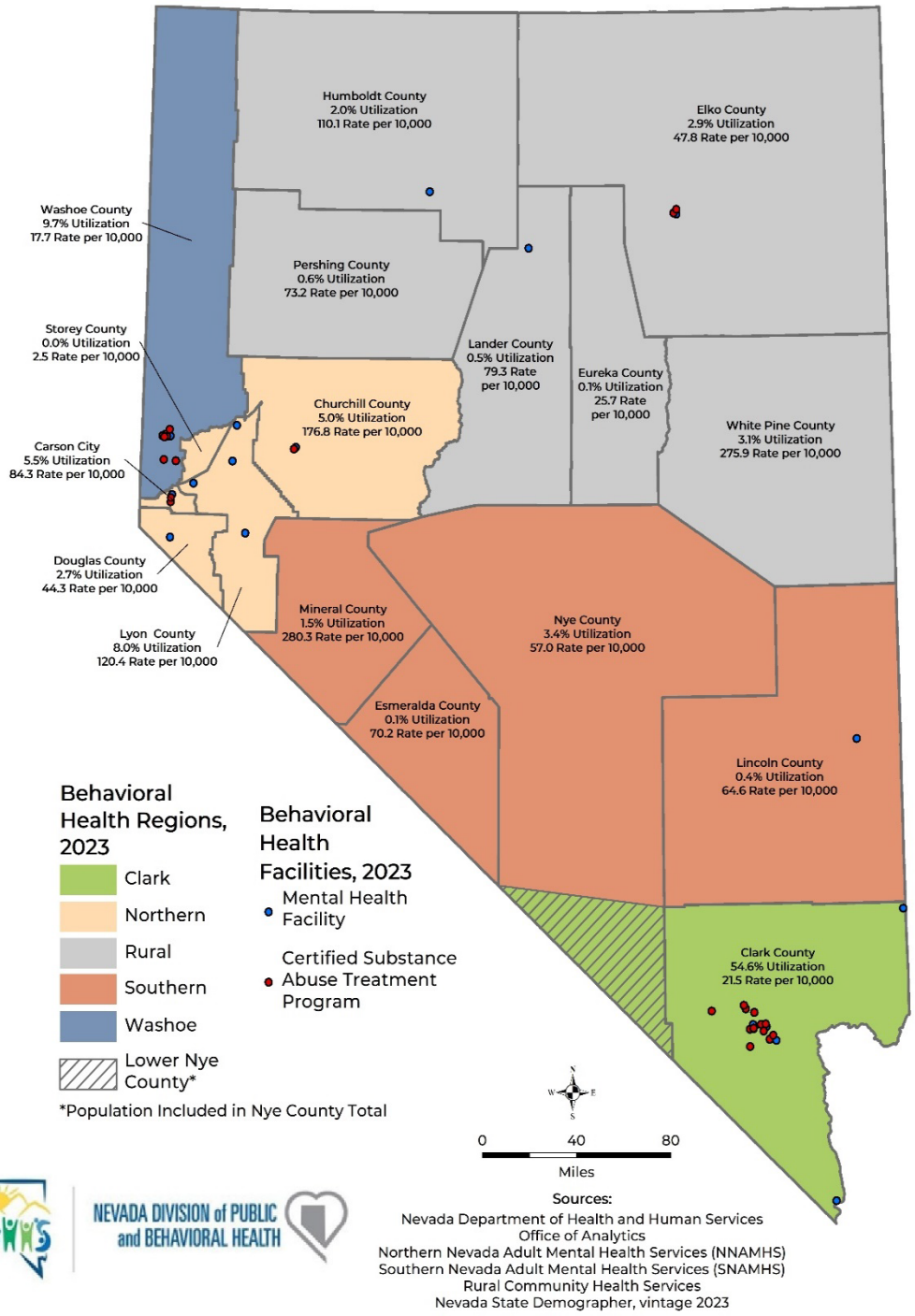


Source: Avatar.
**A client is counted only once per year. Clients may be counted more than once across years.*
***Affordable Care Act.*

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. The Rural Region had a utilization of 9.1% accessing state mental health services.

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. Note that this differs from the standard rate presented elsewhere in this report, which is per 100,000.

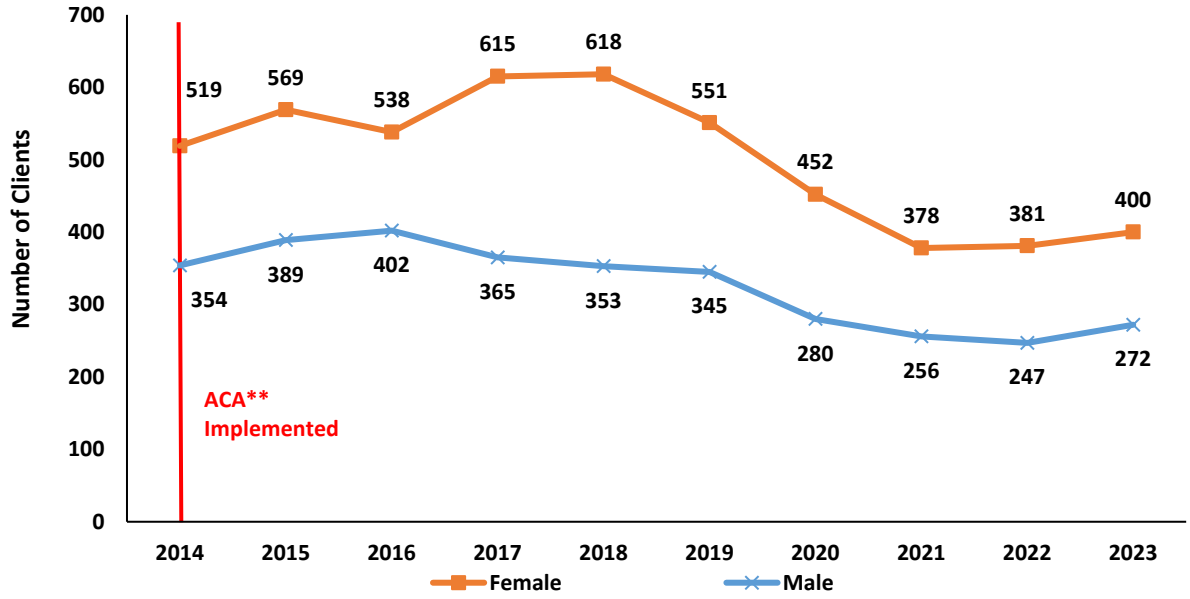
Figure 9. State-Funded Adult (Aged 18+*) Mental Health Clinic Utilization by County, 2023.



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 2014, there has historically been more female than male clients. In 2023, 32.0 per 100,000 of the adult female population utilized the state-funded mental health clinics, compared to adult males at 21.8 per 100,000 of the adult male population.

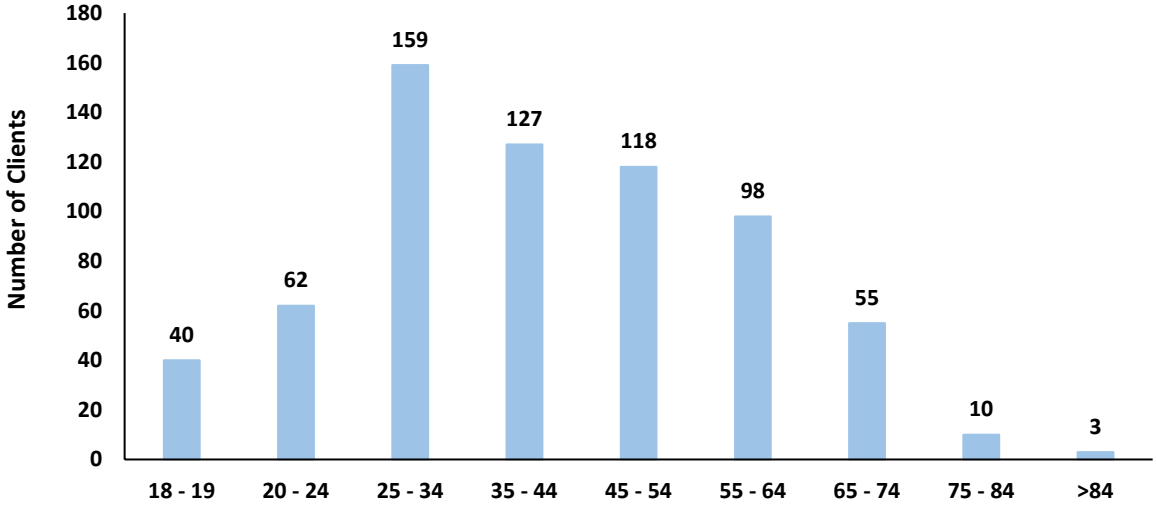
Figure 10. State-Funded Adult (Aged 18+*) Mental Health Clinic Utilization* by Sex, Rural Region Residents, 2014-2023.



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, 23.7% of adult clients were in the 25-34 age group with each age group after decreasing.

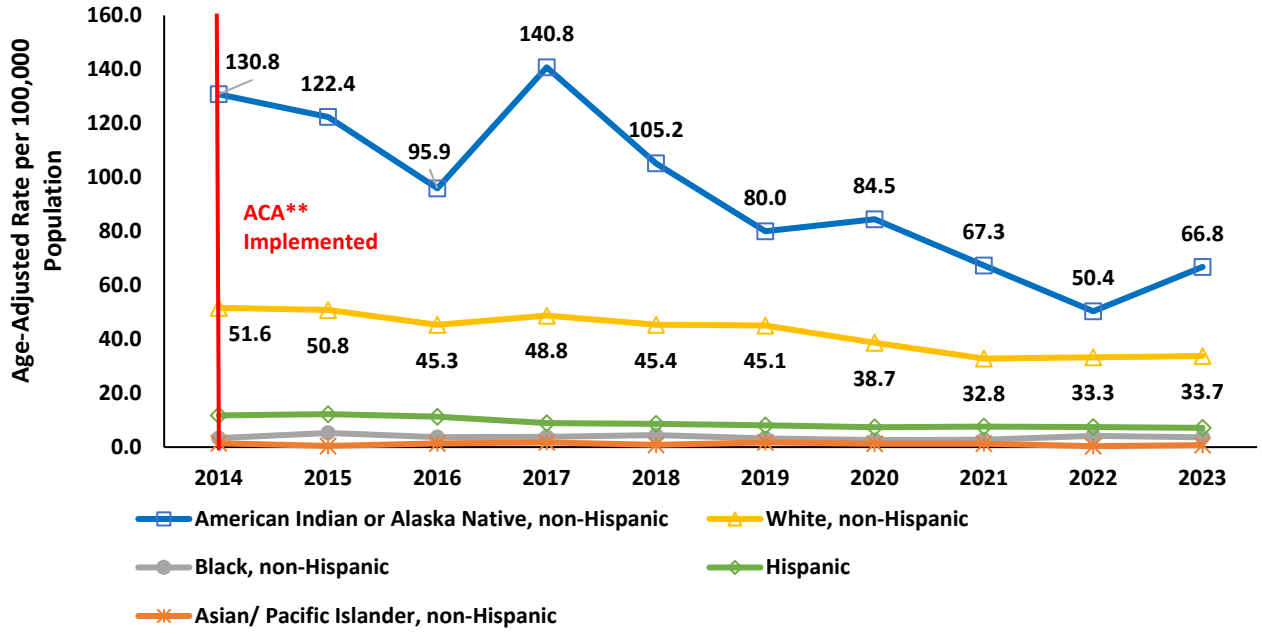
Figure 11. State-Funded Adult (Aged 18+*) Mental Health Clinic Utilization* by Age Group, Rural Region Residents, 2023.



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

Since 2014, the distribution of most racial and ethnic groups has remained relatively consistent apart from the distribution of American Indian or Alaska Native non-Hispanics, which has declined since 2017. In 2023, AI/AN non-Hispanics (66.8 per 100,000) and White non-Hispanics (33.7 per 100,000) had the highest age-adjusted rates.

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

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

Program	Year									
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Elko Medication Clinic	128	159	188	193	163	184	193	157	142	146
Elko Outpatient Counseling	194	185	176	174	170	162	133	82	96	97
Elko Outpatient Screening	96	190	181	211	233	198	52	0	0	72
Ely Medication Clinic	72	90	121	122	130	154	164	155	171	214
Ely Outpatient Counseling	184	194	279	315	318	273	195	91	99	82
Winnemucca Medication Clinic	67	96	106	136	147	173	172	134	118	112
Winnemucca Outpatient Counseling	118	92	94	121	122	117	92	60	66	64
Winnemucca Outpatient Screening	44	43	58	153	276	196	65	0	0	40

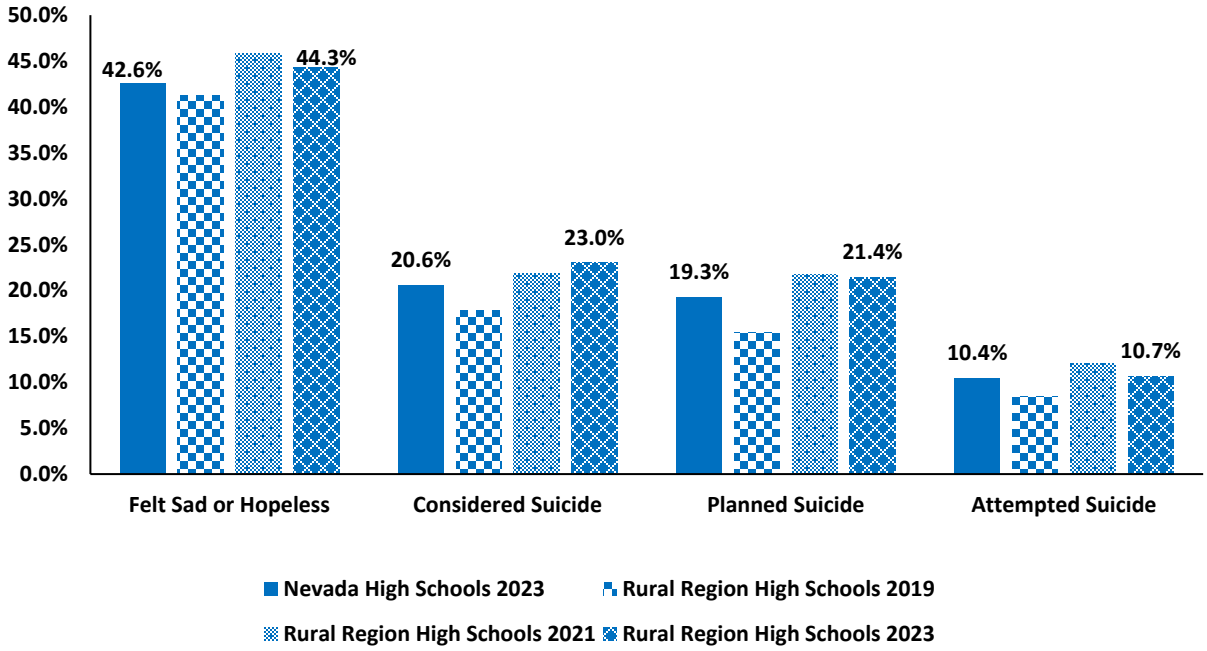
Source: Avatar.
**A client is counted only once per year. Clients may be counted more than once across years.*

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, 716 high school students and 796 middle school students participated in the YRBS in the Rural Region. 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.

From 2019 to 2023, the percent of Rural Region high school students reporting that they felt sad or hopeless, planned suicide, or attempted suicide has increased. The percent of all reported mental health behaviors is higher among Rural Region high school students than among Nevada high school students. There are similar trends among Rural Region middle school students.

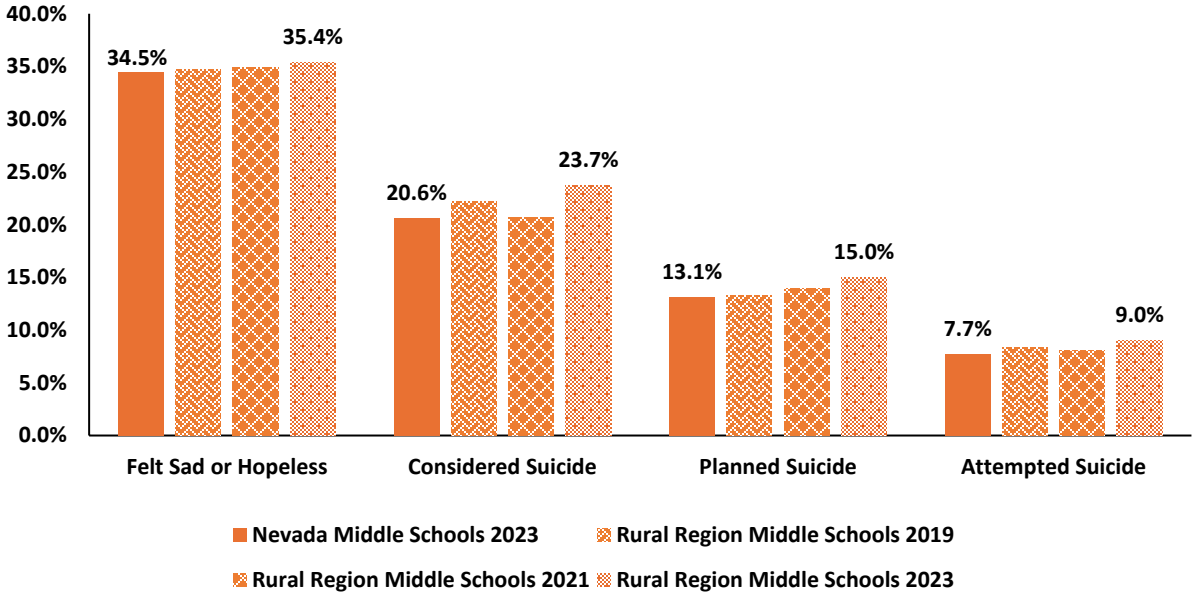
Figure 13. Mental Health Behaviors, Rural Region High School Students, 2019, 2021, 2023 and Nevada High School Students, 2023.



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

Middle school students had lower outcome percentages than high school students in all measures except for those who considered suicide.

Figure 14. Mental Health Behaviors, Rural Region Middle School Students, 2019, 2021, 2023 and Nevada Middle School Students 2023.



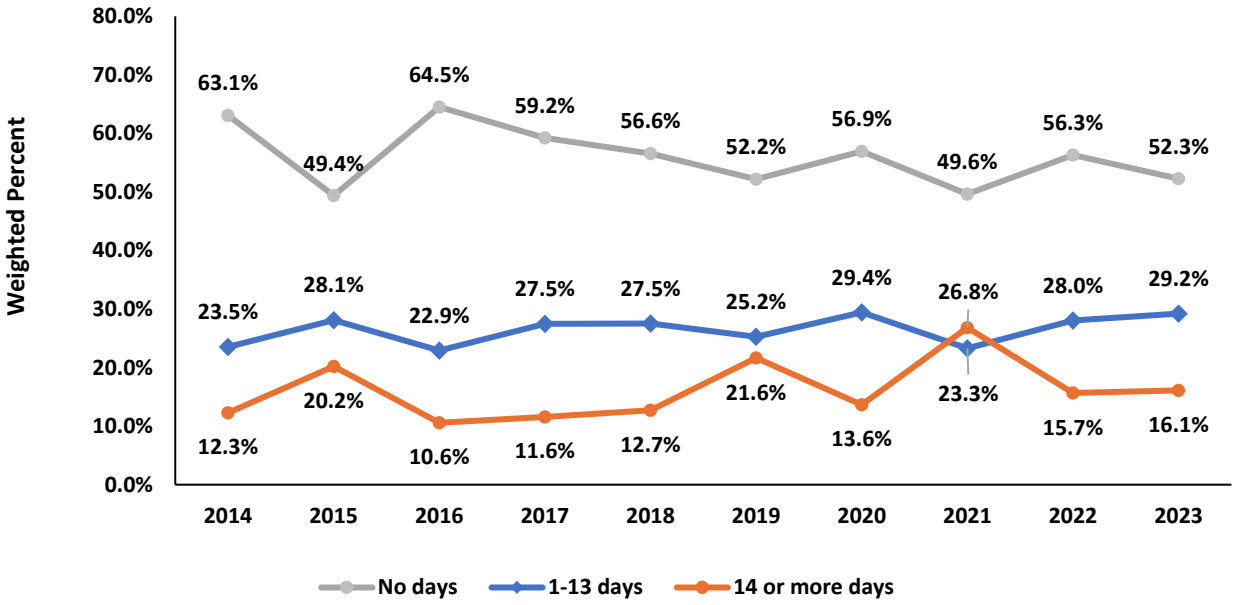
Source: Nevada Youth Risk Behavior Survey (YRBS).
Chart scaled to 40.0% to display differences among groups.

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.

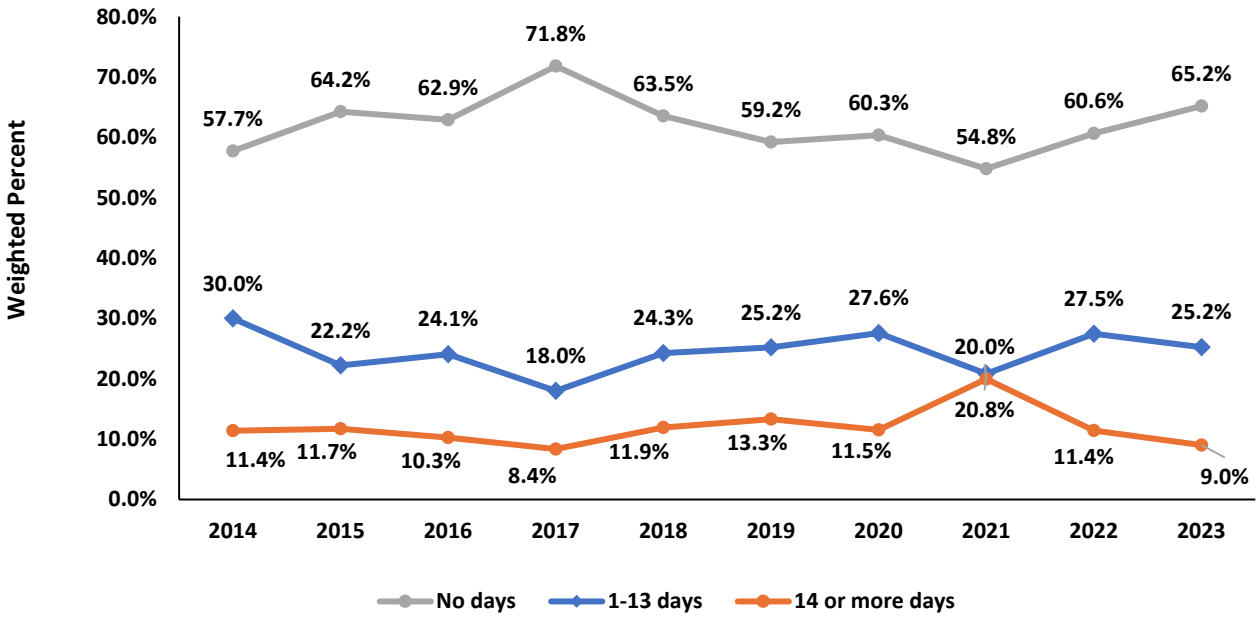
Figure 15. Percent of Adult BRFSS Respondents Who Experienced Poor Mental or Physical Health that Prevented Them from Doing Usual Activities by Days Affected in Past Month, Rural Region Residents, 2014-2023.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 80.0% 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?"
**Interpret figure and generalizability with caution due to small sample size (cell size < 50) and overlapping 95% confidence intervals.*

Generally, adults who reported any number of days in which their mental health was considered "not good" has remained relatively consistent with some dips and spikes while "no days" has increased since 2021.

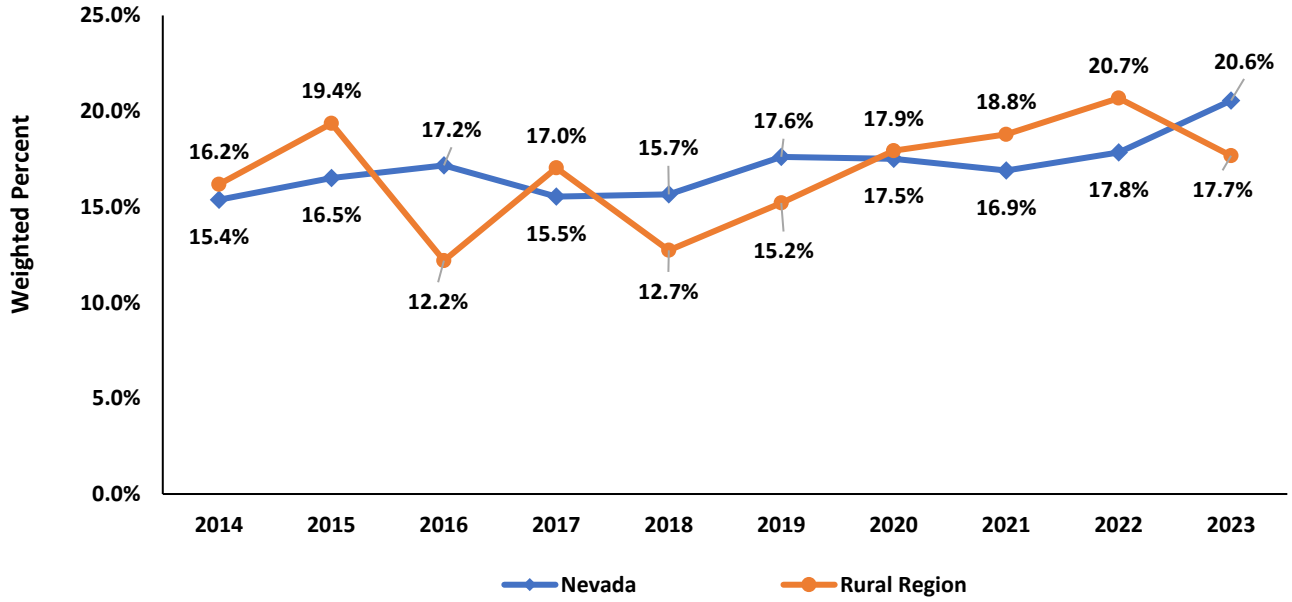
Figure 16. Percent of Adult BRFSS Respondents Whose Mental Health was Not Good by Number of Days Experienced in the Past Month, Rural Region Residents, 2014-2023.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 80.0% 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?"
**Interpret figure and generalizability with caution due to small sample size (cell size < 50).*

The prevalence of those who reported having been told they have a depressive disorder in the Rural Region has remained within the range of what is seen state-wide.

Figure 17. Percent of Adult BRFSS Respondents Who Have Ever Been Told They Have a Depressive Disorder, Including Depression, Major/Minor Depression, or Dysthymia, Rural Region 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)?"
**Interpret figure and generalizability with caution due to small sample size.*

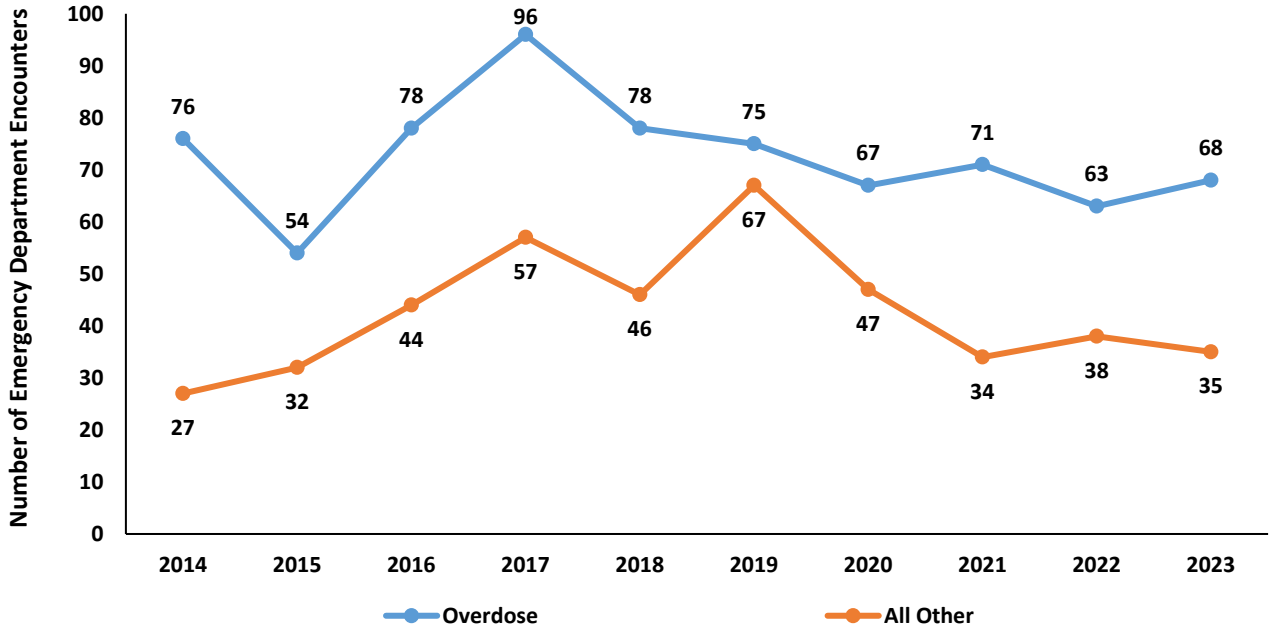
Suicide

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.

Emergency department encounters related to suicide attempts, where the patient did not expire at the hospital, have remained largely steady from 2018 to 2023. The most common method for attempted suicide is substance or drug poisoning (including overdose). The "all other" category includes drowning, firearms, cutting/piercing, jumping from heights, and suffocation/hanging.

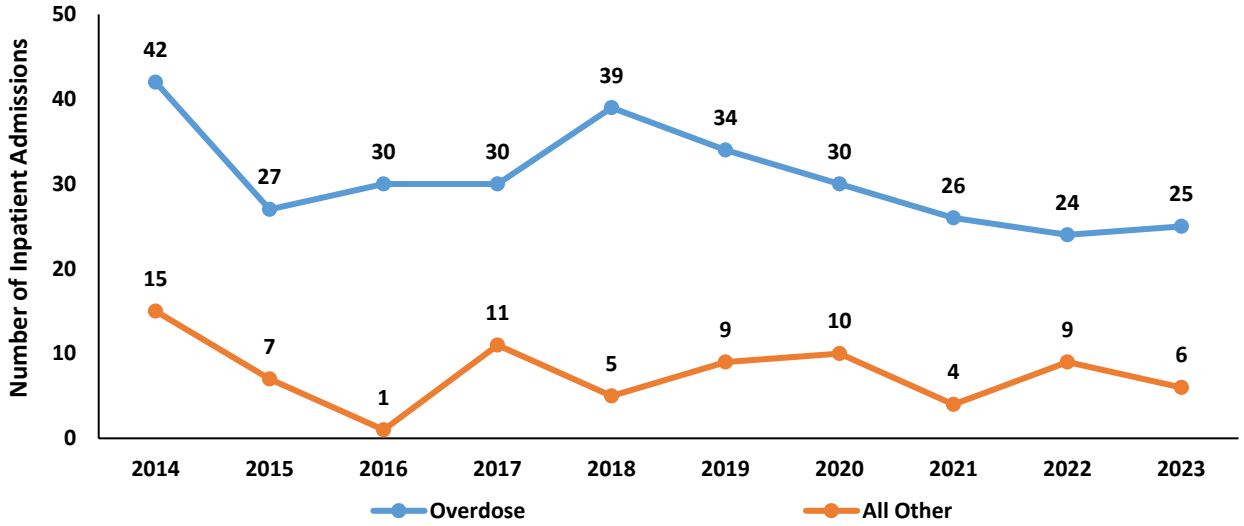
Figure 18. Suicide Attempt Emergency Department Encounters by Method, All Ages, Rural Region Residents, 2014-2023.



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 decreased between 2014 and 2023, except for a notable spike in 2018.

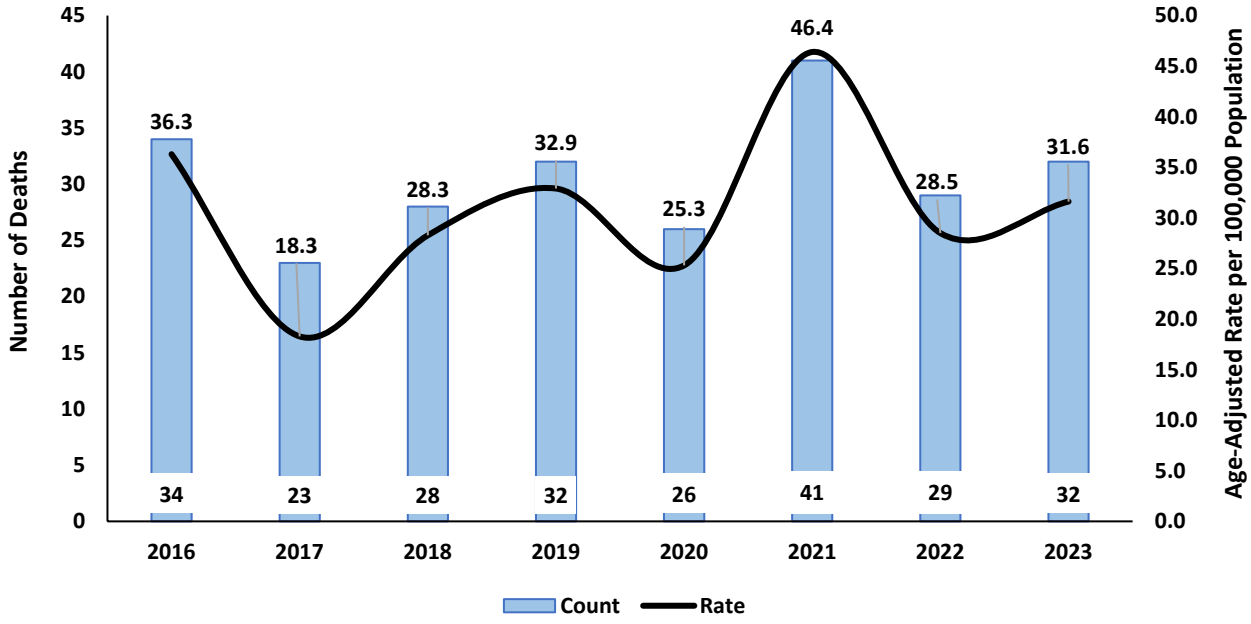
Figure 19. Suicide Attempt Inpatient Admissions by Method, All Ages, Rural Region Residents, 2014-2023.



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.

The age-adjusted suicide rate for the Rural Behavioral Health Region in 2023 was 31.6 per 100,000 population. The rate for Nevada overall was 19.3 per 100,000 population and the national age-adjusted rate in 2022, the most recent year with complete CDC data, was 14.2 per 100,000 population.

Figure 20. Number of Suicides and Rates, All Ages, Rural Region Residents, 2014-2023.



Source: Nevada Electronic Death Registry System.

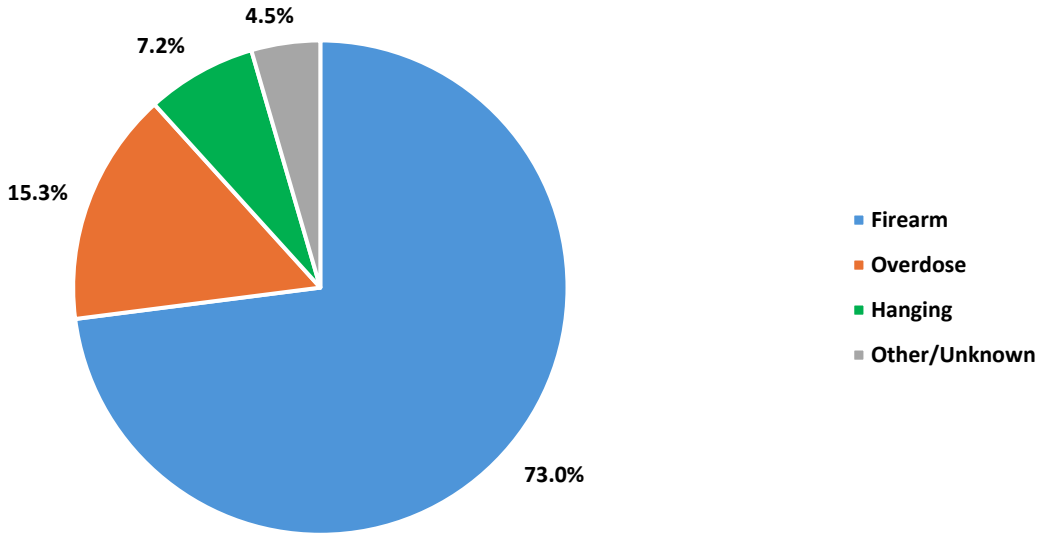
National Violent Death Reporting System (NVDRS)

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 158 deaths among Rural Region residents reported in the Nevada Violent Death Reporting System (NVVDRS). Of those deaths, 70.3% (n=111) were suicides, 17.7% were homicides, 2.5% were legal interventions, and the remainder were categorized as unintentional involving firearms or undetermined.

Among the 111 suicides, the method was firearms in 70.3% of cases (n=81), overdose in 15.3%, hanging/strangulation/suffocation in 7.2%, and 4.5% had a method of other/unknown. About 77% of persons were male and 23% were female.

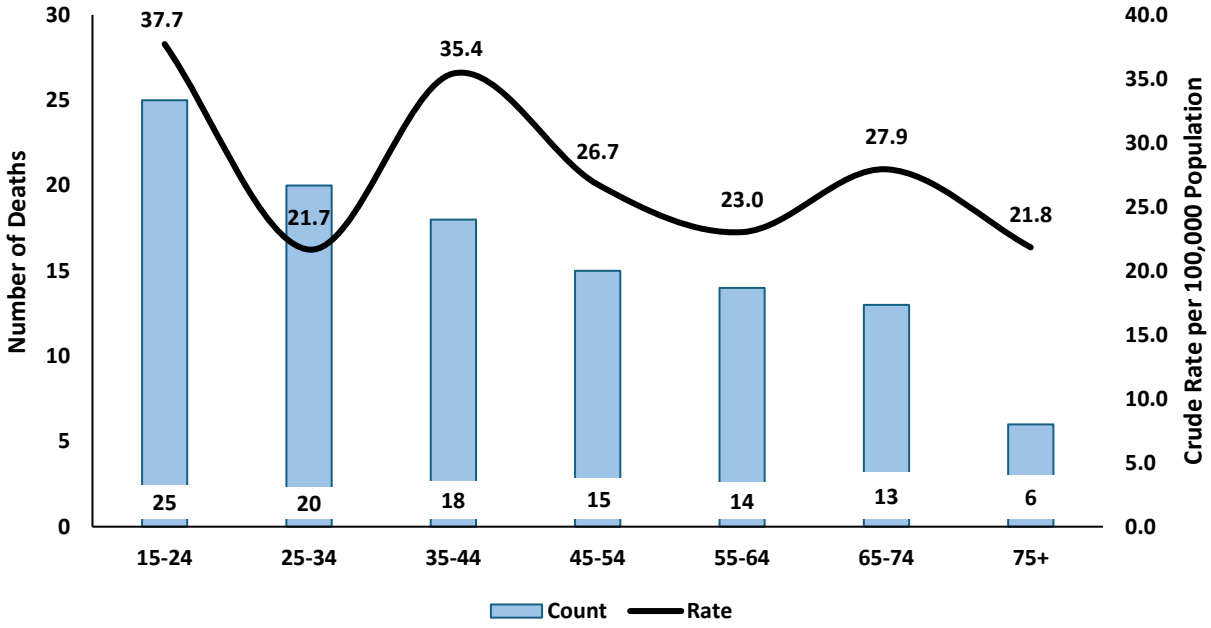
Figure 21. Method of Suicide Deaths, Rural Region Residents, 2018-2022.



Source: Nevada Violent Death Reporting System.

The rates of deaths by suicide were highest among the 15-24 age group and 35-44 age group, at 37.7 and 35.4 per 100,000 population, respectively. This distribution is unique to the Rural Region, being the only region where the suicide death rates are highest among the youngest cohorts.

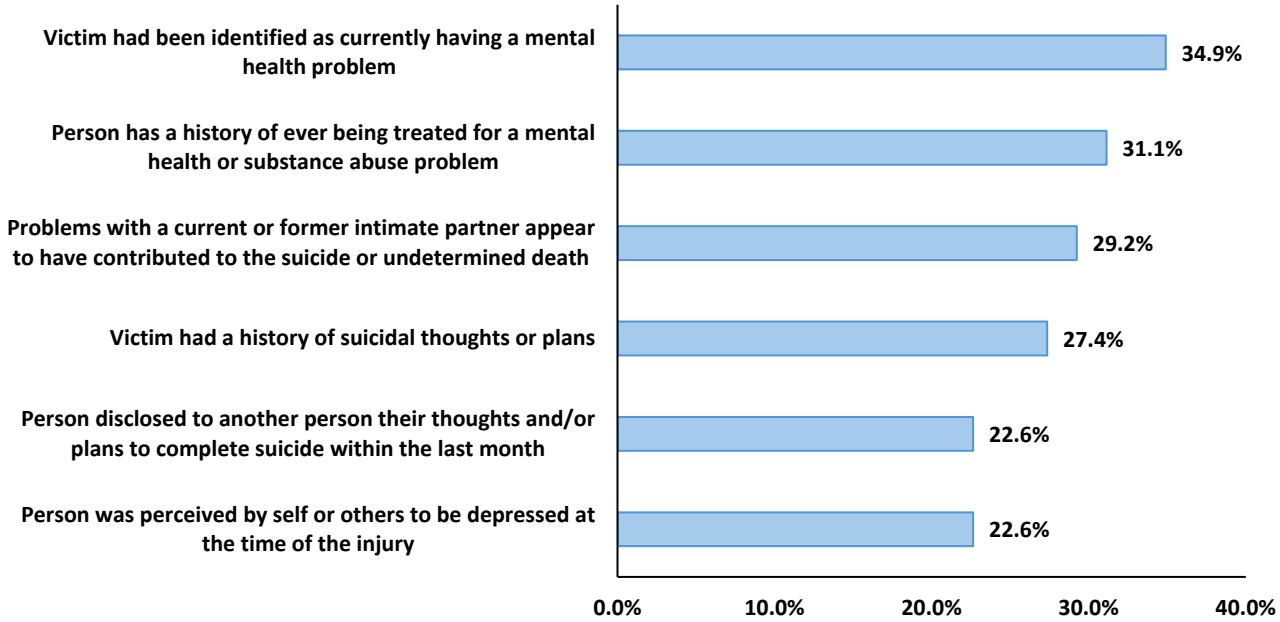
Figure 22. Number of Suicide Deaths and Rates by Age Group, Rural Region Residents, 2018-2022.



Source: Nevada Violent Death Reporting System.

Of the 111 suicides among Rural Region residents from 2018-2022 that were entered into NVDRS, 95.5% (n=106) had circumstantial information available. Nearly 35% of those suicides involved persons reported to have a mental health problem, 31.1% had a history of ever being treated for a mental health or substance abuse problem, 29.2% had problems with a current or former intimate partner that appeared to contribute to the death, 27.4% had a history of suicidal thoughts or plans, 22.6% disclosed to another person their thoughts and/or plans to complete suicide within the last month before death, and 22.6% were perceived by self or others to be depressed at the time of injury.

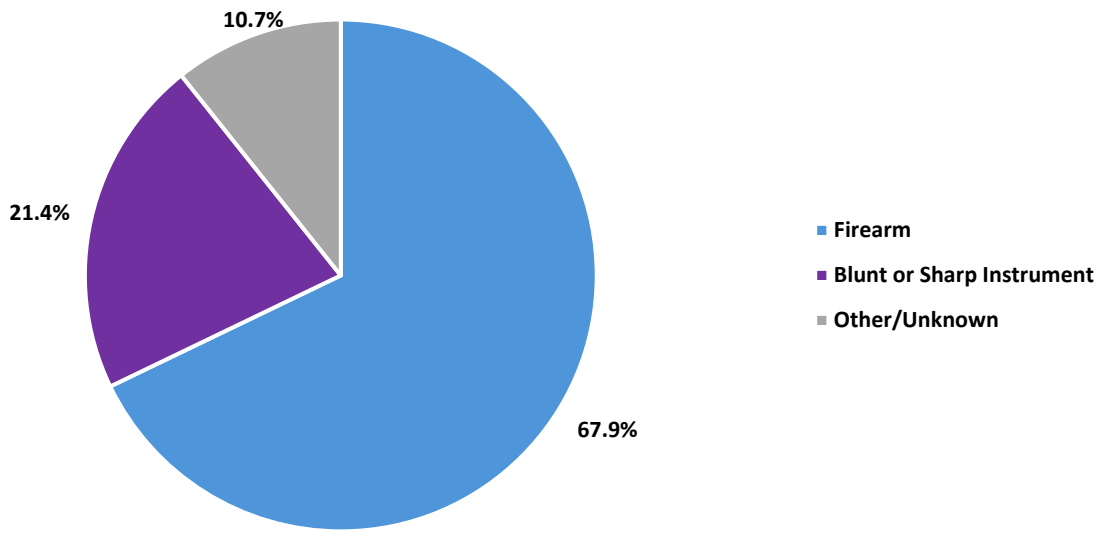
Figure 23. Circumstances Among Suicide Deaths, Rural Region Residents, 2018-2022.



Source: Nevada Violent Death Reporting System.
Chart scaled to 40.0% to display differences among groups.

Among the 28 homicides among Rural Region residents from 2018-2022, the method was firearms in 67.9% of cases, blunt/sharp instrument in 21.4%, and other/unknown in 10.7% of cases. Males accounted for 64.3% of homicide victims, and 35.7% were females.

Figure 24. Method of Homicide Deaths, Rural Region Residents, 2018-2022.



Source: Nevada Violent Death Reporting System.

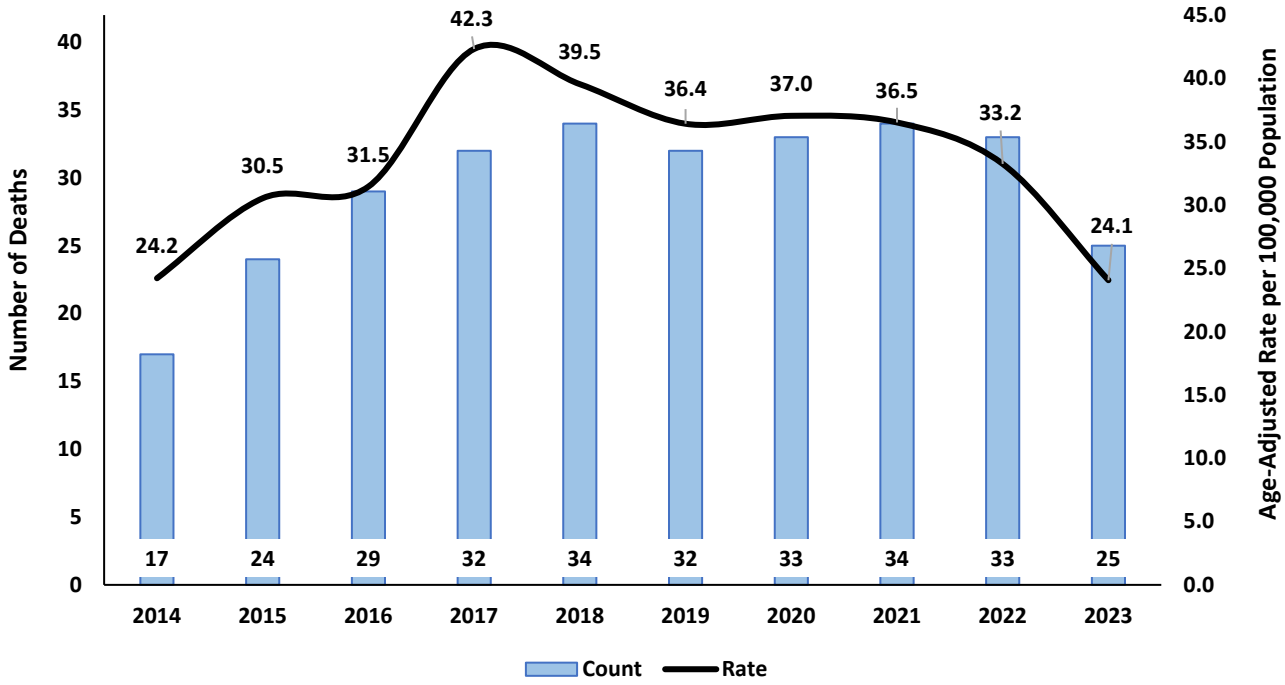
Mental Health-Related Deaths

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 the Rural Region for 2023 occurred at an age-adjusted rate of 24.1 per 100,000 population. This rate is substantially lower than the rate for the state in total (54.5 per 100,000) and has been decreasing since 2017.

Figure 25. Mental Health-Related Deaths and Rates, Rural Region 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 in 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 26 and 27 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 AB 474) 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.

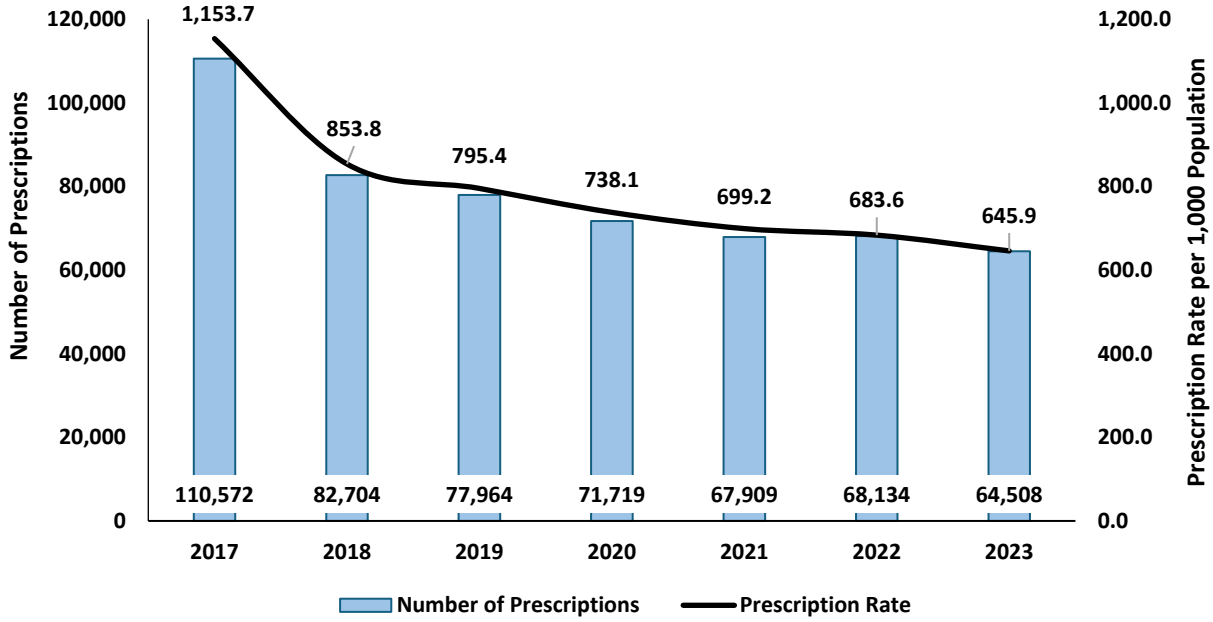
In addition to opioids, Nevada's Prescription Drug Monitoring Program tracks information about all Schedule II–V prescriptions dispensed to patients in the state. These drugs are classified as having accepted medical use and, at minimum, a low potential for abuse and risk of dependence. Schedule I drugs, 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 Rural Region residents have decreased markedly from a rate of 1,153.7 per 1,000 population in 2017 to 645.9 per 1,000 population in 2023.

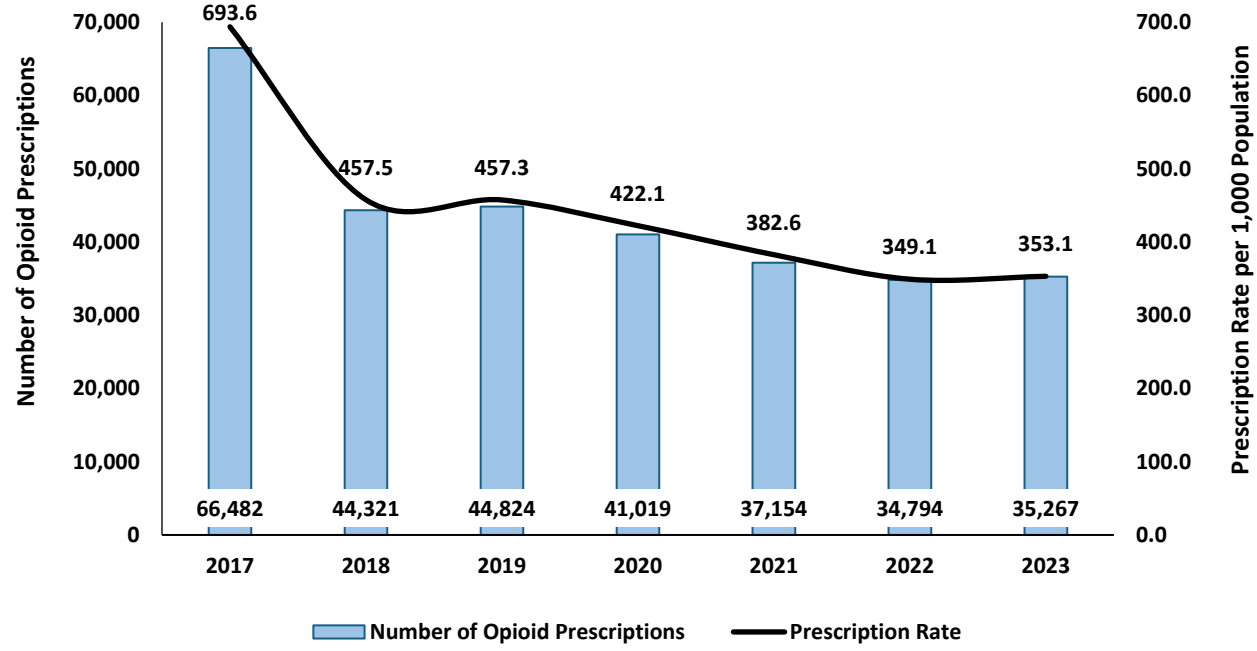
Figure 26. Total Prescriptions and Rates, Rural Region Residents 2017-2023.



Source: Prescription Drug Monitoring Program.

Mirroring total prescription trends, total opioid prescriptions have decreased from a rate of 693.6 per 1,000 population in 2017 to 353.1 per 1,000 population in 2023.

Figure 27. Total Opioid Prescriptions and Rates, Rural Region Residents 2017-2023.

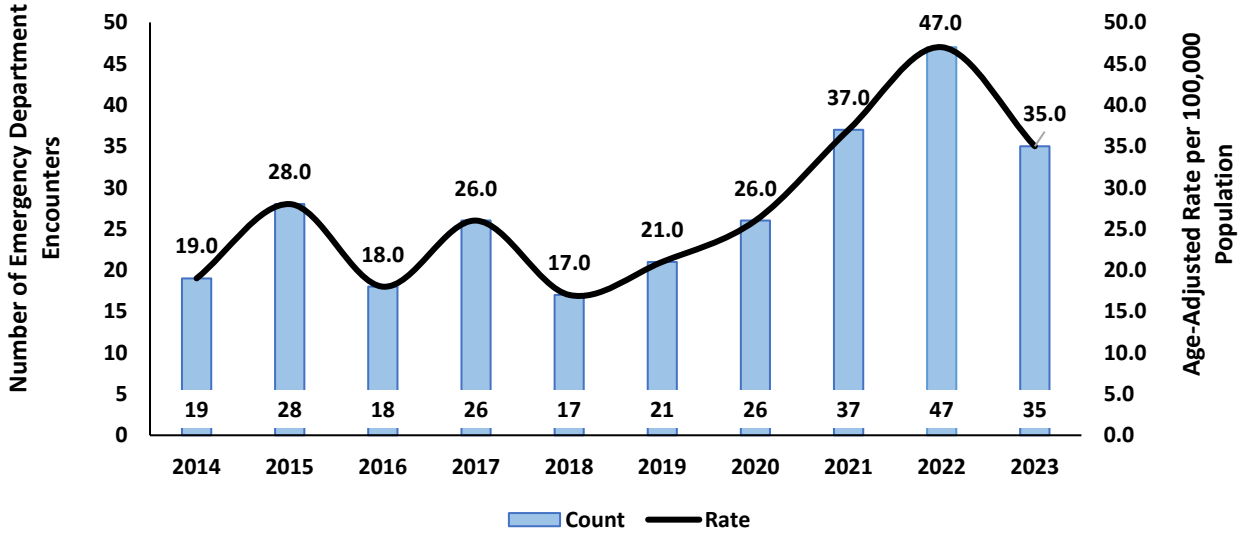


Source: Prescription Drug Monitoring Program.

Hospital Emergency Department Encounters

While total opioid prescriptions among Rural Region residents decreased since 2017, opioid overdose emergency department encounters have notably increased since 2018, with the highest rate in 2022, at 47.0 per 100,000 population. This trend may suggest that there are other factors driving opioid misuse.

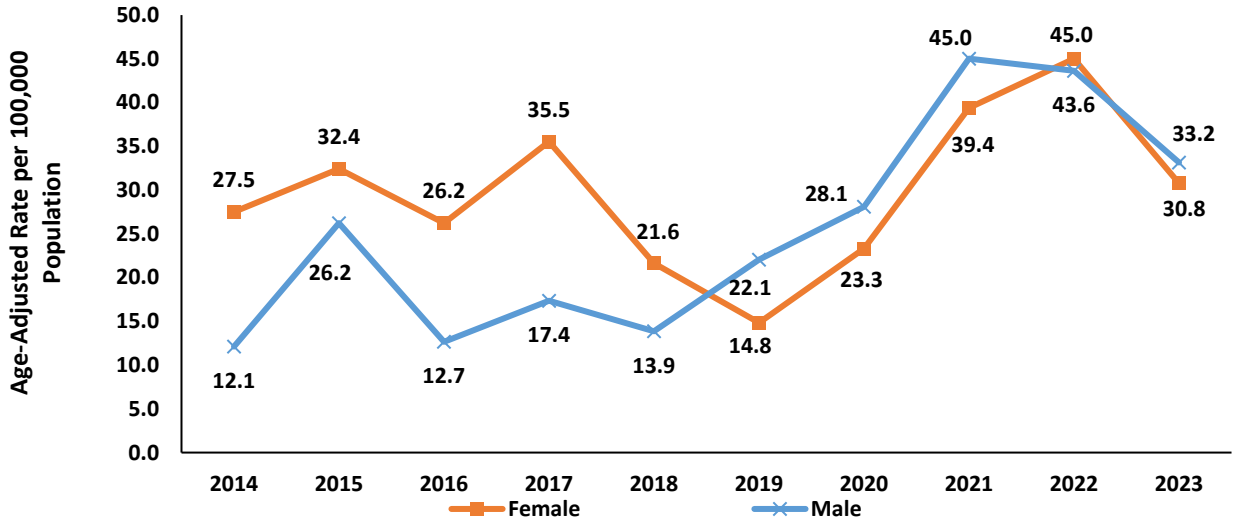
Figure 28. Opioid Overdose Emergency Department Encounters and Rates by Year, Rural Region Residents, 2014-2023.



Source: Hospital Emergency Department Billing.
ICD-9-CM codes were replaced by ICD-10-CM codes in the 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 have remained largely comparable throughout the reporting period since 2019.

Figure 29. Opioid Overdose Emergency Department Encounter Rates by Year and Sex, Rural Region Residents, 2014-2023.

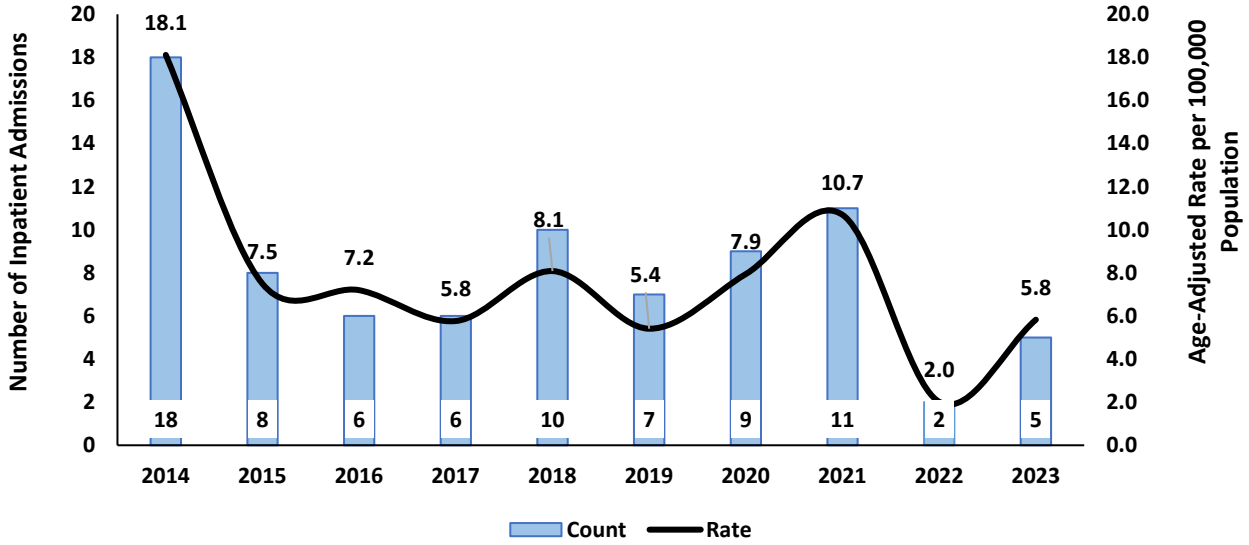


Source: Hospital Emergency Department Billing.
ICD-9-CM codes were replaced by ICD-10-CM codes in the last quarter of 2015, therefore data prior to that may not be directly comparable.

Hospital Inpatient Admissions

Opioid-related inpatient admission rates have decreased since 2014. There is considerable volatility in the rate however, due to the low population and incidence of such admissions in the Rural Region.

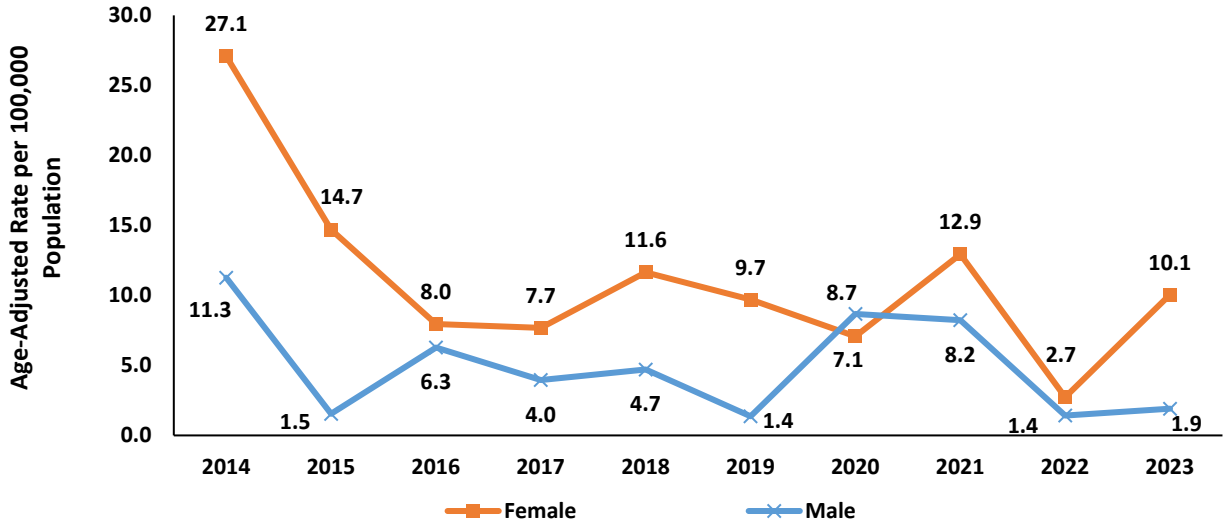
Figure 30. Opioid Overdose Inpatient Admissions and Rates by Year, Rural Region Residents, 2014-2023.



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

The inpatient admission rate for opioid overdoses has remained higher for females than for males for all years of the reporting period except 2020, and the rates for both sexes reflect the overall trends for the region.

Figure 31. Opioid Overdose Inpatient Admission Rates by Year and Sex, Rural Region Residents, 2014-2023.

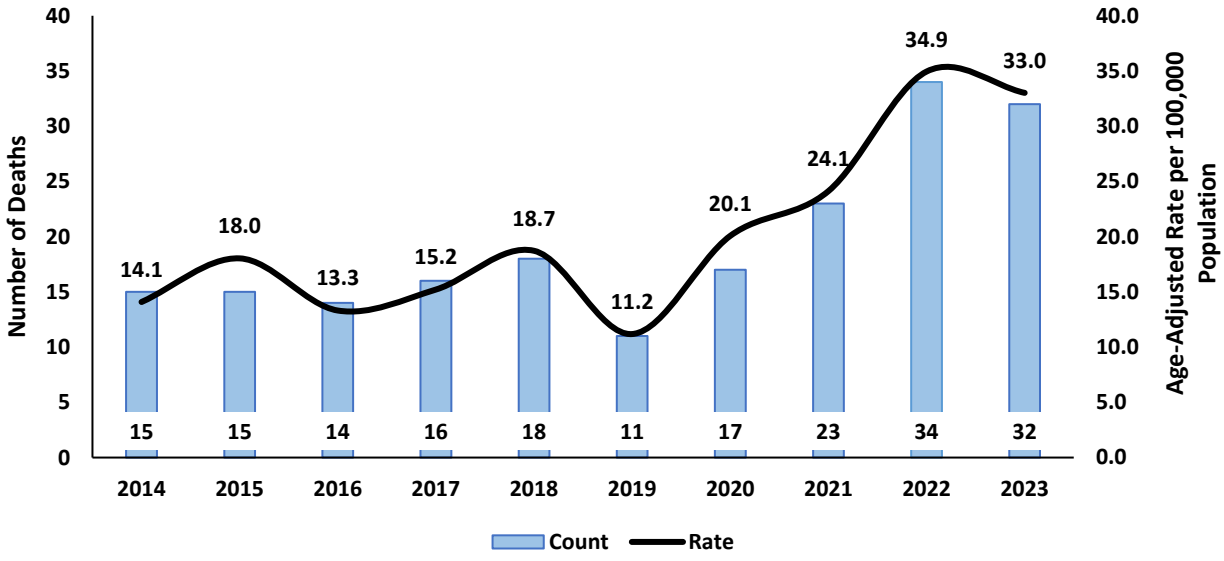


Source: Hospital Inpatient Billing.
ICD-9-CM codes were replaced by ICD-10-CM codes in the last quarter of 2015, therefore data prior to that may not be directly comparable.

Opioid Overdose Deaths

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

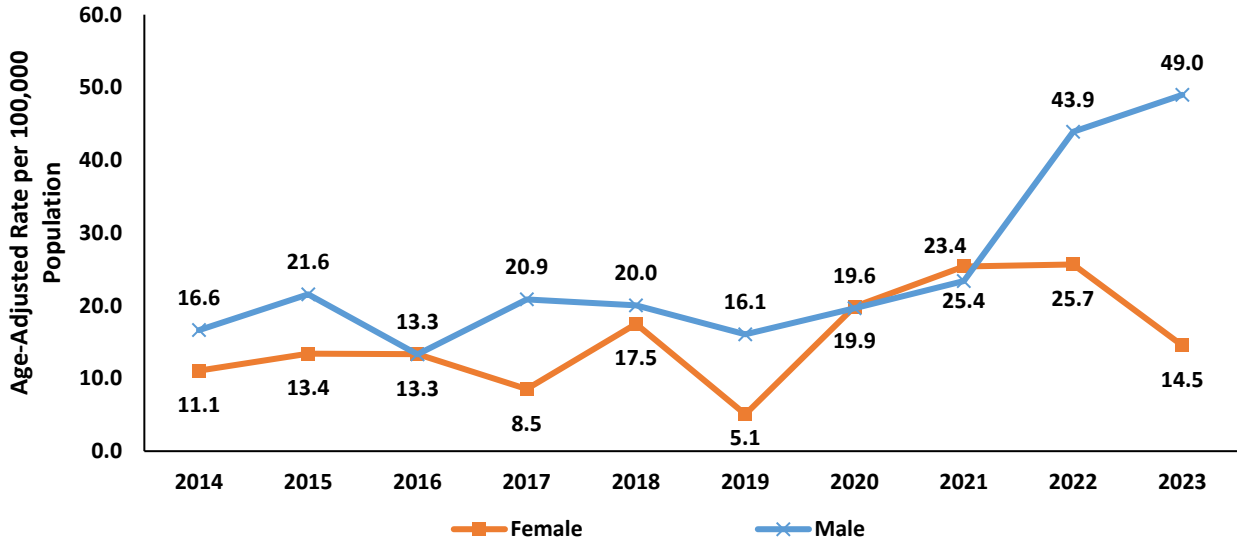
Figure 32. Opioid Overdose Deaths and Rates, Rural Region Residents 2014-2023.



Source: Nevada Electronic Death Registry System.

Opioid overdoses by sex reflect trends in emergency department encounters, with relatively steady rates among females and a notable increase among males starting in 2021.

Figure 33. Opioid Overdose Death Rates by Sex, Rural Region Residents, 2014-2023.



Source: Nevada Electronic Death Registry System.

Stimulants

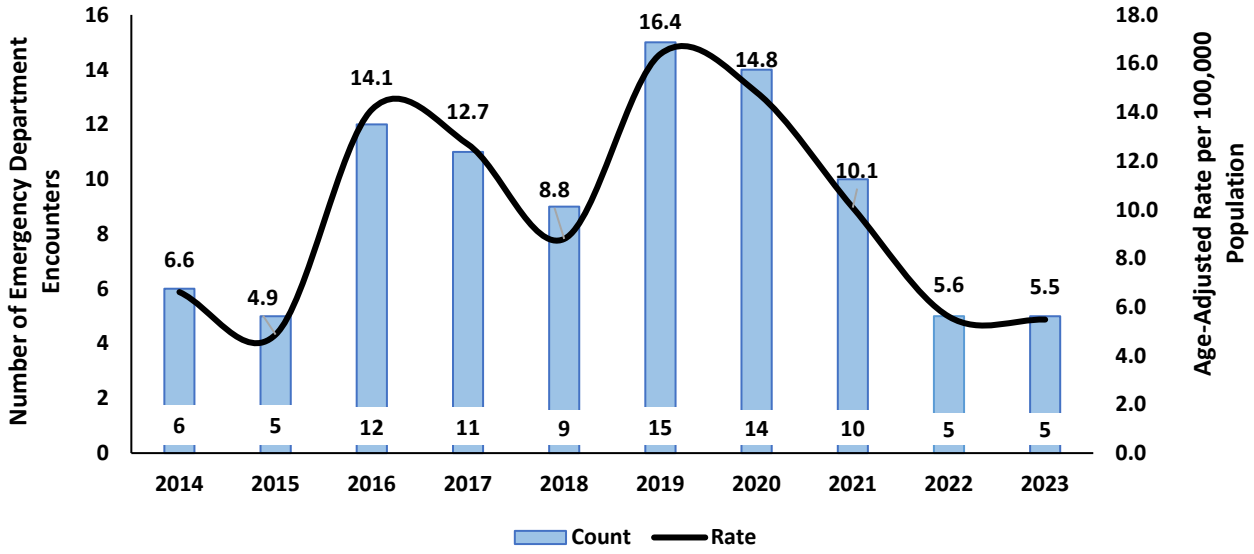
Stimulants are a class of drugs that accelerate communication between the brain and body, often making individuals feel more awake, alert, confident, or energetic. They include legal substances like caffeine and prescription medications such as dexamphetamines, Adderall, and methylphenidate (Ritalin), 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 varied over the reporting period, reaching a high in 2019 of 16.4 per 100,000. The rate for stimulant-related encounters remains notably lower than that of opioids.

Figure 34. Stimulant Overdose Emergency Department Encounters and Rates by Year, Rural Region Residents, 2014-2023.



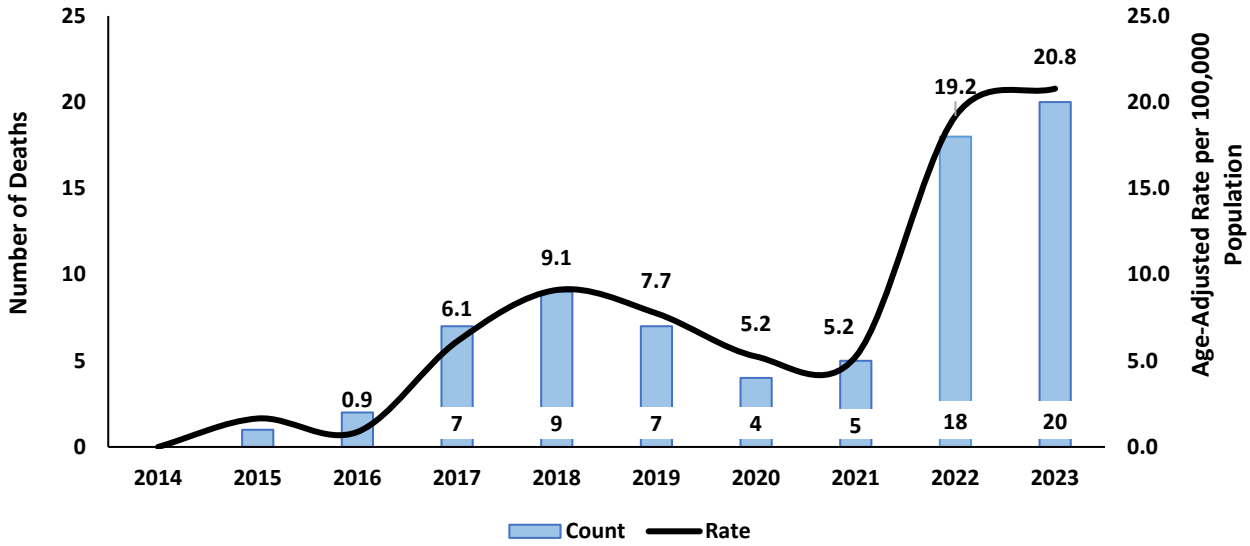
Source: Hospital Emergency Department Billing.
ICD-9-CM codes were replaced by ICD-10-CM codes in the last quarter of 2015, therefore data prior to that may not be directly comparable.

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

Stimulant Overdose Deaths

The rates of stimulant-related overdose deaths in the Rural Region have increased dramatically since 2021.

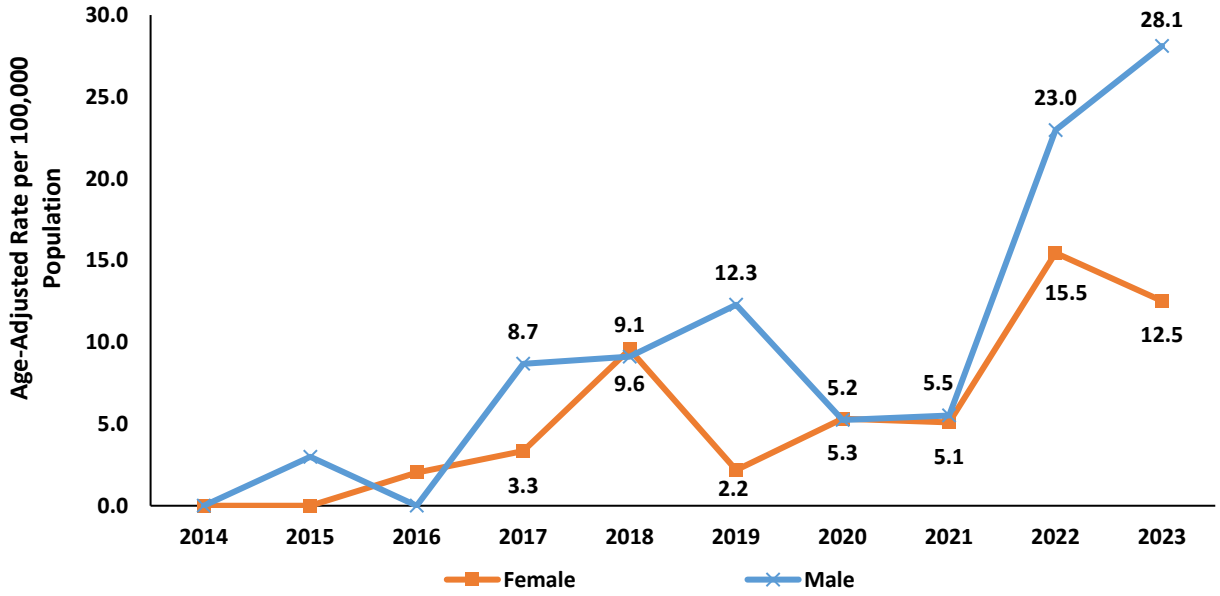
Figure 35. Stimulant Overdose Deaths and Rates, Rural Region Residents, 2014-2023.



Source: Nevada Electronic Death Registry System.

This increase in death rates has been predominantly driven by males.

Figure 36. Stimulant Overdose Death Rates by Sex, Rural Region 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's Rural Region residents (as illustrated in this section) alcohol-related deaths and hospital visits, particularly for chronic alcohol use, disproportionately affect men.

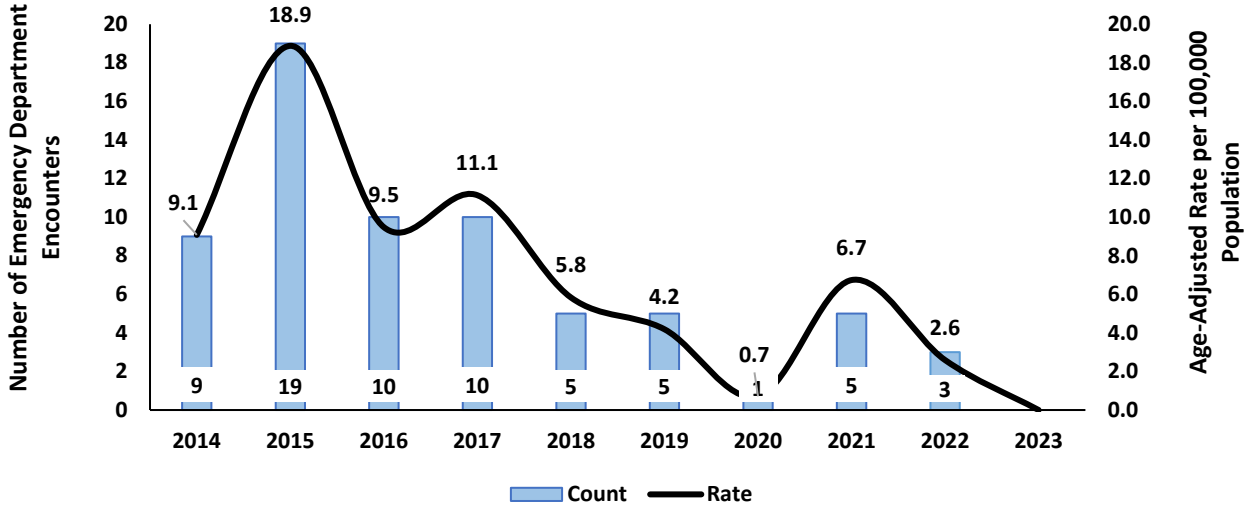
There are several potential causes for the notable increase in deaths and hospitalizations (for chronic conditions) related to alcohol use and misuse. Due to its legality and social acceptability, alcohol is easily accessible and available to most Americans. While the effects of the COVID-19 pandemic 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.

[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

Overdoses

In contrast to the stark increase in emergency department encounters for opioids, alcohol overdose hospitalizations have been trending down. While hospital visits for alcohol overdoses have been decreasing, it should be noted that there has been an increase in alcohol-related deaths in the Rural Region in the past several years.

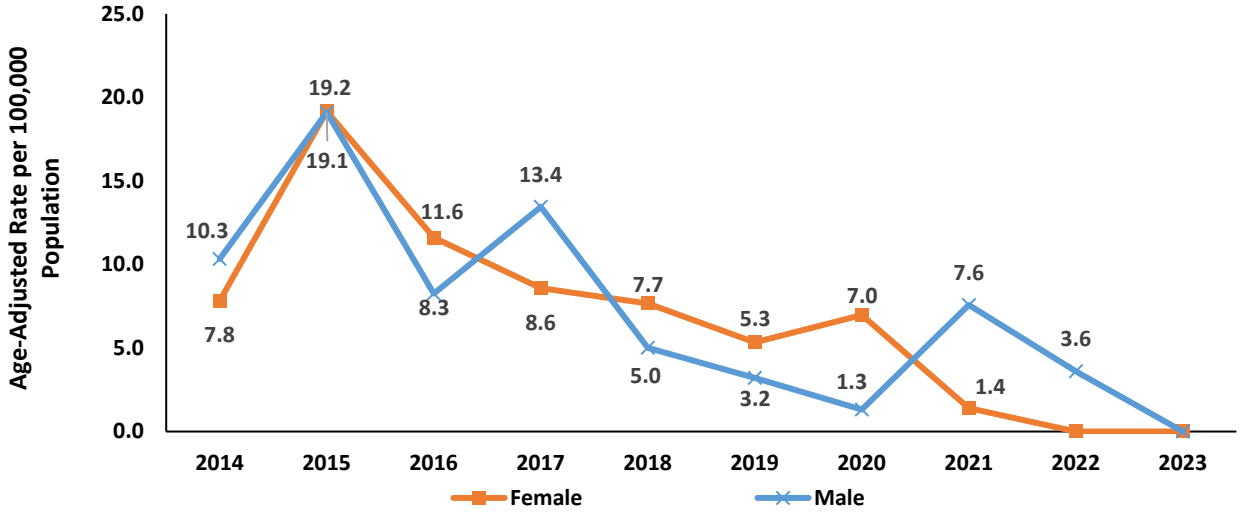
Figure 37. Alcohol Overdose Emergency Department Encounters and Rates by Year, Rural Region Residents, 2014-2023.



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.

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

Figure 38. Alcohol Overdose Emergency Department Encounter Rates by Year and Sex, Rural Region Residents, 2014-2023.



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

Chronic Alcohol Conditions

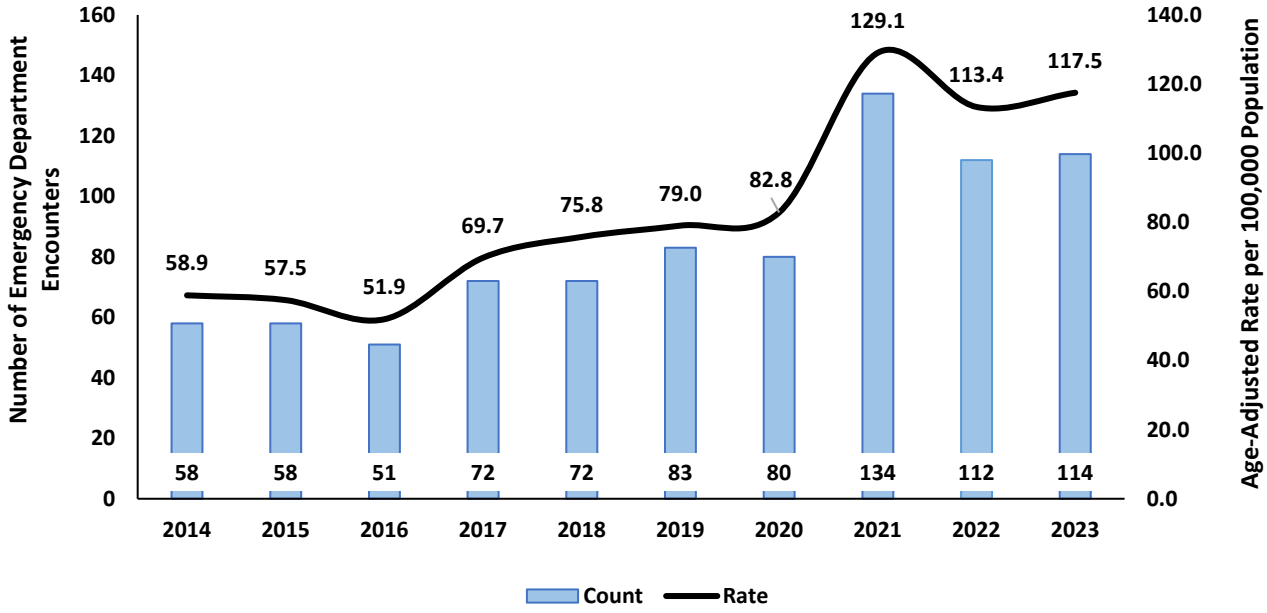
There are many chronic conditions and diseases that can occur from long-term misuse of alcohol and contribute to an increased mortality rate for those users. These include multiple types of cancer (throat, colon, liver, and breast cancer), heart disease, liver disease, high blood pressure, and strokes.

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 substantially over the reporting period reaching a high in 2021 of 129.1 per 100,000 population.

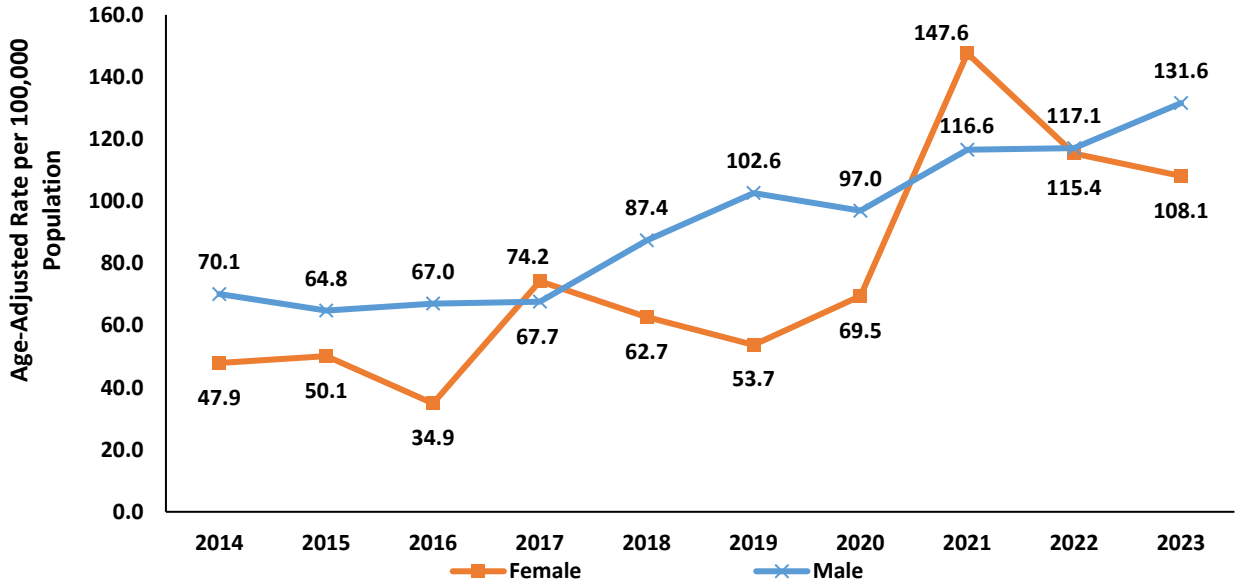
Figure 39. Chronic Alcohol Diseases Emergency Department Encounters and Rates by Year, Rural Region Residents 2014-2023.



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

The rates for both females and males have been increasing over the reporting period with the rate generally higher for males than for females. The exceptions to this are in 2017 and 2021, where spikes in the rate of emergency department encounters for females pushed the rate above that of males.

Figure 40. Chronic Alcohol Diseases Emergency Department Encounter Rates by Year and Sex, Rural Region Residents, 2014-2023.

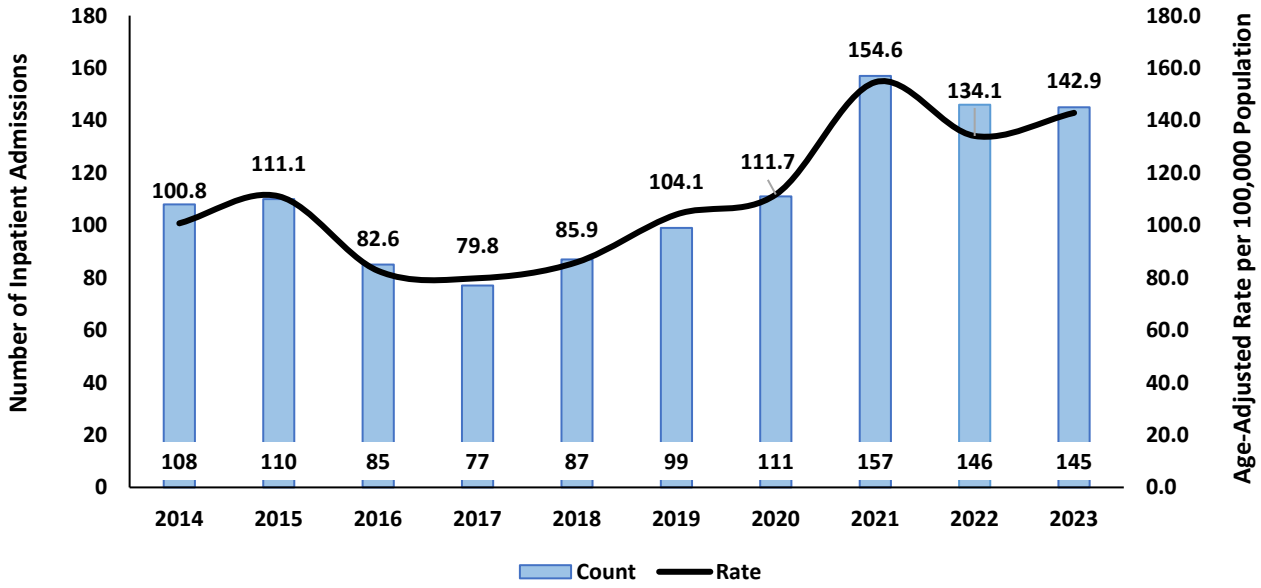


Source: Hospital Emergency Department Billing.
ICD-9-CM codes were replaced by ICD-10-CM codes in the last quarter of 2015, therefore data prior to that may not be directly comparable.

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.

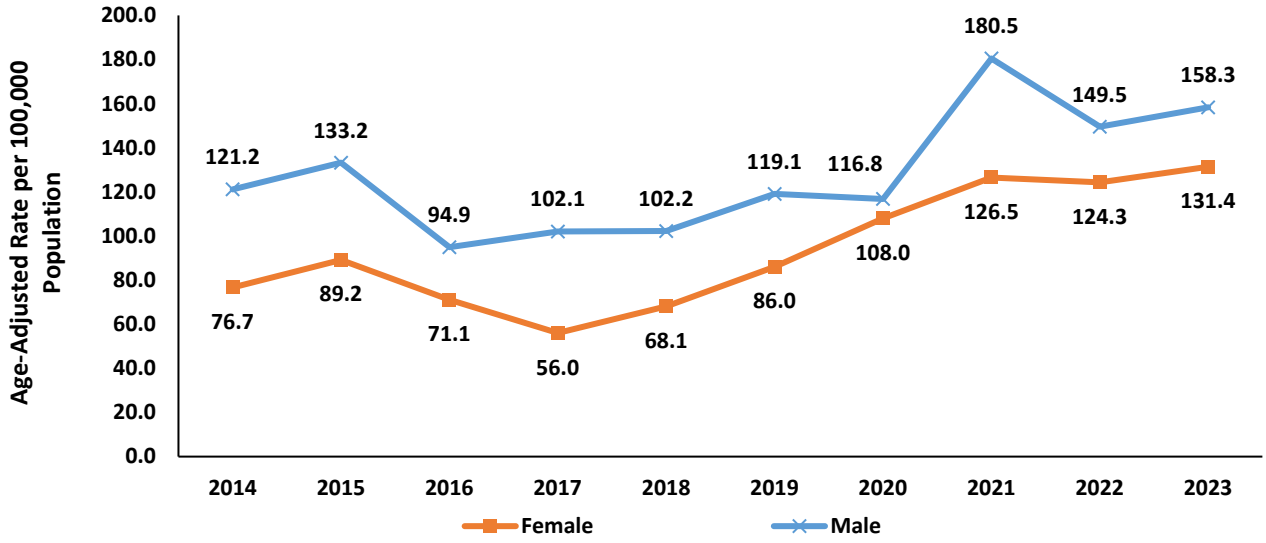
Figure 41. Chronic Alcohol Diseases Inpatient Admissions and Rates by Year, Rural Region Residents, 2014-2023.



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

The rate for males has remained higher than that of females for the duration of the reporting period.

Figure 42. Chronic Alcohol Diseases Inpatient Admission Rates by Year and Sex, Rural Region Residents, 2014-2023.

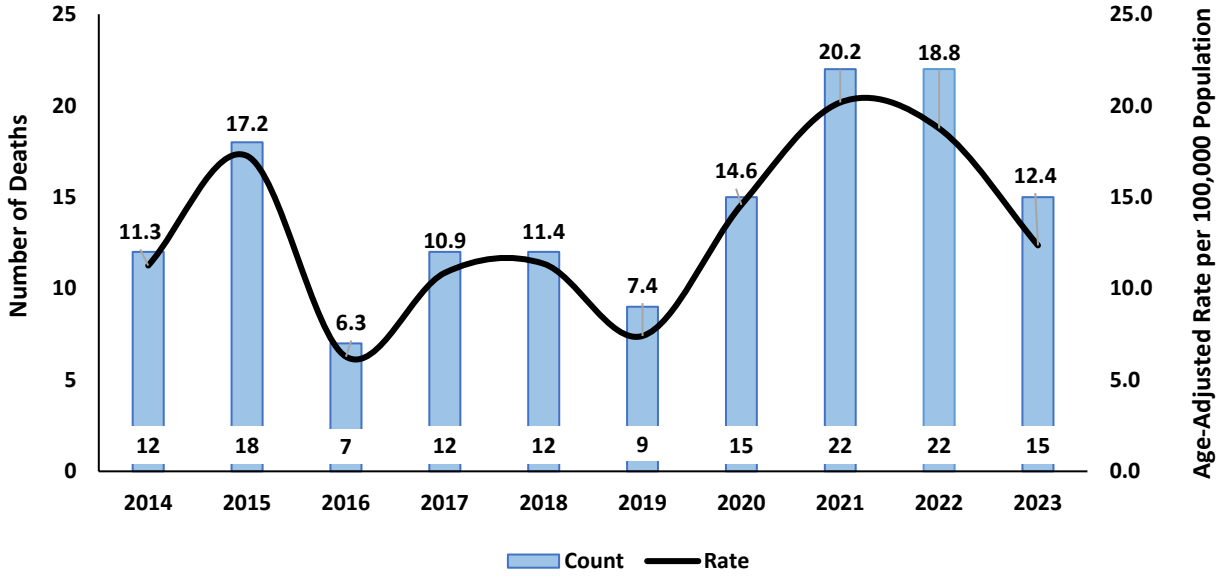


Source: Hospital Inpatient Billing.
ICD-9-CM codes were replaced by ICD-10-CM codes in the last quarter of 2015, therefore data prior to that may not be directly comparable.

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.

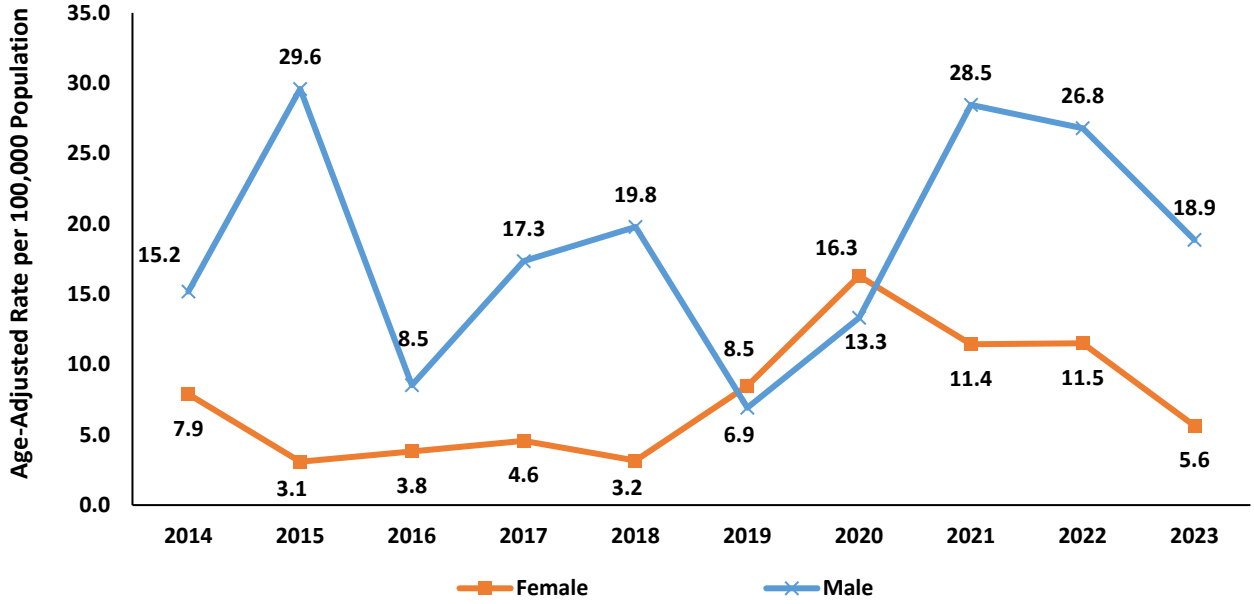
Figure 43. Chronic Alcohol Diseases Deaths and Rates, All Ages, Rural Region Residents 2014-2023.



Source: Nevada Electronic Death Registry System.

As with hospital visits, the rate of deaths from these conditions is generally higher for males than it is for females.

Figure 44. Chronic Alcohol Diseases Death Rates by Sex, Rural Region Residents 2014-2023.



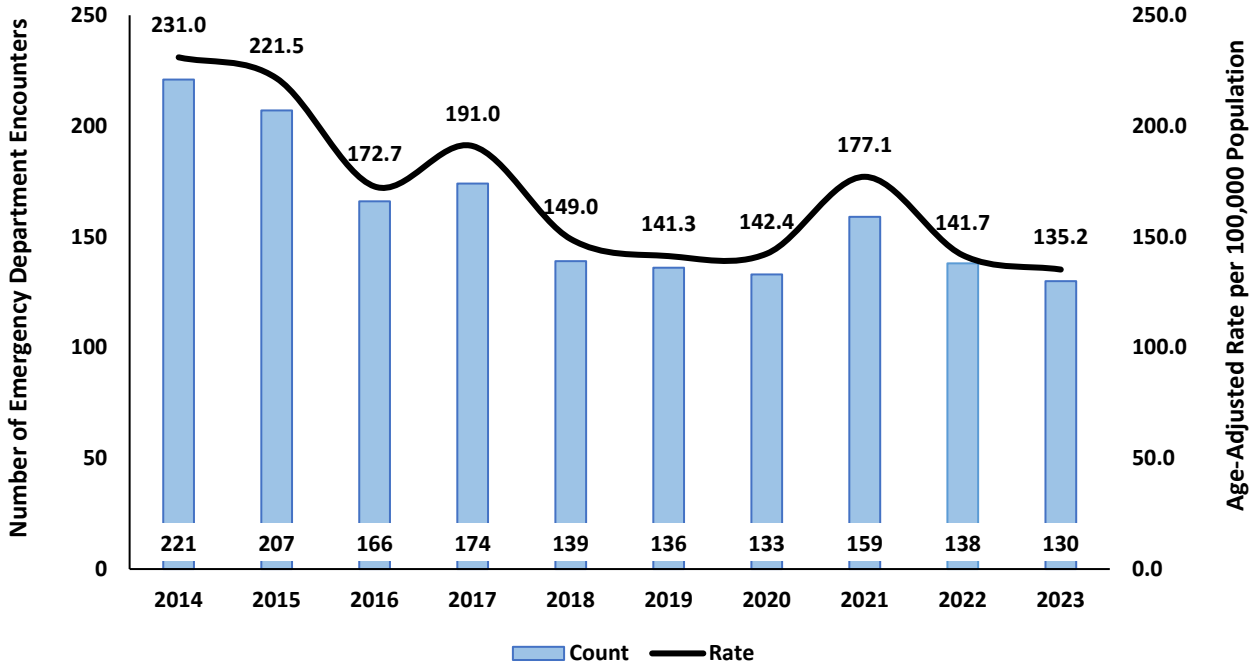
Source: Nevada Electronic Death Registry System.

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

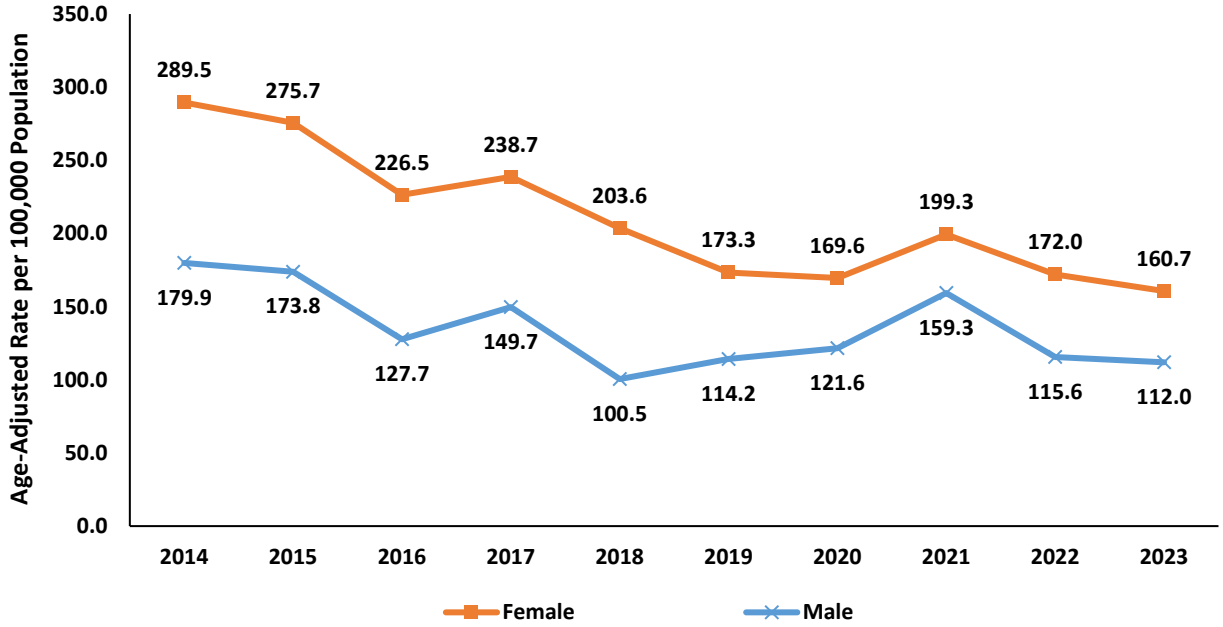
Figure 45. Alcohol- and/or Drug-Related Overdose Emergency Department Encounters and Rates by Year, Rural Region Residents, 2014-2023.



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

Throughout the reporting period, females consistently had higher rates of alcohol- and drug-related overdose emergency department encounters compared to males.

Figure 46. Alcohol- and/or Drug-Related Overdose Emergency Department Encounter Rates by Year and Sex, Rural Region Residents, 2014-2023.

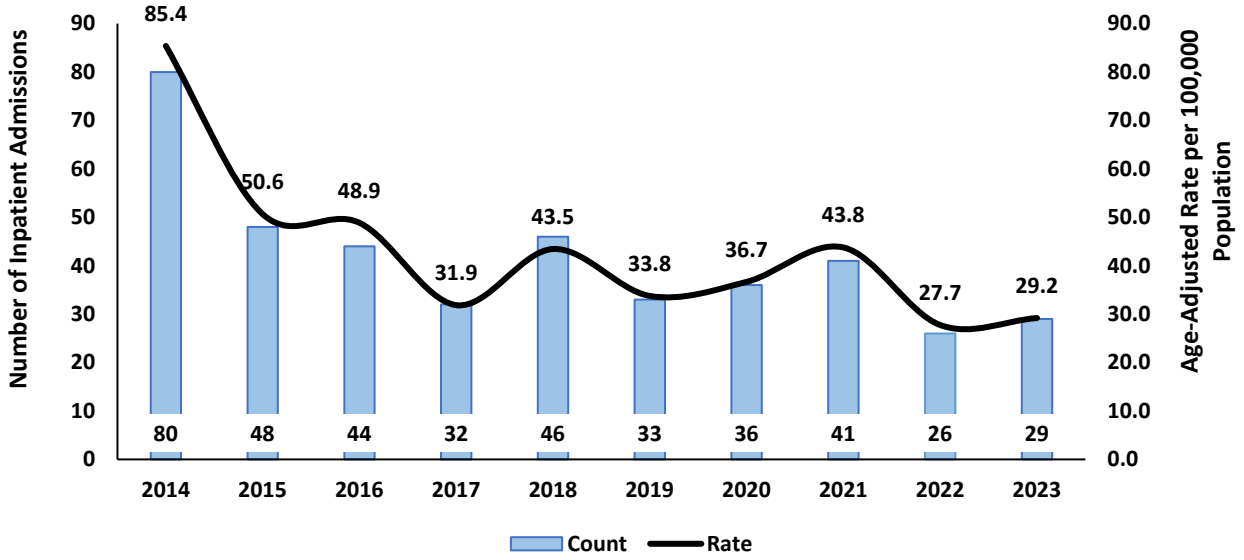


Source: Hospital Emergency Department Billing.
ICD-9-CM codes were replaced by ICD-10-CM codes in the last quarter of 2015, therefore data prior to that may not be directly comparable.

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 2022, at 27.7 per 100,000 population.

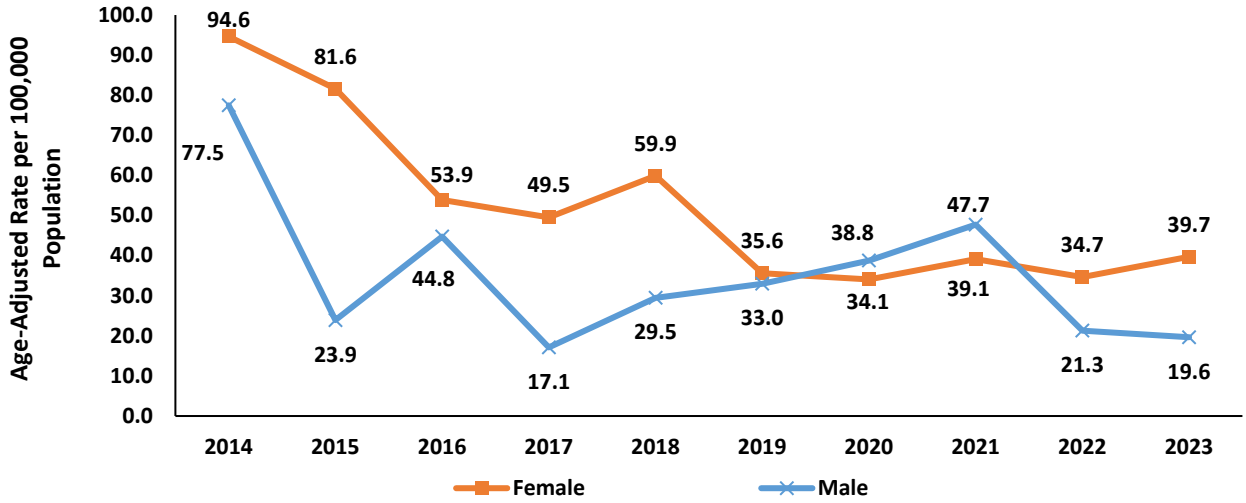
Figure 47. Alcohol- and/or Drug-Related Overdose Inpatient Admissions and Rates by Year, Rural Region Residents, 2014-2023.



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

From 2014 to 2019, females consistently had higher rates of alcohol- and drug-related overdose inpatient admissions compared to males. In 2019 and 2020 the rates were comparable with males at a slightly higher incidence.

Figure 48. Alcohol- and/or Drug-Related Overdose Inpatient Admission Rates by Year and Sex, Rural Region Residents, 2014-2023.

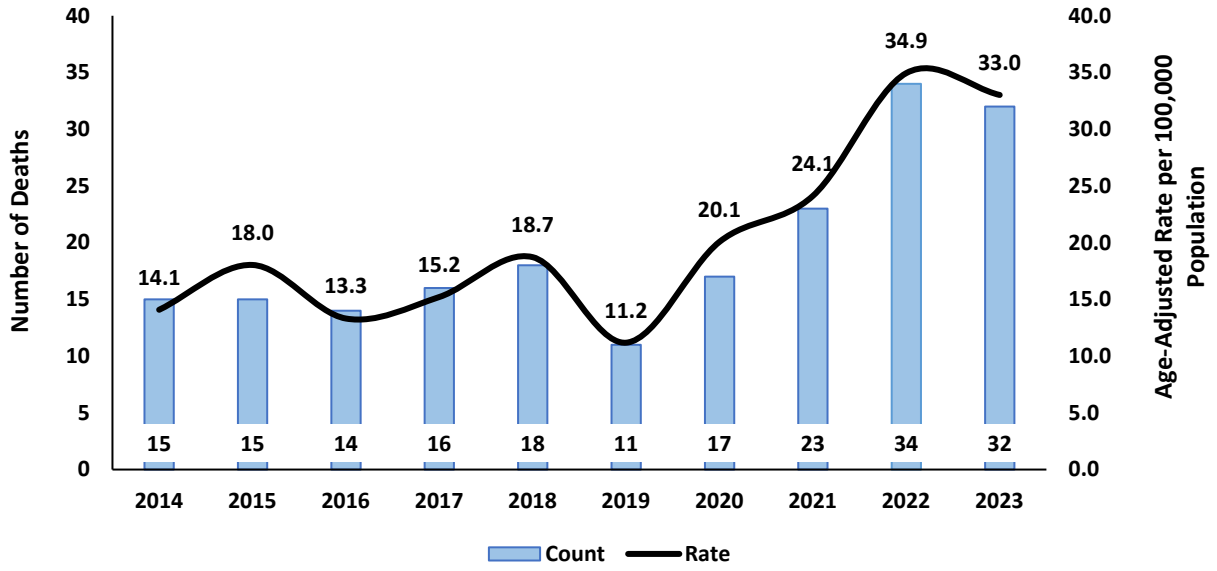


Source: Hospital Inpatient Billing.
ICD-9-CM codes were replaced by ICD-10-CM codes in the last quarter of 2015, therefore data prior to that may not be directly comparable.

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. The rate of such deaths in the Rural Region has been increasing since 2019 to a high in 2022 of 34.9 per 100,000 population.

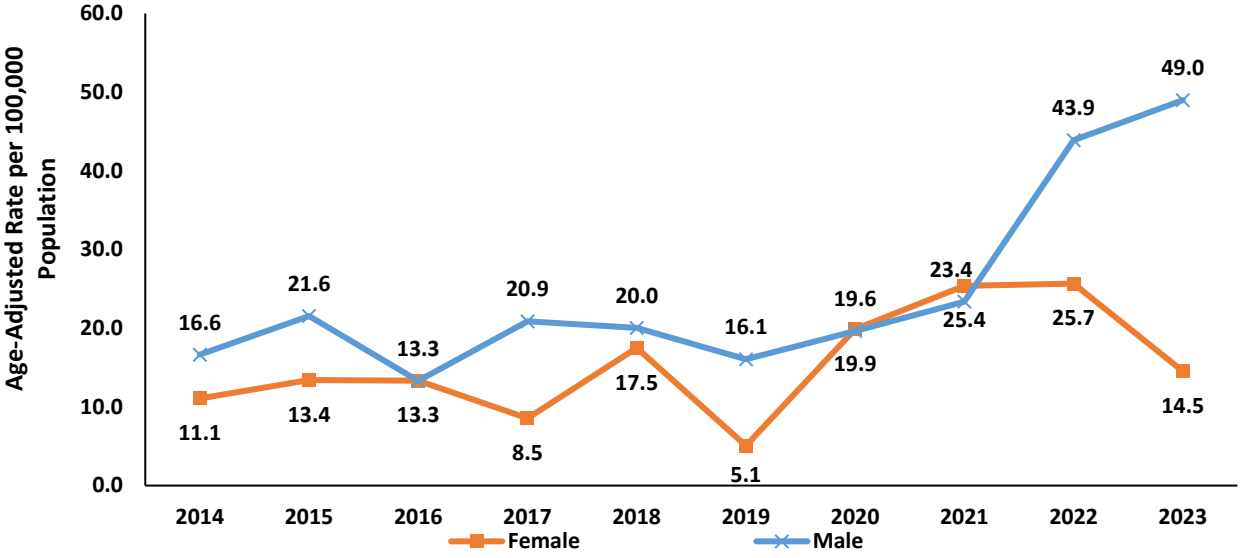
Figure 49. Alcohol- and/or Drug-Related Overdose Deaths and Rates, Rural Region Residents 2014-2023.



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 2021 and 2023 the rate increased substantially for males, while declining for females.

Figure 50. Alcohol- and/or Drug-Related Overdose Death Rates by Sex, Rural Region Residents 2014-2023.



Source: Electronic Death Registry System.

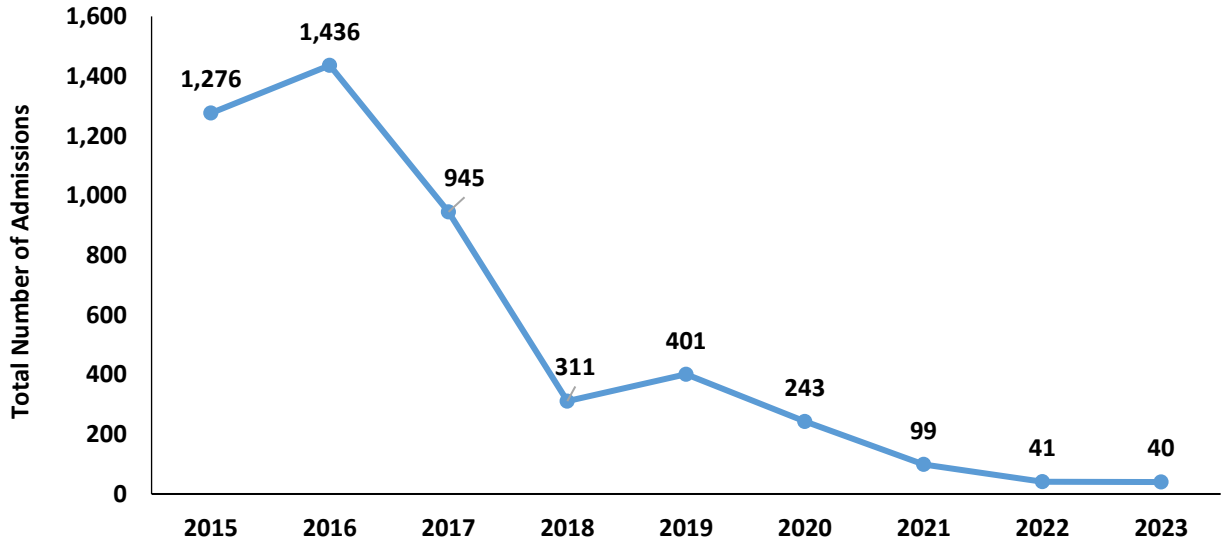
Substance Use Treatment Centers

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 Rural Nevada state-funded substance use treatment facilities is limited to Elko, Humboldt and Pershing Counties. Counts reflect only Elko County after 2017.

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].

Figure 51. Total Number of Admissions in Nevada State-Funded Substance Abuse Treatment Facilities, Rural Region, 2015-2023.

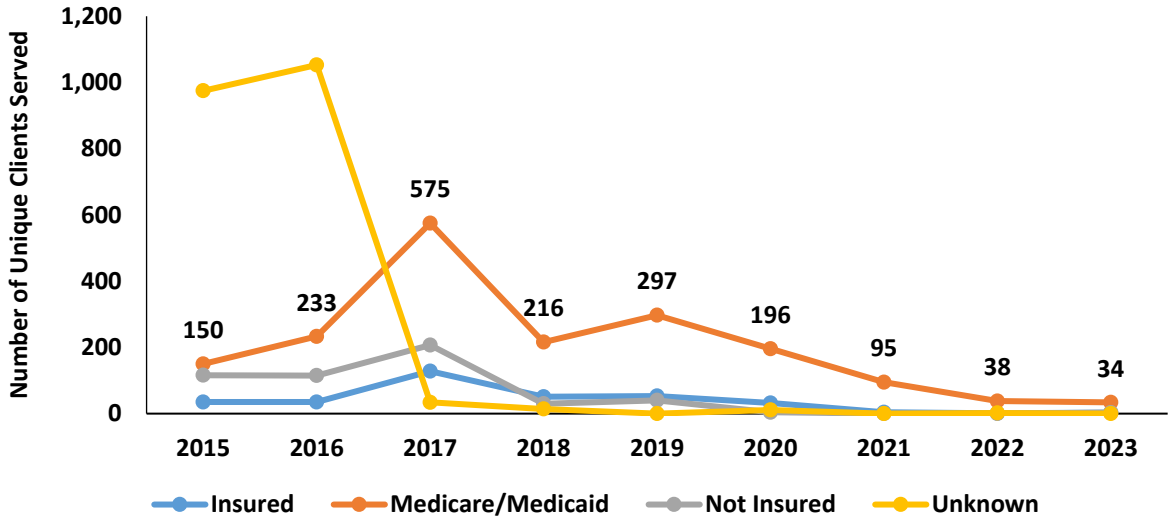


Data Source: Treatment Episode Data Sets.

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. Rural populations rely on Medicaid coverage for treatment and much like statewide trends, it is the most common form of coverage.

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

Figure 52. Insurance Coverage for Individuals Admitted in a Substance Use Treatment Facility, Rural Region, 2015-2023.

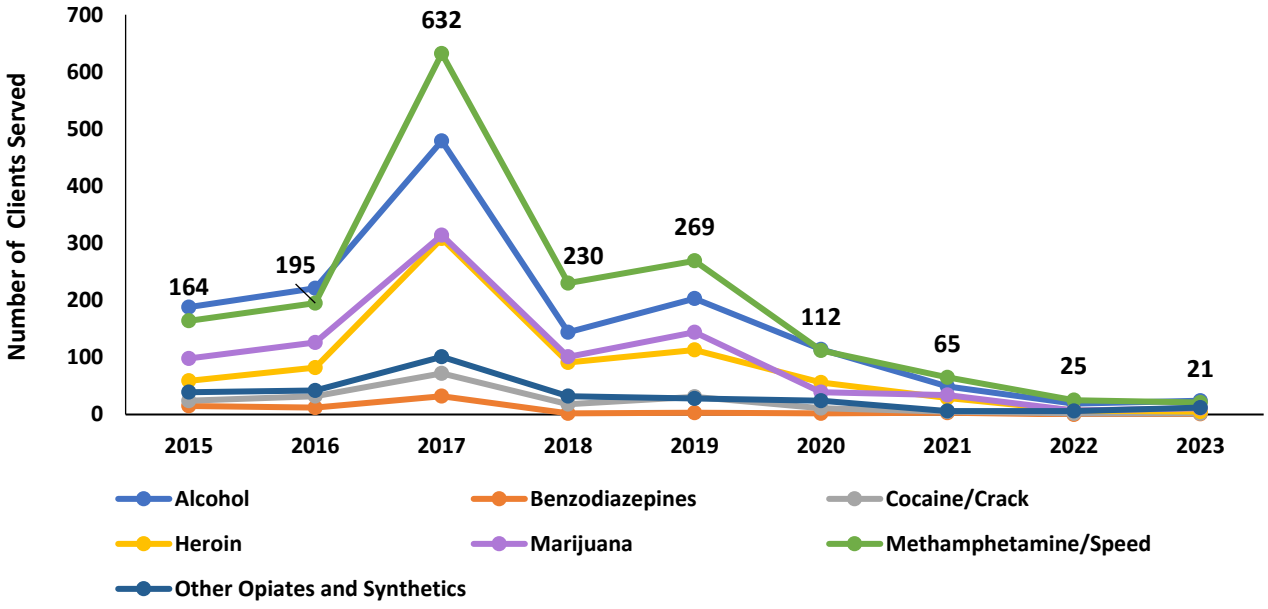


Data Source: Treatment Episode Data Sets.

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.

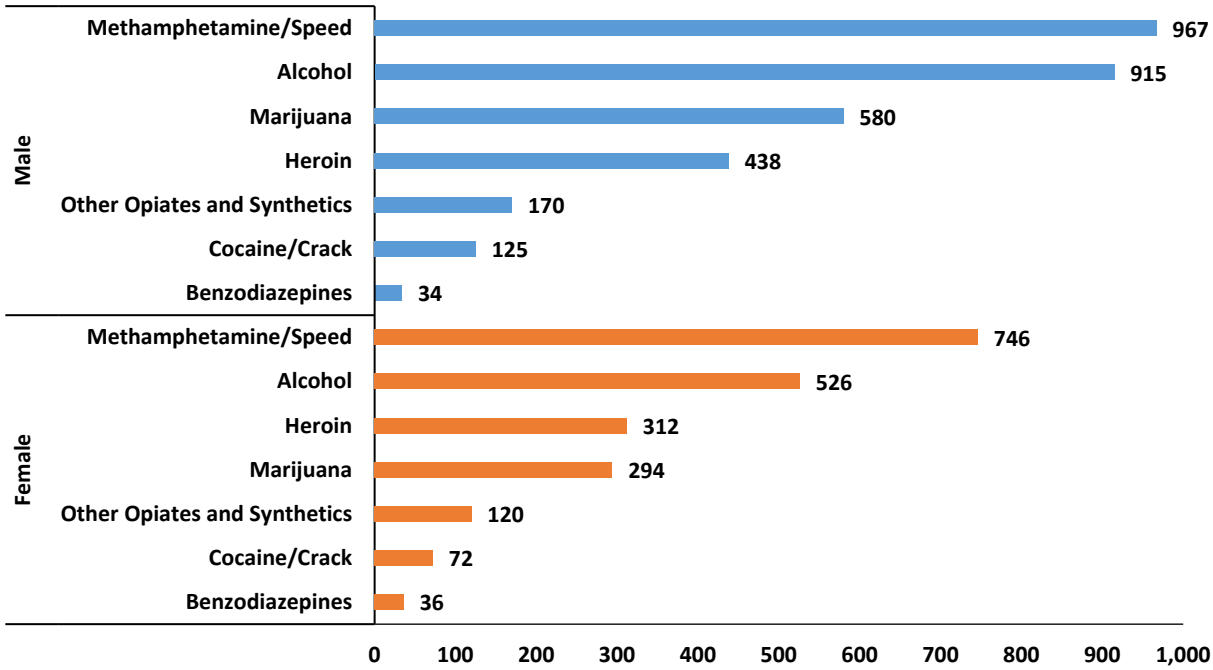
Figure 53. Primary Substance Used for Clients at Adult Substance Abuse Treatment Centers, Rural Region, 2015-2023.



Data Source: Treatment Episode Data Sets.

Methamphetamine/speed was the primary substance reported for both males and females admitted from 2015-2023 in the Rural Region. Statewide, alcohol is the primary reported substance for men, followed by methamphetamine/speed. 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.

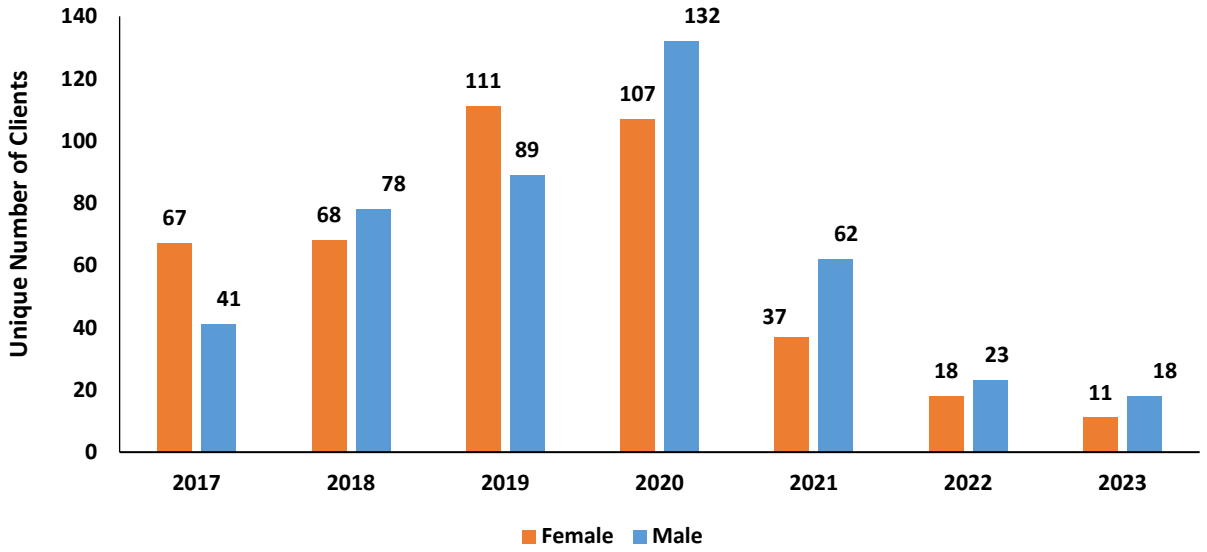
Figure 54. Primary Substance Used for Clients at Adult Substance Abuse Treatment Centers by Sex, Rural Region, 2015-2023.



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; that is until 2021, when numbers of co-occurring disorders decreased.

Figure 55. Individuals Admitted to a Substance Use Treatment Facility with a Co-occurring Mental Health Disorder by Sex, Rural Region, 2015-2023.



Data Source: Treatment Episode Data Sets.

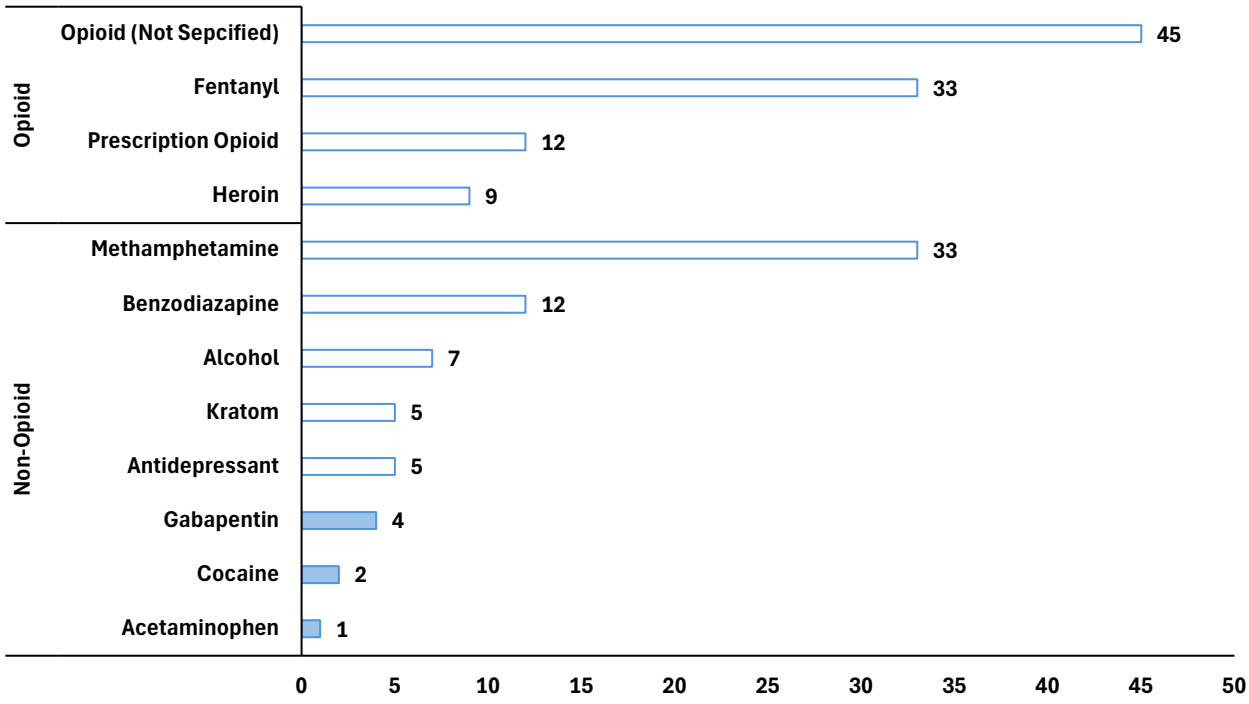
SUDORS

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.

There were 64 total drug overdose deaths of unintentional/undetermined intent among Rural Region residents between 2019 and 2022.

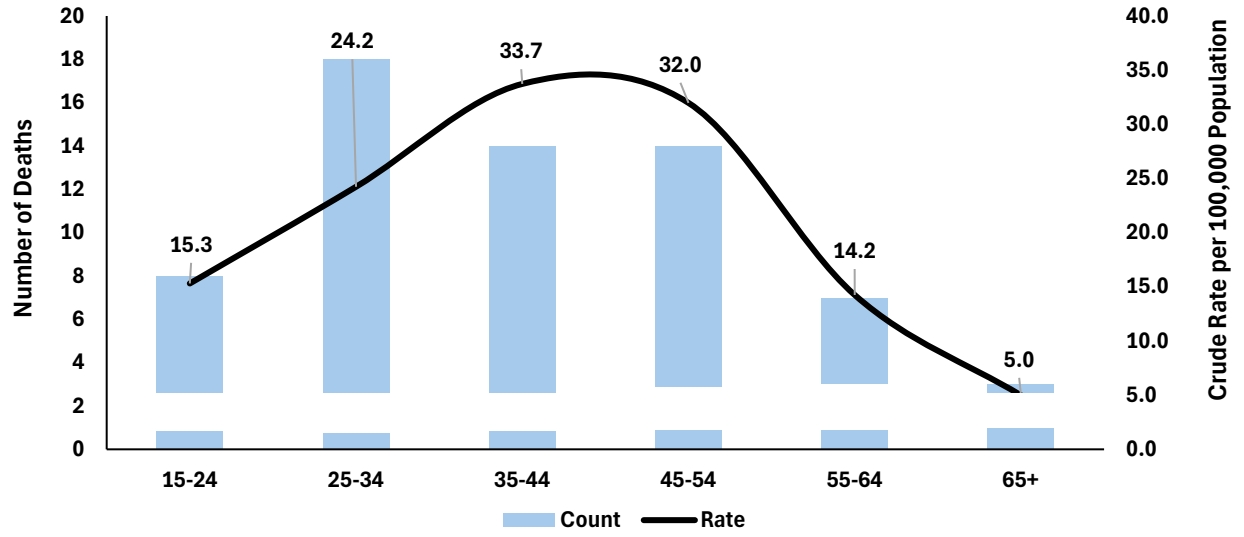
Opioids were listed in the cause of death in roughly 70% of cases and fentanyl was listed in about 50% of cases. Methamphetamine was also listed as one of the substances in the cause of death in about half of cases reported.

Figure 56. Substances Listed in the Cause of Death Among Unintentional/Undetermined Overdose Deaths, Rural Region Residents, 2019-2022.



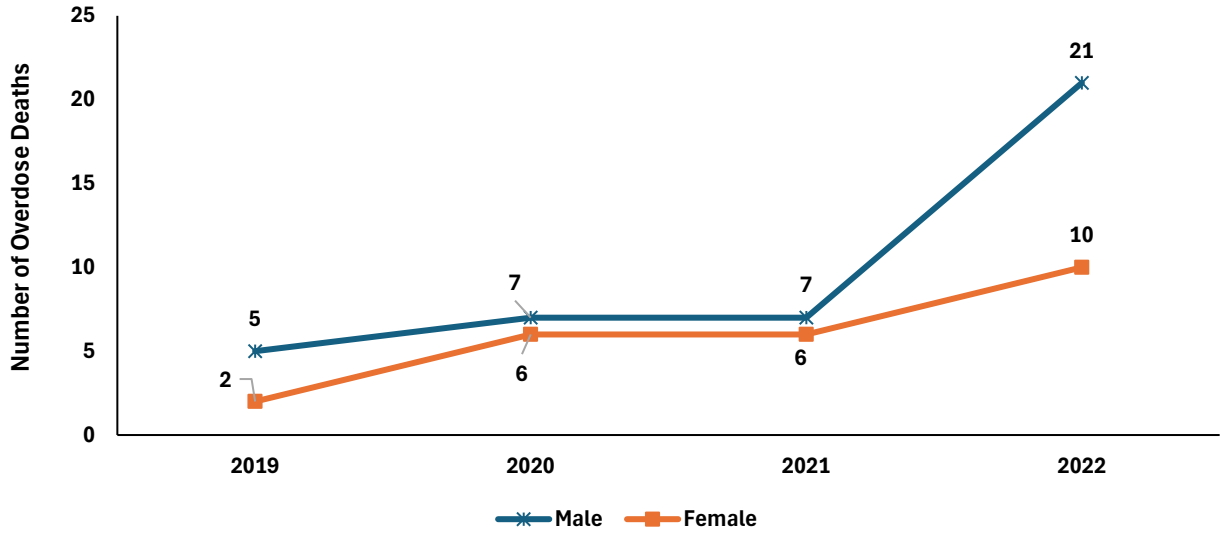
Source: SUDORS.

Figure 57. Total Number of Unintentional/Undetermined Overdose Deaths and Rates by Age Group, Rural Region Residents, 2019-2022.



Source: SUDORS.

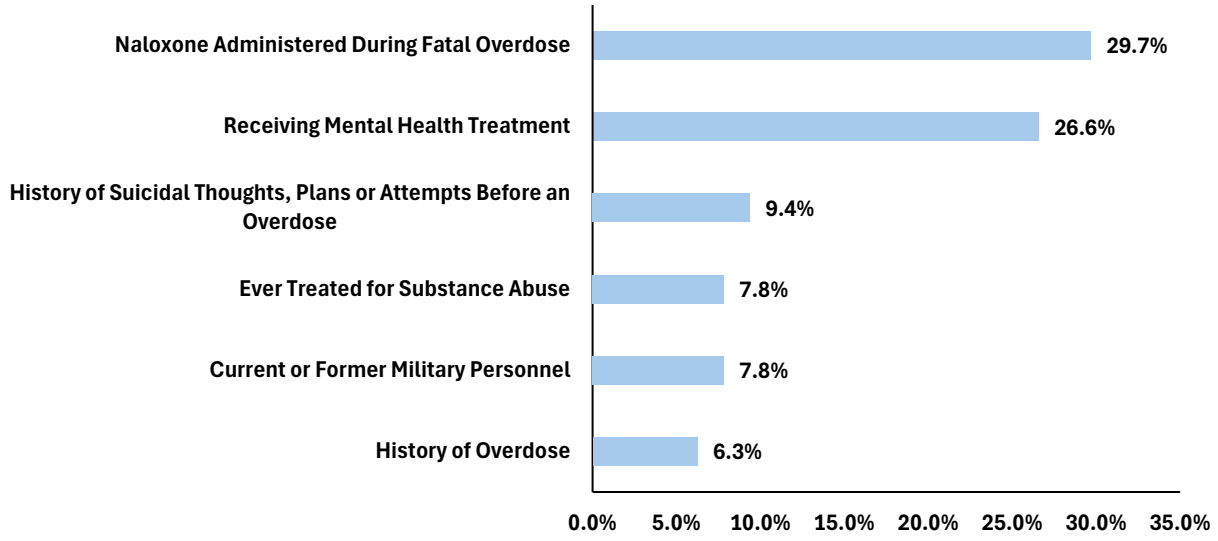
Figure 58. Total Number of Unintentional/Undetermined Overdose Deaths by Sex, Rural Region Residents, 2019-2022.



Source: SUDORS.

29.7% of persons in the SUDORS dataset for the Rural Region had naloxone administered during the fatal overdose, and 26.6% had been receiving mental health treatment. Only about 6.3% of cases had a documented prior history of overdose.

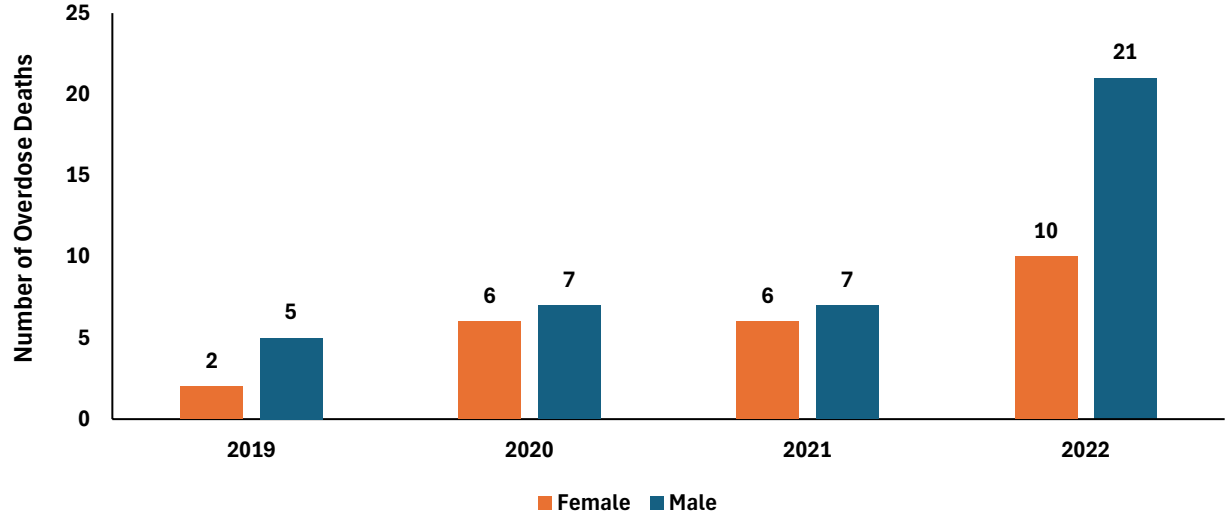
Figure 59. Circumstances Preceding Unintentional/Undetermined Overdose Deaths, Rural Region Residents, 2019-2022.



Source: SUDORS.
Chart scaled to 35.0% 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 2 times more likely have naloxone administered at the scene before dying from an unintentional/undetermined overdose compared to females in 2022.

Figure 60. Naloxone Administered at the Scene Among Unintentional/Undetermined Overdoses Deaths by Sex, Rural Region Residents, 2019-2022.



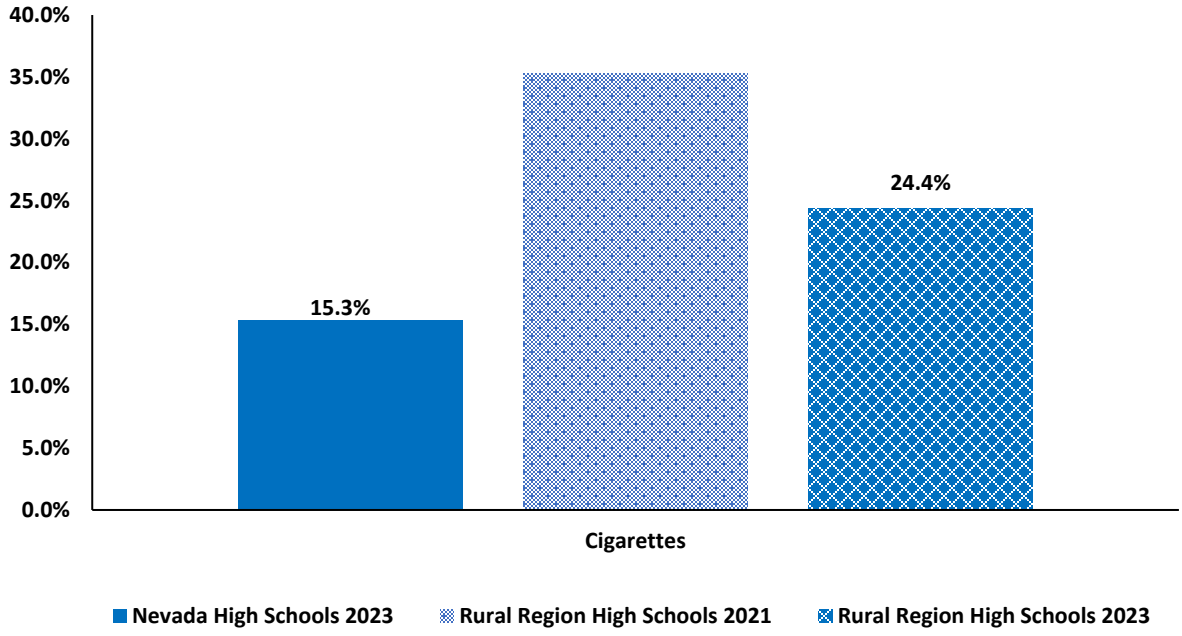
Source: SUDORS.

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, 716 high school students and 796 middle school students participated in the YRBS in the Rural Region. 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.

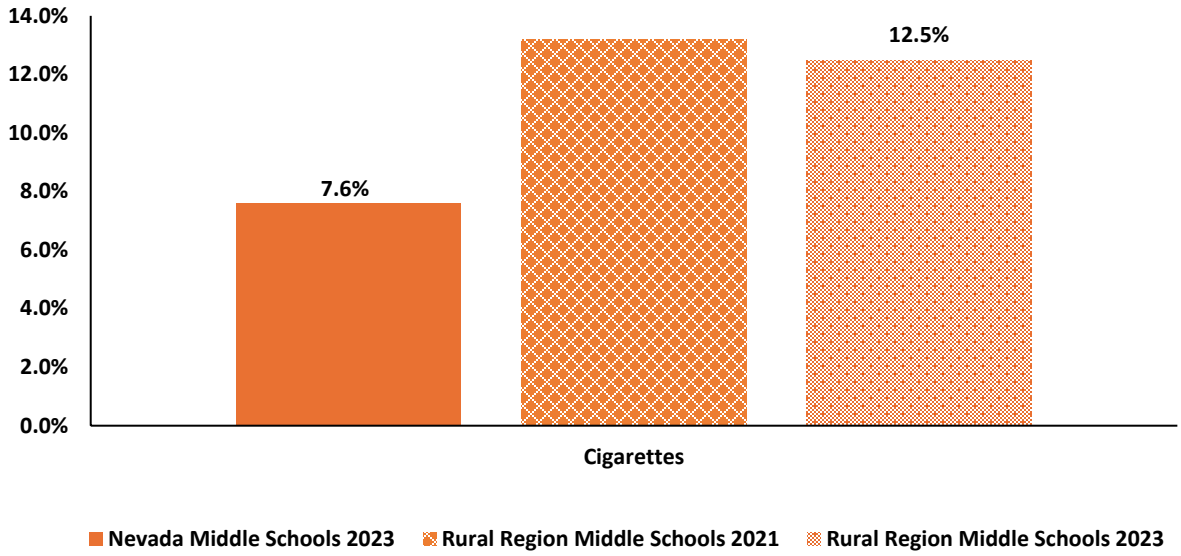
Rural Region high school students in 2023 had a significantly higher percent for ever having ever tried cigarettes compared to Nevada at 24.4% and 15.3% respectively. Middle school students in the Rural Region also had a higher percent for ever trying cigarettes at 12.5% compared to Nevada at 7.6%.

Figure 61a. Percent of Respondents Who Have Ever Tried Cigarette Smoking*, Rural Region High School Students, 2021, 2023 and Nevada High School Students, 2023.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 40.0% to display differences among groups.

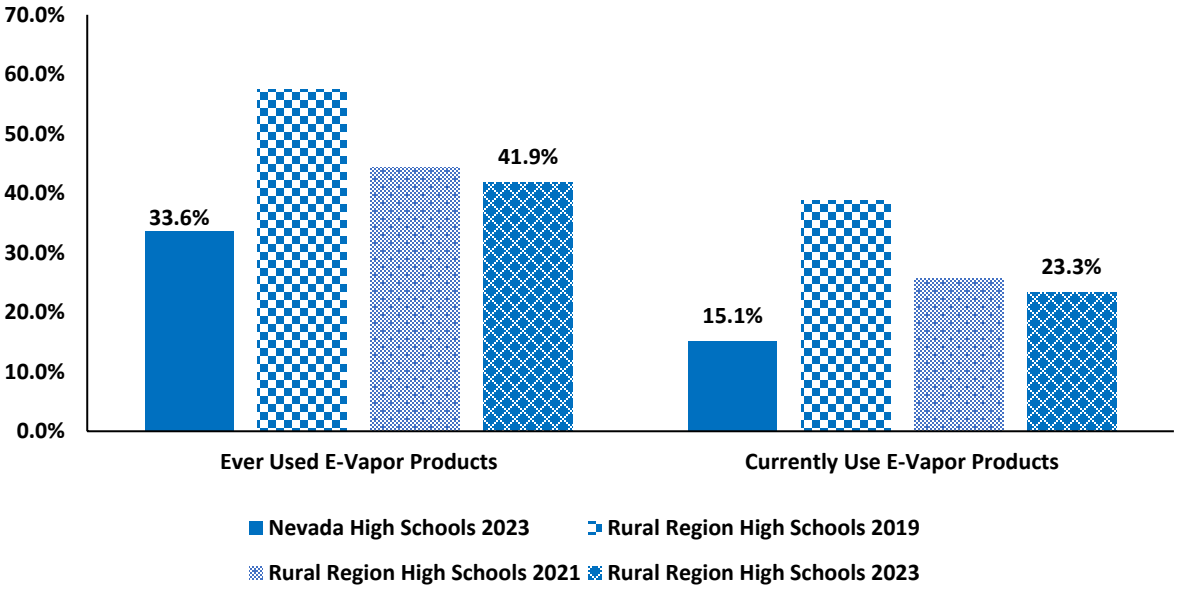
Figure 61b. Percent of Respondents Who Have Ever Tried Cigarette Smoking*, Rural Region Middle School Students, 2021, 2023 and Nevada Middle School Students, 2023.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 14.0% to display differences among groups.

Rural Region high school students have a significantly higher percent for ever using an e-vapor product than Nevada in 2023 (41.9% and 33.6%, respectively) and currently using electronic vapor (e-vapor) products than Nevada in 2023 (23.3% and 15.1%, respectively).

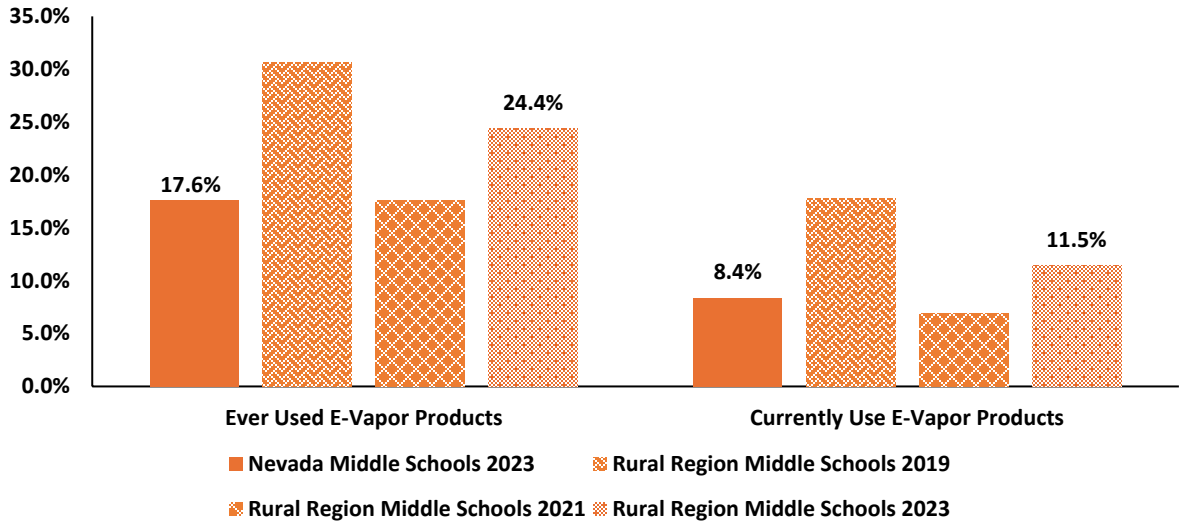
Figure 62a. Electronic Vapor Product* Use, Rural Region High School Students, 2019, 2021, 2023 and Nevada High School Students, 2023.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 70.0% 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'.*

Rural Region middle school students also have a significantly higher percent for ever using an e-vapor product than Nevada in 2023 (24.4% and 17.6%, respectively) and a higher percent of students who currently use e-vapor products (11.5% and 8.4%, respectively).

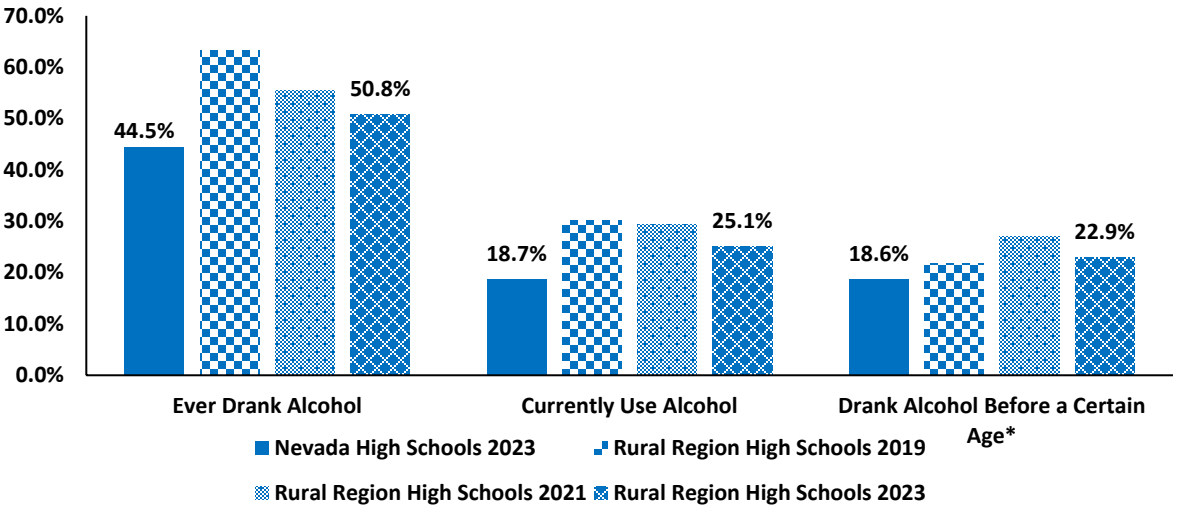
Figure 62b. Electronic Vapor Product* Use, Rural Region Middle School Students, 2019, 2021, 2023 and Nevada Middle School Students, 2023.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 35.0% 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'.*

The percent of Rural Region high school students who reported they ever drank alcohol, currently use alcohol, or drank alcohol before a certain age are all higher than Nevada high school students in 2023.

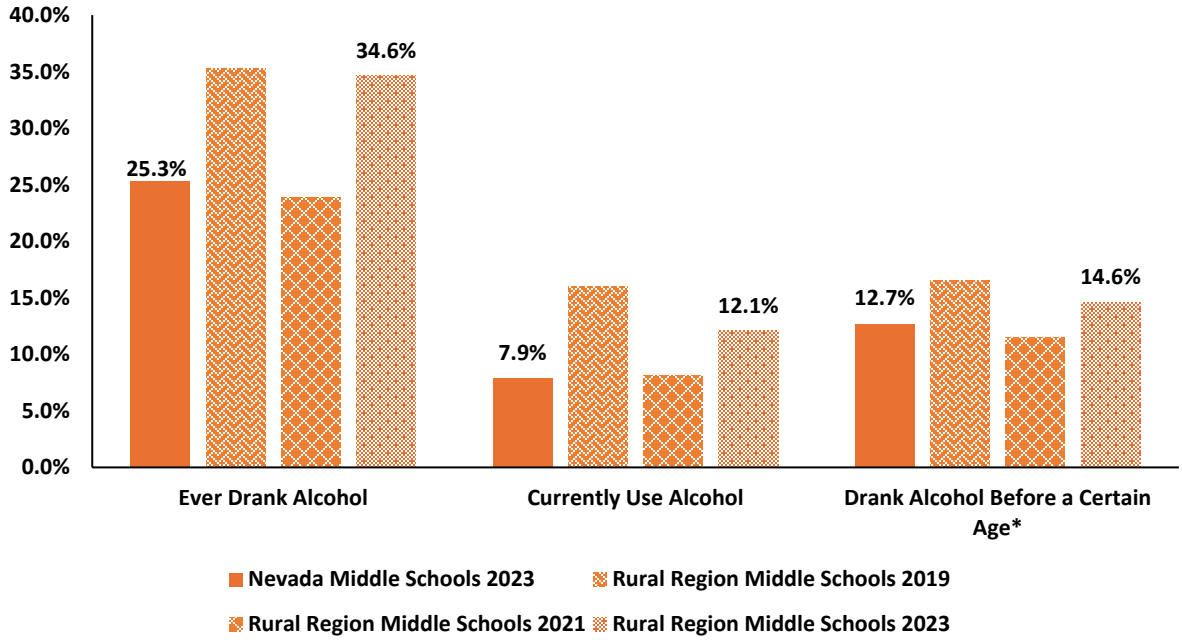
Figure 63a. Alcohol Use, Rural Region High School Students, 2019, 2021, 2023 and Nevada High School Students, 2023.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 70.0% to display differences among groups.
**Among high school students, if they ever drank before age 13.*

The percent of students who ever drank alcohol, currently use alcohol, or drank alcohol before certain age among Rural Region middle school students decreased from 2019 to 2021 before increasing in 2023. Rural Region middle school student percents for ever drinking alcohol, currently drink alcohol, and drank before a certain age are higher than Nevada middle school student percents.

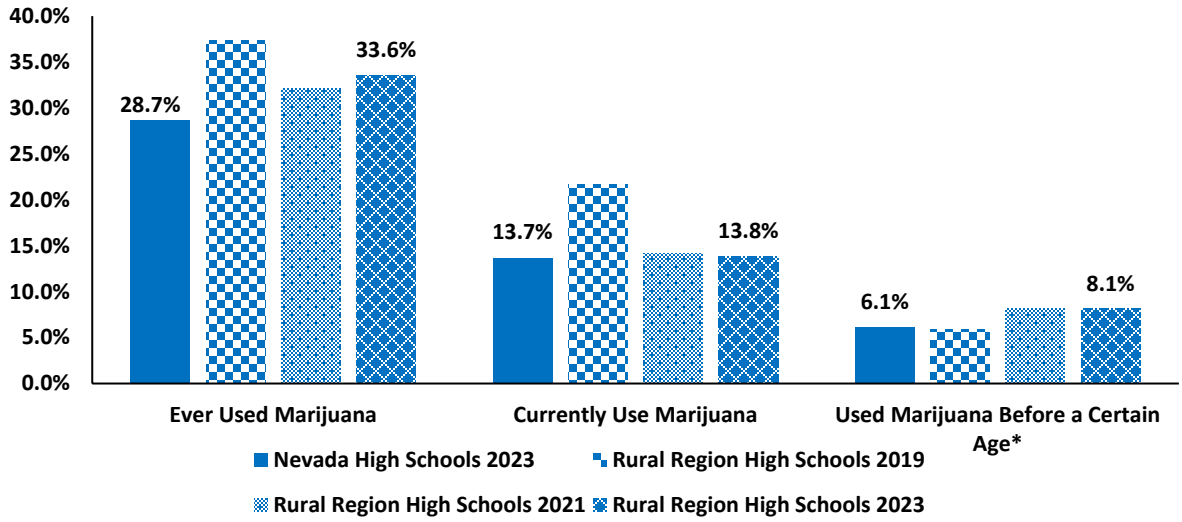
Figure 63b. Alcohol Use, Rural Region Middle School Students, 2019, 2021, 2023 and Nevada Middle School Students, 2023.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 40.0% to display differences among groups.
**Among middle school students, if they ever drank before age 11.*

The percents of Rural Region high school students who have reported to have ever used marijuana, currently use marijuana, or used marijuana before a certain age in 2023 are higher than Nevada high school percents.

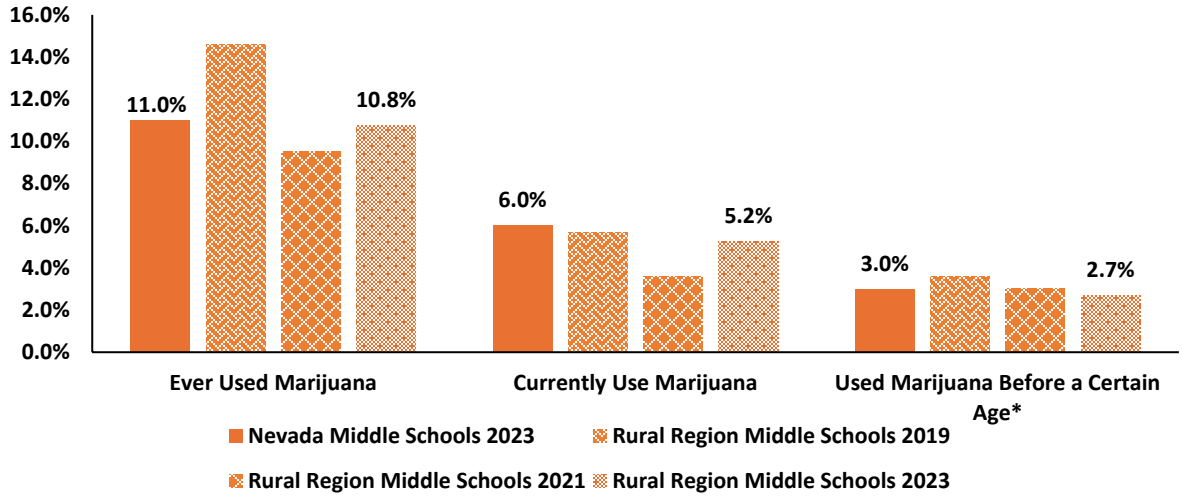
Figure 64a. Marijuana Use, Rural Region High School Students, 2019, 2021, 2023 and Nevada High School Students, 2023.



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.*

The percent of Rural Region middle school students who have reported to have ever used marijuana, currently use marijuana, or used marijuana before a certain age in 2023 were lower in Rural Region middle schools compared to Nevada middle schools in 2023.

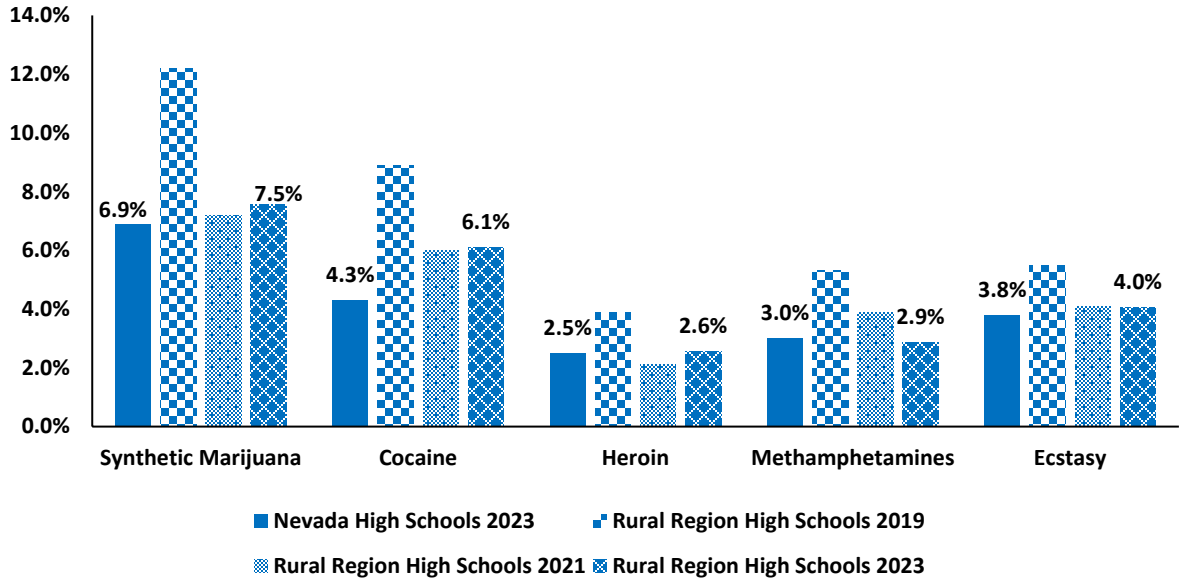
Figure 64b. Marijuana Use, Rural Region Middle School Students, 2019, 2021, 2023 and Nevada Middle School Students, 2023.



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.*

Of the illicit drugs listed in Figure 65a below, lifetime drug use percents among Rural Region high school students was highest in 2019. Lifetime drug use percents among Rural Region high school students was significantly lower in 2023 compared to 2019. Among Rural Region high school students in 2023, synthetic marijuana use, heroin, methamphetamines, and ecstasy use was within 1.0% of Nevada high school student percents, while cocaine use was significantly higher (6.1% and 4.3%, respectively).

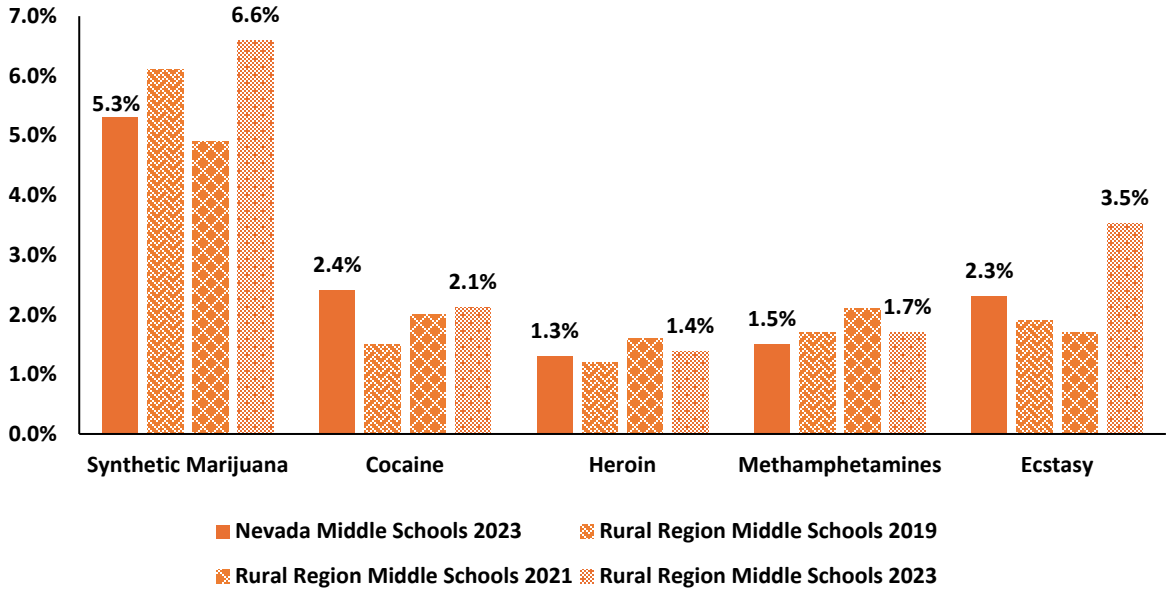
Figure 65a. Lifetime Drug Use, Rural Region High School Students, 2019, 2021, 2023 and Nevada High School Students, 2023.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 14.0% to display differences among groups.

The percent of lifetime drug use among Rural Region middle school students was highest in 2023 for synthetic marijuana (6.6%), cocaine (2.1%), and ecstasy (3.5%). Rural Region middle school student percents of lifetime use for all illicit drugs listed for 2023 were higher than Nevada middle school student percents, except for cocaine which was slightly lower (2.1% and 2.4%, respectively).

Figure 65b. Lifetime Drug Use, Rural Region Middle School Students, 2019, 2021, 2023 and Nevada Middle School Students, 2023.



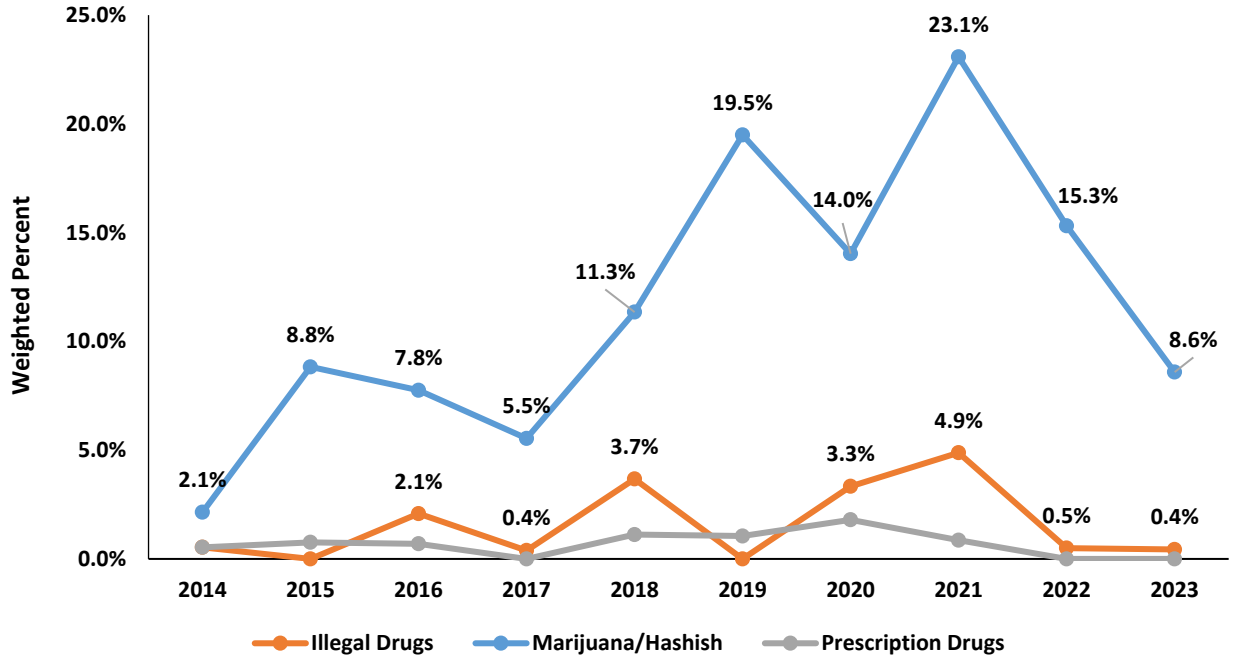
Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 7.0% to display differences among groups.

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 alcohol use.

Marijuana use has more than tripled statewide since 2014. In 2023, 8.6% of respondents reported to have used marijuana in the past 30 days, up from 2.1% in 2014 and a high of 23.1% in 2021. Self-reported use of marijuana has increased, as expected, since recreational marijuana use was legalized in Nevada in 2017. Although statewide, the trajectory of marijuana use has increased, The Rural Region has experienced a decline in usage since its peak in 2021. Of Rural Region residents surveyed from 2014 to 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 66. Percent of Adult BRFSS Respondents Who Used Marijuana/Hashish, Illegal Substances, or Painkillers to Get High in the Last 30 Days, Rural Region Residents, 2014-2023.



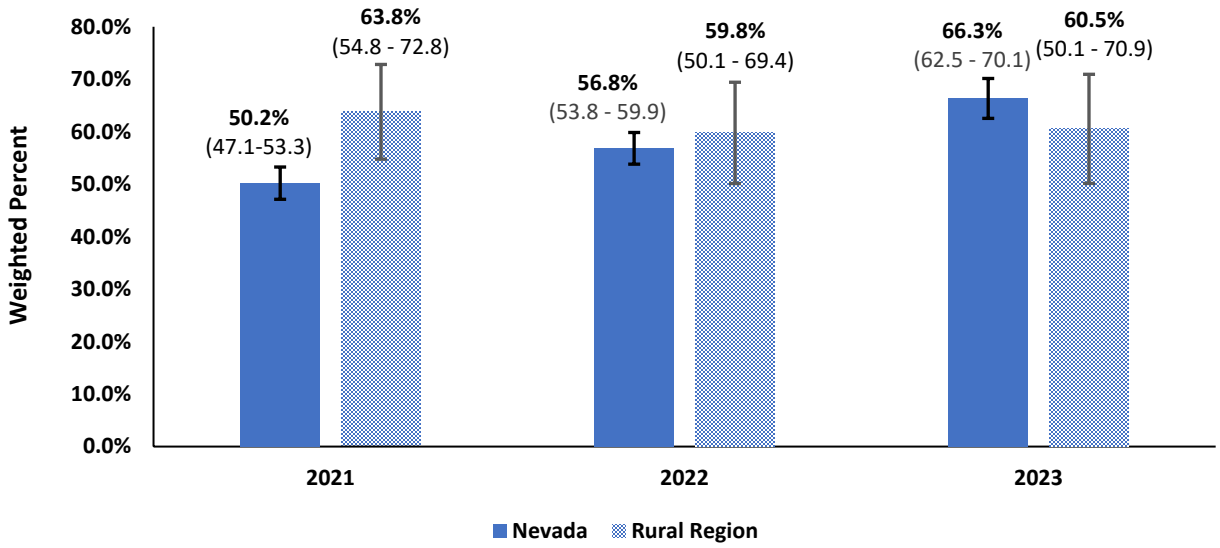
Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 25.0% to display differences among groups.
Specific question asked in survey: "During the past 30 days, on how many days did you use marijuana or hashish/any other illegal drug/ prescription drugs without a doctor's order, just to "feel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

Rural Region Narcan knowledge has stayed relatively consistent with a high prevalence of knowledge in 2021 (the first year the question was added to BRFSS).

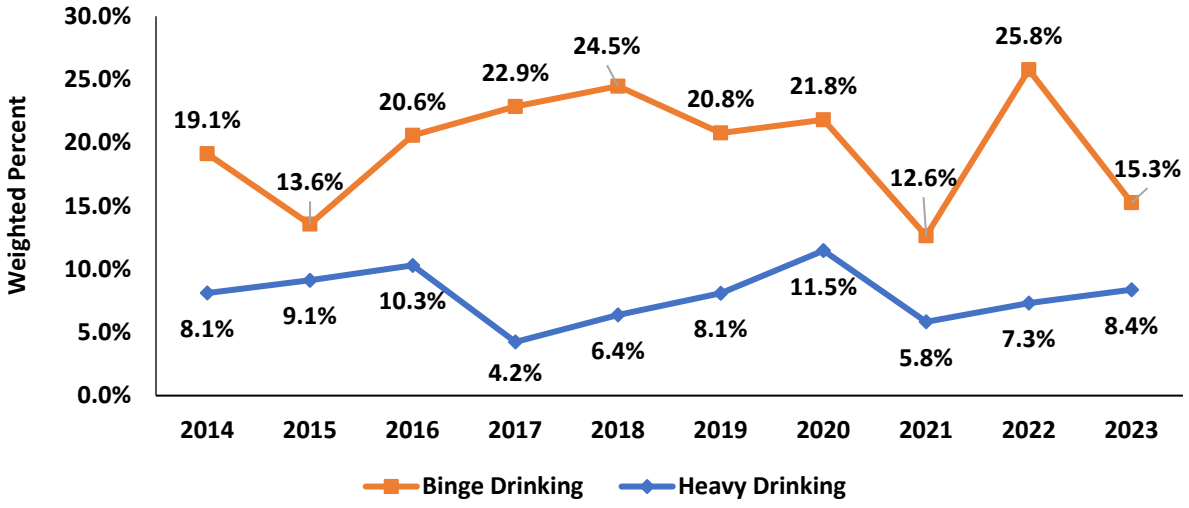
Figure 67. Percentage of BRFSS Respondents who Reported Knowing what Narcan is, Rural Region Residents, 2021-2023.



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

Binge drinking is defined in men as having five or more alcoholic beverages and women 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. Heavy drinking was lowest in 2017 and binge drinking was lowest in 2021. The dip in 2021 for both binge drinking and heavy drinking is similar to statewide trends. In 2022, the percentage of binge drinkers doubled before decreasing in 2023.

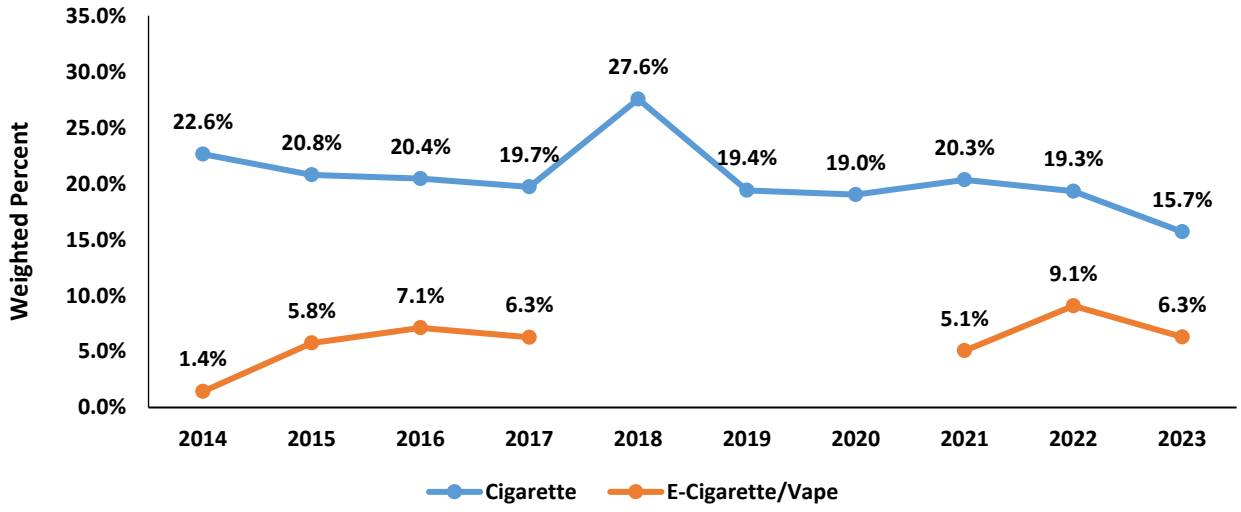
Figure 68. Percent of Adult BRFSS Respondents Who are Considered Binge Drinkers or Heavy Drinkers, Rural Region Residents, 2014-2023.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 30.0% to display differences among groups.

In 2023, 15.7% of adults were current cigarette smokers, which has decreased since peaking in 2018, at 27.6%. Percents for cigarette smoking is higher in rural regions compared to the rest of the state. E-cigarette use reached a high of 9.1% in 2022, before decreasing to 6.3% in 2023. In 2018 through 2020, the e-cigarette use question was asked differently compared to years prior and thus had to be excluded from the graph.

Figure 69. Percent of Adult BRFSS Respondents Who are Current Cigarette or E-Cigarette Smokers, Rural Region Residents, 2014-2023.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 35.0% 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.

Youth

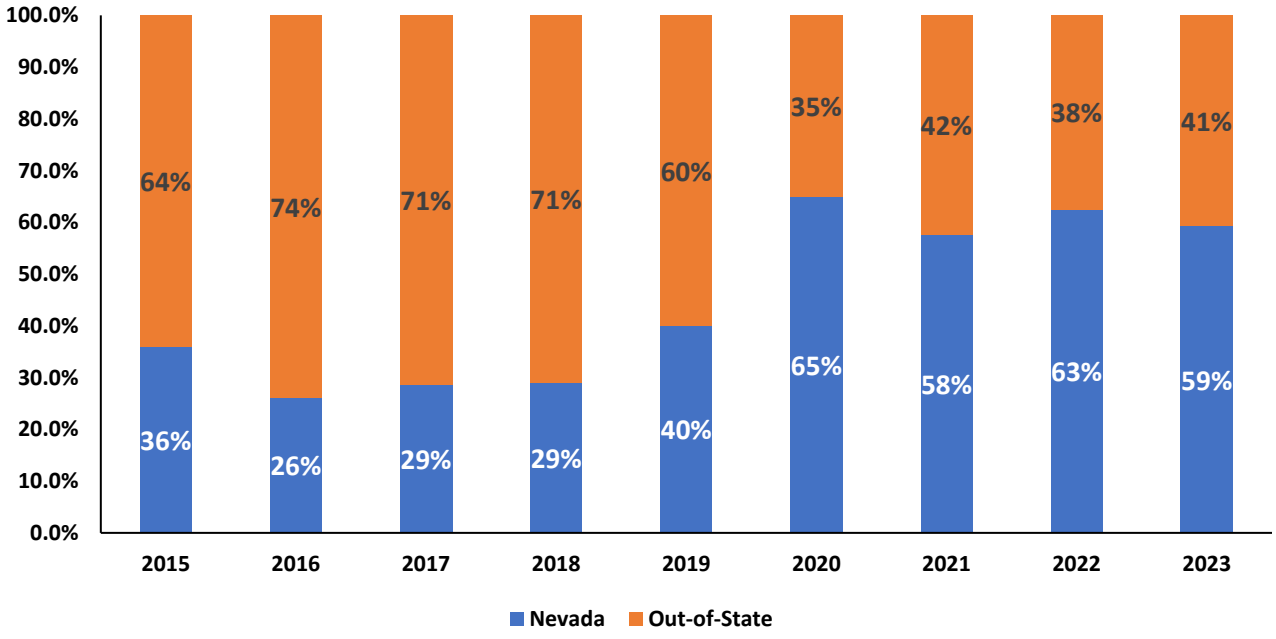
This section focuses on other factors that affect youth not directly related to substance use or mental health.

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 Rural Region children admitted to facilities in the state of Nevada (rather than out-of-state facilities) has increased by over twenty percent. This reflects statewide efforts to keep the treatment of Nevada youth in-state.

Figure 70. Medicaid-Funded Residential Treatment Center Placement for Rural Region 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 Rural Region Children, 2015-2023.

Year	Provider State			
	Nevada	Out of State	Nevada %	Out of State %
2015	9	16	36.0%	64.0%
2016	6	17	26.1%	73.9%
2017	10	25	28.6%	71.4%
2018	9	22	29.0%	71.0%
2019	10	15	40.0%	60.0%
2020	13	7	65.0%	35.0%
2021	15	11	57.7%	42.3%
2022	10	6	62.5%	37.5%
2023	16	11	59.3%	40.7%

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.

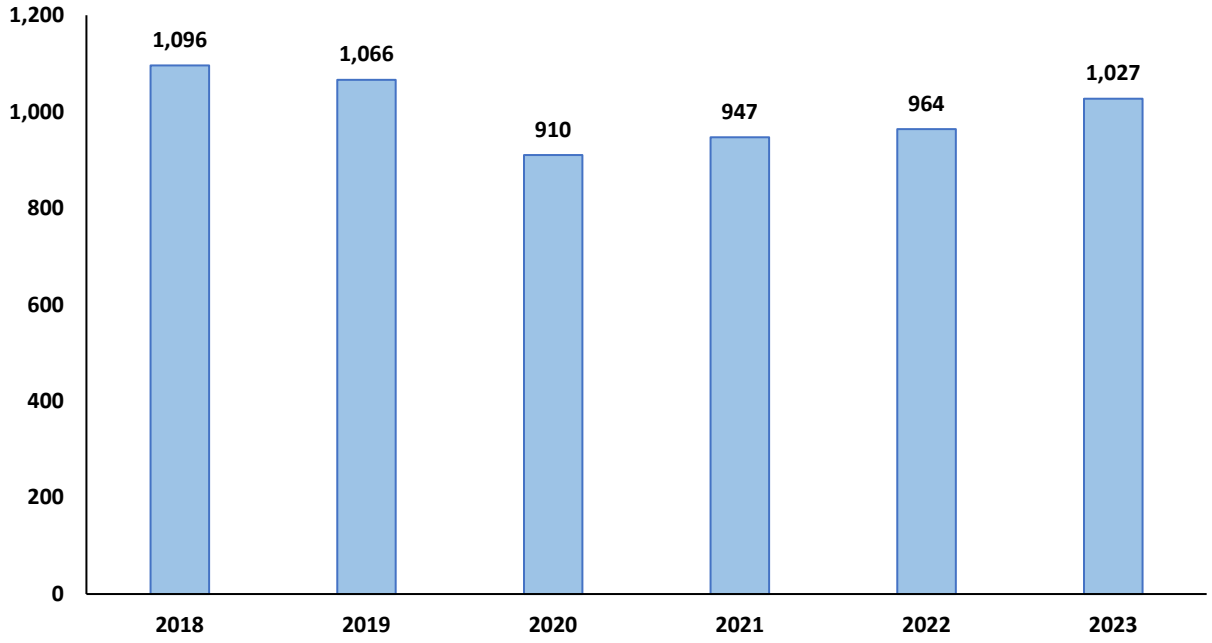
Child Protective Services

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 the Rural Region considered 6,010 reports. The prevalence of reported cases is consistent year over year.

Figure 71. Child Protective Services Reports, Rural Region, 2018-2023.



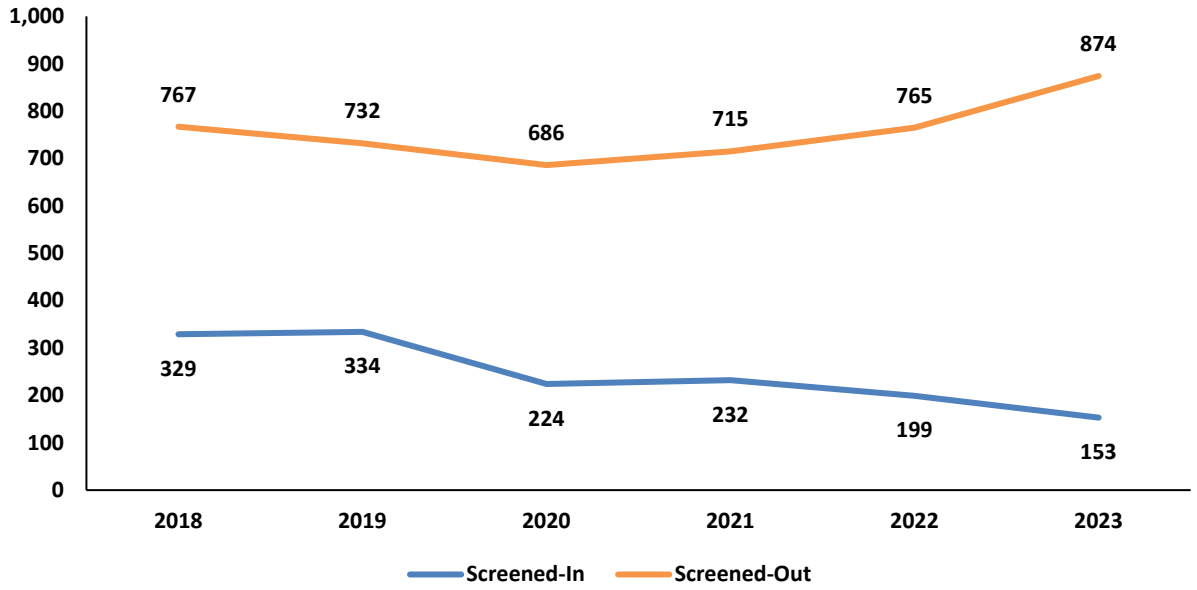
Source: UNITY Database.

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 6,010 reports made between 2018 and 2023 roughly 25% (n=1,471) were screened-in resulting in agency response. This percent of screened-in reports has decreased over the reporting period.

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

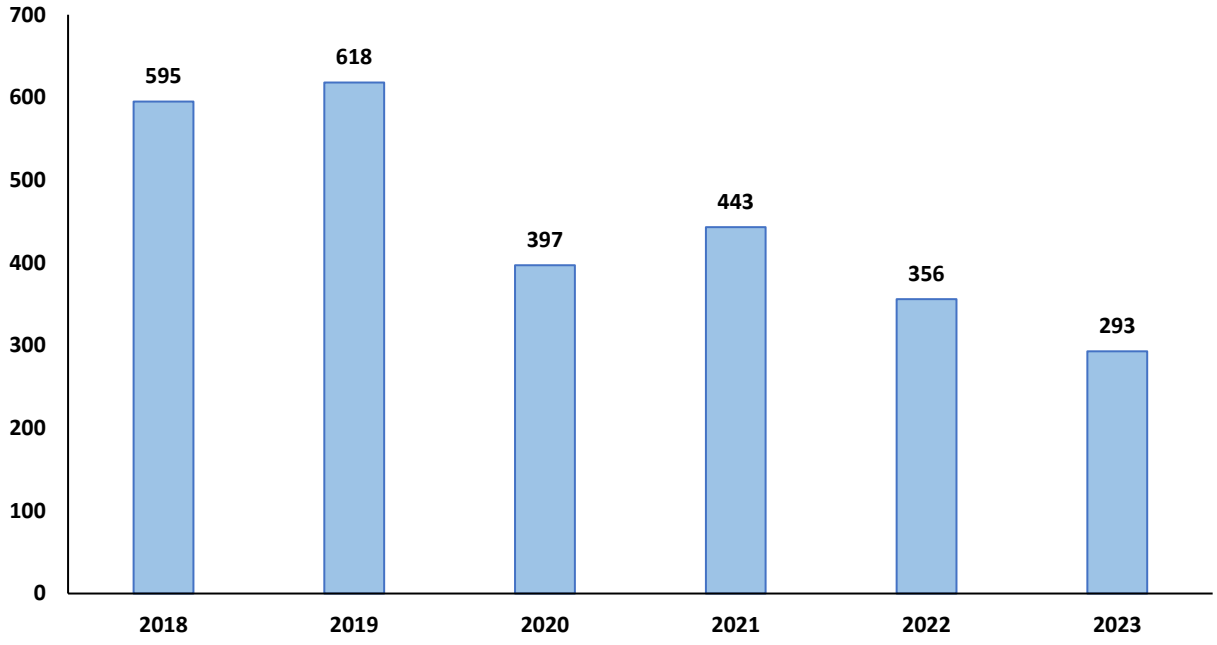
Figure 72. Child Protective Services Reports Screened-In and Screened-Out, Rural Region, 2018-2023.



Source: UNITY Database.

During the reporting period, the 1,471 screened-in reports involved 2,178 youth—an average of about 450 per year participating in a CPS investigation, assessment, or response. These counts are not distinct; some youth may be counted more than once if they were involved in multiple investigations.

Figure 73. Unique Rural Region Youth Screened-In, 2018-2023.



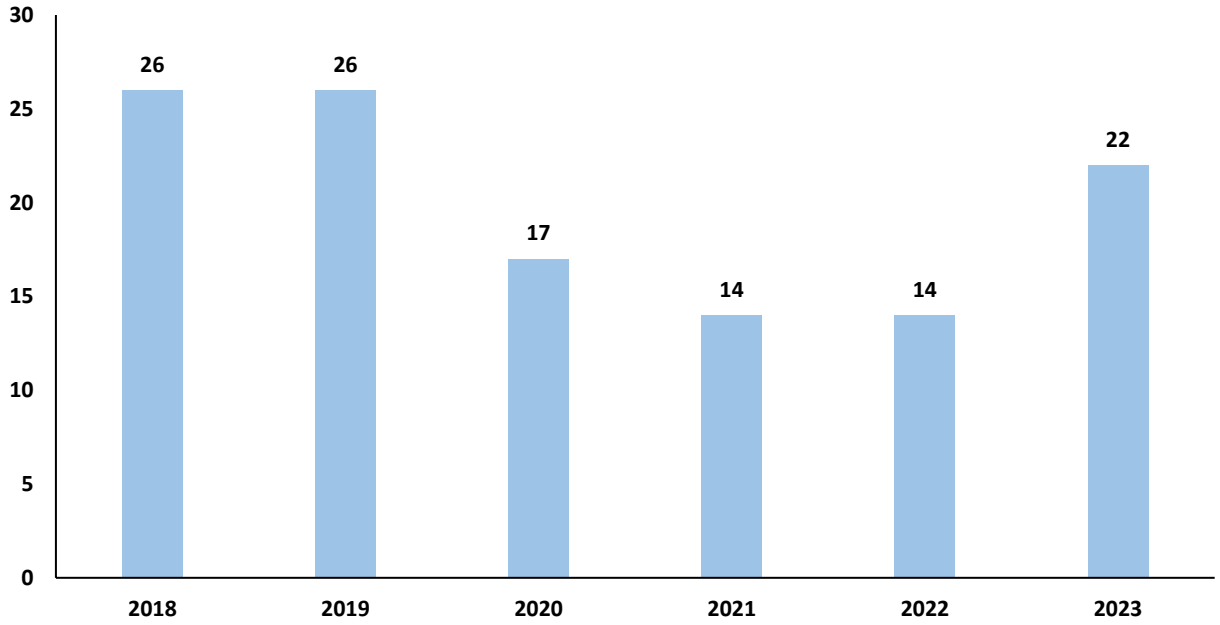
Source: UNITY Database.

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 112 unique youth were served in the foster care system in the Rural Region, accounting for 119 entries. Some youth entered, exited, and later re-entered the foster care system, with each entry counted separately.

Figure 74. Foster Care Entries, Rural Region, 2018-2023.



Source: UNITY Database.

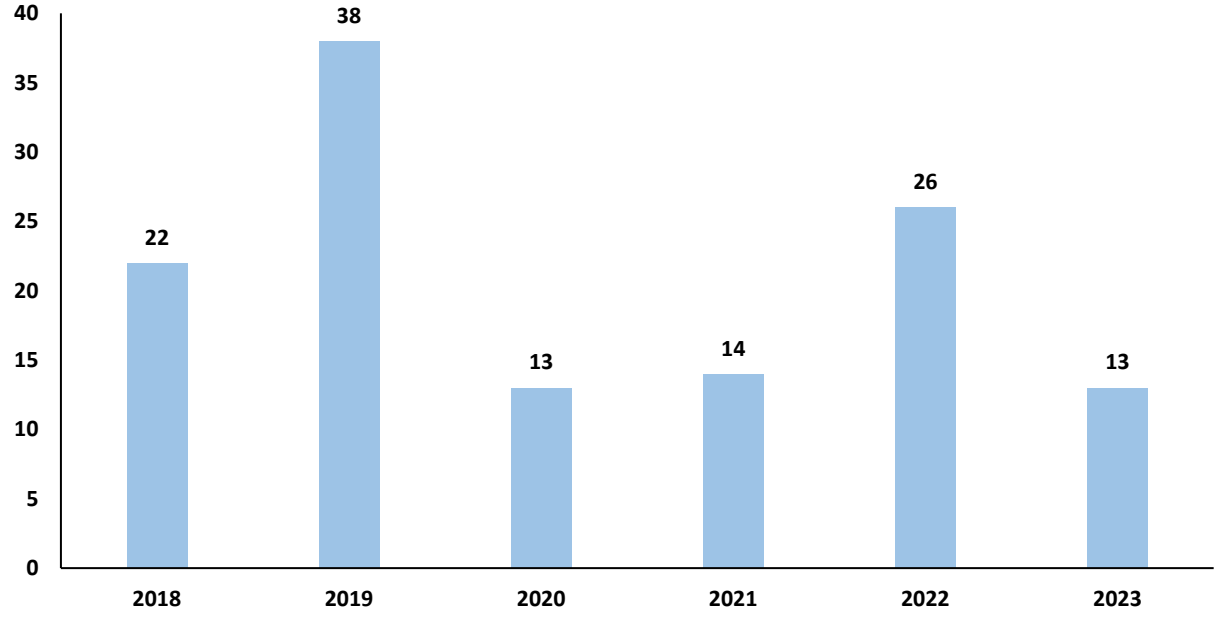
Neglect is the primary driver of Rural Region youth being placed into foster care. Youth may have multiple placements, and placements may have multiple reasons listed on the associated report. These entries are not mutually exclusive.

Table 4. Top Reason for Foster Care Entries, Rural Region, 2018-2023.

Entry Reason	2018	2019	2020	2021	2022	2023	Total
NEGLECT	42	42	26	14	22	16	162
PARENTAL SUBSTANCE ABUSE	2	12	24	22	34	28	122
ABUSE	18	16	18	4	0	14	70
DOMESTIC VIOLENCE	8	4	4	6	0	10	32
INCARCERATION OF PARENT(S)	10	0	0	8	2	2	22
OTHER	2	6	4	14	12	18	56

Source: UNITY Database.

Figure 75. Foster Care Exits, Rural Region, 2018-2023.



Source: UNITY Database.

Reunification with family is the most common outcome for youth leaving foster care, accounting for nearly 50% of exits.

Table 5. Reason for Foster Care Exits, Rural Region, 2018-2023.

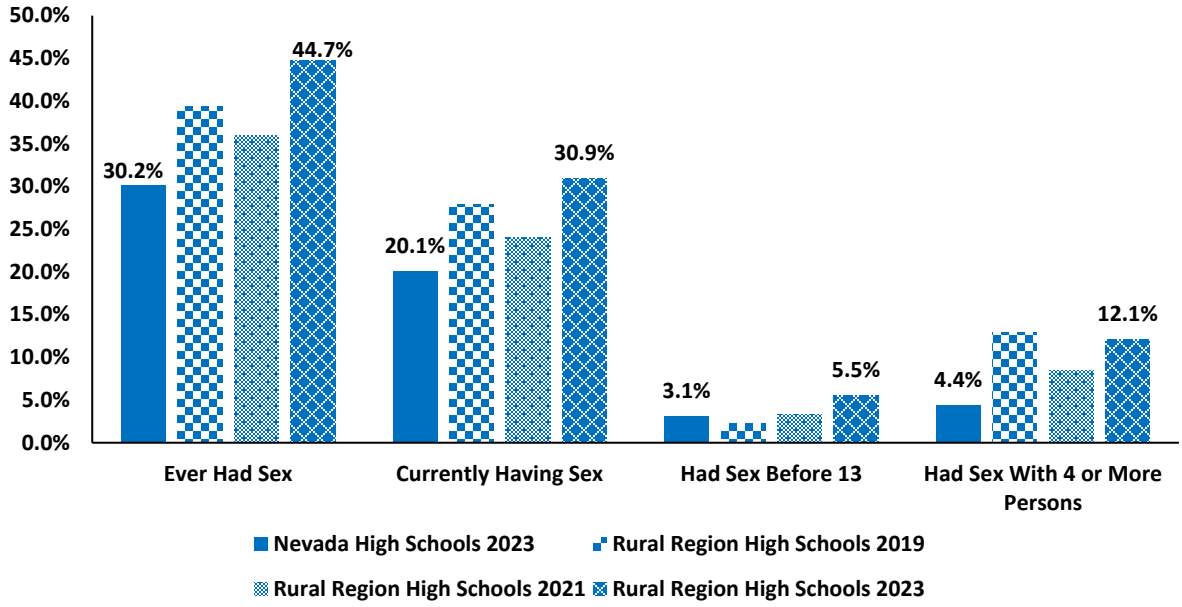
Exit Reason	2018	2019	2020	2021	2022	2023	Total
REUNIFICATION	14	17	8	4	13	3	59
ADOPTION	6	11	3	5	11	4	40
GUARDIANSHIP	1	9	0	4	0	2	16
AGED OUT	1	0	2	1	2	2	8
TRANSFER TO OTHER AGENCY	0	0	0	0	0	2	2
OTHER	0	0	0	0	0	0	0
TOTAL	22	38	13	14	26	13	126

Source: UNITY Database.

Youth Risk Behavior Survey (YRBS)

From 2019 to 2021 there was a decrease in the percent of Rural Region high school students that ever-had sex, are currently having sex, or had sex with 4 or more persons. From 2021 to 2023, there was an increase in the percent of Rural Region high school students who reported ever having sex, are currently having sex, had sex before 13, or had sex with 4 or more persons. The percents of all reported sexual behaviors are higher in Rural Region high school students compared to Nevada high school students.

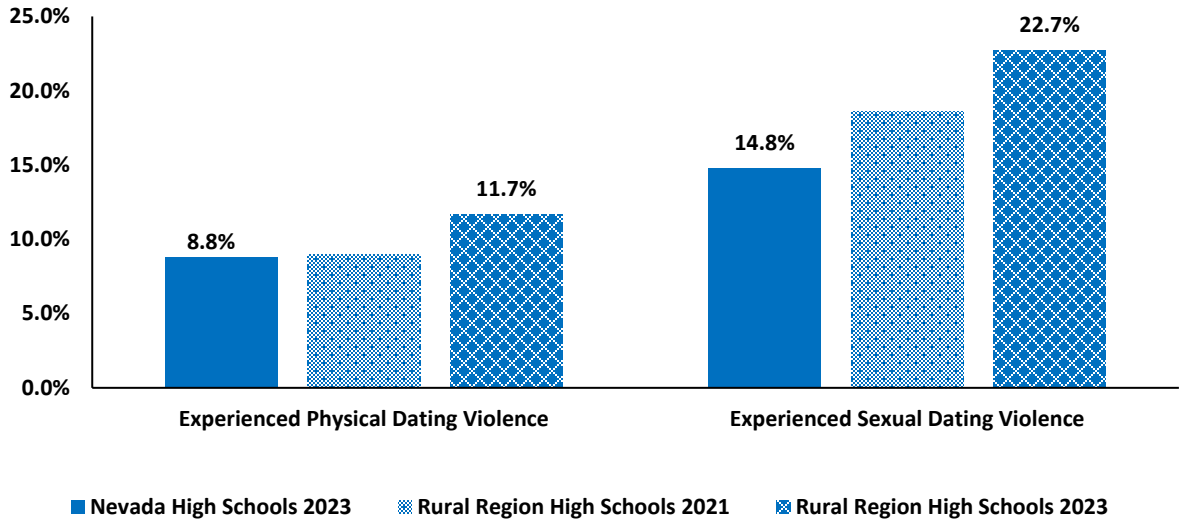
Figure 76. Sexual Behaviors Among Rural Region High School Students, 2019, 2021, 2023 and Nevada High School Students, 2023.



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

The percent of Rural Region high school students who reported physical dating violence or sexual dating violence increased from 2021 to 2023. Compared to all Nevada high school students, the percents are higher for reported physical or sexual violence in 2023.

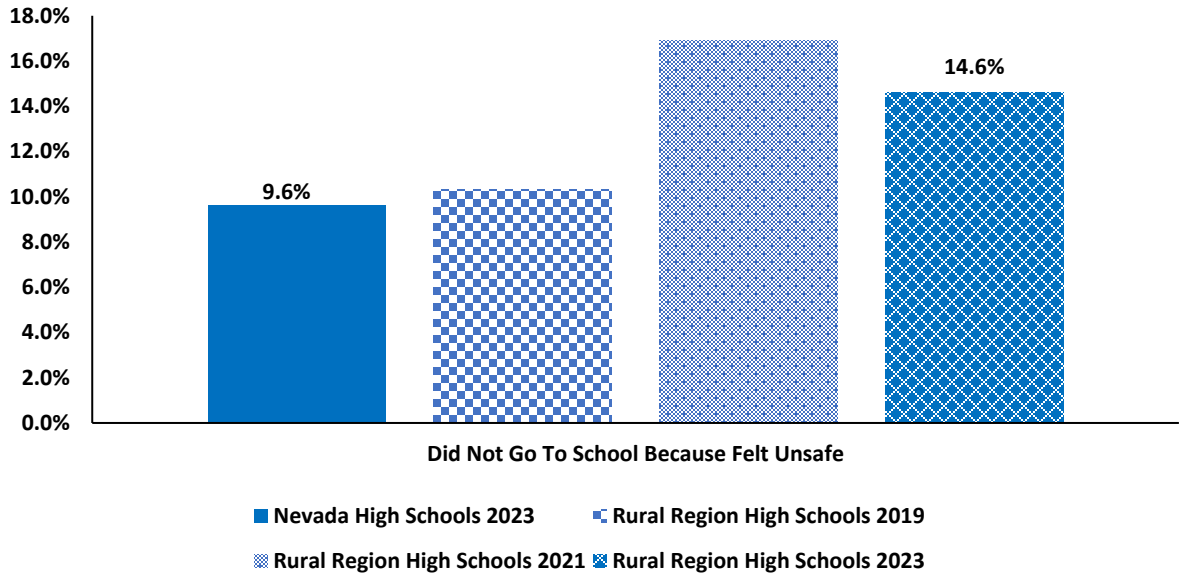
Figure 77. Sexual Violence Among Rural Region High School Students 2021, 2023 and Nevada High School Students, 2023.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 25.0% to display differences among groups.

The percent of Rural Region high school students who reported not going to school because they felt unsafe increased from 2019 to 2021, followed by a decrease in 2023 to 14.6%.

Figure 78. Violence Among Rural Region High School Students, 2019, 2021, 2023 and Nevada High School Students, 2023.



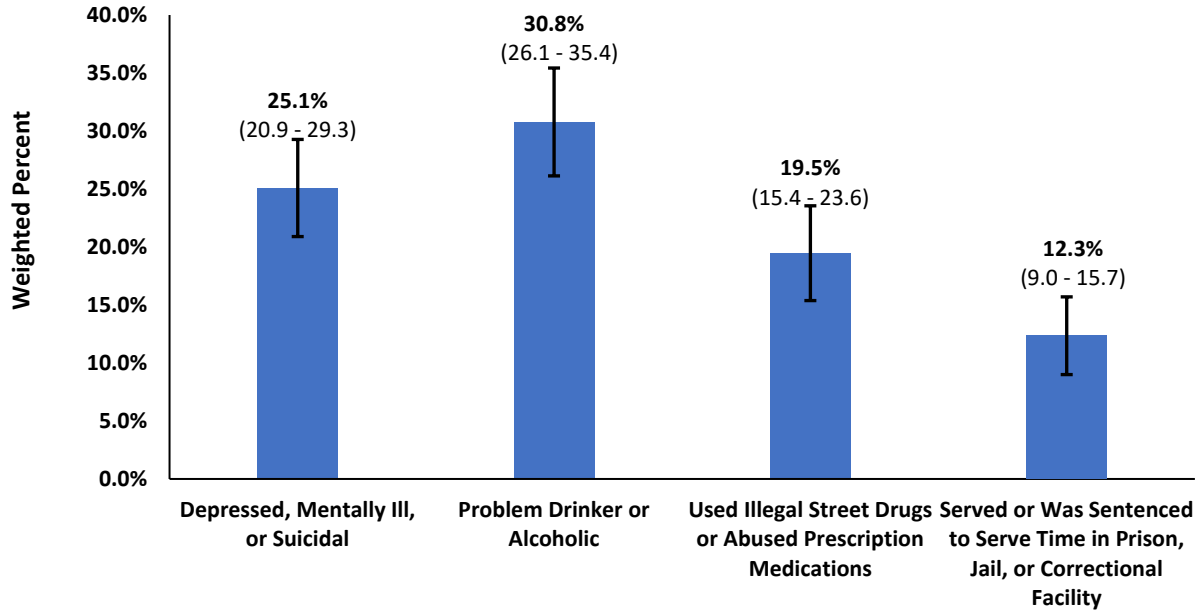
Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 18.0% to display differences among groups

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, 30.8% of adults, before the age of 18, lived with someone who was a problem drinker or alcoholic, and 25.1% 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 79. Adult BRFSS Respondents Who, During Childhood, Lived with Others Who Had Certain Conditions, Rural Region Residents, 2019-2023.

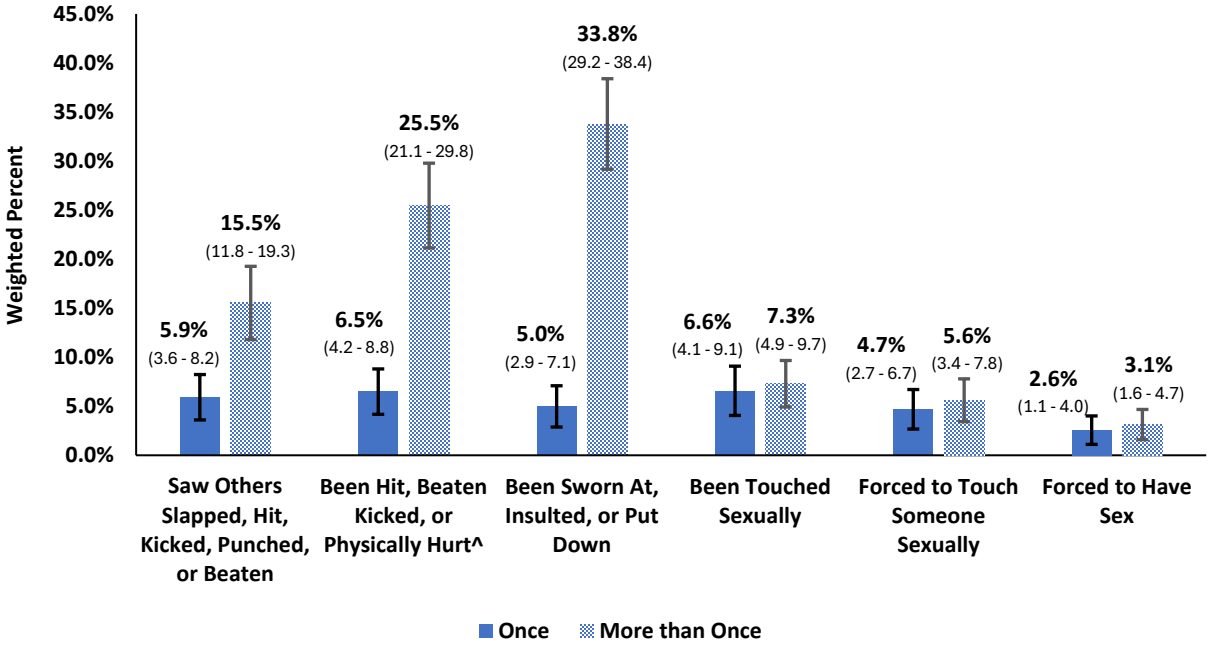


Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 40.0% to display differences among groups.
Childhood refers to before the age of 18.
Questions: "Did you live with anyone who was depressed, mentally ill, or suicidal?"
"Did you live with anyone who was a problem drinker or alcoholic?"
"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 aggregate data from 2019-2023, 38.8% of adults reported that, before the age of 18, they had been sworn at, insulted, or put down at least once. In this range, 32.0% of adults reported they were "hit, beaten, kicked, or physically hurt" (not including spanking) at least once and 13.9% had been touched sexually at least once.

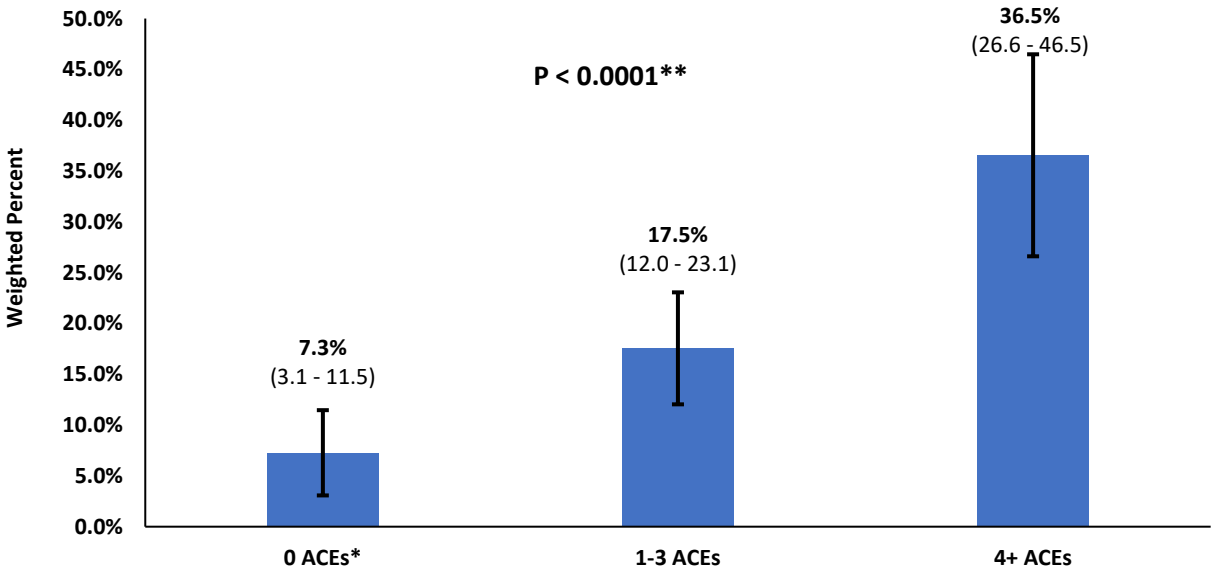
Figure 80. Adult BRFSS Respondents with Adverse Childhood Experiences, Rural Region Residents, 2019-2023.



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: "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.
**Interpret figure and generalizability with caution due to some values with small sample size (cell size <50) and overlapping 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, 36.5% also reported having depression, compared to just 7.3% of those reporting depression who experienced no ACEs.

Figure 81. Percentage of BRFSS Respondents who Reported Having Depression, by Number of Adverse Childhood Events, Rural Region Residents, 2019-2023.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 50.0% 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?"

0.05 test of significance.
***Significant P-value.*

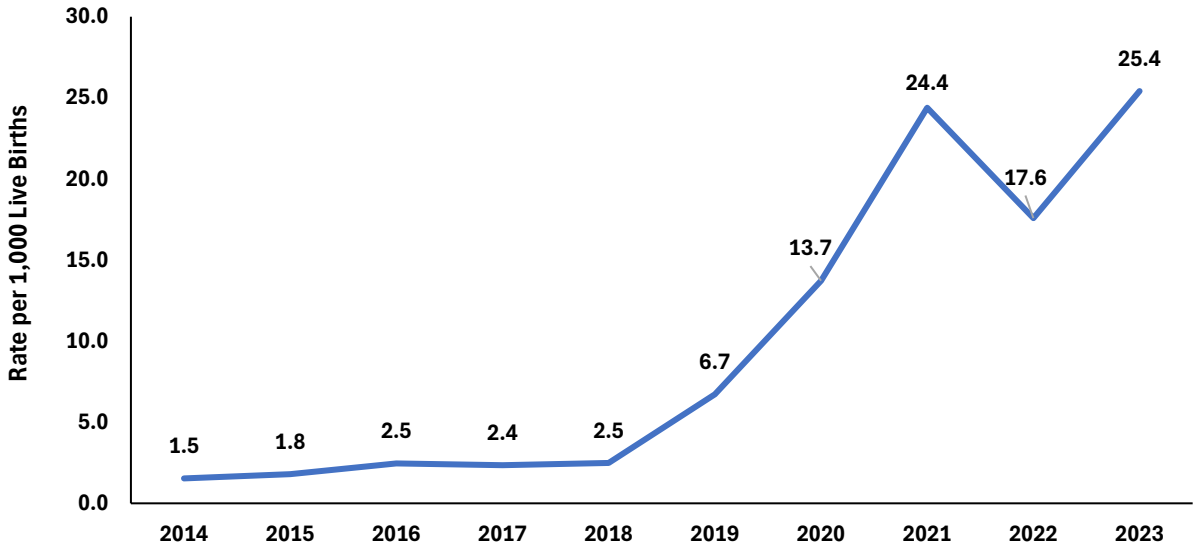
Maternal and Child Health

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 1,153 live births per year to Rural Region residents between 2014 and 2023. In 2023, 26 birth certificates indicated marijuana use.

Of the self-reported marijuana use during pregnancy among Rural Region Nevadans who gave birth between 2014 and 2023, the highest rate was in 2023, at 25.4 per 1,000 live births.

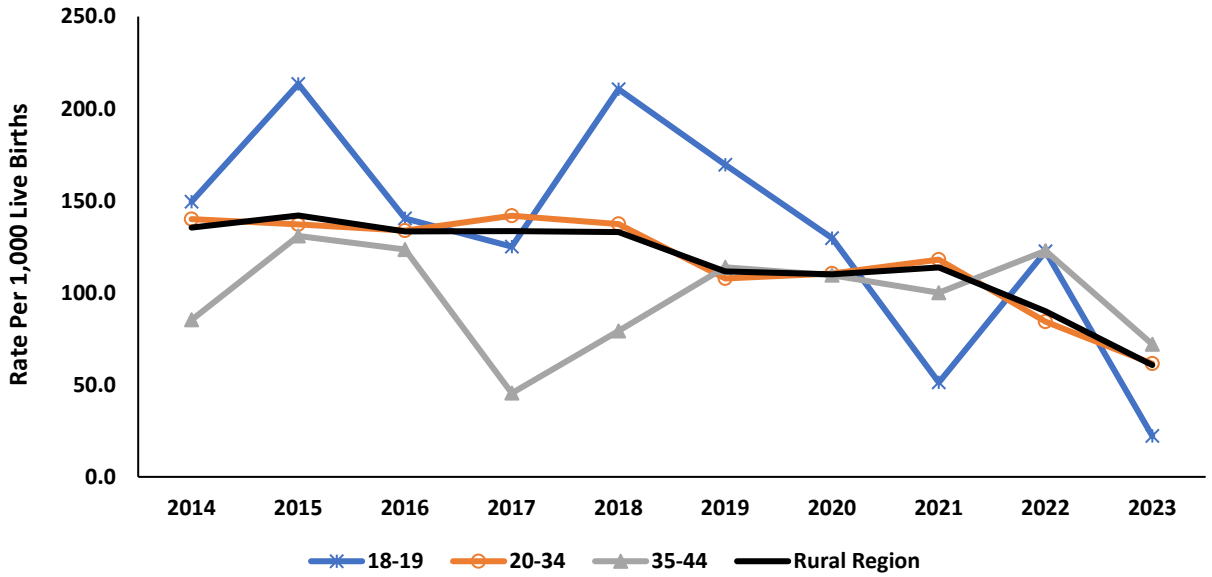
Figure 82. Self-Reported Prenatal Marijuana Use Birth Rates, Rural Region Residents, 2014-2023.



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. The rates among 18-19 age groups fluctuate greatly due to small populations and are not statistically significant.

Figure 83. Self-Reported Prenatal Tobacco Use Birth Rates by Maternal Age, Rural Region Residents, 2014-2023.



Source: Nevada Electronic Birth Registry System.

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