Behavioral Health Epidemiologic Profile 2024: Southern Region, Nevada

Esmeralda, Lincoln, Mineral, and Nye Counties

March 2025

Department of Health and Human Services
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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 (43.3%) and depression (21.6%) are the leading diagnoses for mental health-related emergency department encounters for 2023. These diagnoses both spiked in 2023 (Mental Health - ER).
- Anxiety (35.7%) and depression (32.6%) are the leading diagnoses for mental health-related inpatient encounters for 2023. In 2023, the Southern Region, in contrast with statewide data for Nevada, had equal prevalences for suicidal ideation for both males and females (Mental Health - IP).
- The Southern Region has a utilization rate of 5.4% for adults accessing state mental health services in 2023 (Mental Health - Clinic Utilization).
- In 2023, American Indian or Alaska Native non-Hispanics (35.1 per 100,000) and White non-Hispanics (19.6 per 100,000) had the highest age-adjusted rates (Avatar - State-Funded Mental Health Services).

National Violent Death Reporting System (NVDRS)

- Firearms were used in 70.1% of suicides among Southern Region residents from 2018-2022 (Firearm Deaths - NVDRS).
- Males accounted for 83.6% of suicide cases from 2018-2022 (Deaths by Sex - NVDRS).
- The rate of suicide deaths among Southern Region residents from 2018-2022 was highest in the 75+ age group at 37.7 per 100,000 population (Deaths by Age Group - NVDRS).
- Among suicide deaths in the Southern Region from 2018-2022, it was reported that 34% involved persons who had a physical health problem(s) that appeared to contribute to the death and 27.1% reported currently having a mental health problem (Circumstances of Deaths - NVDRS).

Substance Use

- The total number of opioid prescriptions for Southern Region residents and the associated rates per 100,000 population have decreased dramatically since 2017 (PDMP Rates).
- The rates of stimulant-related overdose deaths have increased since 2019 to a high of 29.4 per 100,000 population (Stimulant-Related Overdose Deaths).
- Emergency department encounters and deaths from diseases and chronic conditions related to long-term alcohol use have increased over the reporting period, particularly in the years 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).

State Unintentional Drug Overdose Reporting System

- Of the 16 unintentional/ undetermined intent drug overdose deaths among Southern Region residents from 2019-2022, 56.3% had non-specified opioids and 37.5% had methamphetamines listed in the cause of death (Toxicology - SUDORS).

Youth – Adverse Childhood Experiences

- Between 2019-2023, 37.1% of adults before the age of 18 lived with someone who was a problem drinker or alcoholic, 7.8% higher than what is seen statewide at 29.3% (BRFSS).
- Combined data from 2019-2023 shows that 16.2% of Southern Region adults have been touched sexually at least once during childhood (ACEs - BRFSS).
- Southern 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

- The rate of neonatal abstinence syndrome among Southern Region resident from 2014-2023 was highest in 2023 23.6 per 1,000 live births (Rate of NAS).

Data Sources

Behavioral Risk Factor Surveillance System

The Behavioral Risk Factor Surveillance System (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

The Hospital Emergency Department Billing (HEDB) 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

The Hospital Inpatient Billing (HIB) 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 are 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 include 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 include 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 Registry System
The National Violent Death Registry System (NVDRS), funded by the Centers for Disease Control and Prevention (CDC), is a 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
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, visit NV PMP or 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 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, visit United States Census Bureau.

Unified Nevada Information Technology for Youth

The Unified Nevada Information Technology for Youth (UNITY) 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

Statewide births and deaths are collected by the Office of Vital Records in the Division of Public and Behavioral Health. Web-Enabled Vital Records Registry Systems (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

The Youth Risk Behavior Survey (YRBS) is a national surveillance system that was established by the 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 sixth through eighth 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), visit CDC YRBSS.

For more information on Nevada YRBS, visit 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. This report's authors recognize that the terms "female" and "woman" do not include all birthing people but are used as descriptors presented from source data. The authors also recognize that all sexual preferences and gender identities may not be present in the source data.

Demographic Snapshot

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, visit nvbh.org. The Southern Region comprises Esmeralda, Lincoln, Mineral, and Nye Counties.

In 2023, the estimated population for the Southern Region was 62,999, a 11.2% increase from the 2014 estimated population. The median household income was $58,685, which is lower than both the median household income of Nevada ($75,561), and the United States ($78,535). The percent of uninsured Southern Region residents in 2023 was 10.2%, which is lower than Nevada's percent (11.4%), but higher than the national percent (8.6%).

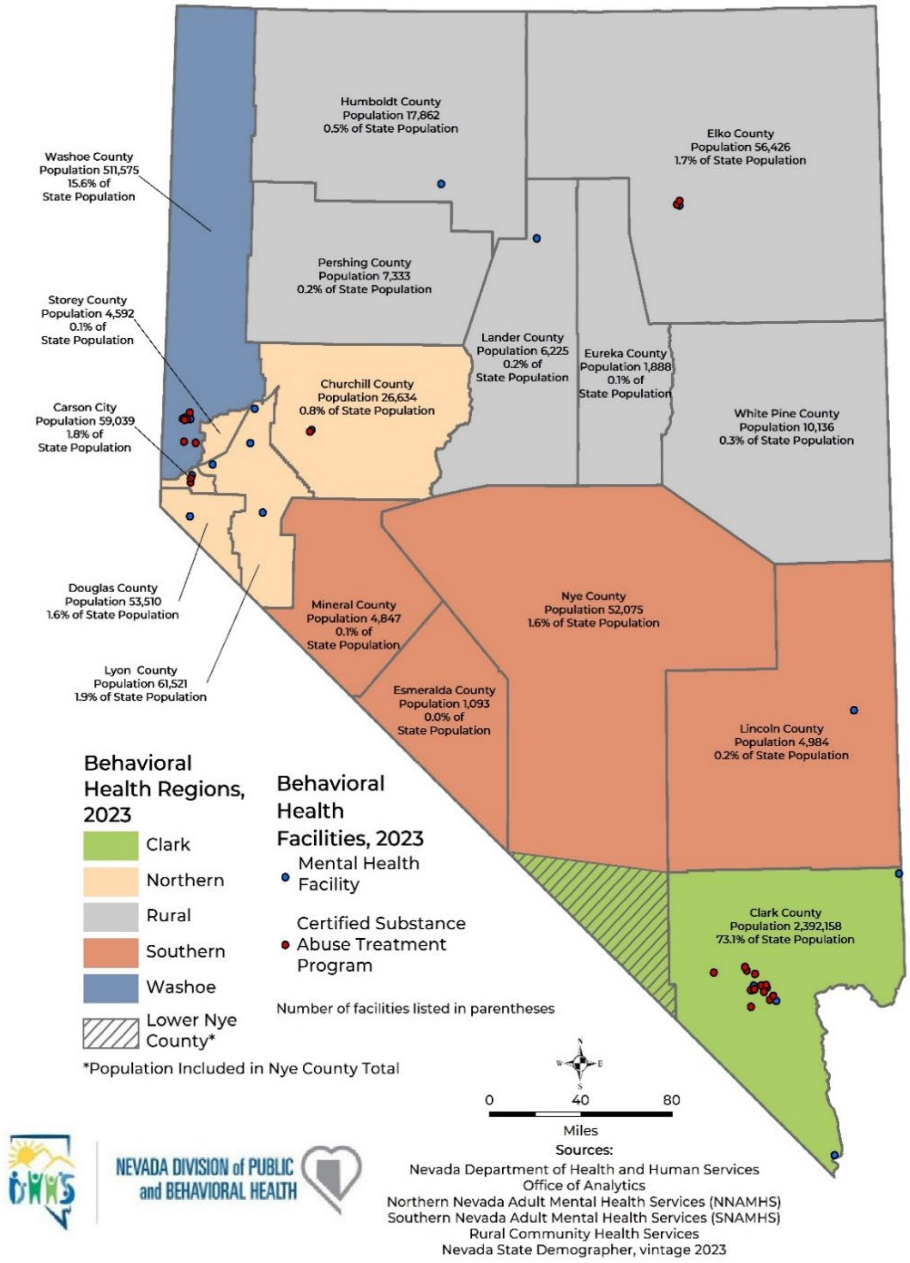
Table 1. Select Demographics for the Southern Region and the United States, 2023.

Population, Southern Region, 2023 estimate*	62,999
Population, Southern Region, 2014 estimate*	55,970
Population, Southern Region, percent change*	11.2%
Female persons, Southern Region, 2023 estimate*	31,185
Male persons, Southern Region, 2023 estimate*	31,814
Median household income, Southern Region (2023) **	$58,685
Median household income, Nevada (2023) **	$75,561
Per capita income in the past 12 months, Southern Region (2023)**	$31,329
Per capita income in the past 12 months, Nevada (2023)**	$39,963
Percent of persons below poverty level, Southern Region (2023) **	14.9%
Percent of persons below poverty level, Nevada (2023)**	12.6%
Percent uninsured, Southern Region (2023)**	10.2%
Percent uninsured, Nevada (2023)**	11.4%

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

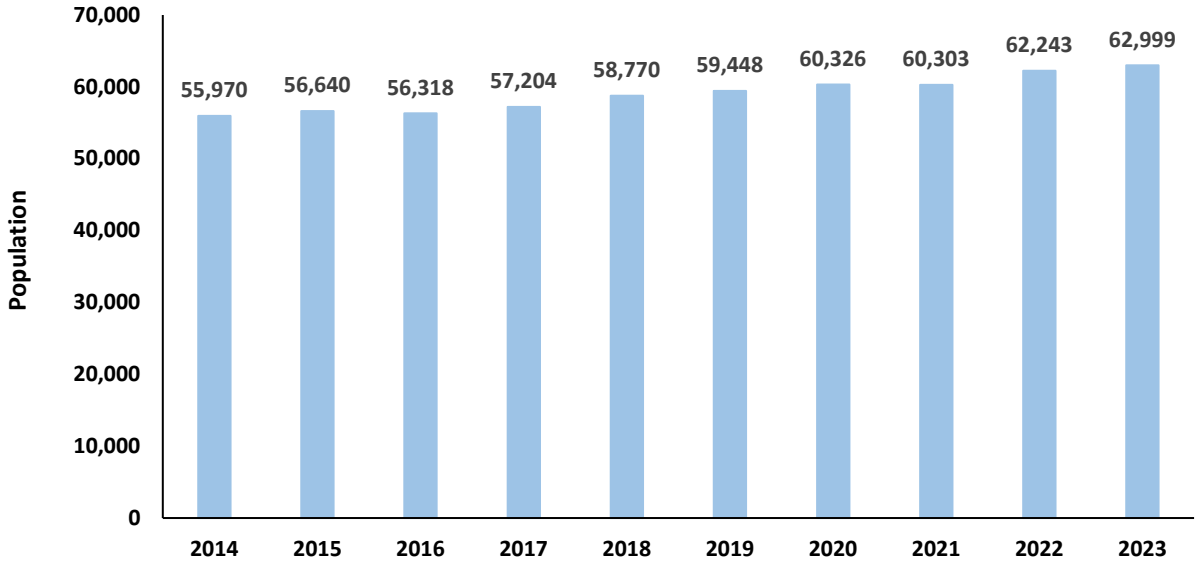
Figure 1 below shows the population for each of Nevada's 17 counties, the percent of Nevada population each county represents, the behavioral health regions, and the locations of mental health and substance abuse facilities.

Figure 1. Nevada Population Distribution by County, 2023.



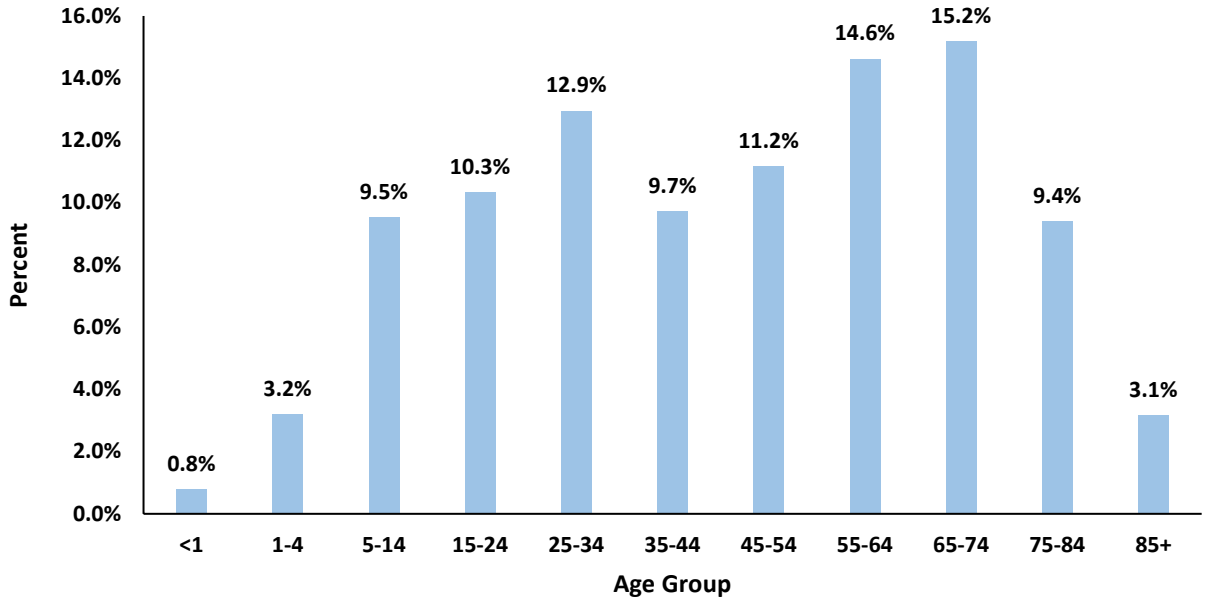
Source: Nevada State Demographer, Vintage 2023
***Clark Region**: Clark County and southern Nye County*
***Northern Nevada Region:** Carson City, Churchill, Douglas, Lyon, and Storey counties*
***Rural Nevada Region:** Elko, Eureka, Humboldt, Lander, Pershing, and White Pine counties*
***Southern Nevada Region:** Esmeralda, Lincoln, Mineral counties, and northern Nye County*
***Washoe Region**: Washoe County*
**Nye County: Northern Nye County is included in Southern Region and southern Nye County is in part of Clark County Region. For data purposes, Nye County data is included in Southern Nevada Region Report and not in the Clark County Region report.*

Figure 2. Southern Region Population, 2014-2023.



Source: Nevada State Demographer, Vintage 2023.

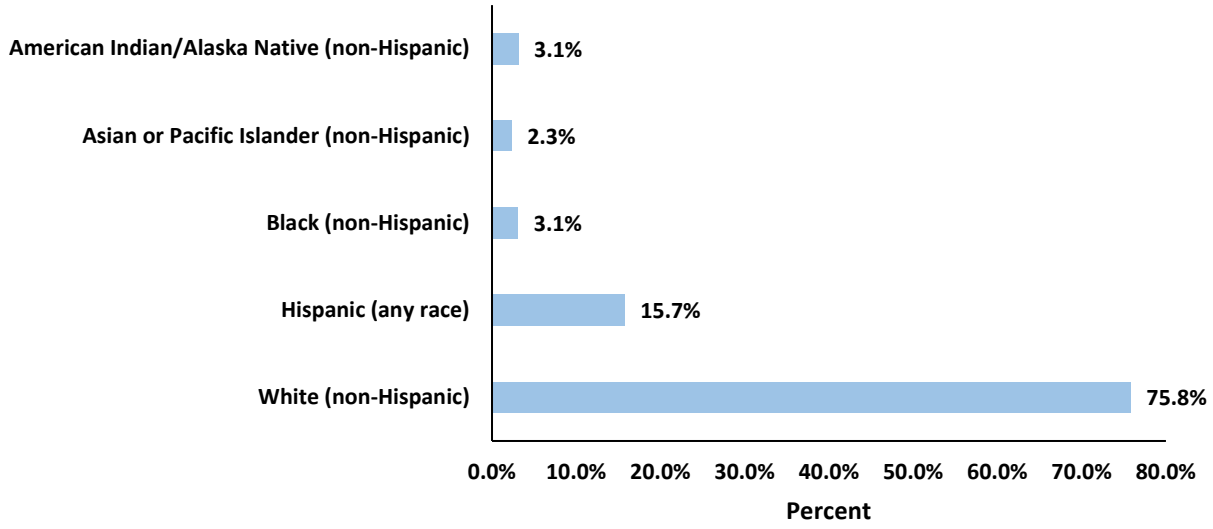
Figure 3. Southern Region Population by Age Group, 2023.



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

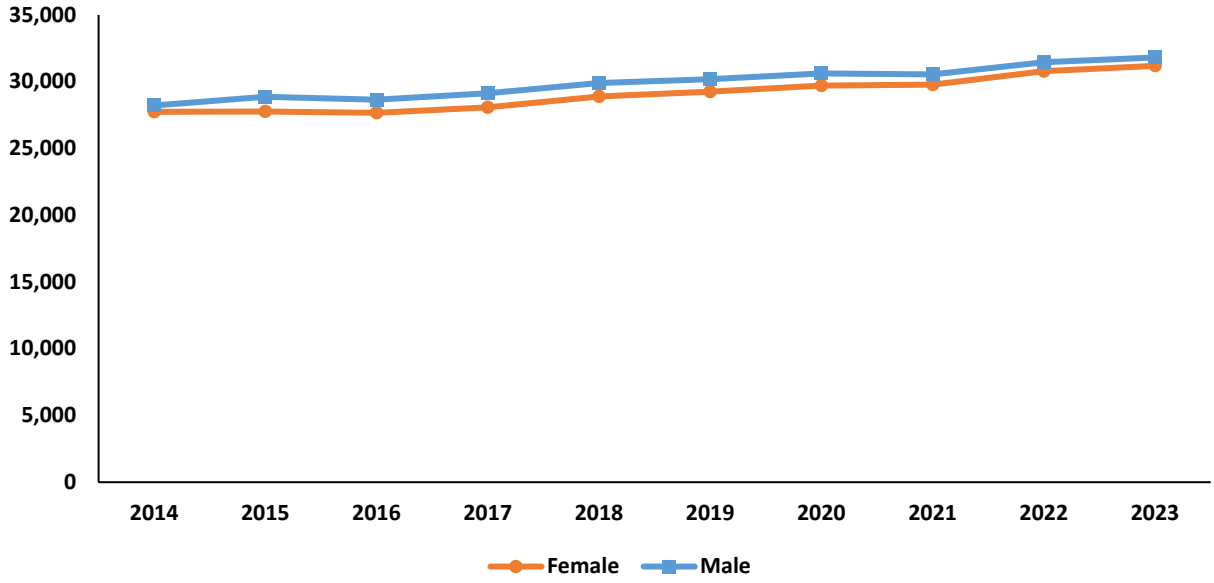
White non-Hispanic comprises 75.8% of Southern Region's population, followed by Hispanic (15.7%), American Indian/Alaska Native non-Hispanic (3.1%), Black non-Hispanic (3.1%), and Asian/Pacific Islander non-Hispanic (2.3%). The population consists of approximately equal percentages of males and females.

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



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

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



Source: Nevada State Demographer, Vintage 2023

Mental Health

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

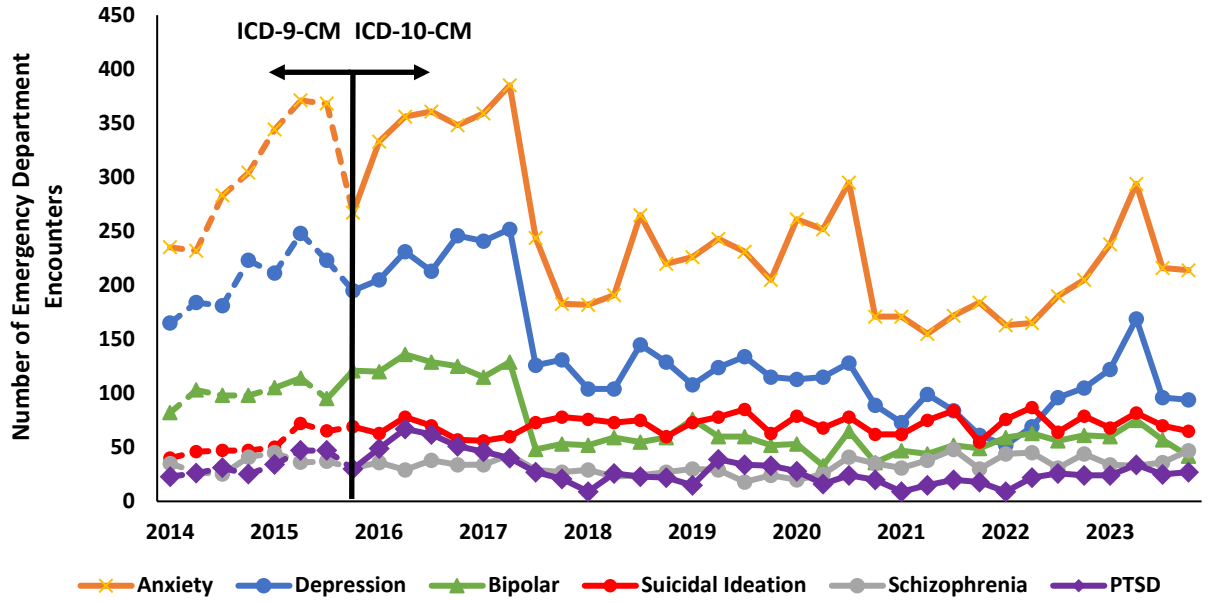
Hospital Emergency Department Encounters

The hospital emergency department billing data include data for emergency room patients of all ages for Nevada's non-federal hospitals. There were 2,222 visits related to mental health disorders among Southern 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 241 and 121 encounters per quarter in 2023, respectively.

For 2023, males had a higher prevalence of visits for schizophrenia (54.7%), whereas females had a higher prevalence of visits for anxiety (64.2%), depression (64.5%), bipolar disorder (64.1%), and post-traumatic stress disorder, or PTSD (52.7%)

Figure 6. Mental Health-Related Emergency Department Encounters by Quarter and Year, Southern 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 last quarter of 2015, therefore data prior to that may not be directly comparable.

Hospital Inpatient Admissions

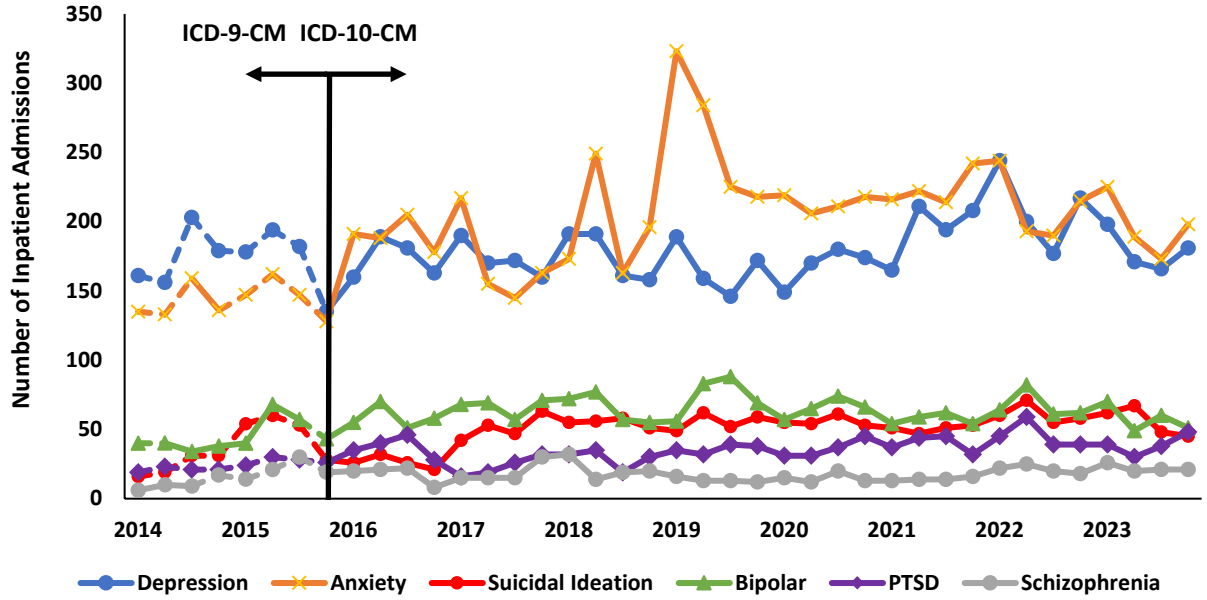
Hospital inpatient billing data include data for patients of all ages discharged from Nevada's non-federal hospitals. There were 2,196 inpatient admissions related to mental health disorders among Southern Region residents in 2023. Since an individual can have more than one diagnosis during a single 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 197 and 179 encounters per quarter, respectively.

For 2023, males had a higher prevalence of visits for schizophrenia (54.6%), whereas females had a higher prevalence of visits for anxiety (63.7%), depression (63.7%), bipolar disorder (62.2%), and PTSD (56.8%). Both genders had 50.0% prevalence for suicidal ideation, which differs from statewide trends where males had a higher prevalence for suicidal ideation related visits.

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

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



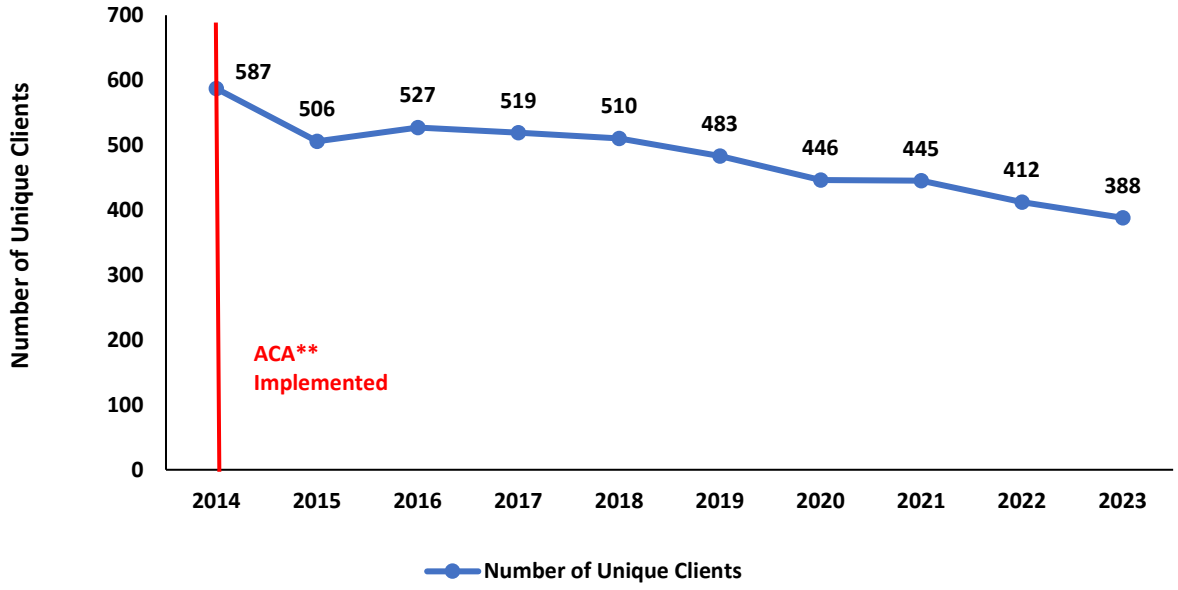
Source: Hospital Inpatient Billing
Categories are not mutually exclusive.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

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. State-funded mental health facilities provide inpatient acute psychiatric, mobile crisis, outpatient counseling, service coordination, and case management. Services are not denied if an individual does not have the ability to pay.

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

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

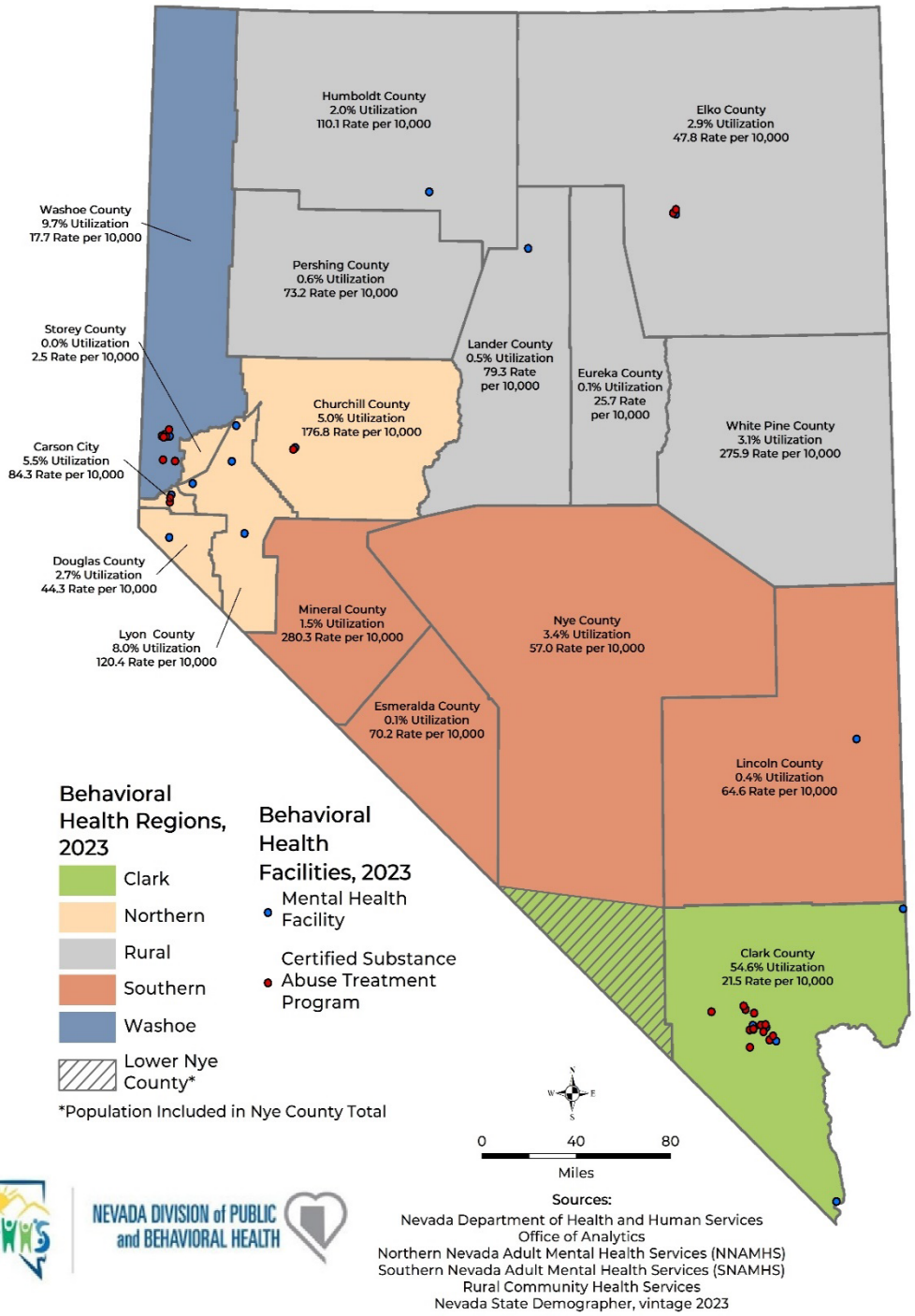


Source: Avatar
**A client is counted only once per year. Clients may be counted more than once across years.*
***Affordable Care Act.*

Of the Nevada residents accessing Division of Public and Behavioral Health-funded adult mental health services in 2023, 5.4% lived in the Southern Region. Mineral County had the highest rate of adults accessing state mental health services at 280.3 per 10,000 population. Note that this differs from the standard rate presented in this report, which is per 100,000.

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

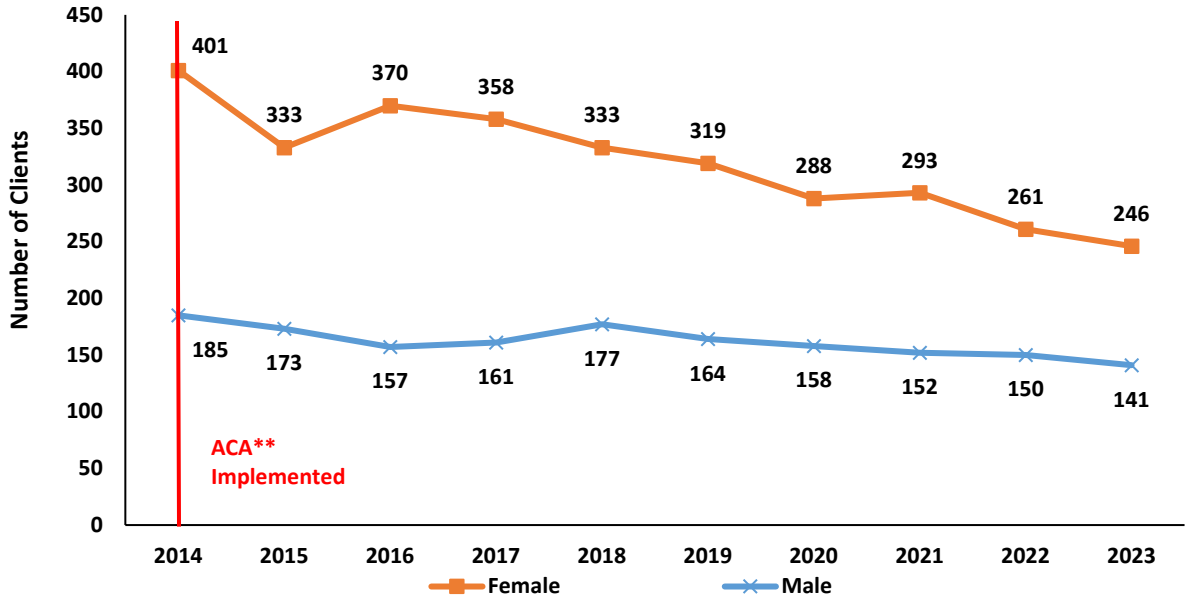
Figure 9. State-Funded Adult (Aged 18+*) Mental Health Clinic Utilization by County, 2023.



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.*

The number of female clients has been higher than male clients by at least 100 clients each year since 2014. In 2023, 18.7 per 100,000 of the adult female population utilized the state-funded mental health clinics, compared to adult males at 11.3 per 100,000 of the adult male population.

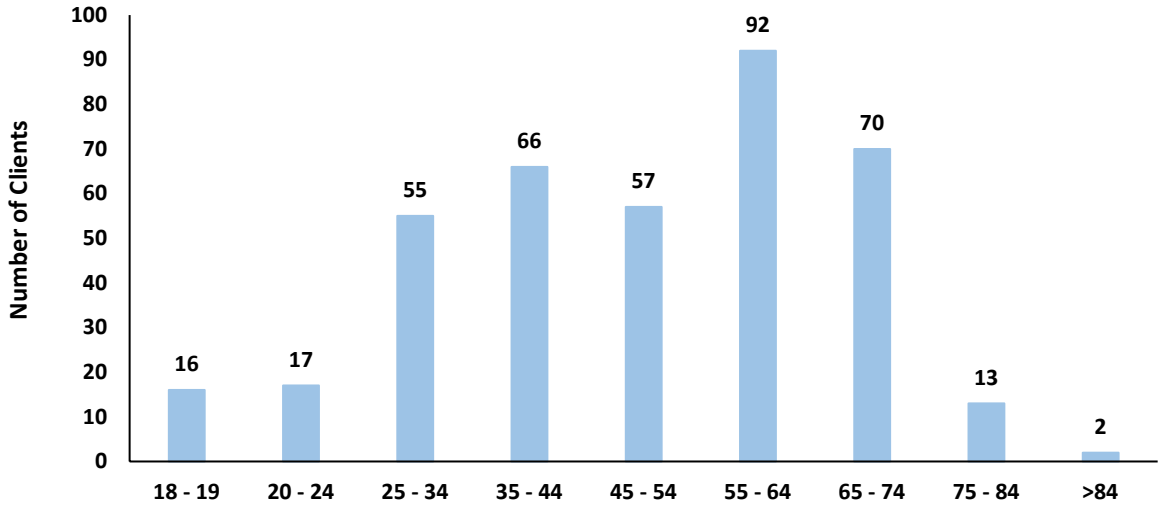
Figure 10. State-Funded Adult (Aged 18+*) Mental Health Clinic Utilization* by Sex, Southern Region Residents, 2014-2023.



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, 41.8% of clients were between the ages of 55 and 74.

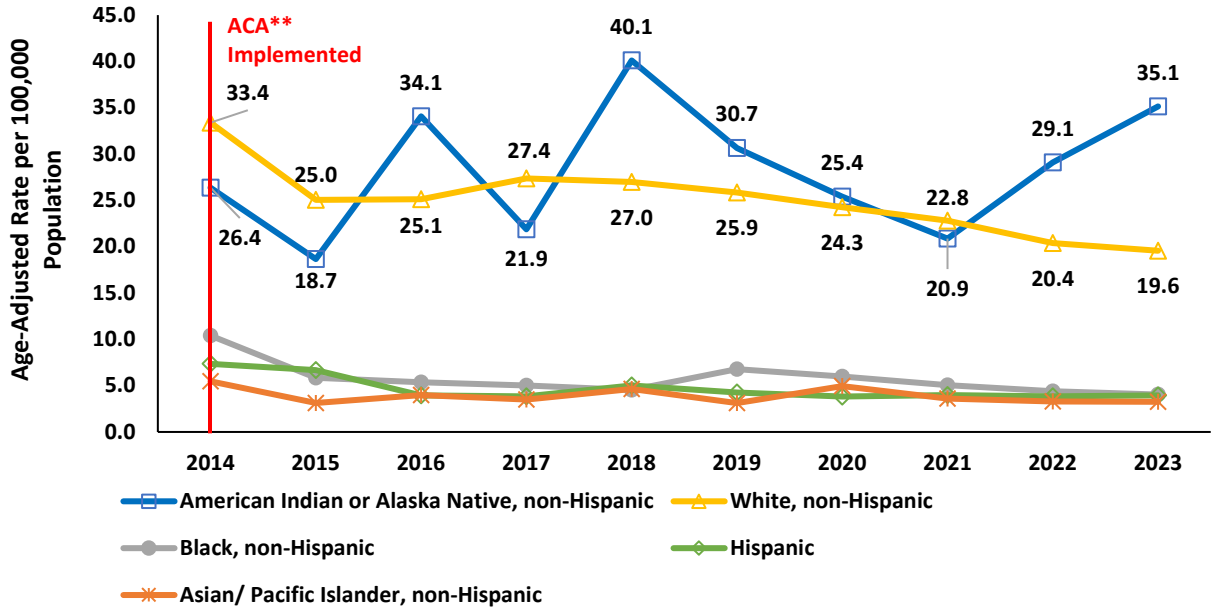
Figure 11. State-Funded Adult (Aged 18+*) Mental Health Clinic Utilization* by Age Group, Southern Region Residents, 2023.



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

While the rate of clinic utilization for White non-Hispanics has been steadily decreasing since 2017 to a low in 2023 (19.6 per 100,000), American Indian/ Alaska Native non-Hispanics has been increasing since 2021 to a second high in 2023 (35.1 per 100,000).

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

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

Program	Year									
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Hawthorne Med Clinic	42	44	65	73	101	94	79	75	84	86
Hawthorne OP Counseling	76	41	40	69	92	95	65	44	57	54
Pahrump Med Clinic	299	237	308	320	295	248	230	205	184	160
Pahrump OP Counseling	204	141	186	240	163	136	125	117	111	87
Pahrump OP Screening	228	179	225	190	134	120	25	2	0	12
Pahrump RMH**	94	30	18	11	39	29	4	2	14	1
Pahrump Service Coordination	59	43	33	40	22	34	18	36	47	22
SNAMHS Med Clinic Adult	11,014	7,616	5,355	4,711	3,993	3,827	3,607	3,396	3,114	2,915

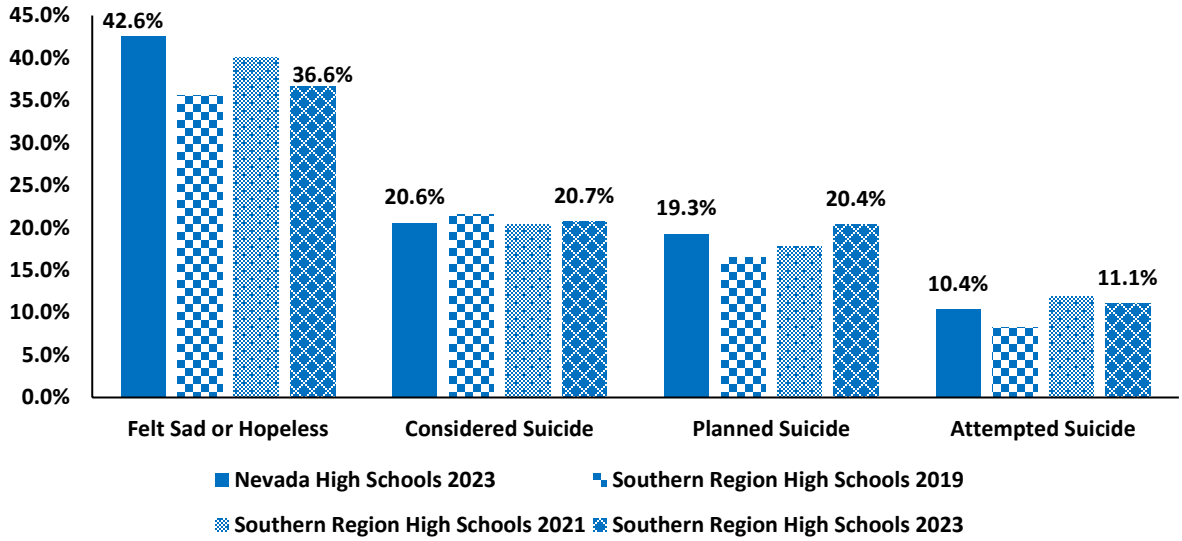
Source: Avatar
**A client is counted only once per year. Clients may be counted more than once across years.*
***Rehabilitative Mental Health*

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, 379 high school students and 387 middle school students participated in the YRBS in the Southern 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, refer to UNR YRBS.

The percent of Southern Region high school students that reported feeling sad or hopeless was lower than the percent that all Nevada high school students reported. The percent of students who reported considering suicide, planning suicide, or attempting suicide were all within 1.0% of Nevada high school percents. In 2023, 36.6% of Southern Region high school students reported feeling sad or hopeless; just over 20% considered suicide or planned suicide; and 11.1% attempted suicide.

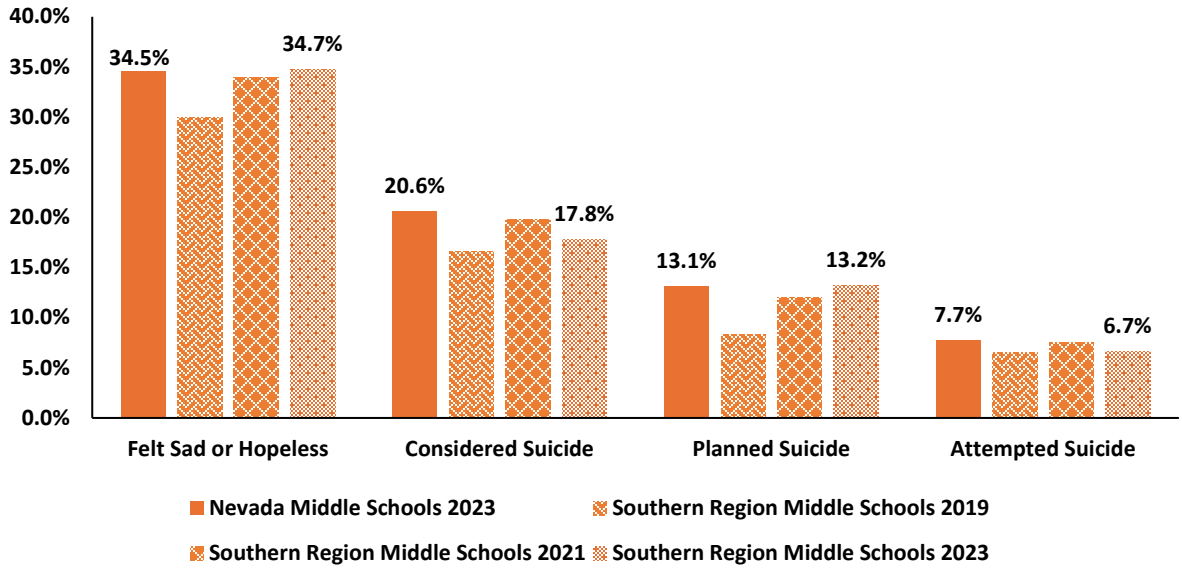
Figure 13. Mental Health Behaviors, Southern Region High School Students, 2019, 2021, 2023 and Nevada High School Students, 2023.



Source: Nevada Youth Risk Behavior Survey (YRBS)
Chart scaled to 45.0% to display differences among groups.

The percent of Southern Region middle school students who reported feeling sad or hopeless (34.7%), planning suicide (13.2%), or attempting suicide (6.7%) were all similar to the overall reported percent of middle schoolers throughout the state. The percent who reported considering suicide was notably lower than the state (17.8% compared to 20.6%).

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



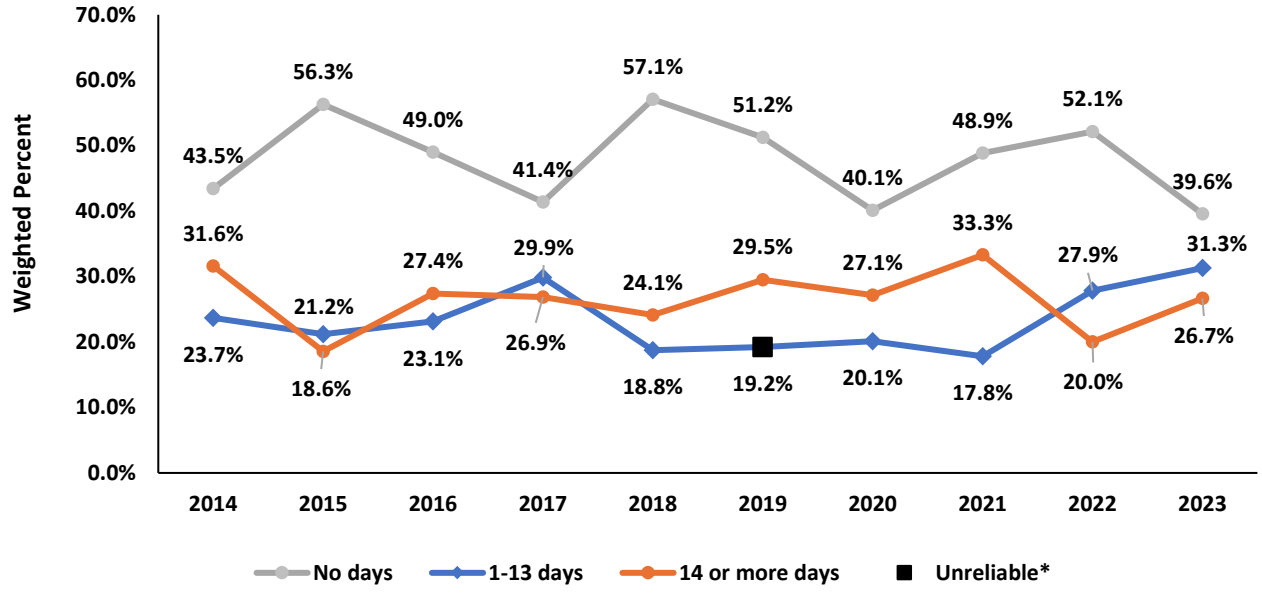
Source: Nevada Youth Risk Behavior Survey (YRBS)
Chart scaled to 40.0% to display differences among groups.

Behavioral Risk Factor Surveillance System

BRFSS collects information on self-reported adult health-related risk behaviors. According to the 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 to 39.6% in 2023; while "1-13 days" and "14 or more" days have stayed the same or had a minor increase, landing at 31.3% and 26.7% respectively.

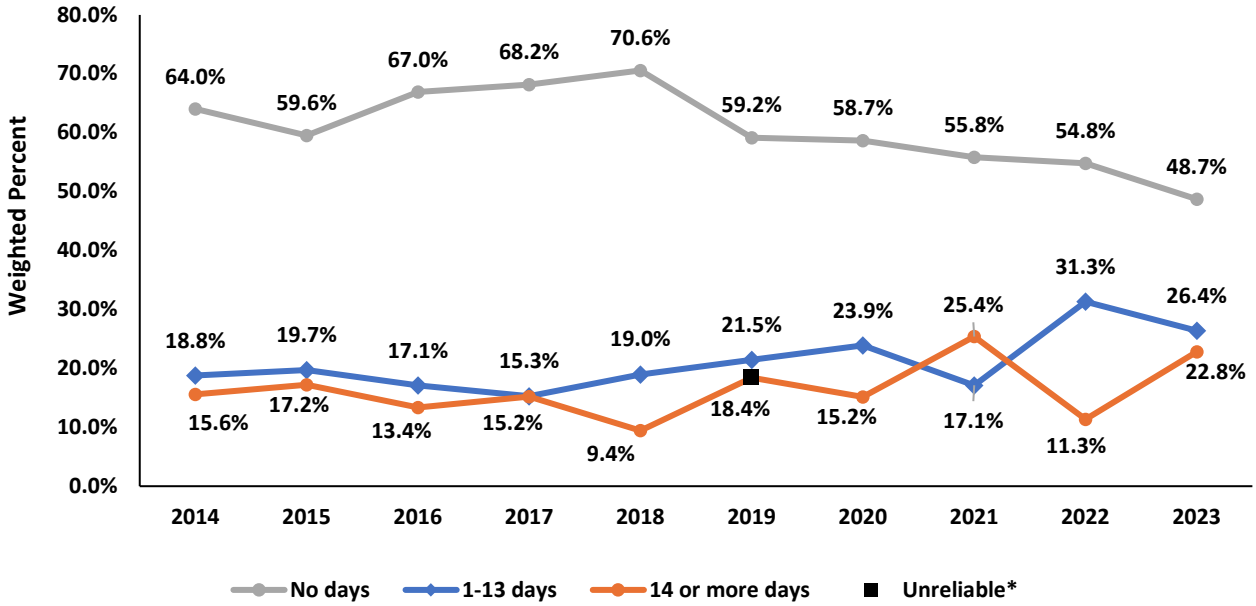
Figure 15. Percent of Adult BRFSS Respondents Who Experienced Poor Mental or Physical Health that Prevented Them from Doing Usual Activities by Days Affected in Past Month, Southern Region Residents, 2014-2023.



Source: Behavioral Risk Factor Surveillance System
Chart scaled to 70.0% to display differences among groups.
Frequent physical or mental distress is defined as feeling emotionally unhealthy, very sad, anxious, or troubled for 14 or more days out of the past 30 days.
Specific question asked in survey: "During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?"
**Interpret figure and generalizability with caution due to small sample size, overlapping 95% confidence intervals, and unreliable values (RSE >30).*

Generally, adults who reported any number of days in which their mental health was considered "not good" has increased, while "no days" has decreased since 2014.

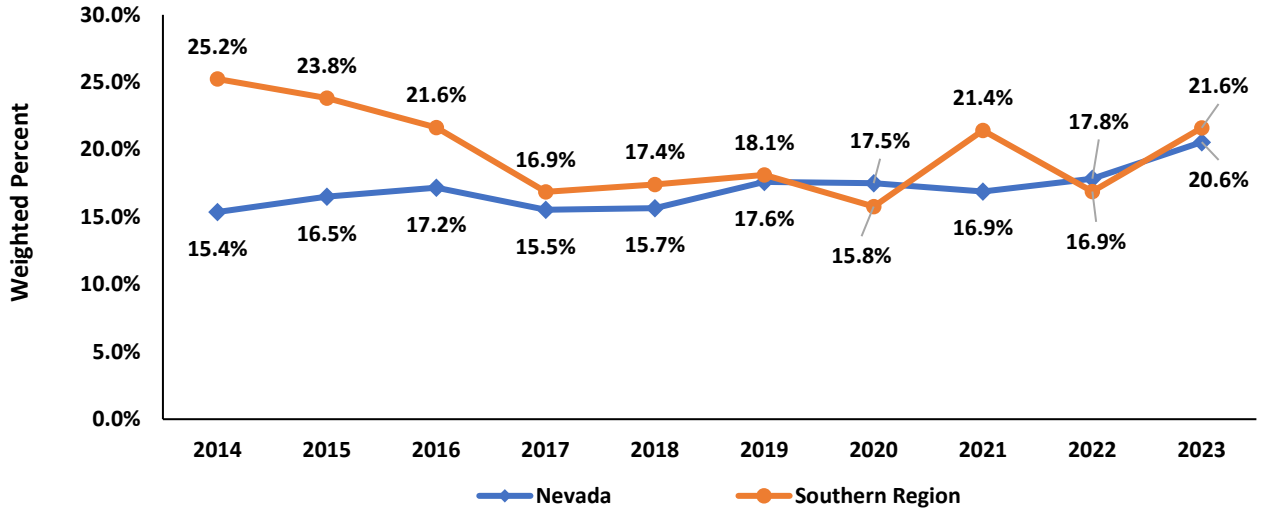
Figure 16. Percent of Adult BRFSS Respondents Whose Mental Health was Not Good by Number of Days Experienced in the Past Month, Nevada Residents, Southern Region Residents, 2014-2023.



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, overlapping 95% confidence intervals, and unreliable values (RSE >30).*

The prevalence of those in the Southern Region who reported having ever been told they have a depressive disorder by a doctor, nurse, or other health professional was consistently higher than Nevada for all years of the reporting period except 2020 and 2022.

Figure 17. Percent of Adult BRFSS Respondents Who Have Ever Been Told They Have a Depressive Disorder, Including Depression, Major/Minor Depression, or Dysthymia, Southern Region Residents, 2014-2023.



Source: Behavioral Risk Factor Surveillance System
Chart scaled to 30.0% 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.*

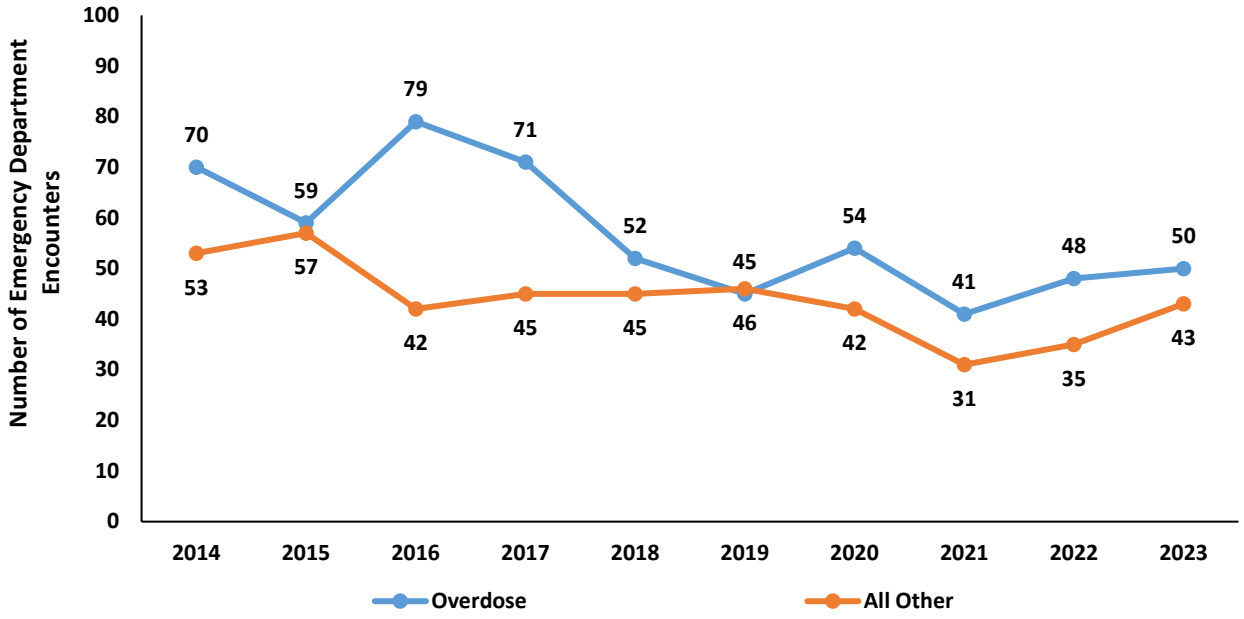
Suicide

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 a suicide attempt, where the patient did not expire at the hospital, have decreased slightly from 2014 to 2023. The most common method for attempted suicide is substance or drug poisoning (including overdose). The "all other" category includes drowning, firearms, cutting/piercing, jumping from heights, and suffocation/hanging.

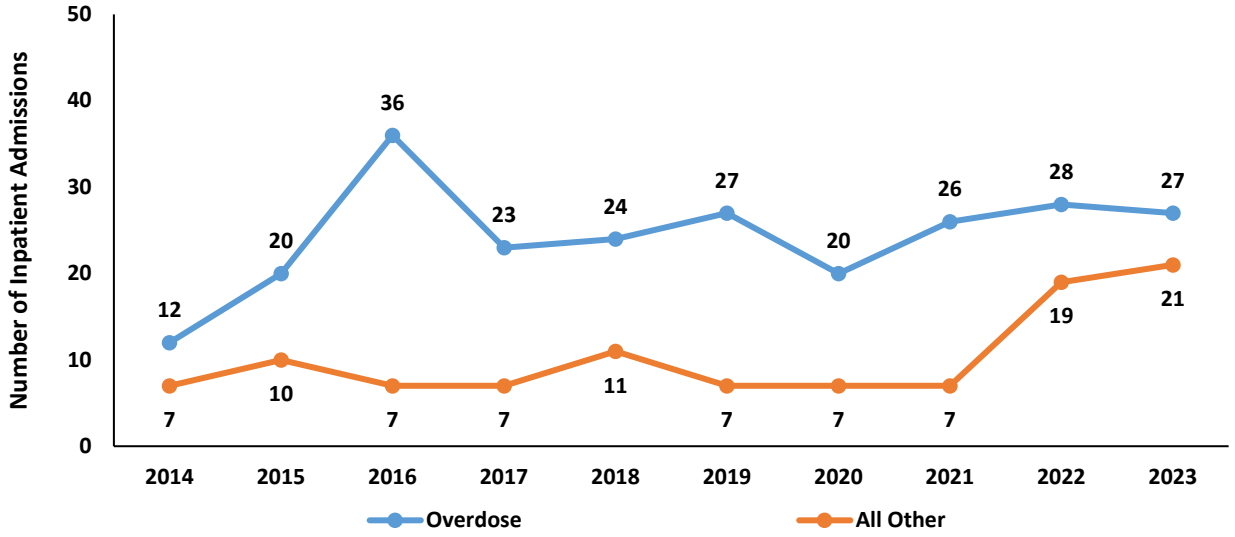
Figure 18. Suicide Attempt Emergency Department Encounters by Method, All Ages, Southern Region Residents, 2014-2023.



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 increased between 2014 and 2023. Like emergency department encounters, the most common method for attempts was overdose.

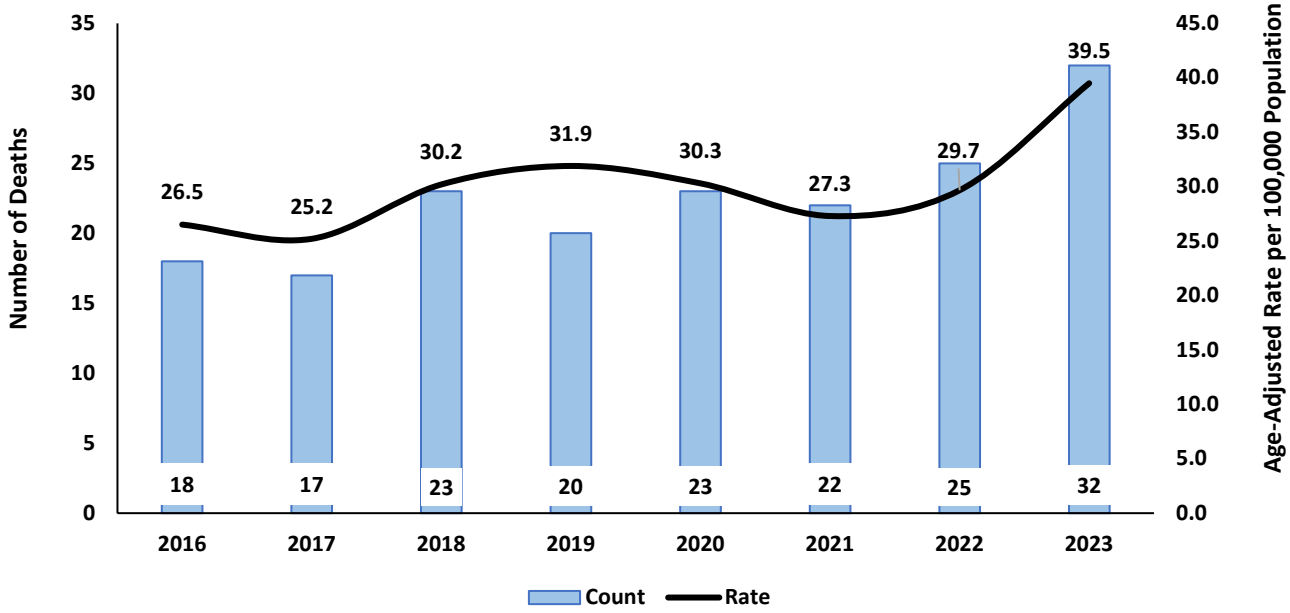
Figure 19. Suicide Attempt Inpatient Admissions by Method, All Ages, Southern Region Residents, 2014-2023.



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 Southern Region residents in 2023 was 39.5 per 100,000 population. This was the highest rate in the reporting period. For comparison, the rate for Nevada was 19.3 per 100,000 in 2023 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, Southern Region Residents, 2016-2023.



Source: Nevada Electronic Death Registry System

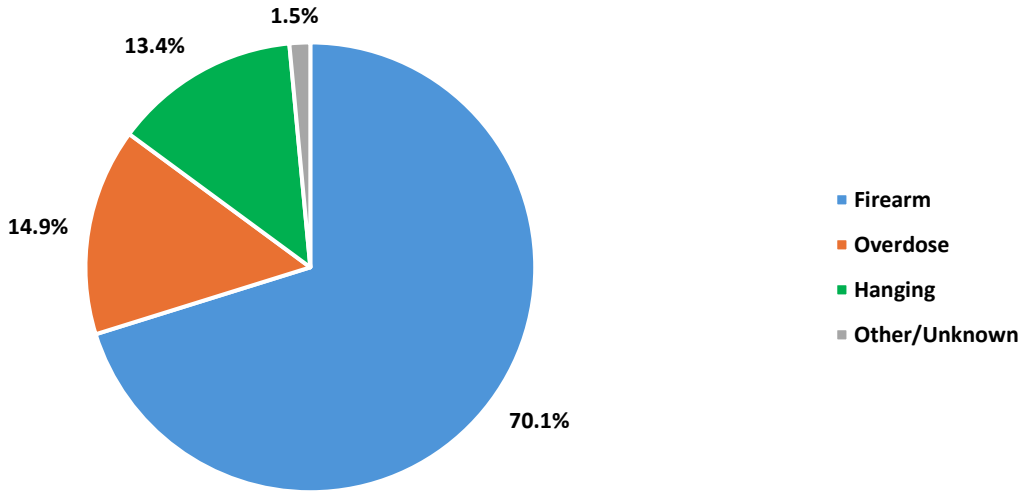
National Violent Death Reporting System (NVDRS)

The National Violent Death Reporting System (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 82 deaths among Southern Region residents reported in the Nevada Violent Death Reporting System (NVVDRS). Of those deaths, 81.7% (n=67) were suicides, 12.2% were homicides, 2.4% were legal interventions, and the remainder were categorized as unintentional involving firearms or undetermined.

Among the 67 suicides, the method was firearms in 70.1% of cases (n=47), 14.9% overdose, 13.4% hanging/strangulation/suffocation, and 1.5% other/unknown. About 84% of persons were male and 16% were female.

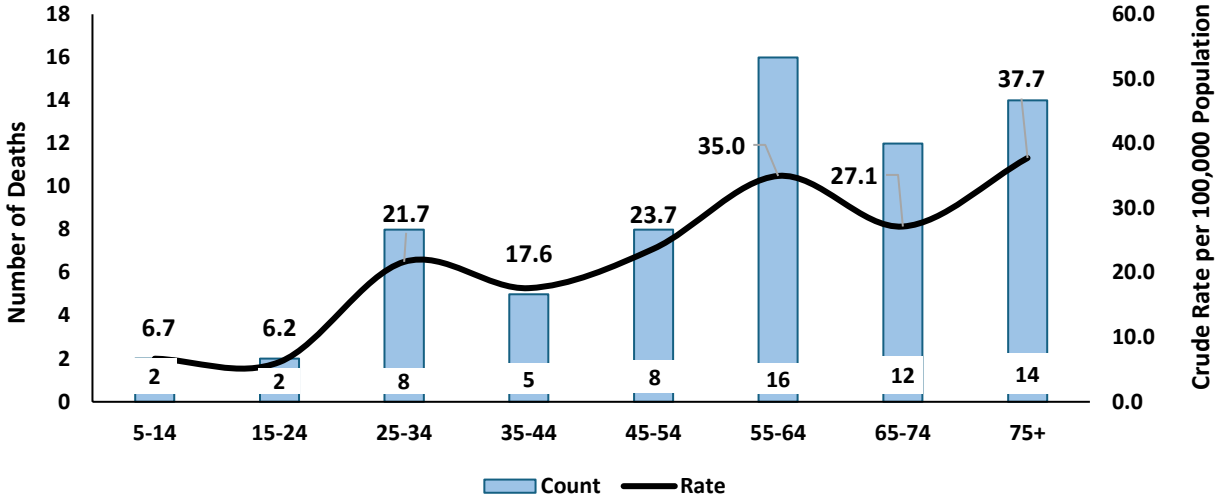
Figure 21. Method of Suicide Deaths, Southern Region Residents, 2018-2022.



Source: Nevada Violent Death Reporting System

The rates of deaths by suicide were highest among the 75+ age group (37.7 per 100,000 population).

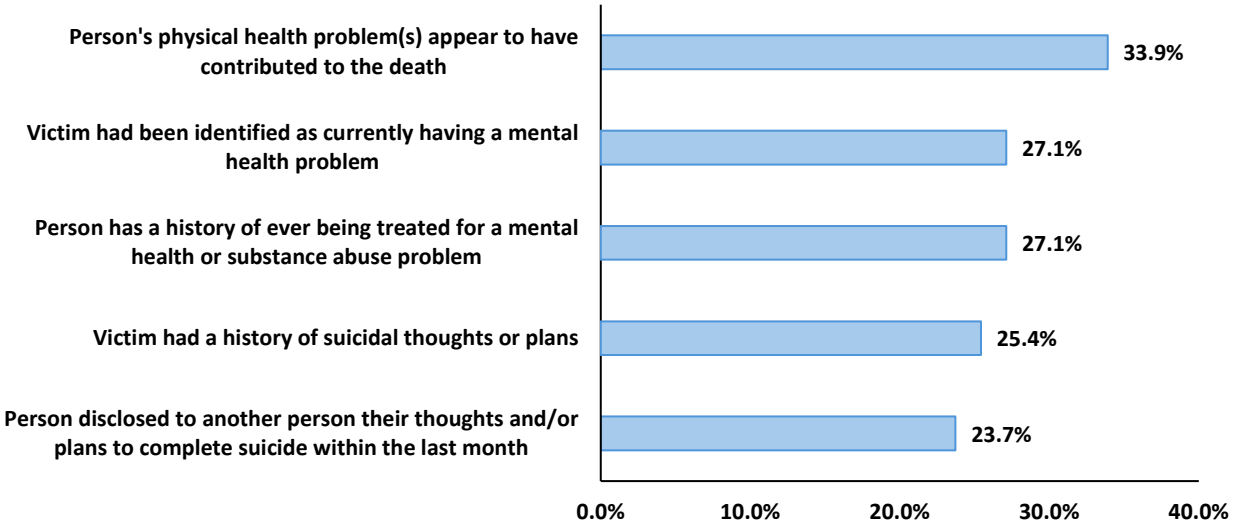
Figure 22. Number of Suicide Deaths and Rates by Age Group, Southern Region Residents, 2018-2022.



Source: Nevada Violent Death Reporting System

Of the 67 suicides among Southern Region residents from 2018-2022 that were entered into NVDRS, 88.1% (n=59) had circumstantial information available. Nearly 34% of those suicides involved persons who had a physical health problem(s) that appeared to contribute to the death; 27.1% reported to currently having a mental health problem; 27.1% had a history of ever being treated for a mental health or substance abuse problem; 25.4% had a history of suicidal thoughts or plans; and 23.7% disclosed to another person their thoughts and/or plans to complete suicide within the month before death.

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



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

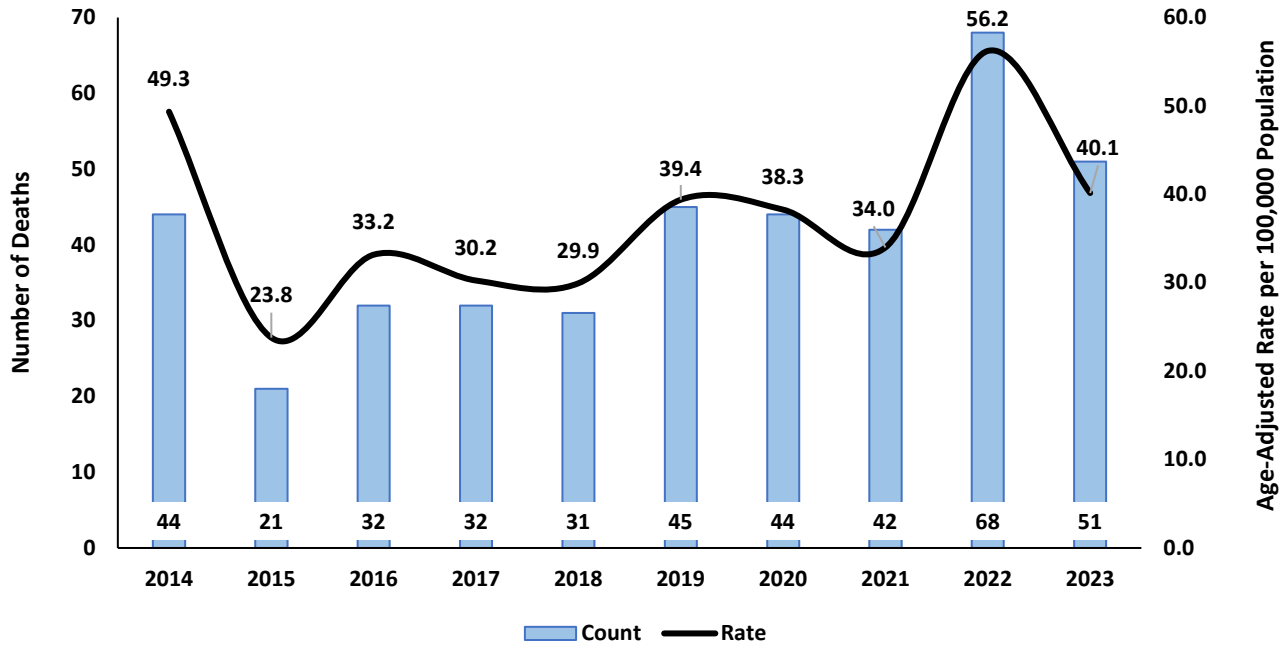
Mental Health-Related Deaths

Mental health-related deaths are deaths with the following ICD-10 code groups listed as a contributing cause (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 for residents of the Southern Region occurred at an age-adjusted rate of 40.1 per 100,000 population in 2023. This is below the Nevada rate of 54.4 per 100,000 population.

Figure 24. Mental Health-Related Deaths and Rates, Southern 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 such as fentanyl and fentanyl analogs (IMFs). Synthetic opioids became the leading cause of overdose deaths in the United States starting 2016.[1]

In 2017, the U.S. Department of Health and Human Services (HHS) officially declared the opioid crisis a public health emergency. In response to this crisis, Nevada introduced Assembly Bill 474, which went into effect on Jan. 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's AB 474 has led to measurable outcomes. Figures 31 and 32 below show the sharp decline in the number and rate of both opioid and controlled substance prescriptions in the state since 2017. These Nevada trends reflect the broader national picture of decreased prescription and utilization of opioids.

Per NRS 453.226 (as revised by 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 health care providers and public health authorities with timely insights into patient prescription behaviors.

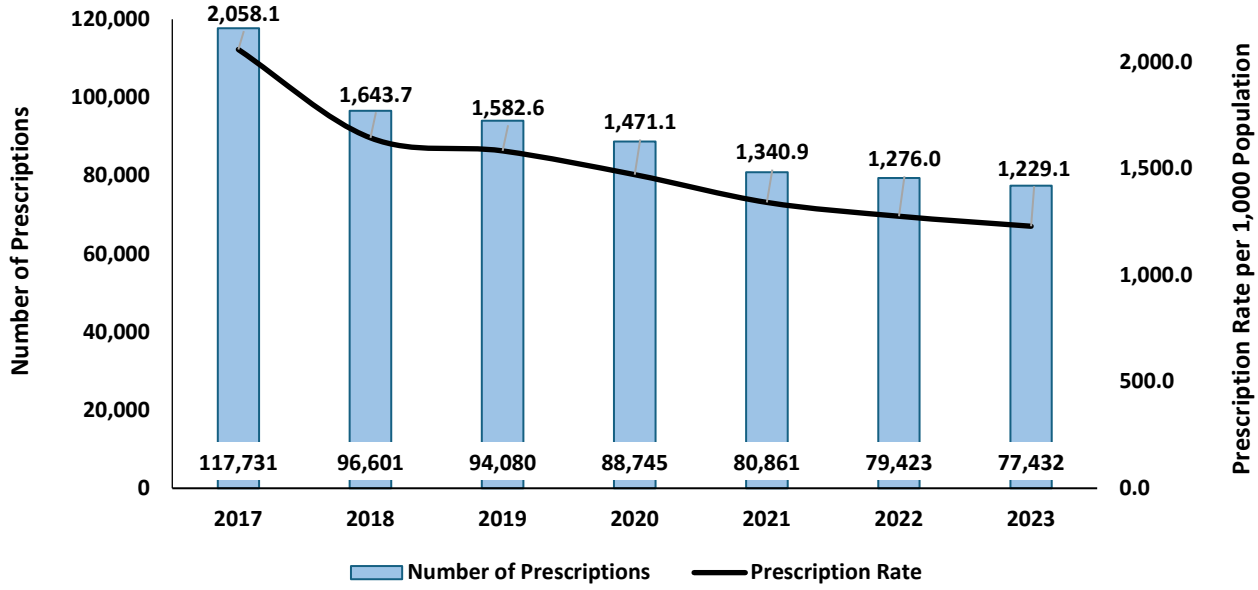
In addition to opioids, Nevada's PDMP tracks information about all Schedule II–V prescriptions dispensed to patients in the state. These drugs are classified as having accepted medical use and, at minimum, a low potential for abuse and risk of dependence. Schedule I drugs, such as ecstasy, heroin, lysergic 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 Southern Region residents have decreased markedly from a rate of 2,058.1 per 1,000 population in 2017 to 1,229.1 per 1,000 population in 2023.

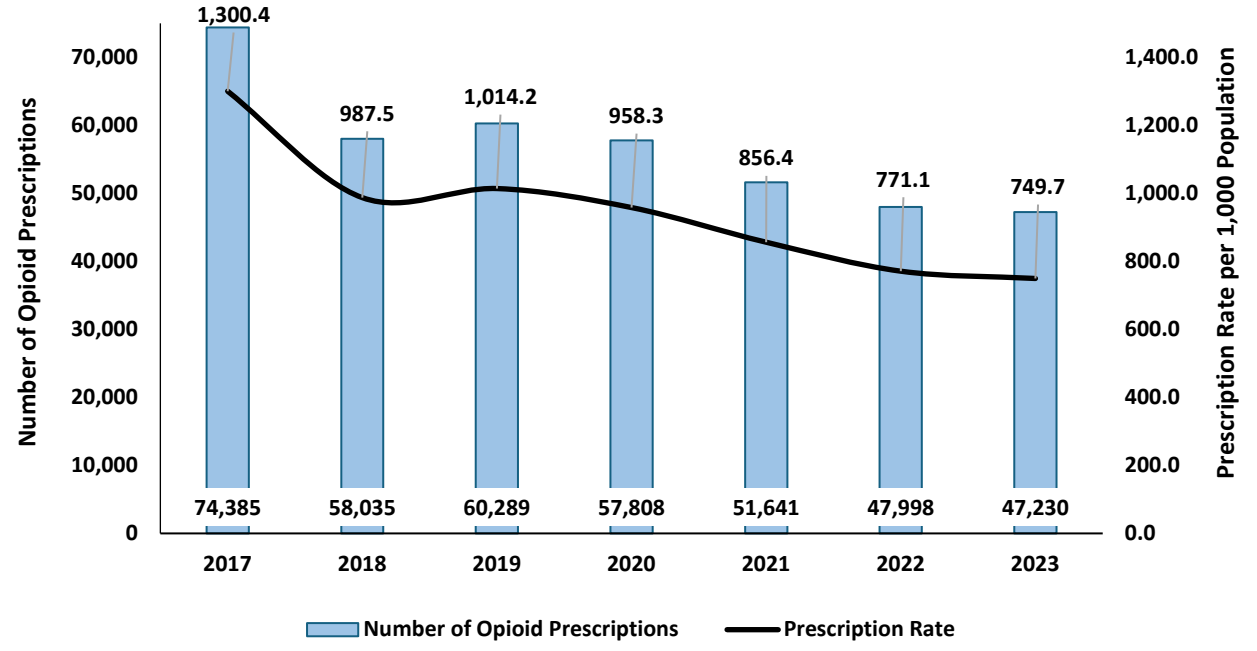
Figure 25. Total Prescriptions and Rates, Southern Region Residents, 2017-2023.



Source: Prescription Drug Monitoring Program

Mirroring total prescription trends, total opioid prescriptions have decreased from a rate of 1,300.4 per 1,000 population in 2017 to 749.7 per 1,000 population in 2023.

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

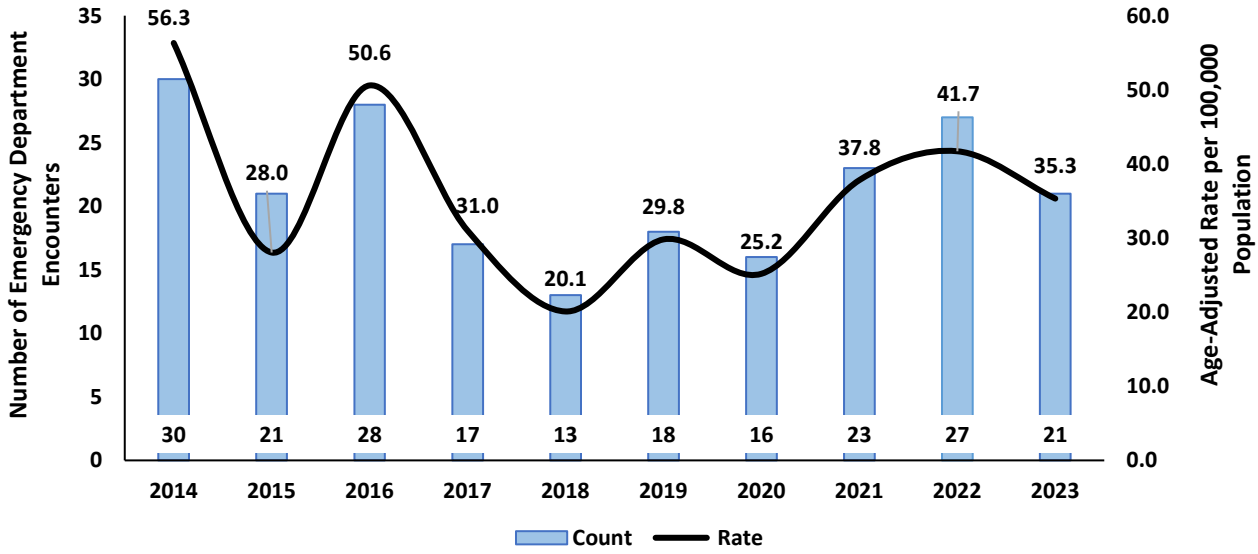


Source: Prescription Drug Monitoring Program

Hospital Emergency Department Encounters

Opioid overdose emergency department encounters decreased between 2014 and 2020 before increasing post-COVID-19 pandemic.

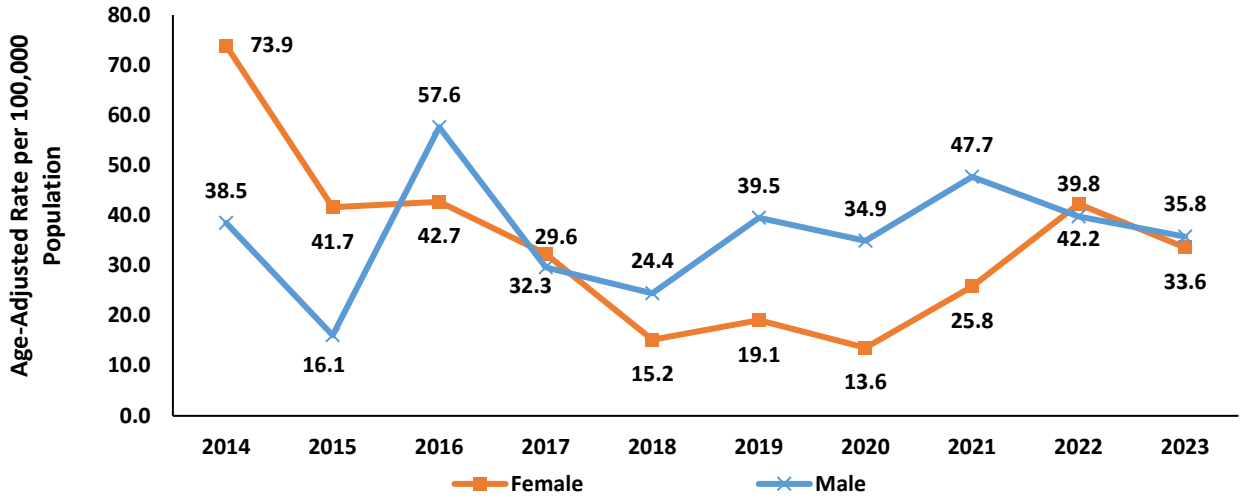
Figure 27. Opioid Overdose Emergency Department Encounters and Rates by Year, Southern Region Residents, 2014-2023.



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.

Opioid overdose emergency department encounter rates for both female and male Southern Region residents have been largely comparable over the reporting period. The average rates from 2014 to 2023 are 34.0 and 36.4 per 100,000 population for females and males, respectively.

Figure 28. Opioid Overdose Emergency Department Encounter Rates by Year and Sex, Southern Region Residents, 2014-2023.

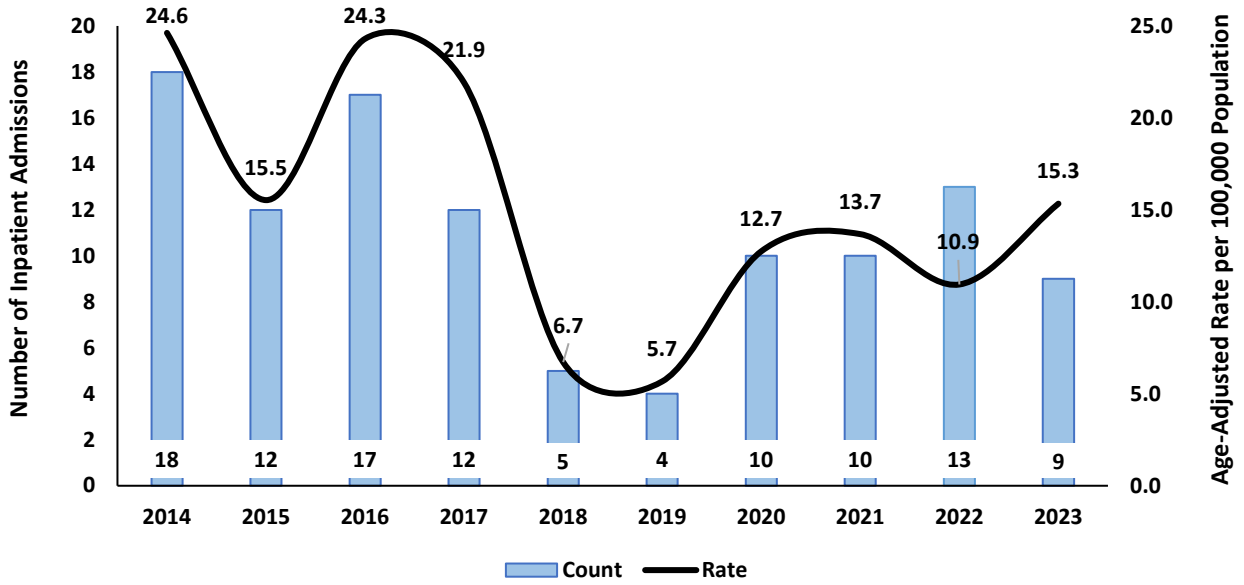


Source: Hospital Emergency Department Billing
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Hospital Inpatient Admissions

Opioid-related inpatient admission rates also decreased from 2014 to 2019 before increasing during and after the COVID-19 pandemic.

Figure 29. Opioid Overdose Inpatient Admissions and Rates by Year, Southern Region Residents, 2014-2023.



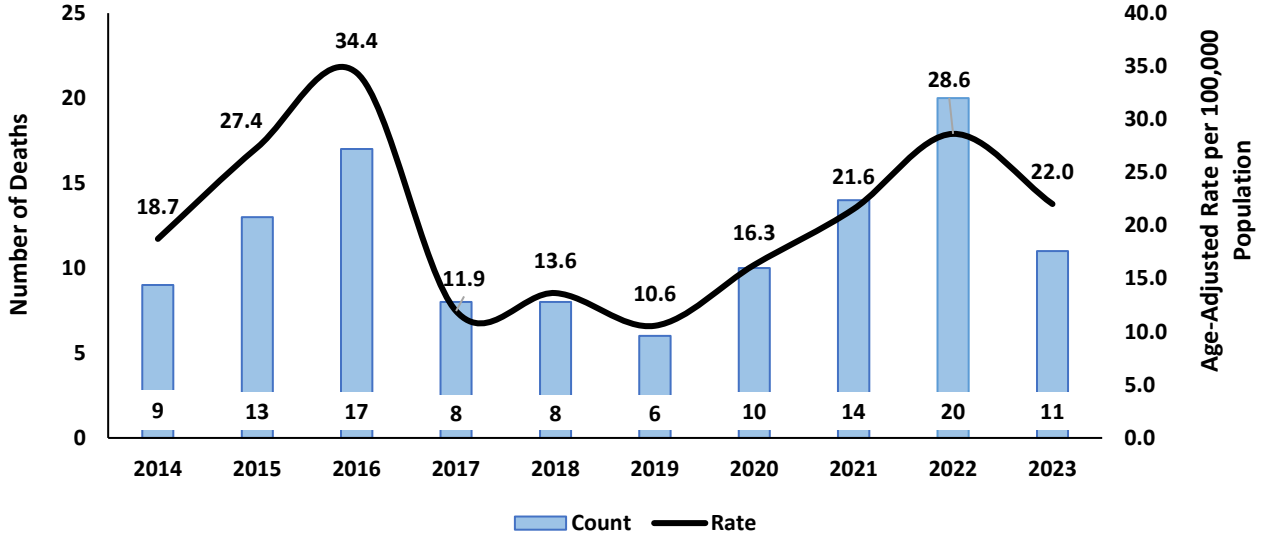
Source: Hospital Inpatient Billing
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Due to volatility in rates of opioid overdose inpatient admissions by sex and race/ethnicity because of the relatively smaller populations in the Southern Region, the associated figures have been omitted.

Opioid Overdose Deaths

After a high in 2016 of 34.4 per 100,000, the rate of opioid overdose deaths for residents of the Southern Region decreased through 2019. The rates then increased again throughout the COVID-19 pandemic.

Figure 30. Opioid Overdose Deaths and Rates, Southern Region Residents 2014-2023.



Source: Nevada Electronic Death Registry System.

Due to volatility in rates of opioid overdose deaths by sex and race/ethnicity because of the relatively smaller populations in the Southern Region, the associated figures have been omitted.

Stimulants

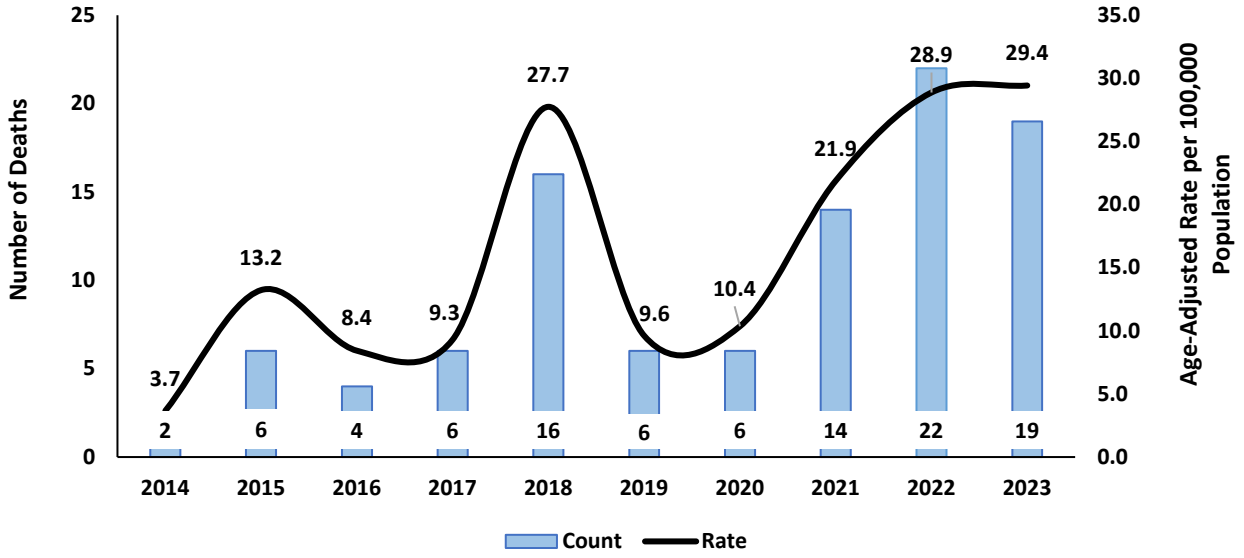
Stimulants are a class of drugs that accelerate communication between the brain and body, often making individuals feel more awake, alert, confident, or energetic. They include legal substances such as caffeine, and prescription medications such as dexamphetamines, Adderall, and methylphenidate (Ritalin),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

Stimulant Overdose Deaths

The rates of stimulant-related overdose deaths have increased over the reporting period to a high of 29.4 in 2023. Despite the volatility due to low counts, there has been a nearly 700% overall increase from 2014 to 2023.

Figure 31. Stimulant Overdose Deaths and Rates, Southern Region Residents, 2014-2023.



Source: Nevada Electronic Death Registry System

Due to volatility in rates of stimulant overdose hospitalizations, and of stimulant overdose deaths by sex and race/ethnicity because of the relatively smaller populations in the Southern Region, the associated figures have been omitted.

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

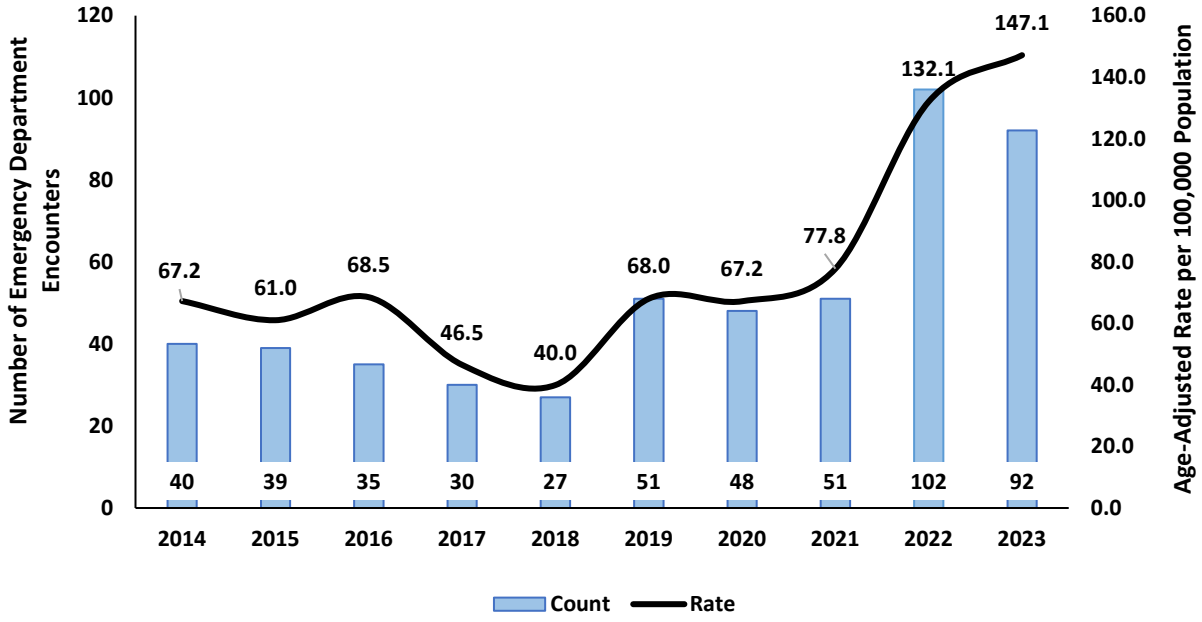
Chronic Alcohol Conditions

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.

Hospital Emergency Department Encounters

Emergency department encounters for alcohol-related diseases have increased 118% between 2014 and 2023.

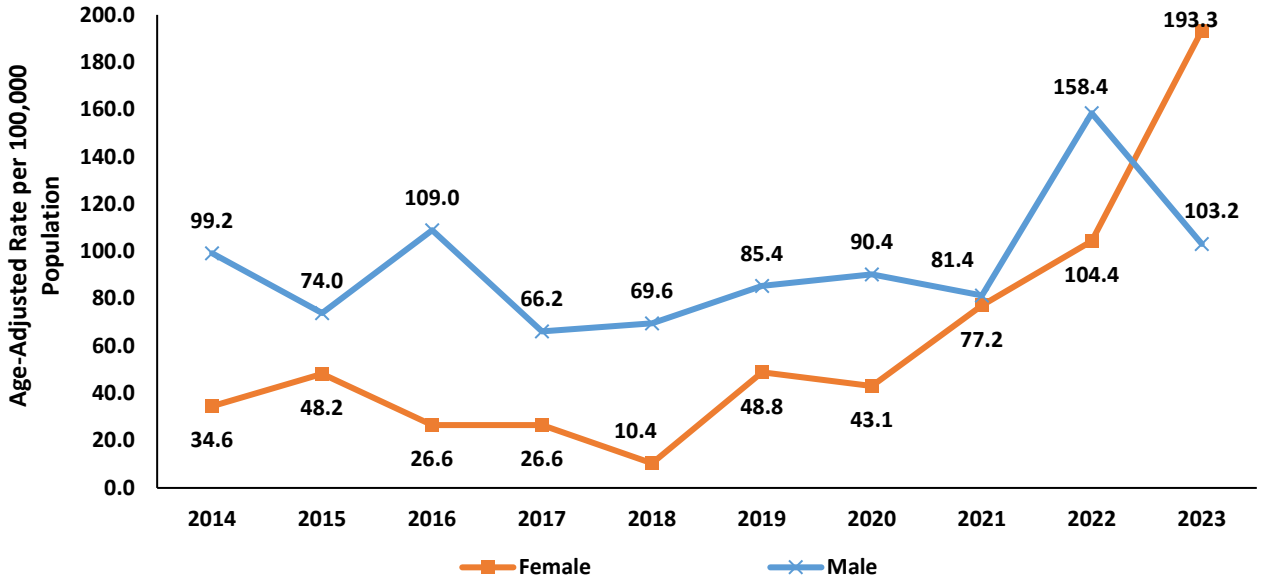
Figure 32. Chronic Alcohol Diseases Emergency Department Encounters and Rates by Year, Southern Region Residents, 2014-2023.



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 rate of emergency department encounters for alcohol-related diseases has been higher for men throughout the reporting period until 2023 when the rate for women increased dramatically.

Figure 33. Chronic Alcohol Diseases Emergency Department Encounter Rates by Year and Sex, Southern Region Residents, 2014-2023.



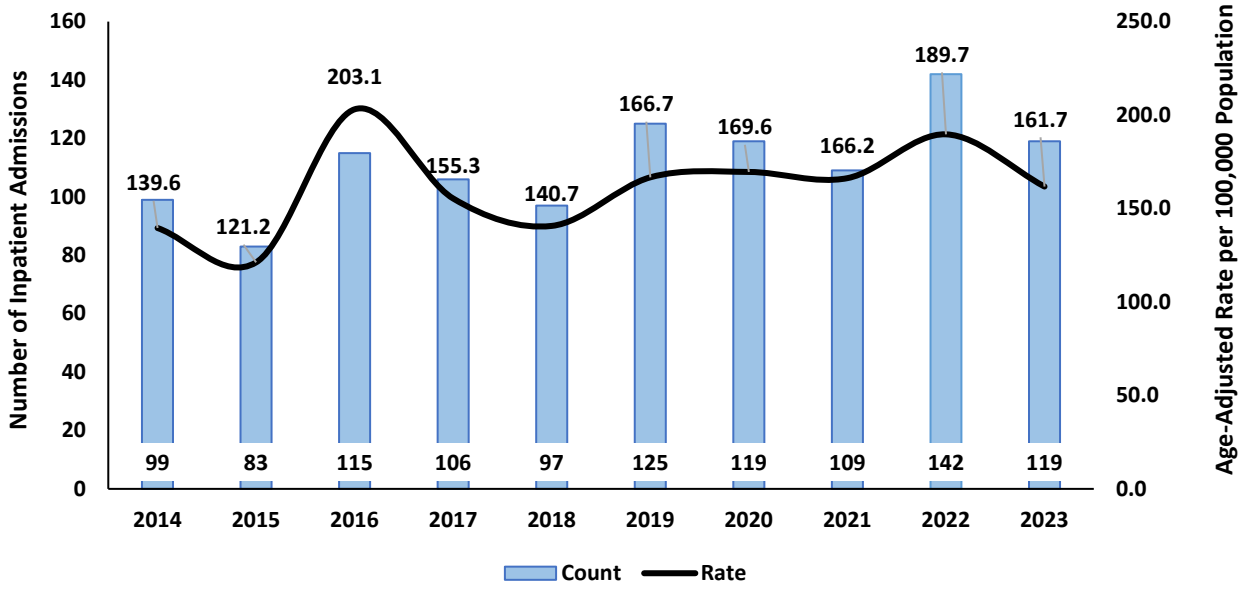
Source: Hospital Emergency Department Billing
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Due to volatility in rates of emergency room encounters for chronic alcohol conditions by race/ethnicity because of the relatively smaller populations in the Southern Region, the associated figure has been omitted.

Hospital Inpatient Admissions

The rate of inpatient admissions for alcohol-related diseases has remained stable throughout the reporting period.

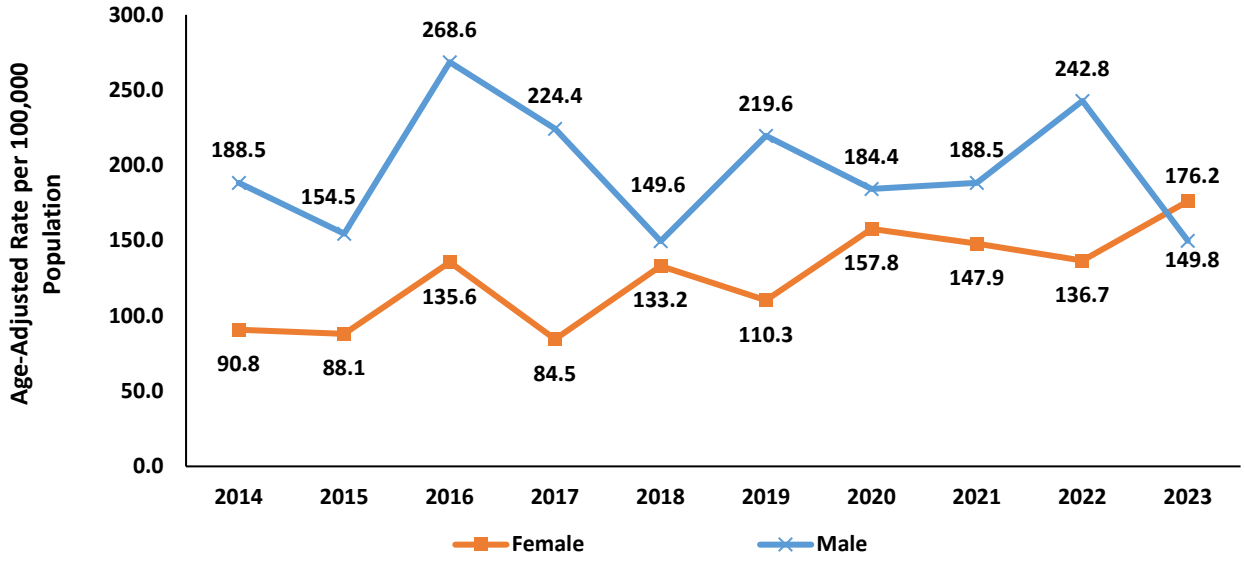
Figure 34. Chronic Alcohol Diseases Inpatient Admissions and Rates by Year, Southern Region Residents, 2014-2023.



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.

Mirroring the trends noted for emergency department encounters for alcohol-related diseases, inpatient admissions have been higher for men throughout the reporting period until 2023 when the rate for women increased.

Figure 35. Chronic Alcohol Diseases Inpatient Admission Rates by Year and Sex, Southern Region Residents, 2014-2023.



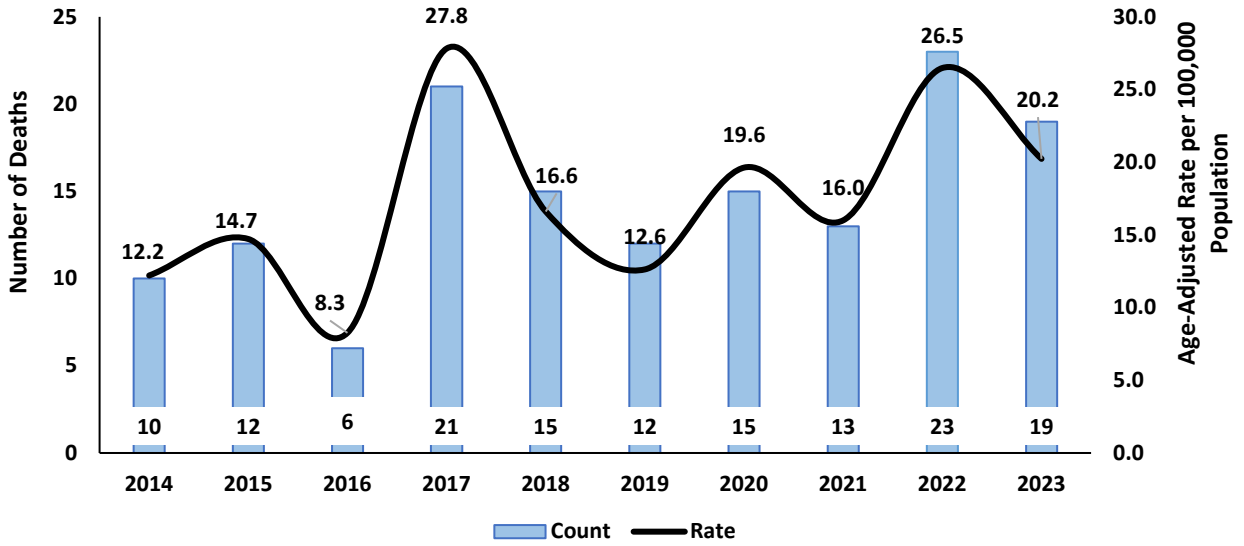
Source: Hospital Inpatient Billing
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Due to volatility in rates of hospitalizations for chronic alcohol conditions by race/ethnicity because of the relatively smaller populations in the Southern Region, the associated figures have been omitted.

Chronic Alcohol Diseases Deaths

Deaths due to chronic alcohol-related diseases for the Southern Region peaked in 2017 at a rate of 27.8 per 100,000 before declining through 2019. Rates then increased again throughout the COVID-19 pandemic.

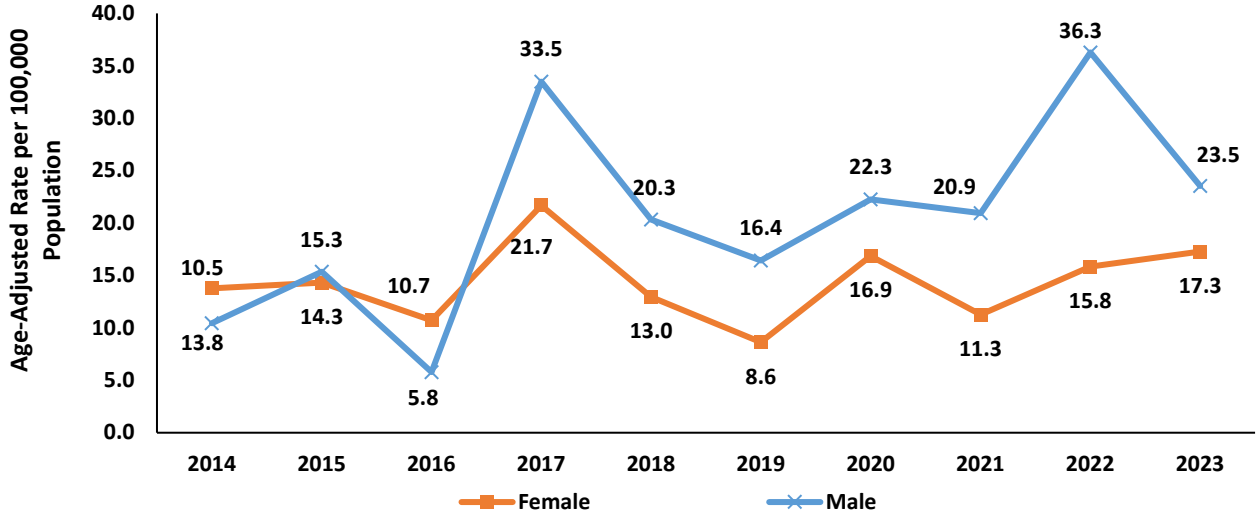
Figure 36. Chronic Alcohol Diseases Deaths and Rates, All Ages, Southern Region Residents, 2014-2023.



Source: Nevada Electronic Death Registry System.

The rates for both men and women mirror the overall trend in chronic alcohol-related deaths. The rate has been higher for men in all years since 2017.

Figure 37. Chronic Alcohol Diseases Death Rates by Sex, Southern Region Residents, 2014-2023.



Source: Nevada Electronic Death Registry System

Due to volatility in rates of deaths from chronic alcohol conditions by race/ethnicity because of the relatively smaller populations in the Southern Region, the associated figure has been omitted.

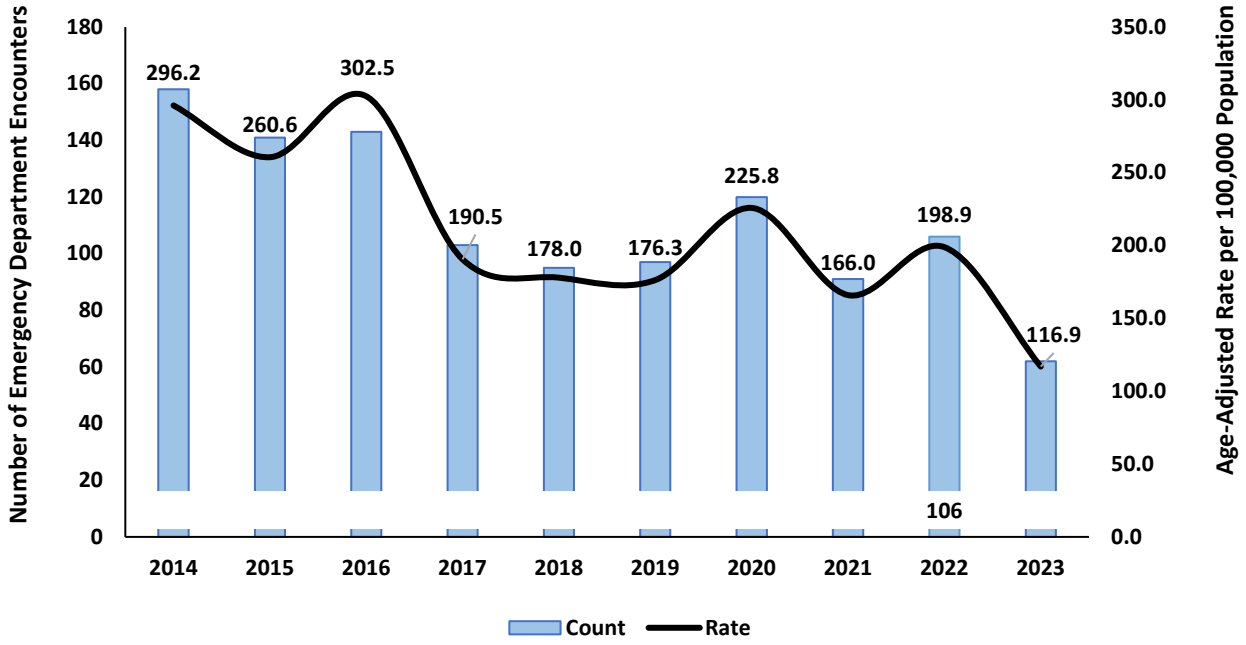
Alcohol- and/or Drug-Related Overdoses

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

When accounting for all substances, the rate of emergency department encounters for overdoses has decreased substantially over the reporting period, from 296.2 per 100,000 in 2014 to 116.9 per 100,000 in 2023. This is a roughly 87% decrease.

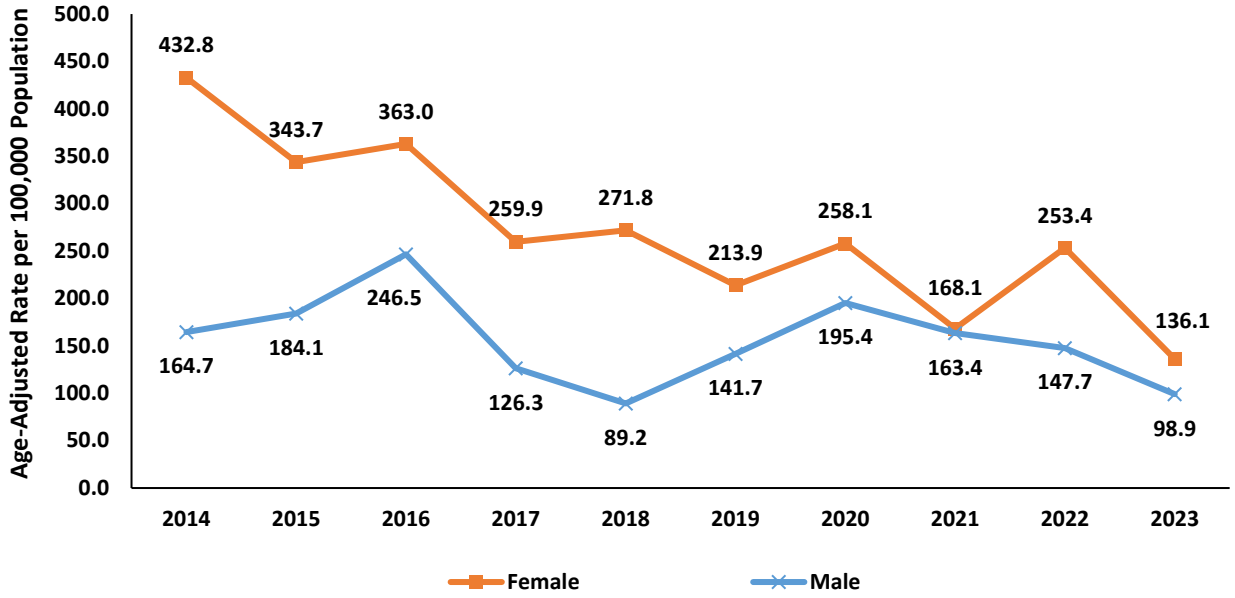
Figure 38. Alcohol- and/or Drug-Related Overdose Emergency Department Encounters and Rates by Year, Southern Region Residents, 2014-2023.



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.

While the rates for emergency department encounters due to overdose for both men and women have decreased over the reporting period, the rates have been consistently higher for women.

Figure 39. Alcohol- and/or Drug-Related Overdose Emergency Department Encounter Rates by Year and Sex, Southern Region Residents, 2014-2023.



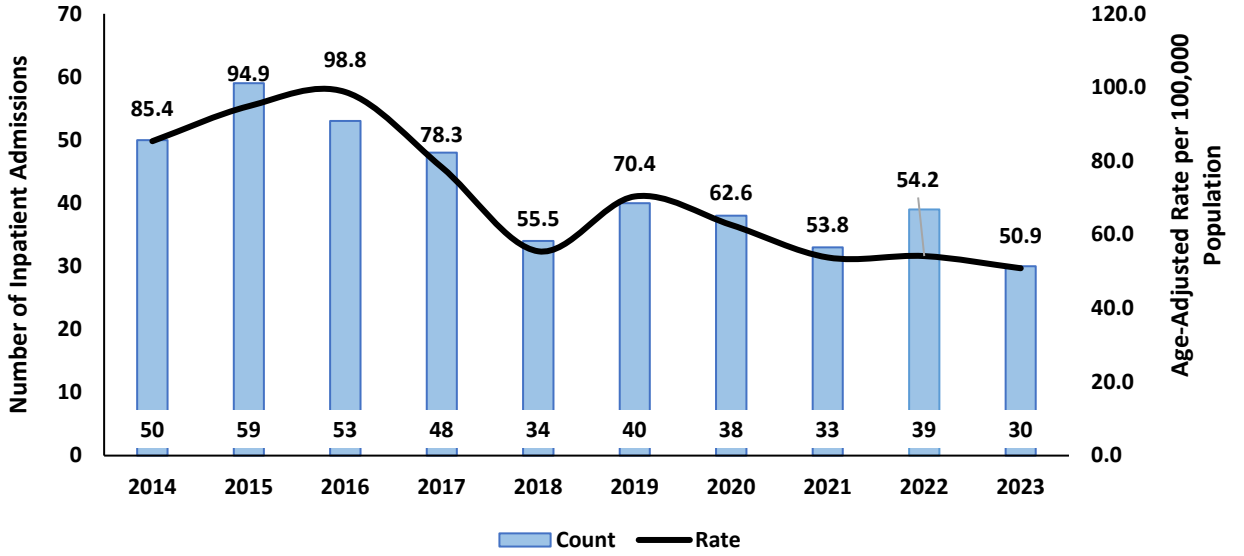
Source: Hospital Emergency Department Billing
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Due to volatility in rates of overdose by race/ethnicity because of the relatively smaller populations in the Southern Region, the associated figure has been omitted.

Hospital Inpatient Admissions

The rate of inpatient admissions for overdoses has decreased substantially between 2016 and 2023.

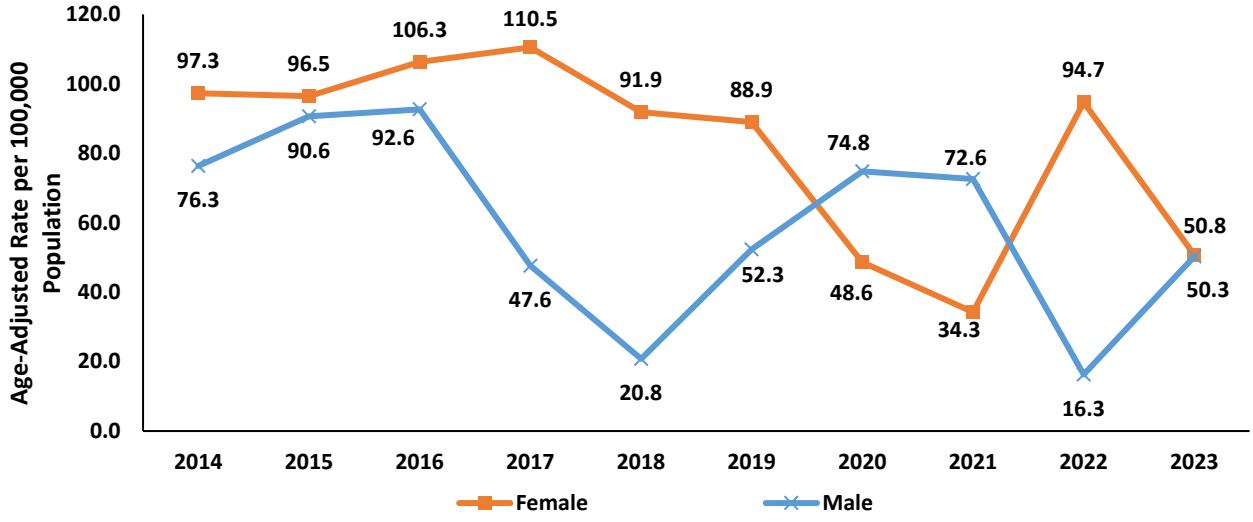
Figure 40. Alcohol- and/or Drug-Related Overdose Inpatient Admissions and Rates by Year, Southern Region Residents, 2014-2023.



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.

The rate of inpatient admissions for all overdoses has decreased for both men and women between 2016 and 2023. The rate is higher for women for all years except 2020 and 2021.

Figure 41. Alcohol- and/or Drug-Related Overdose Inpatient Admission Rates by Year and Sex, Southern Region Residents, 2014-2023.

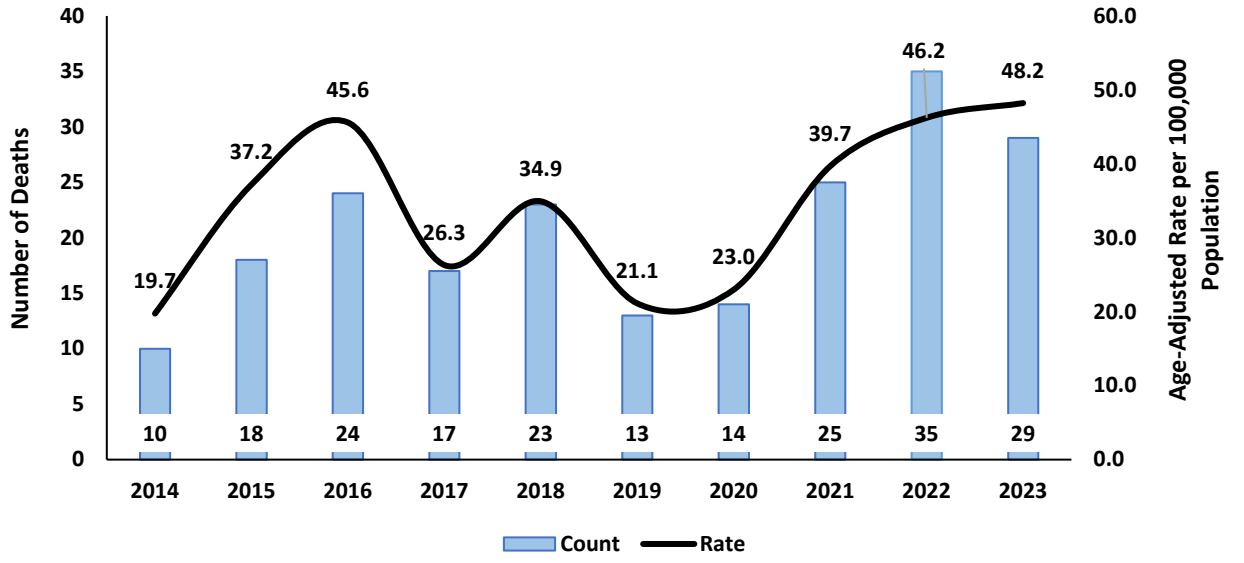


Source: Hospital Inpatient Billing.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Alcohol- and/or Drug-Related Overdose Deaths

Mirroring trends noted previously, the rate of overdose deaths for residents of the Southern Region peaked in 2016 and increased substantially in the years immediately following the COVID-19 pandemic.

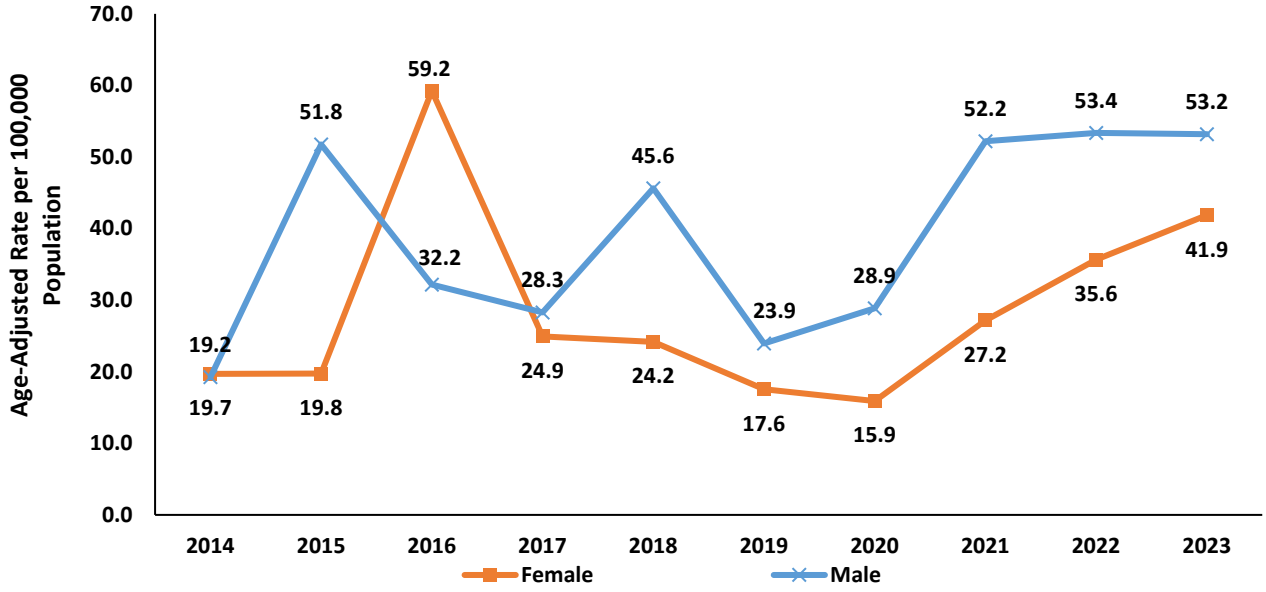
Figure 42. Alcohol- and/or Drug-Related Overdose Deaths and Rates, Southern Region Residents, 2014-2023.



Source: Electronic Death Registry System

The rates of death for both men and women follow the overall trend for the Southern Region and the rate has been higher for men in all years except 2014 and 2016.

Figure 43. Overdose Death Rates by Sex, Southern Region Residents, 2014-2023.



Source: Electronic Death Registry System

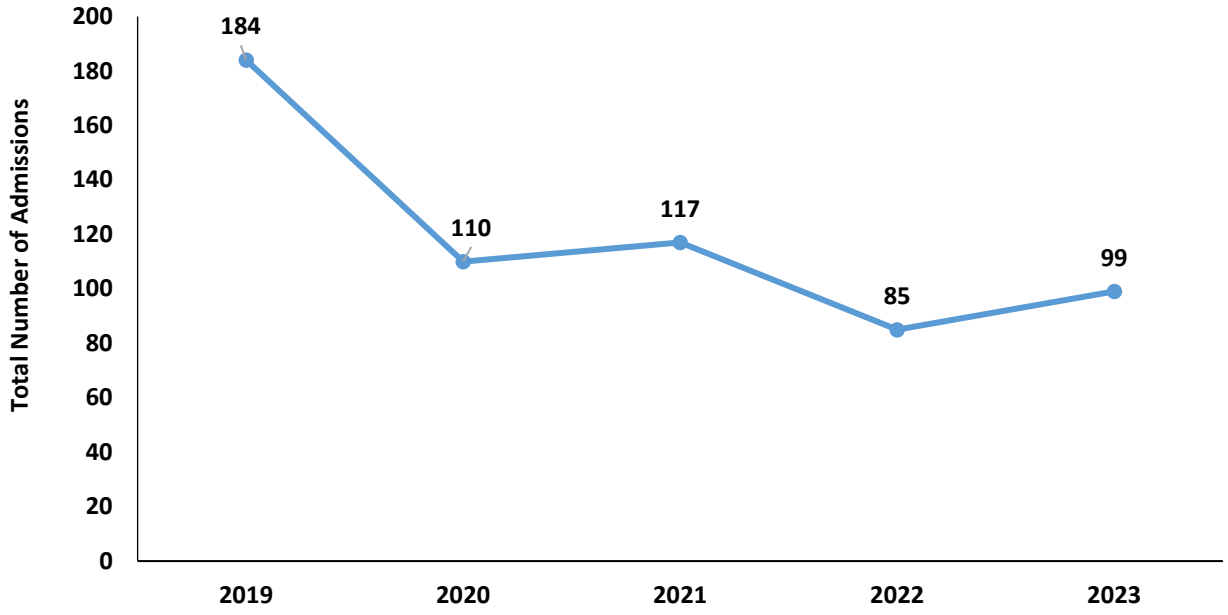
Substance Use Treatment Centers

Treatment Episode Data Sets (TEDS) is 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.

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.[4] Due to the prevalence of Medicaid utilization at these facilities, there was a notable increase in admissions in 2022 and 2023.

The number of admissions to Nevada state-funded substance use treatment facilities in Southern Region counties has declined between 2019 and 2022, with a small increase in 2023. Within the Southern Region counties in this report, Nye County is the only one with a TEDS facility. Due to data integrity issues, total admission counts for years prior to 2019 have been omitted.

Figure 44. Total Number of Admissions in Adult Substance Abuse Treatment Centers, Southern Region Facilities, 2019-2023.



Data Source: Treatment Episode Data Sets

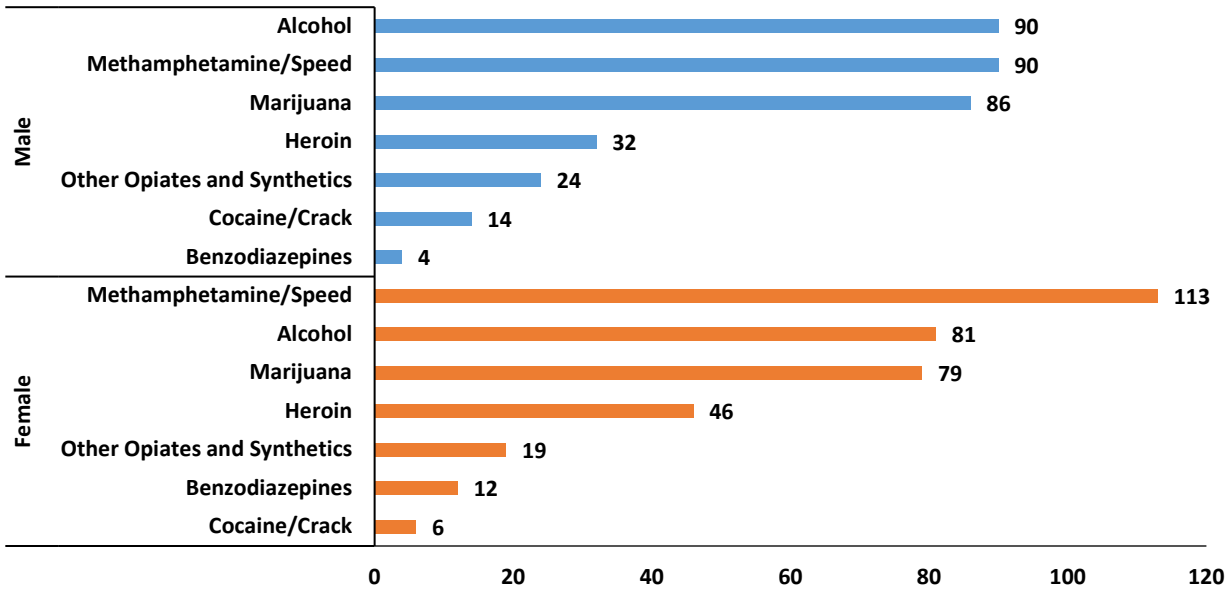
Among all insured individuals admitted to state-funded substance use treatment facilities, 53% are covered by Medicaid or Medicare. This utilization rate is in line with expectations as TEDS data represent state-funded safety-net services.

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

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

Alcohol and methamphetamine/speed were the primary substances reported for males admitted from 2015-2023. For females methamphetamine/speed was the primary substance reported in the same timeframe. This is in comparison to national TEDS data from 2018-2022, when the primary substances were alcohol followed by heroin. This indicates that methamphetamines have a higher utilization in Nevada compared to the United States. These counts of primary substance at admission are not mutually exclusive as clients could be admitted with current use of multiple substances.

Figure 45. Primary Substance Used for Clients at Adult Substance Abuse Treatment Centers by Sex, Southern Region Facilities, 2015-2023.



Data Source: Treatment Episode Data Sets

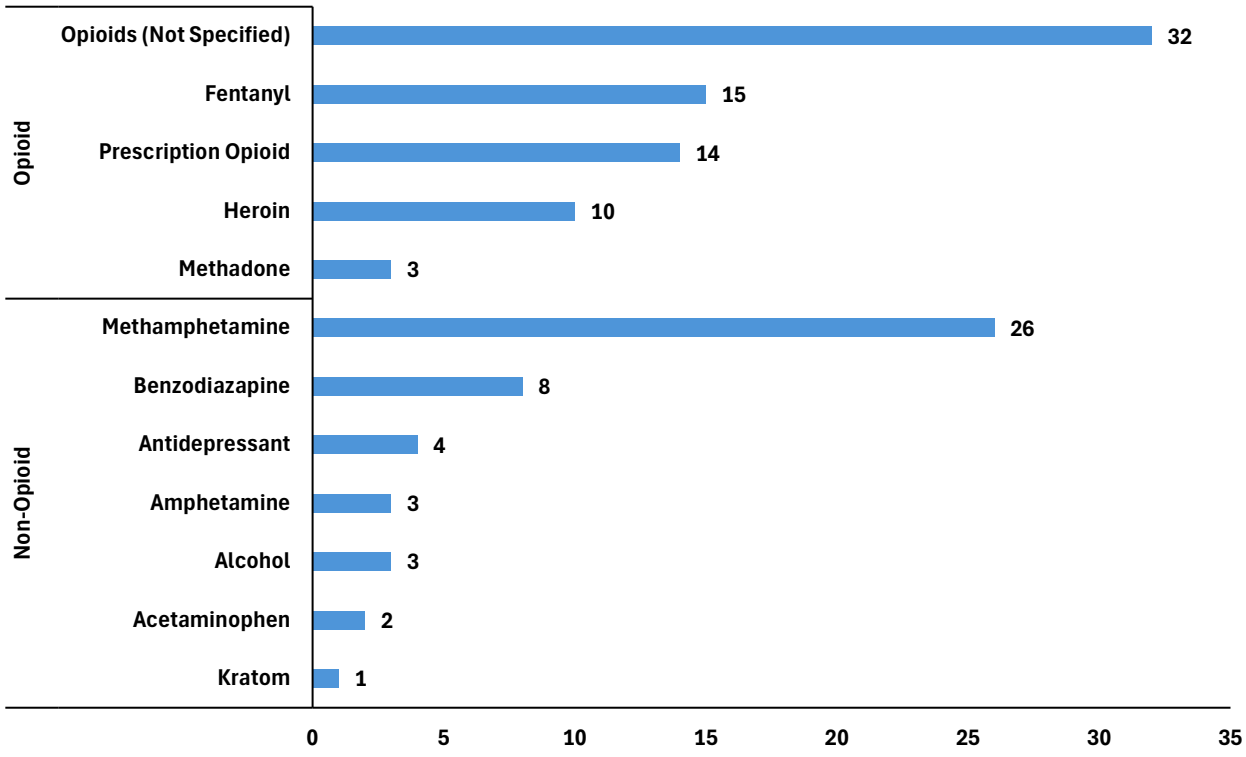
State Unintentional Drug Overdose Reporting System

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

Of the 52 total drug overdose deaths of unintentional/undetermined intent among Southern Region residents between 2019 and 2022, decedents were mostly white and a high school graduate or had a completed GED.

Opioids were listed in the cause of death for more than half of cases (type not specified 61%). Methamphetamine was also listed as one of the substances in the cause of death in 50% of cases reported.

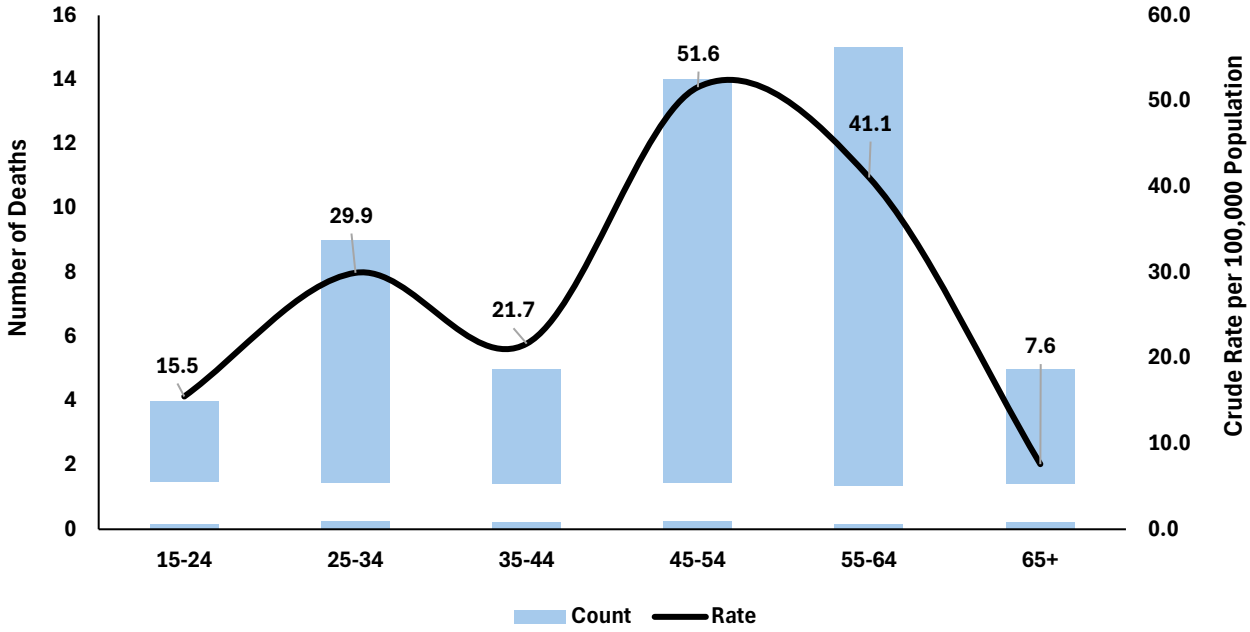
Figure 46. Substances Listed in the Cause of Death Among Unintentional/Undetermined Overdose Deaths, Southern Region Residents, 2019-2022.



Source: SUDORS

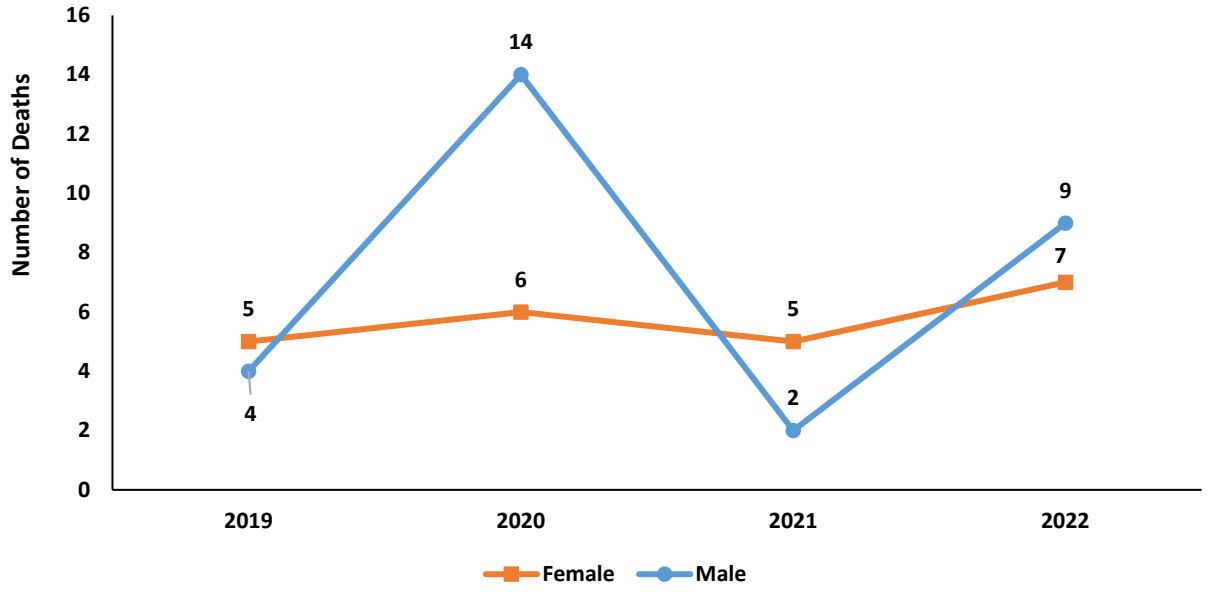
The majority of unintentional overdose deaths in the Southern Region occurred among the 45 to 64 age groups. This is in line with the overall age demographics of the region.

Figure 47. Total Number of Unintentional/Undetermined Overdose Deaths and Rates by Age Group, Southern Region Residents, 2019-2022.



Source: SUDORS

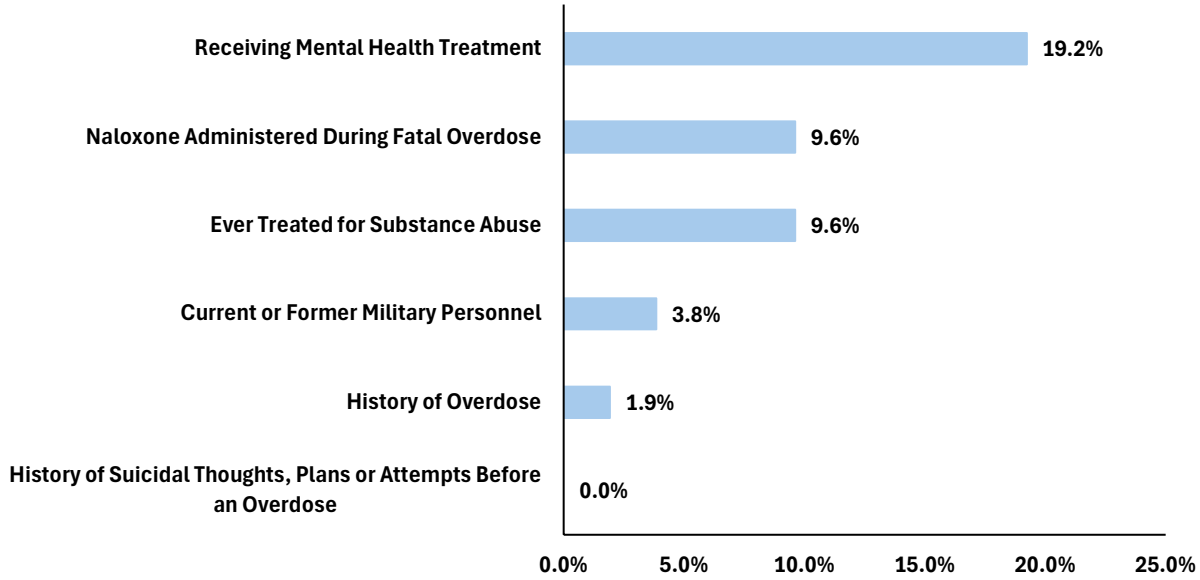
Figure 48. Total Number of Unintentional/Undetermined Overdose Deaths by Sex, Southern Region Residents, 2019-2022.



Source: SUDORS.

Over 19% of persons in the SUDORS dataset for the Southern Region had been receiving mental health treatment services, and 9.6% had naloxone administered during the fatal overdose. Both of these percents are lower than the reported rates for Nevada at 25.3% and 21.4%, respectively.

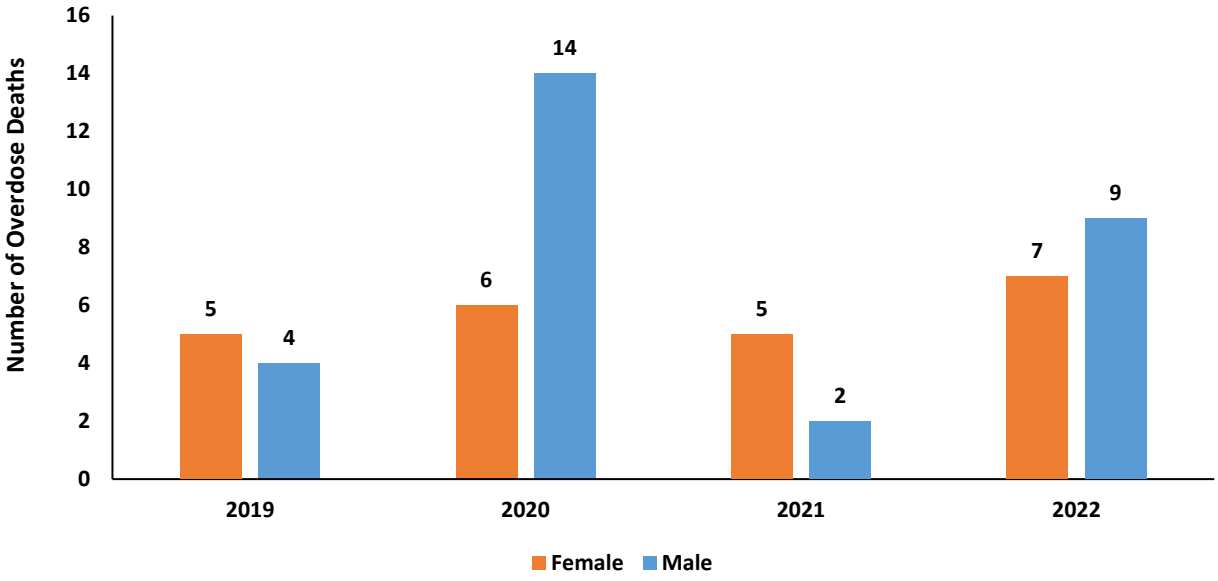
Figure 49. Circumstances Preceding Unintentional/Undetermined Overdose Deaths, Southern Region Residents, 2019-2022.



Source: SUDORS
Chart scaled to 25.0% 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 targeted by opioids such as heroin, fentanyl, or prescription painkillers, thereby reversing life-threatening symptoms such as slowed or halted breathing. Narcan can be administered via injection or nasal spray, and it is commonly used by first responders, health care professionals, and even bystanders during emergencies. By counteracting the dangerous respiratory depression caused by opioids, Narcan can help save lives. Males were slightly more likely have naloxone administered at the scene before dying from an unintentional/undetermined overdose compared to females in the Southern Region from 2019-2022 (n=29 and n=23).

Figure 50. Naloxone Administered at the Scene Among Unintentional/Undetermined Overdoses Deaths by Sex, Southern Region Residents, 2019-2022.



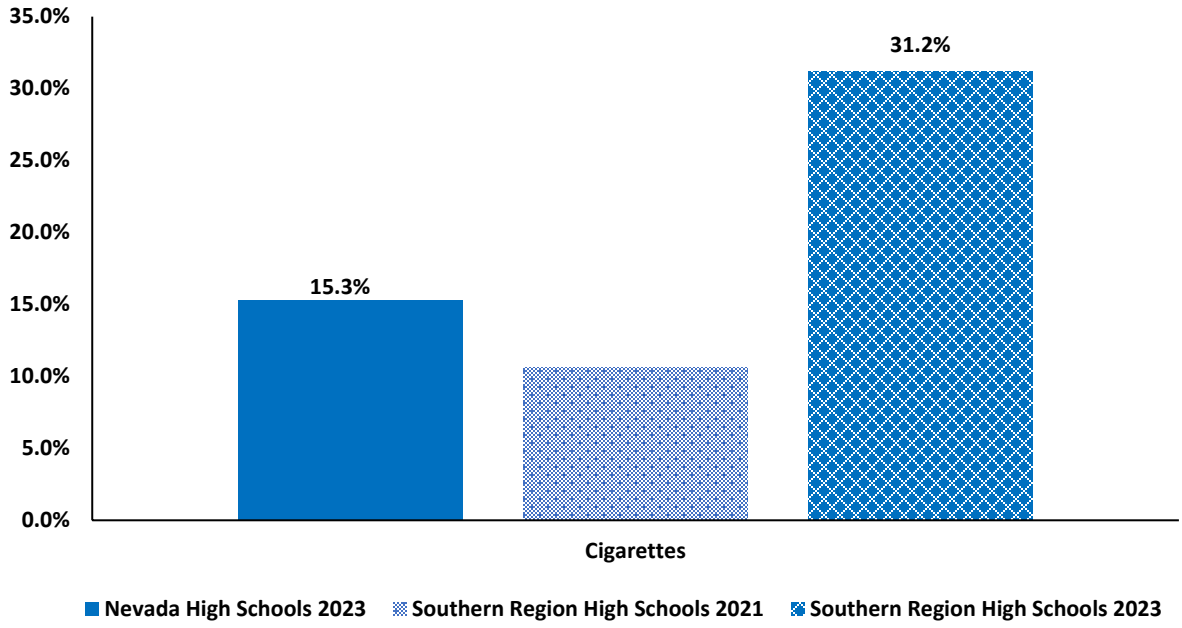
Source: SUDORS

Youth Risky Behaviors: Alcohol, Smoking, Drugs

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, 379 high school students and 387 middle school students participated in the YRBS in the Southern 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, visit UNR YRBS.

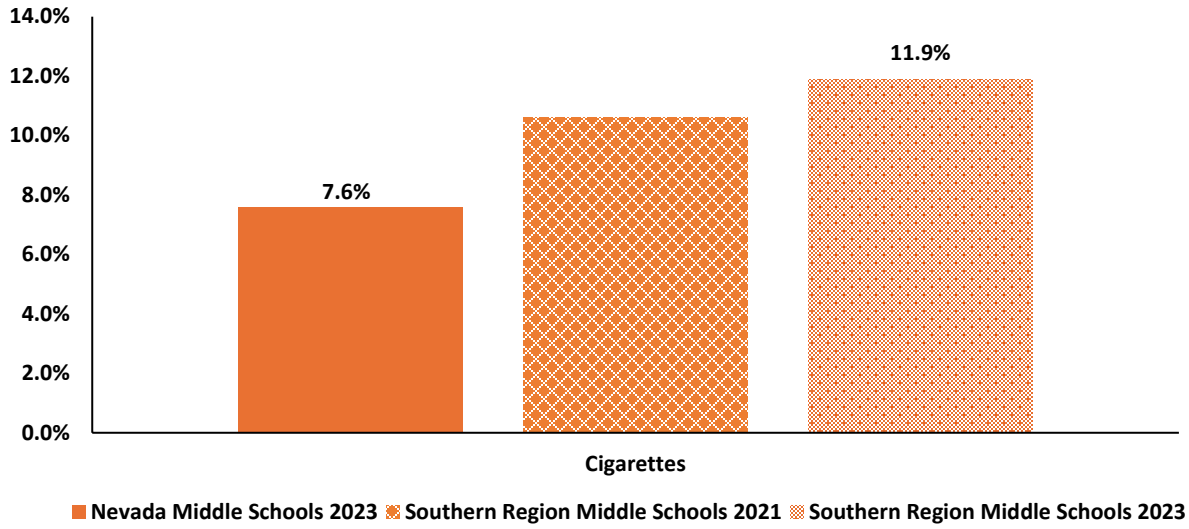
Southern Region high school students in 2023 had a significantly higher percent for ever having ever tried cigarettes compared to Nevada at 31.2% and 15.3%, respectively. The middle school students in the Southern Region also had a higher percent for ever trying cigarettes at 11.9% compared to Nevada at 7.6%. Additionally, there is a significant increase in reported cigarette smoking for Southern Region high school students between 2021 and 2023 (from 10.6% to 31.2%).

Figure 51a. Percent of Respondents Who Have Ever Tried Cigarette Smoking*, Southern Region High School Students, 2019, 2021, 2023 and Nevada High School Students, 2023.



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

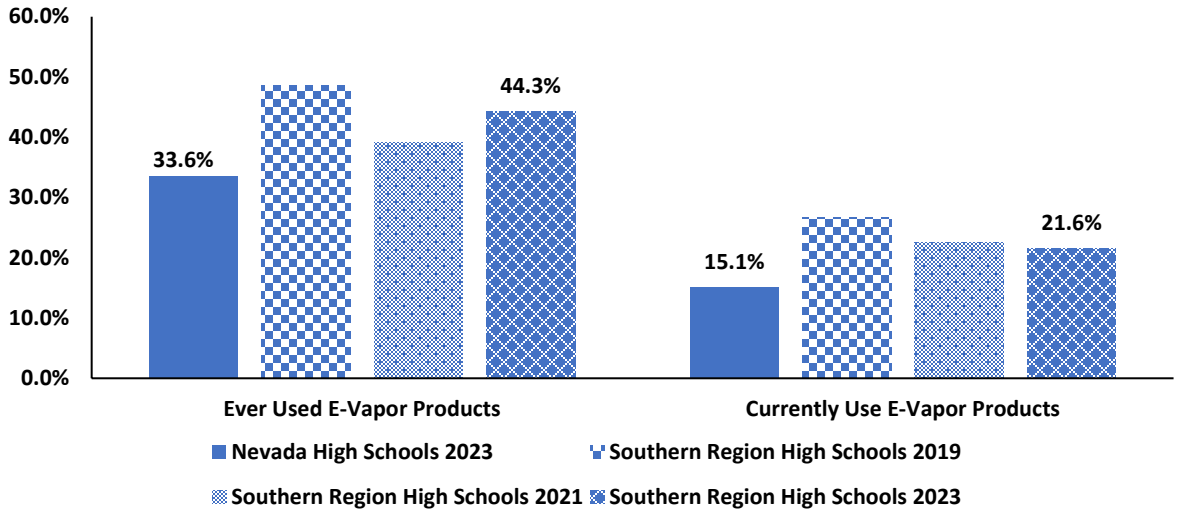
Figure 51b. Percent of Respondents Who Have Ever Tried Cigarette Smoking*, Southern Region Middle School Students, 2019, 2021, 2023 and Nevada Middle School Students, 2023.



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

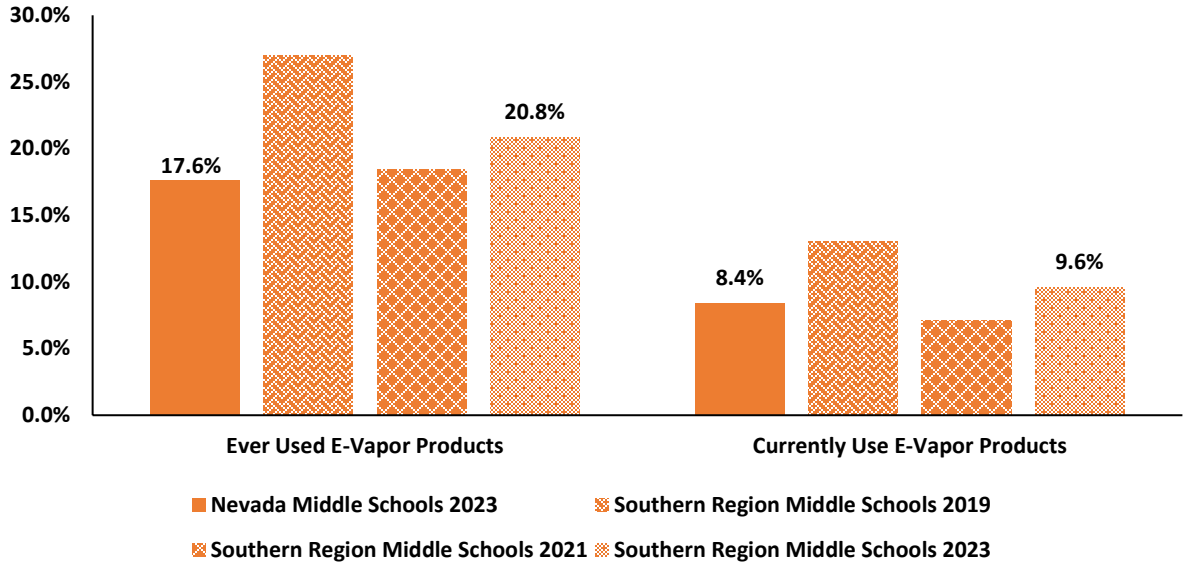
Southern Region high school students have a notably higher percent for ever using an e-vapor product than Nevada in 2023 (44.3% and 33.6%, respectively) and currently using electronic vapor (e-vapor) products than Nevada in 2023 (21.6% and 15.1%, respectively). Southern Region middle school students also have a higher percent for ever using an e-vapor product than Nevada in 2023 (20.8% and 17.6%, respectively) and a higher percent of students who currently use e-vapor products (9.6% and 8.4%, respectively).

Figure 52a. Electronic Vapor Product* Use, Southern Region High School Students, 2019, 2021, 2023 and Nevada High School Students, 2023.



Source: Nevada Youth Risk Behavior Survey
Chart scaled to 60.0% 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'.*

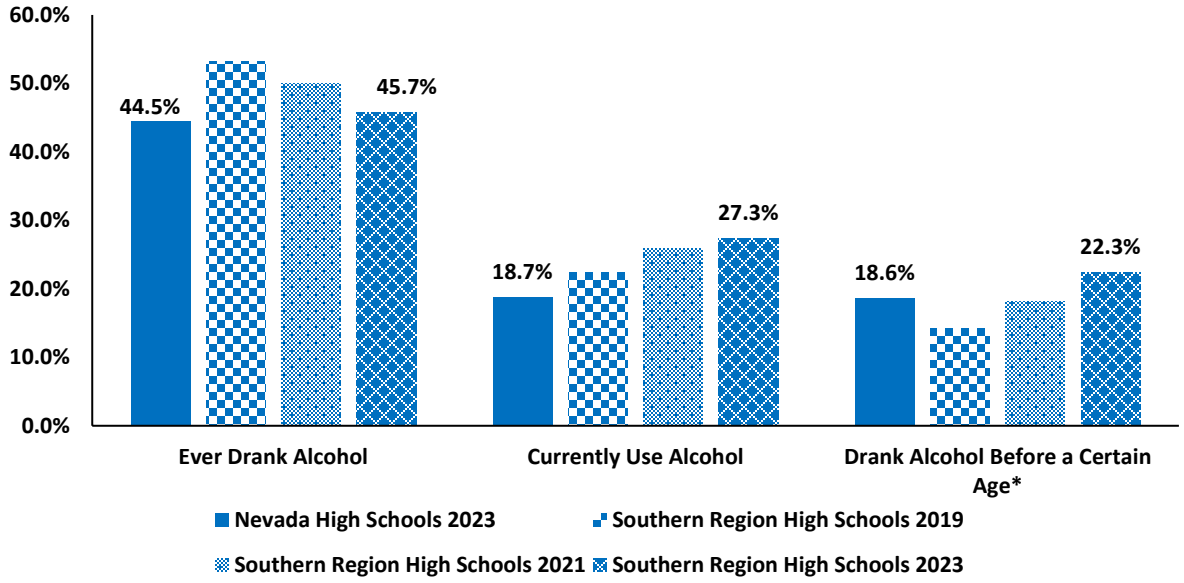
Figure 52b. Electronic Vapor Product* Use, Southern Region Middle School Students, 2019, 2021, 2023 and Nevada Middle School Students, 2023.



Source: Nevada Youth Risk Behavior Survey
Chart scaled to 30.0% 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 Southern Region high school students who reported ever drank alcohol, currently use alcohol, and drank alcohol before a certain age are all higher than Nevada high school student percents.

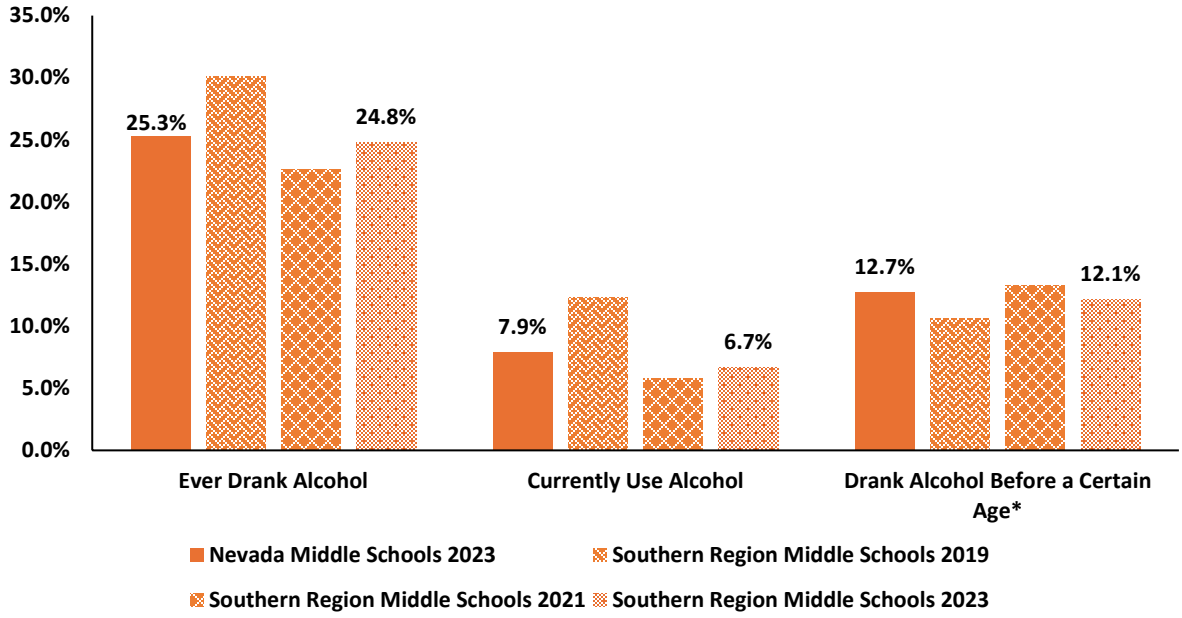
Figure 53a. Alcohol Use, Southern Region High School Students, 2019, 2021, 2023 and Nevada High School Students, 2023.



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

The percent of ever drank alcohol and currently use alcohol among Southern Region middle school students decreased from 2019 to 2021 before increasing in 2023. Southern Region middle school student percents for ever drinking alcohol, currently drink alcohol, and drank before a certain age are within 1.2% of Nevada middle school students.

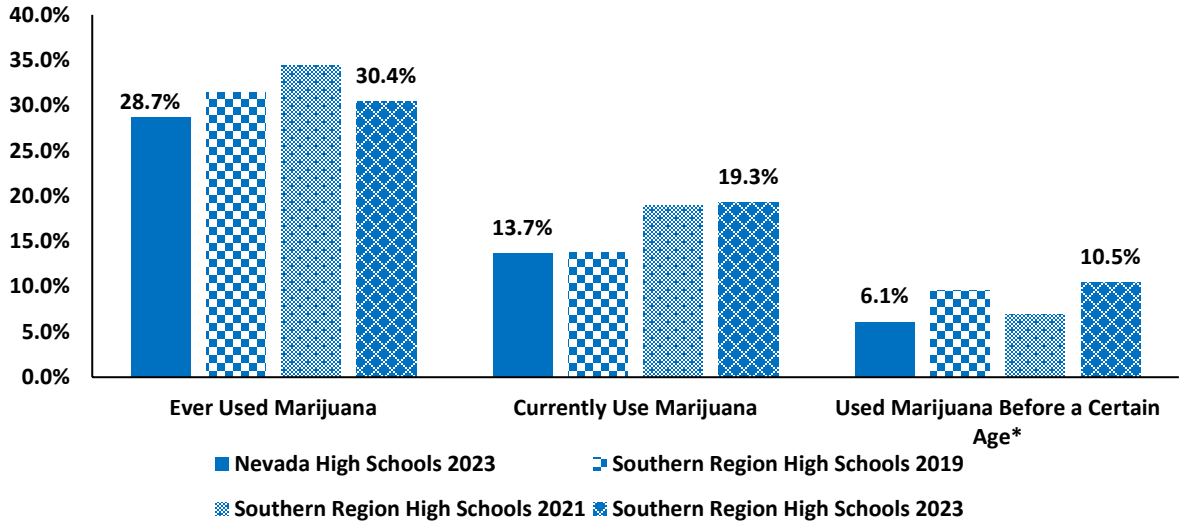
Figure 53b. Alcohol Use, Southern Region Middle School Students, 2019, 2021, 2023 and Nevada Middle School Students, 2023.



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

The percents of Southern 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 for Nevada high school students.

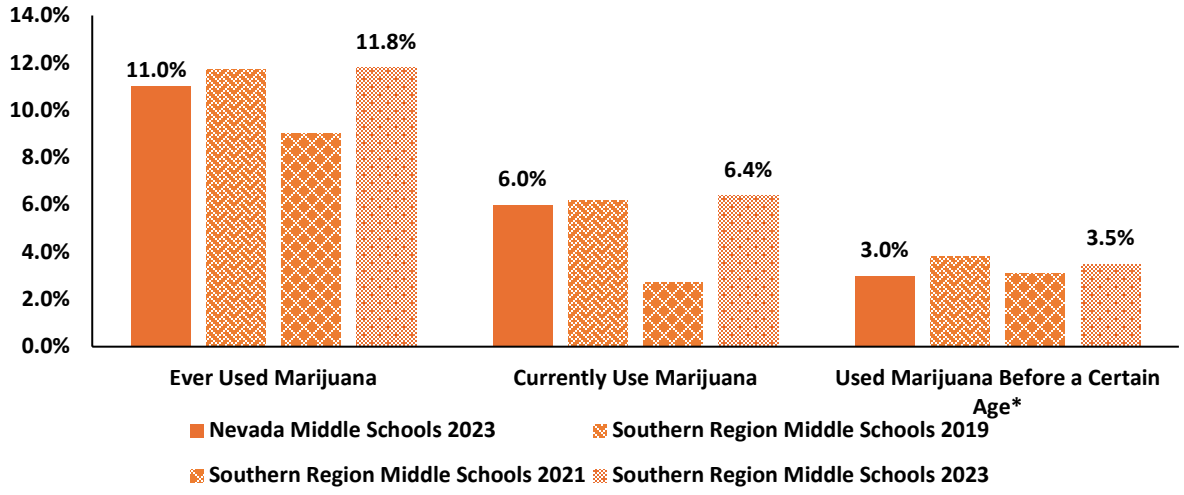
Figure 54a. Marijuana Use, Southern Region High School Students, 2019, 2021, 2023 and Nevada High School Students, 2023.



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 percents of Southern Region middle school students who have reported to have ever used marijuana, currently use marijuana, or used marijuana before a certain age were highest in 2019 before decreasing in 2021, then increasing in 2023. The percent reported for all categories was higher than that of Nevada middle school students in total.

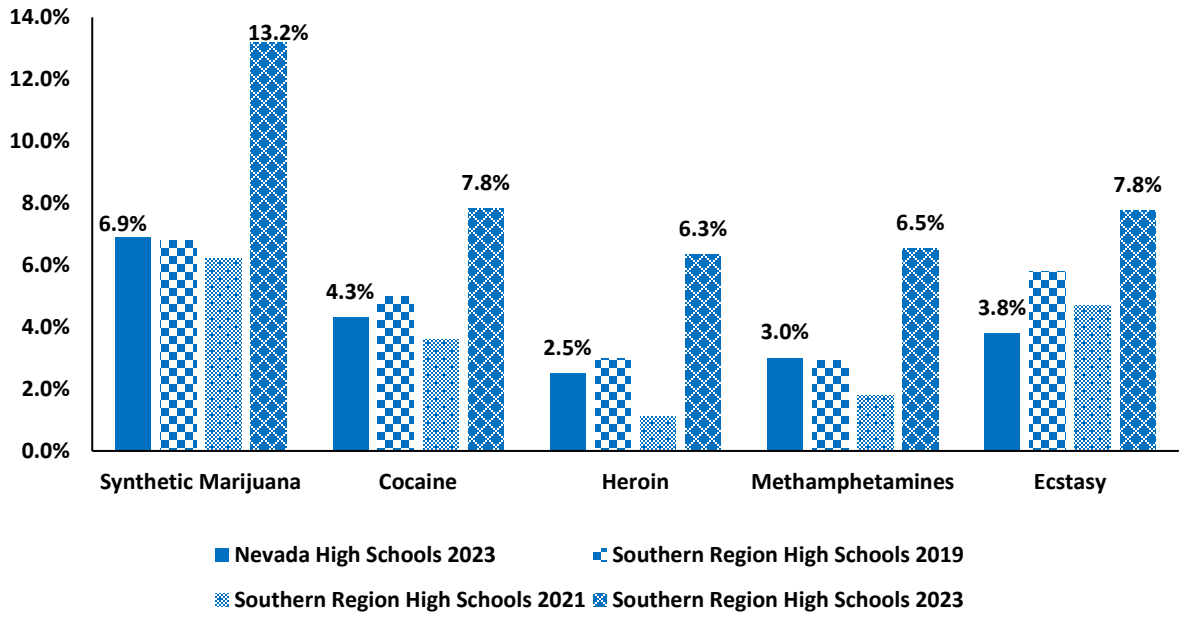
Figure 54b. Marijuana Use, Southern Region Middle School Students, 2019, 2021, 2023 and Nevada Middle School Students, 2023.



Source: Nevada Youth Risk Behavior Survey
Chart scaled to 14.0% to display differences among groups.
**Among middle school students, if they ever used marijuana before age 11.*

Of the illicit drugs listed in Figure 55a below, lifetime drug use among Southern Region high school students was highest with synthetic marijuana use (13.2%), which is significantly higher than the Nevada high school student percent (6.9%). Lifetime percent use of cocaine, heroin, methamphetamines, and ecstasy among Southern Region high school students are all significantly higher than Nevada high school students in 2023.

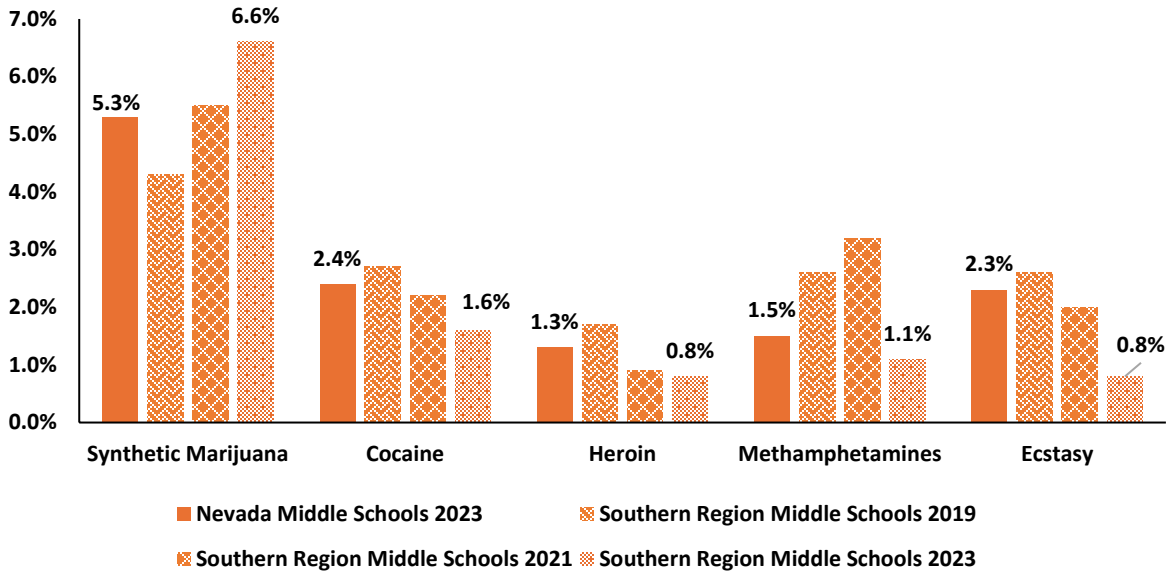
Figure 55a. Lifetime Drug Use, Southern Region High School Students, 2019, 2021, 2023 and Nevada High School Students, 2023.



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

Lifetime percent drug use among Southern Region middle school students was highest in 2023 for synthetic marijuana (6.6%). Southern Region middle school student percent of lifetime use for all illicit drugs listed for 2023 were lower than Nevada middle school student percents except for synthetic marijuana, which was higher than Nevada middle school percents (6.6% and 5.3%, respectively).

Figure 55b. Lifetime Drug Use, Southern Region Middle School Students, 2019, 2021, 2023 and Nevada Middle School Students, 2023.



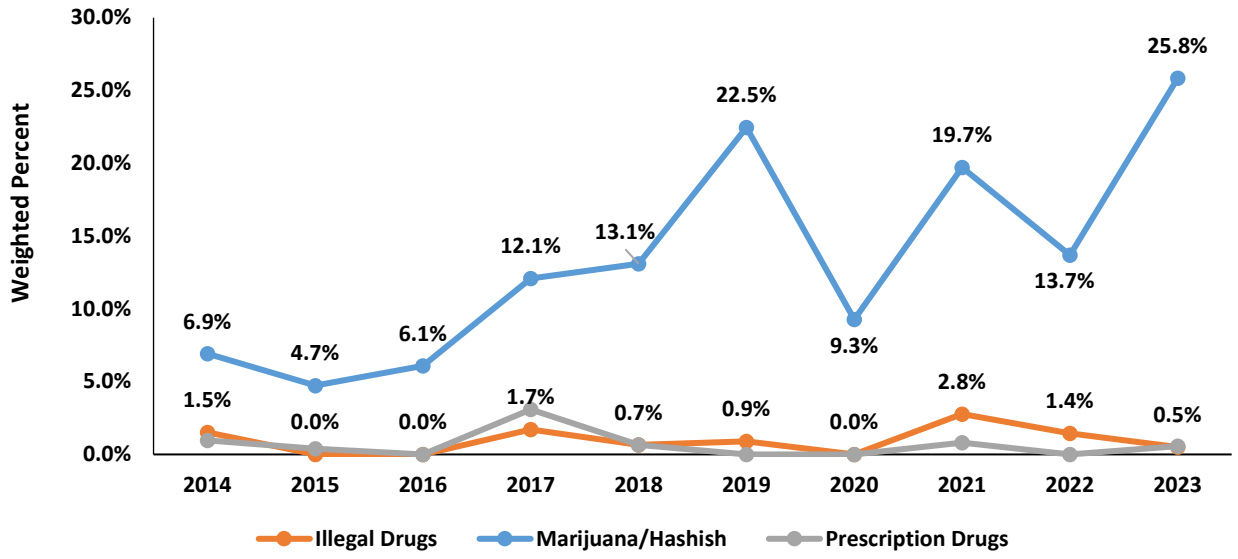
Source: Nevada Youth Risk Behavior Survey
Chart scaled to 7.0% to display differences among groups.

Behavioral Risk Factor Surveillance System

The Behavioral Risk Factor Surveillance System (BRFSS) collects information on adult self-reported health-related risk behaviors. According to the CDC, the BRFSS is a powerful tool for targeting and building health promotion activities. The survey has questions focusing on substance use including illegal drug use, e-cigarettes, and drunkenness.

Marijuana use has more than tripled since 2014. In 2023, 25.8% of respondents reported to have used marijuana in the past 30 days, up from 6.9% in 2014. Self-reported use of marijuana has increased, as expected, since recreational marijuana use was legalized in Nevada in 2017. Illegal drug use and prescription drug use are lower compared to statewide percentages.

Figure 56. Percent of Adult BRFSS Respondents Who Used Marijuana/Hashish, Illegal Substances, or Painkillers to Get High in the Last 30 Days, Southern Region Residents, 2014-2023.

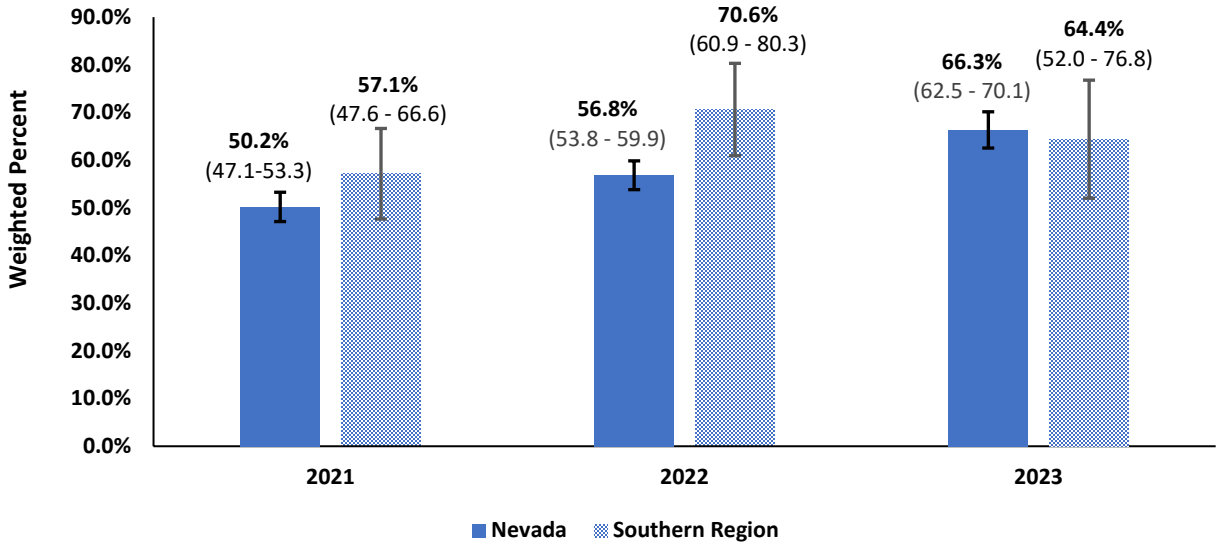


Source: Behavioral Risk Factor Surveillance System
Chart scaled to 30.0% to display differences among groups.
Specific question asked in survey: "During the past 30 days, on how many days did you use marijuana or hashish/any other illegal drug/ prescription drugs without a doctor's order, just to "feel good," or to "get high"?"

There has been an array of efforts in regard to tackling the opioid epidemic in Nevada with the help of the Division of Public and Behavioral Health State Opioid Response funding (DPBH SOR). Nevada has launched an educational initiative to address opioid overdoses and promote harm reduction, particularly at the University of Nevada, Reno, through CASAT and the Nevada Opioid Center of Excellence. 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 DPBH with partnerships from organizations such as the Nevada Board of Pharmacy and the School of Public Health at the University of Nevada, Reno.

In the Southern Region, reported narcan knowledge has increased by 7.3% since 2021 (the first year the question was added to BRFSS) and was higher than statewide values until 2023.

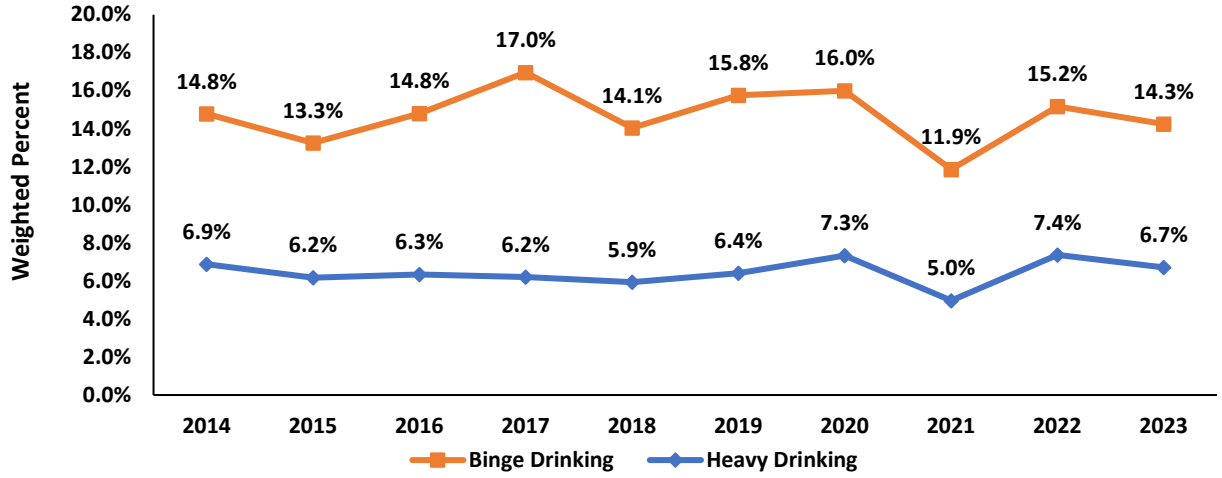
Figure 57. Percentage of BRFSS Respondents who Reported Knowing what Narcan is, Southern Region Residents, 2021-2023.



Source: Behavioral Risk Factor Surveillance System
Question added to BRFSS beginning in 2021.
Chart scaled to 90.0% to display differences among groups.

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

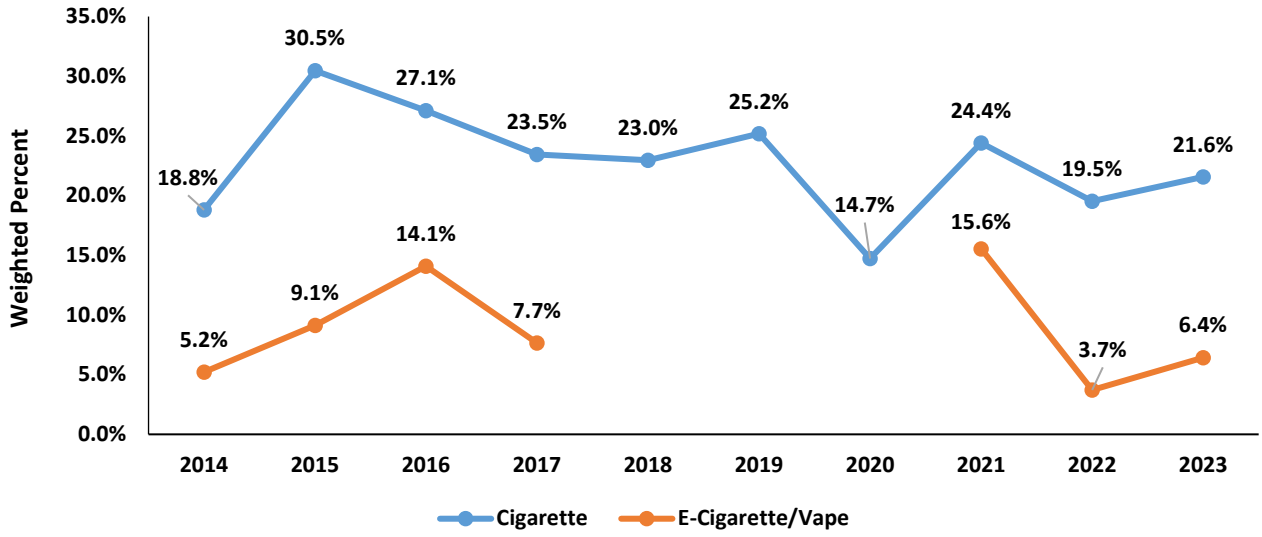
Figure 58. Percent of Adult BRFSS Respondents Who are Considered Binge Drinkers or Heavy Drinkers, Southern Region Residents, 2014-2023.



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

In 2023, 21.6% of adults were current cigarette smokers, which is a decrease from the reporting period high of 30.5% in 2015. In 2018 through 2020, the e-cigarette use question was asked differently compared to years prior, thus had to be excluded from the graph.

Figure 59. Percent of Adult BRFSS Respondents Who are Current Cigarette or E-Cigarette Smokers, Southern 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

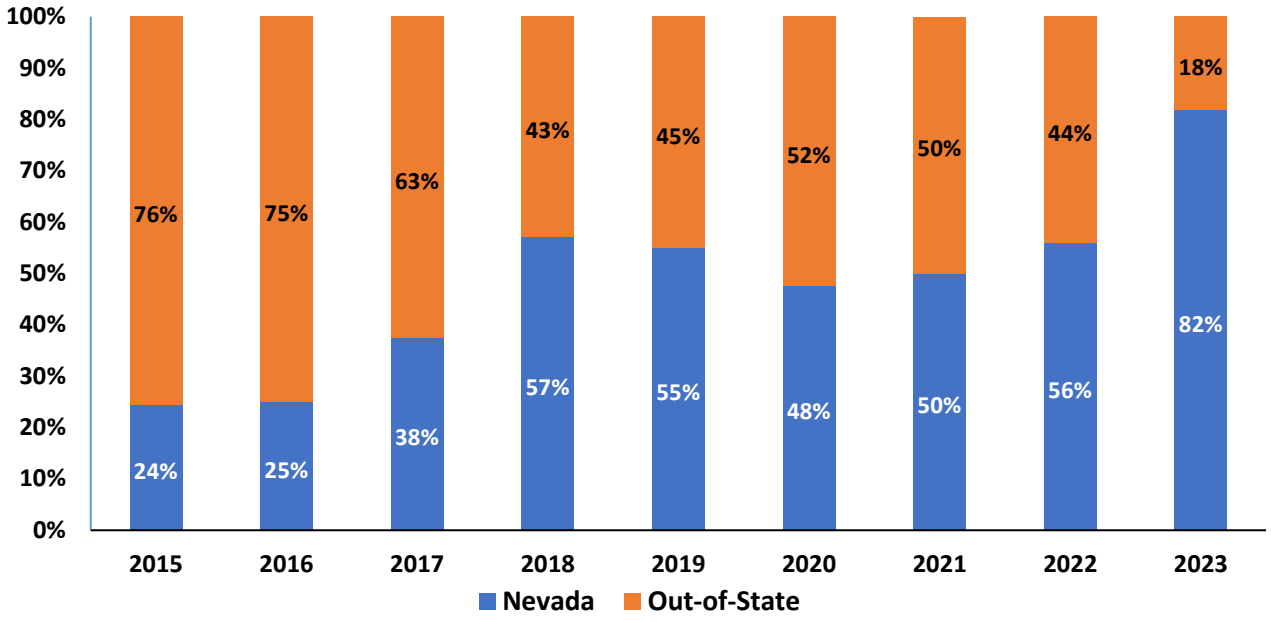
This section focuses on other factors that affect youth not directly related to substance use or mental health.

Residential Treatment Centers and Medicaid

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 Southern Region children admitted to facilities in the state of Nevada (rather than out-of-state facilities) has increased by nearly 60%. This reflects statewide efforts to keep the treatment of Nevada youth in state.

Figure 60. Medicaid-Funded Residential Treatment Center Placement for Southern 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 Southern Region Children, 2015-2023.

Year	Provider State			
	Nevada	Out of State	Nevada %	Out of State %
2015	10	31	24.4%	75.6%
2016	9	27	25.0%	75.0%
2017	12	20	37.5%	62.5%
2018	16	12	57.1%	42.9%
2019	11	9	55.0%	45.0%
2020	10	11	47.6%	52.4%
2021	10	31	50.0%	50.0%
2022	9	27	56.0%	44.0%
2023	12	20	81.8%	18.2%

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

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

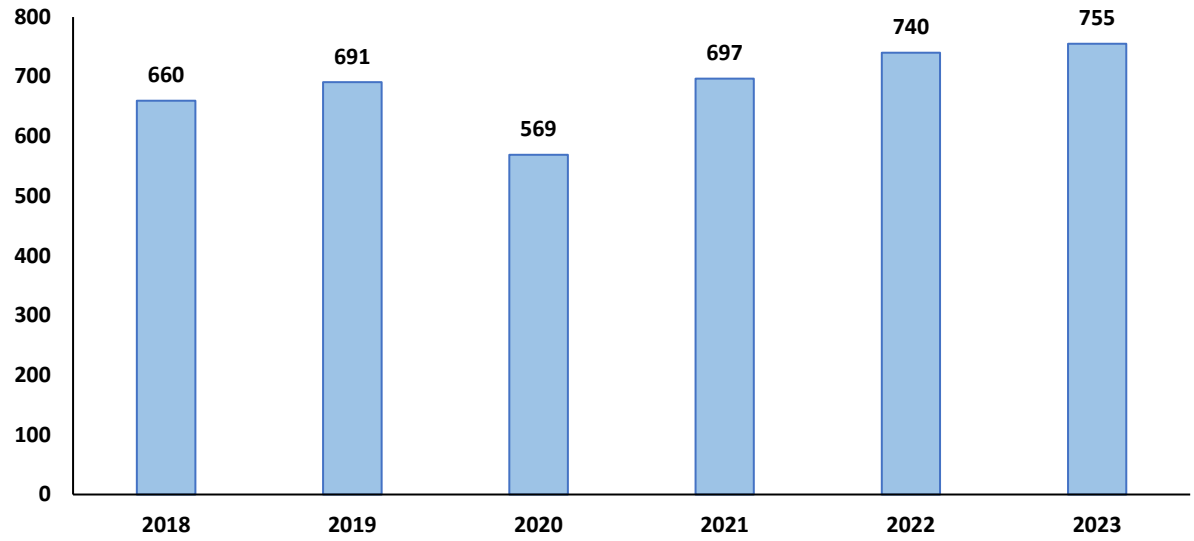
Child Protective Services

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 18.[5]

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 Southern Region considered 4,112 reports. Aside from a notable decrease in 2020 due to the COVID pandemic, the prevalence of reported cases is relatively consistent year over year.

Figure 61. Child Protective Services Reports, Southern Region, 2018-2023.



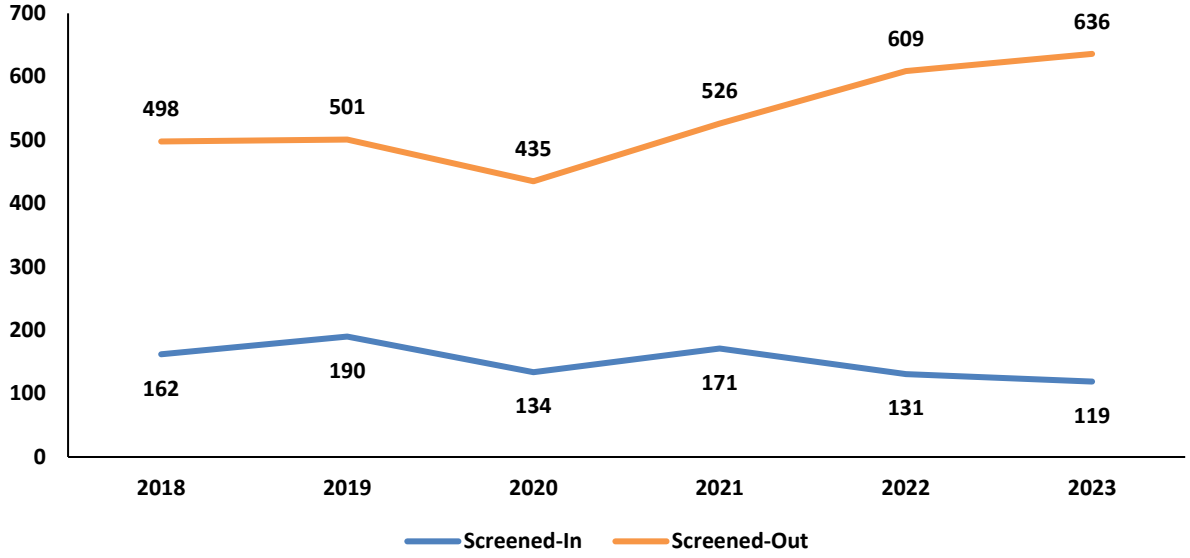
Source: UNITY Database

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 4,112 reports made between 2018 and 2023, roughly 22% (n=907) were screened-in resulting in agency response. This percent of screened-in reports decreased slightly over the reporting period.

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

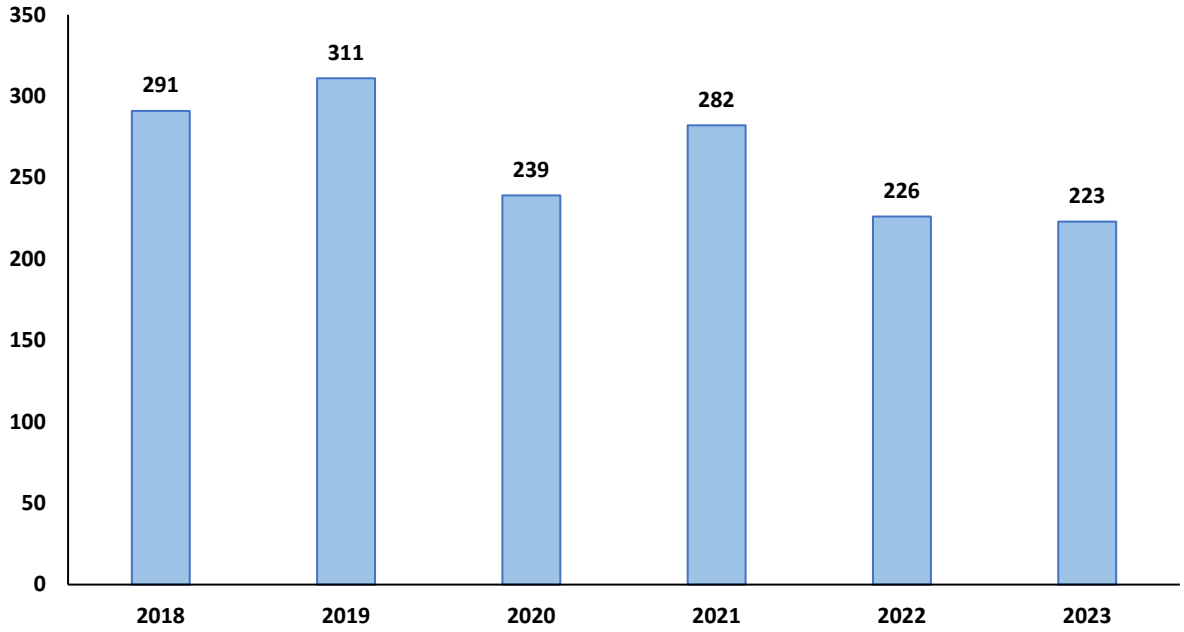
Figure 62. Child Protective Services Reports Screened-In and Screened-Out, Southern Region, 2018-2023.



Source: UNITY Database

During the reporting period, the 907 screened-in reports involved 1,572 Nevada youth. The following counts are not distinct; some youth may be counted more than once if they were involved in multiple investigations.

Figure 63. Unique Southern Region Youth Screened-In, 2018-2023.



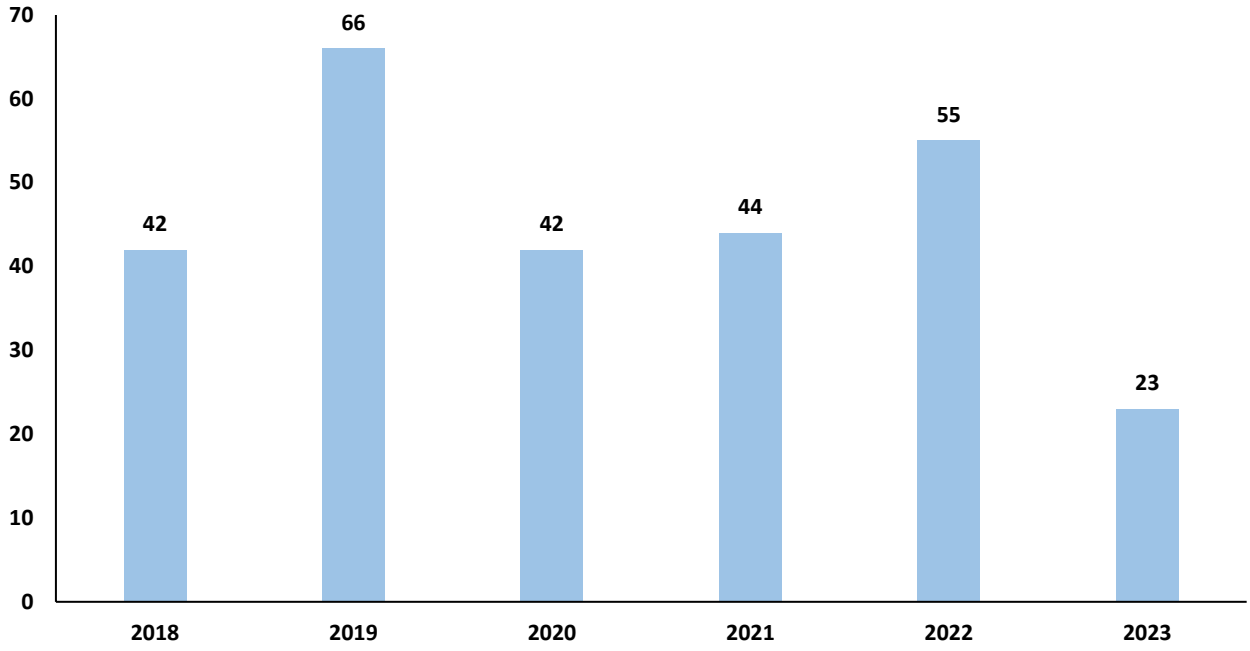
Source: UNITY Database

Foster Care

Some investigations reveal that a child cannot safely remain in the home and must be removed and placed in 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 271 unique youth were served in the foster care system, accounting for 272 entries. Some youth entered, exited, and later re-entered the foster care system, with each entry counted separately.

Figure 64. Foster Care Entries, Southern Region, 2018-2023.



Source: UNITY Database

Parental substance abuse is the primary driver of Southern Region youth being placed into foster care.

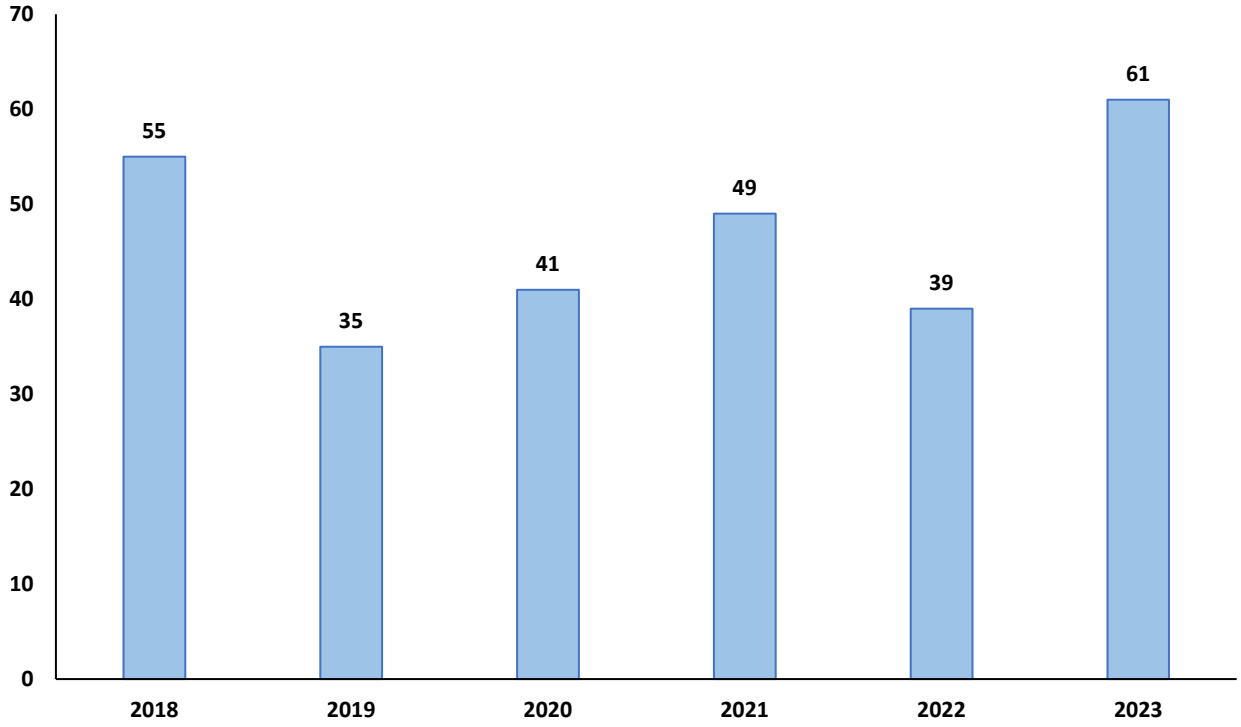
Table 4. Top Reason for Foster Care Entries, Southern Region, 2018-2023.

Entry Reason	2018	2019	2020	2021	2022	2023
Parental substance abuse	24	60	52	42	88	40
Neglect	26	82	34	40	36	28
Incarceration of parent(s)	40	24	20	16	20	8
Inadequate housing / homelessness	18	6	20	28	26	8
Domestic violence	4	34	14	6	14	2
Abuse	12	22	20	12	4	0
All other	12	24	32	32	36	32

Source: UNITY Database

In each year of the reporting period, there were more exits from the foster care system than entries.

Figure 65. Foster Care Exits, Southern Region, 2018-2023.



Source: UNITY Database

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

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

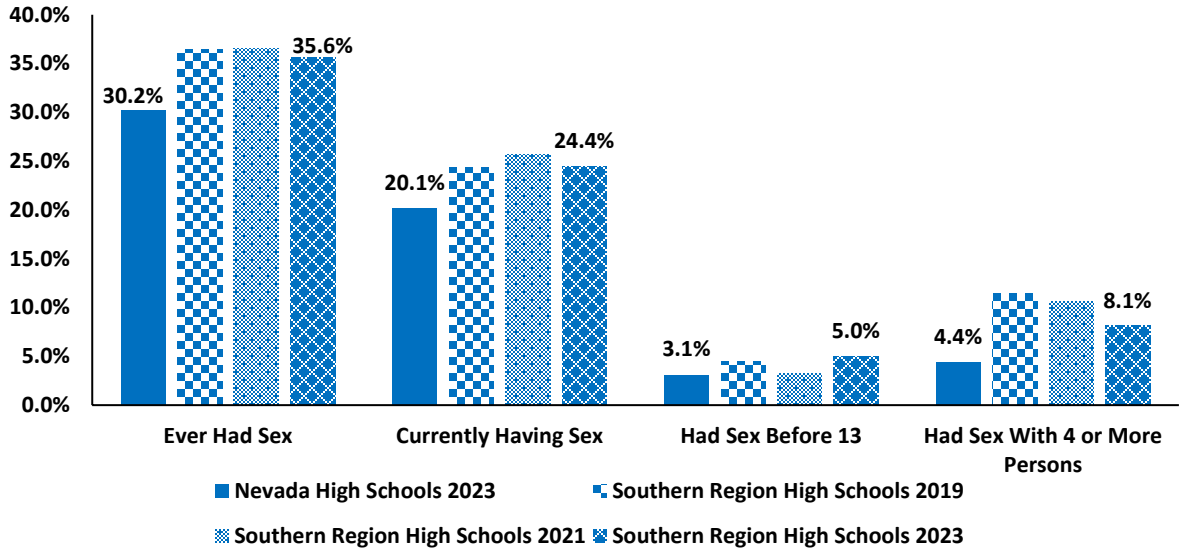
Exit Reason	2018	2019	2020	2021	2022	2023
Reunification	38	24	22	32	20	32
Adoption	8	5	7	11	4	15
Guardianship	0	2	7	1	11	10
Aged out	8	3	5	5	2	4
Transfer to another agency	0	0	0	0	2	0
Other	1	1	0	0	0	0
Total	55	35	41	49	39	61

Source: UNITY Database

Youth Sexual Activity and Violence

From 2021 to 2023 there was a decrease in the percent of Southern Region high school students who ever-had sex, are currently having sex, and had sex with four or more persons. The percents of all reported sexual behaviors are higher in Southern Region high school students compared to Nevada high school students for 2023.

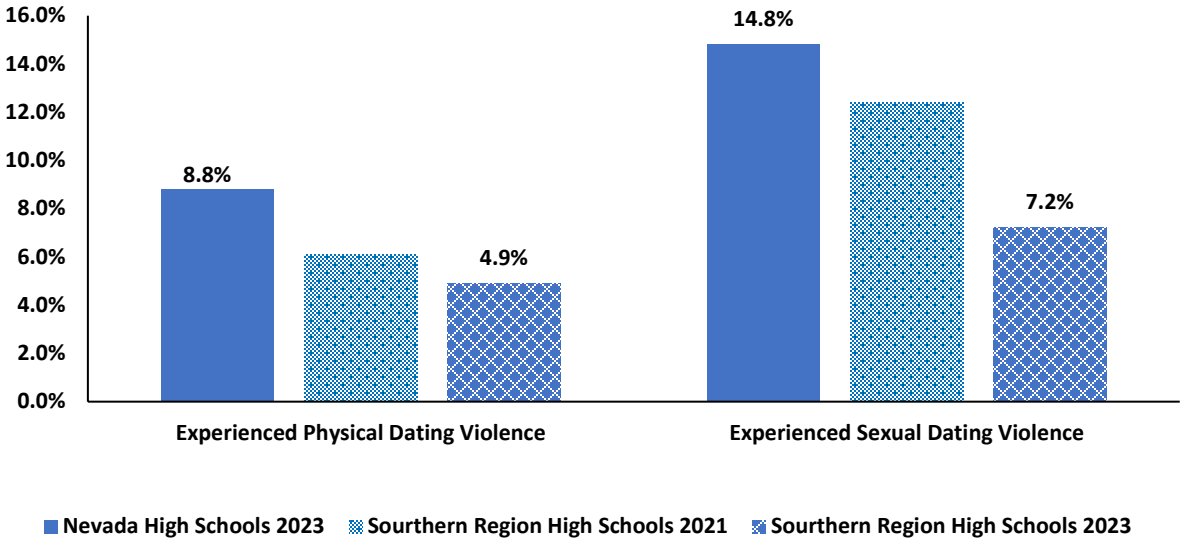
Figure 66. Sexual Behaviors Among Southern Region High School Students, 2019, 2021, 2023 and Nevada High School Students, 2023.



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

The percent of Southern Region high school students who reported physical dating violence or sexual dating violence decreased from 2021 to 2023 and are lower than the percents among Nevada high school students.

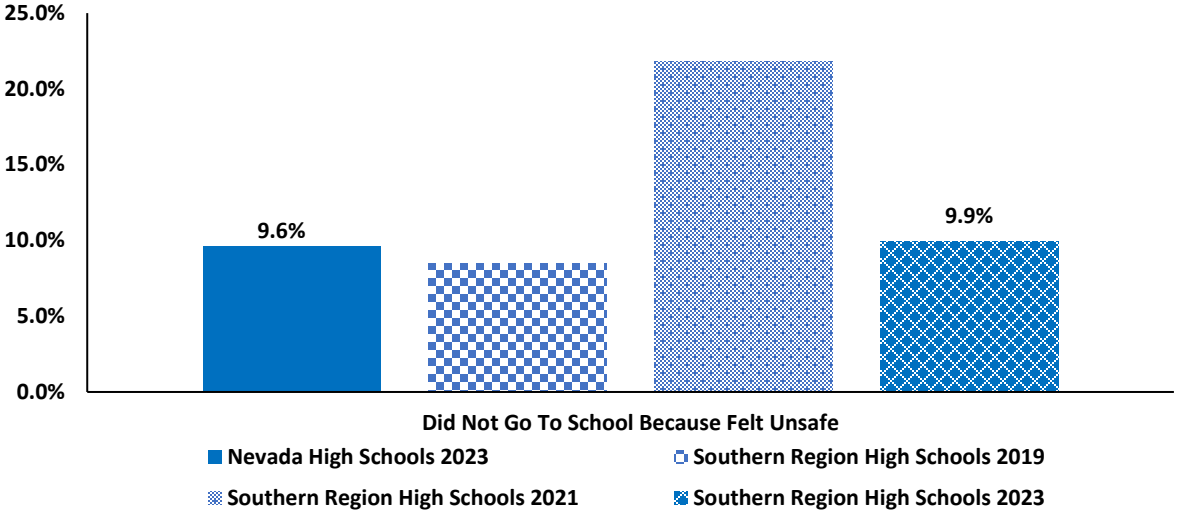
Figure 67. Sexual Violence Among Southern Region High School Students 2021, 2023 and Nevada High School Students, 2023.



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

The percent of Southern High School students who reported not going to school because they felt unsafe increased significantly from 2019 to 2021, then it decreased significantly in 2023 to 9.9%, which is similar to the Nevada High School reported percent (9.6%).

Figure 68. Violence Among Southern Region High School Students, 2019, 2021, 2023 and Nevada High School Students, 2023.



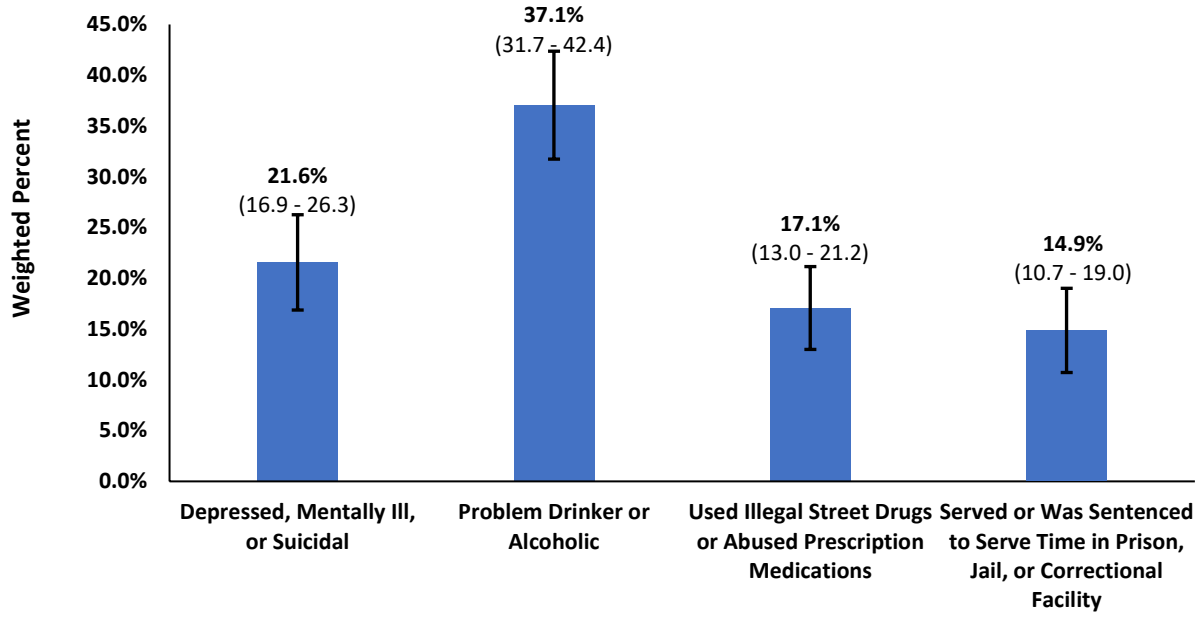
Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 25.0% to display differences among groups.

Adverse Childhood Experiences

The following charts are from state-added Behavioral Risk Factor Surveillance System (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.[6] Prevention of ACEs is vital to preventing worse health outcomes in the community.

Between 2019-2023, 37.1% of adults, before the age of 18, lived with someone who was a problem drinker or alcoholic, 7.8% higher than what is seen statewide (29.3%). These early exposures (ACEs) may be associated with increased adverse health outcomes later in life.

Figure 69. Adult BRFSS Respondents Who, During Childhood, Lived with Others Who Had Certain Conditions, Southern Region Residents, 2019-2023.

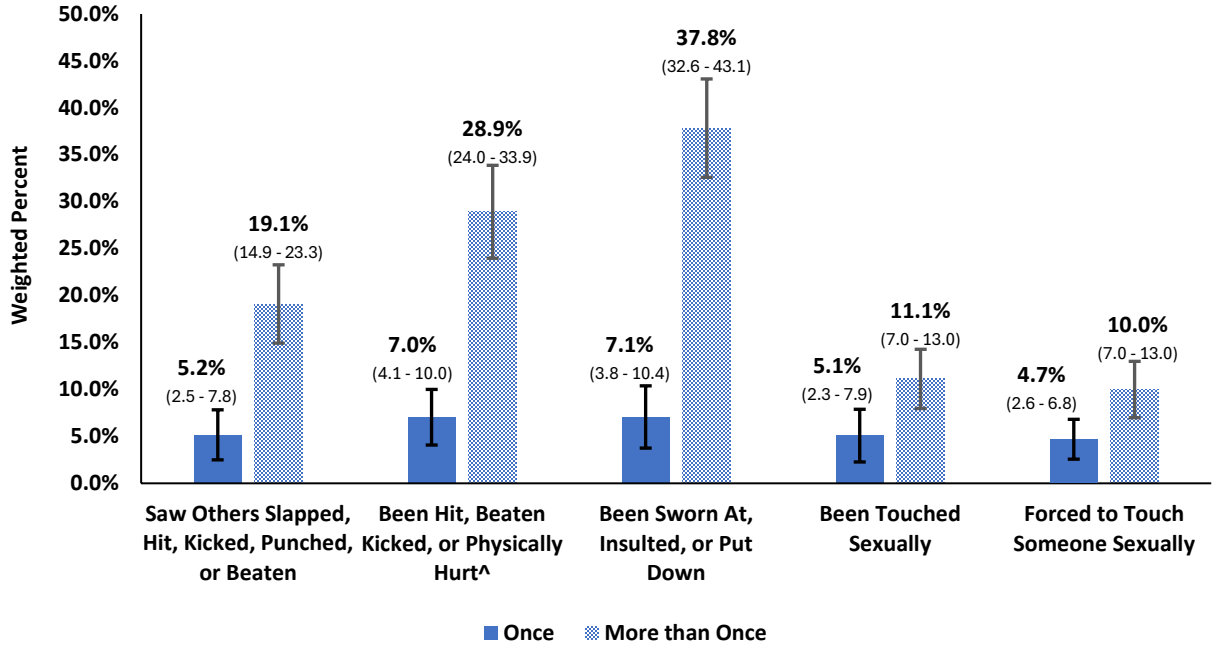


Source: Behavioral Risk Factor Surveillance System
Chart scaled to 45.0% to display differences among groups.
Childhood refers to before the age of 18.
Questions: "Did you live with anyone who was depressed, mentally ill, or suicidal?"
"Did you live with anyone who was a problem drinker or alcoholic?"
"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.

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

Using combined data from 2019-2023, 44.9% of Southern Region adults reported that, before the age of 18, they had been sworn at, insulted, or put down at least once; 36.0% were "hit, beaten, kicked, or physically hurt" (not including spanking) at least once; and 16.2% of adults had been touched sexually at least once.

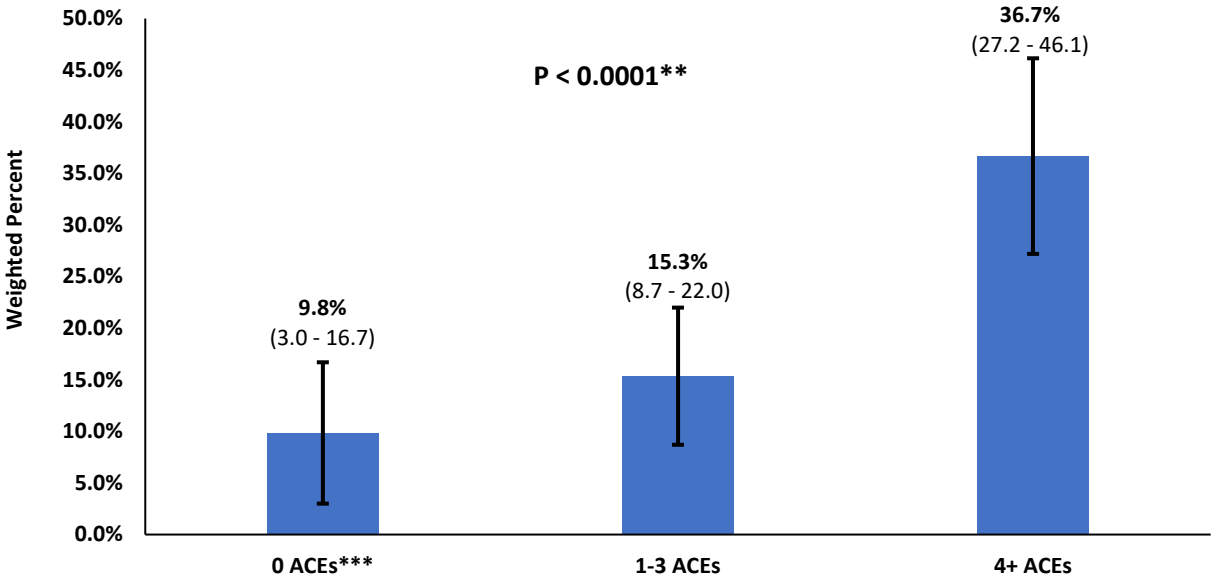
Figure 70. Adult BRFSS Respondents with Adverse Childhood Experiences, Southern Region Residents, 2019-2023.



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: "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 small sample size.*

Higher exposure to ACEs is significantly associated with a greater prevalence of depression among adults. Among adults who reported experiencing at least four ACEs, 36.7% also reported having depression, compared to just 9.8% of those reporting depression who experienced no ACEs.

Figure 71. Percentage of BRFSS Respondents Who Reported Having Depression, by Number of Adverse Childhood Events, Southern 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?"

**Someone at least 5 years older than you or an adult.*
0.05 test of significance.
***Significant P-value.*
**** Interpret point estimate and generalizability with caution due to small sample size (RSE > 30).*

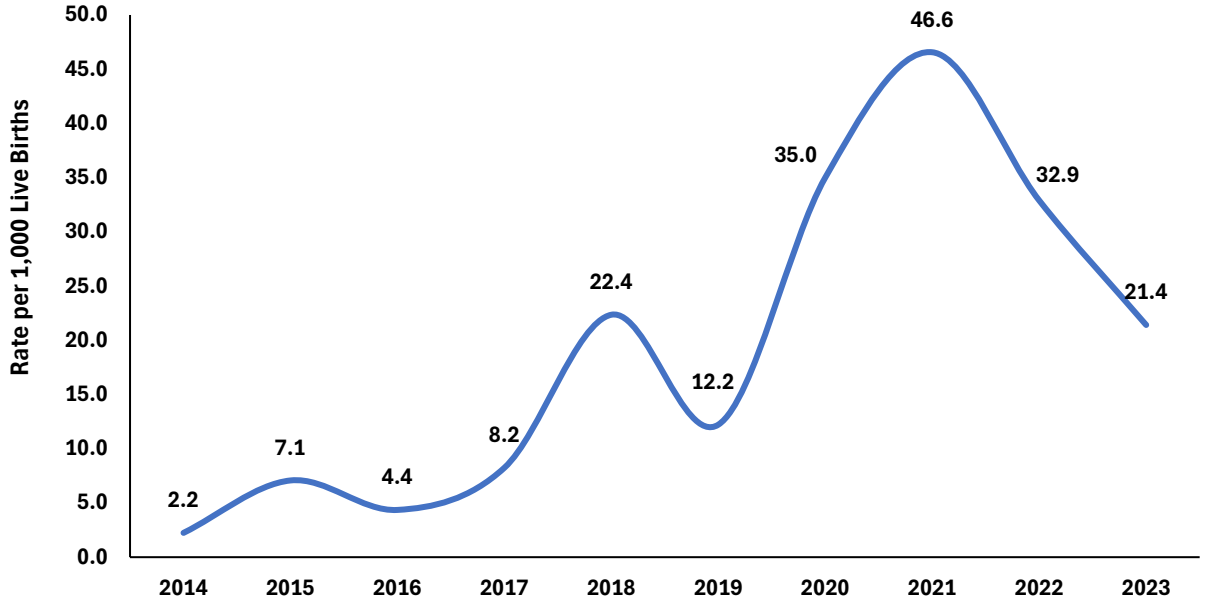
Maternal and Child Health

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 463 live births per year to Southern Region residents between 2014 and 2023. In 2023, 10 birth certificates indicated marijuana use, six indicated meth/amphetamine use, and six indicated polysubstance (more than one substance) use.

Of the self-reported substance use during pregnancy among Nevadans who gave birth between 2014 and 2023, the highest rate was with marijuana use in 2021, at 46.6 per 1,000 live births, up from 2.2 in 2014.

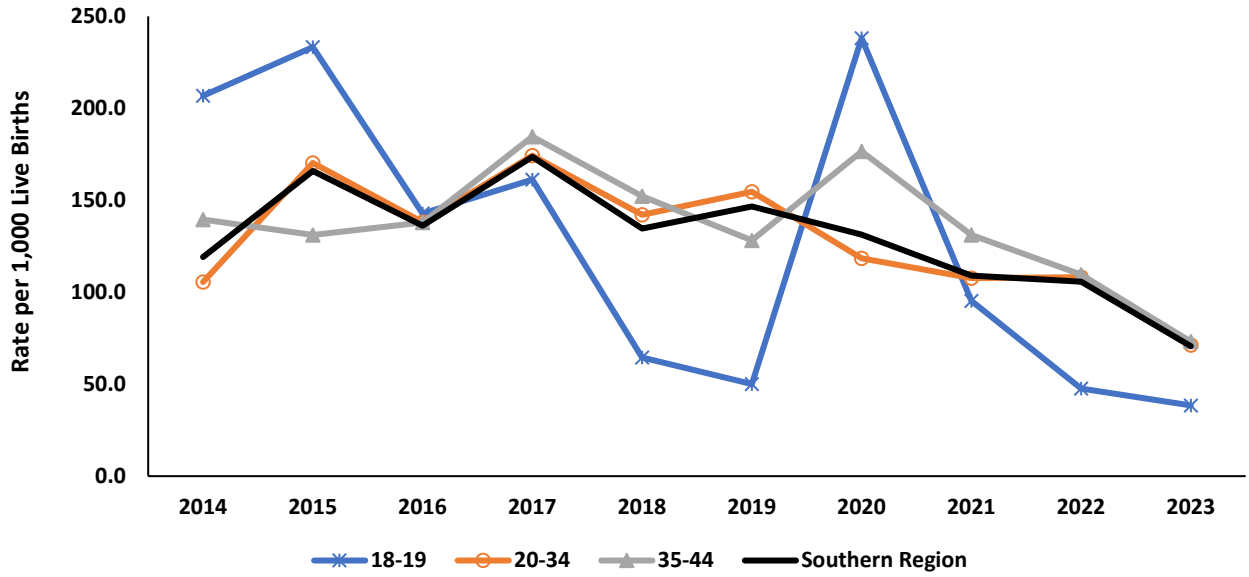
Figure 72. Self-Reported Prenatal Marijuana Use Birth Rates, Southern Region Residents, 2014-2023.



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. However, the Southern Region average rate from 2014-2023 is nearly three times higher than the average rate in Nevada. The rates among the 18-19 age group fluctuate greatly due to small populations and are not statistically significant.

Figure 73. Self-Reported Prenatal Tobacco Use Birth Rates by Maternal Age, Southern Region Residents, 2014-2023.



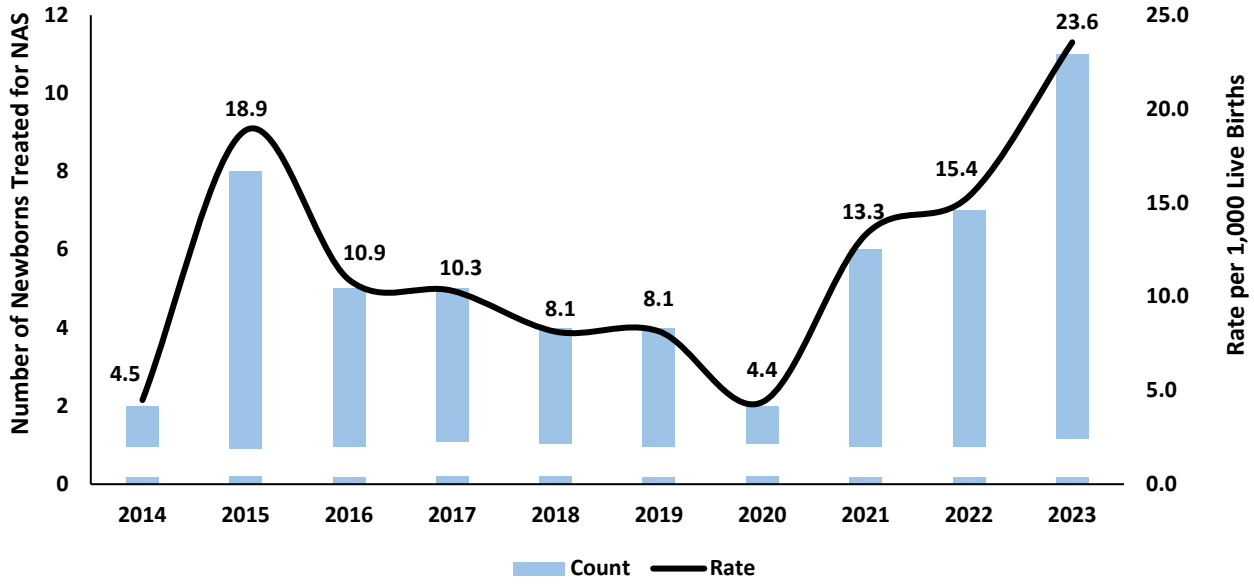
Source: Nevada Electronic Birth Registry System

Neonatal Abstinence Syndrome

Neonatal abstinence syndrome (NAS) is a group of issues that occur in a newborn who was exposed to addictive, illegal, or prescription drugs while in the mother's womb. Withdrawal or abstinence symptoms develop shortly after birth.

Inpatient admissions for NAS have fluctuated from 2014 to 2023, peaking in 2023 with 11 admissions and a rate of 23.6 per 1,000 live births.

Figure 74. Neonatal Abstinence Syndrome, Southern Region Residents, 2014-2023.



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

Due to small counts, NAS rates by race/ethnicity have been omitted from this report.

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 seven-digit code, versus mortality where the ICD codes are four digits. 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 consist 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 diagnoses:

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 diagnoses:

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