Behavioral Health Wellness and Prevention 2024 Epidemiologic Profile: Washoe County Nevada

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Executive Summary

Purpose

This report is intended to provide an overview of behavioral health in Washoe County 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 (39.8%) and depression (22.9%) are the leading diagnoses for mental health-related emergency department encounters for 2023. These diagnoses have increased in Washoe County since 2022, in contrast to the decline observed statewide in Nevada. (Mental Health - ER).
- Anxiety (32.0%) and depression (30.0%) are the leading diagnoses for mental health-related inpatient encounters for 2023. Washoe County, in contrast with statewide data for Nevada, has consistently had more cases for depression than anxiety with an upward trend in 2023 (Mental Health - IP).
- In 2023, American Indian/Alaska Native non-Hispanics had the highest age-adjusted rate of state mental health service utilization compared to White non-Hispanics (40.5 and 29.5 per 100,000 population, respectively) (Avatar - State-Funded Mental Health Services).
- Adults reporting poor mental health for 14 or more days in the past 30 days has increased from 11.4% in 2014 to 18.5% in 2023 (Mental Health - BRFSS).
- 9.0% of Washoe County BRFSS respondents considered attempting suicide in 2022 compared to 6.4% statewide (Mental Health - BRFSS).

National Violent Death Reporting System (NVDRS)

- Firearms were used in 56.5% of suicides and 72.1% of homicides among Washoe County residents from 2018-2022 (Firearm Deaths - NVDRS).
- Males accounted for 76.0% of suicide cases and 77.5% of homicide cases from 2018-2022 (Deaths by Sex - NVDRS).

Substance Use

- Males are disproportionately affected by opioid emergency room overdose encounters (Opioid Overdose - ER), inpatient admissions (Opioid Overdose - IP) and deaths (Opioid Overdose - Deaths).
- The rates of stimulant-related overdose deaths have steadily increased since 2014 resulting in an 865% overall increase from 2014 to 2023 (Stimulant-Related Overdose Deaths).
- The rate of overdose deaths, when considering all substances including alcohol, has increased substantially since the start of the COVID-19 pandemic. There was a 76% increase in such deaths between 2019 and 2023 (Alcohol- and/or Drug-Related Overdose Deaths).

State Unintentional Drug Overdose Reporting System (SUDORS)

- Of the 223 unintentional/undetermined intent drug overdose deaths among Washoe County residents in 2022, 63.7% had non-specified opioids and 59.2% had methamphetamines listed in the cause of death (Toxicology - SUDORS).

Youth – Adverse Childhood Experiences

- Combined data from 2019-2023 shows that 15.4% of Washoe County BRFSS respondents have been touched sexually at least once during childhood (ACEs - BRFSS).
- Washoe County 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 Washoe County residents from 2014-2023 was highest in 2017 (7.9 per 1,000 live births) and had a rate of 7.5 per 1,000 live births in 2023 (Rate of NAS).

Lesbian, Gay, Bisexual, Transgender (LGBT)

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

Data Sources

Behavioral Risk Factor Surveillance System (BRFSS)

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) system 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 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 in 2015 may not be directly comparable to data thereafter. In addition, the data include 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 is for patients who spent at least 24 hours as an inpatient, but do not include patients who were discharged from the emergency room. The data includes demographics such as age, gender, race/ethnicity and uses International Classification of Diseases-9-Clinical Modification (ICD-9-CM) diagnoses codes and International Classification of Diseases-10-Clinical Modification (ICD-10-CM) diagnoses (up to 33 diagnoses respectively). ICD-10-CM diagnoses codes replaced ICD-9-CM diagnoses codes in the last quarter of 2015. Therefore, data prior to last quarter of 2015 may not be directly comparable to data thereafter. In addition, the data includes billed hospital charges, procedure codes, length of hospital stay, discharge status, and external cause of injury codes. The billing data information is for billed charges and not the actual payment received by the hospital. Due to lag in the reporting of billing information, numbers may differ from prior reporting.

Medicaid Data Warehouse

The Medicaid Data Warehouse is a database which stores medical and pharmacy claims data for the Medicaid Managed Care and Fee for Service populations, at a claim line level. The data includes provider information, member demographics such as age, gender, race/ethnicity, eligibility/enrollment information, and information of the diagnoses given to members and treatment received. It uses International Classification of Diseases-9-Clinical Modification (ICD-9-CM) diagnoses codes and International Classification of Diseases-10-Clinical Modification (ICD-10-CM) diagnoses, as well as standard billing and coding schemes such as CPT/HCPCS, NDC, etc.

National Violent Death Reporting System

Funded by the Centers for Disease Control and Prevention (CDC), the National Violent Death Reporting System (NVDRS) 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, Nevada: NV PMP. CDC: CDC PDMP

State-Funded Mental Health Services: Avatar

Avatar is a database containing demographic, treatment, billing, and financial information for Nevada mental health facilities throughout the state. These data are representative of clients served at Nevada state-operated mental health facilities and are not generalizable to the rest of the population.

Treatment Episode Data Sets

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

United States Census Bureau

The United States Census Bureau is responsible for the United States Census, the official decennial (10-year period) count of people living in the United States of America. Collected data are disseminated through web browser-based tools like the American Community Survey, which provides quick facts on frequently requested data collected from population estimates, census counts, and surveys of population and housing for the nation, states, counties, and large cities. The Bureau also offers the American Fact Finder, which profiles the American population and economy every five years. For more information: United States Census Bureau

UNITY

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

Web-Enabled Vital Records Registry Systems (WEVRRS)

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

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

For more information on CDC's Youth Risk Behavior Surveillance System (YRBSS), go to CDC YRBSS.

For more information on Nevada YRBS, go to 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. The terms “female” and “woman” do not include all birthing people but are used as descriptors presented from source data. Also, all sexual preferences and gender identities may not be present in the source data.

Demographic Snapshot

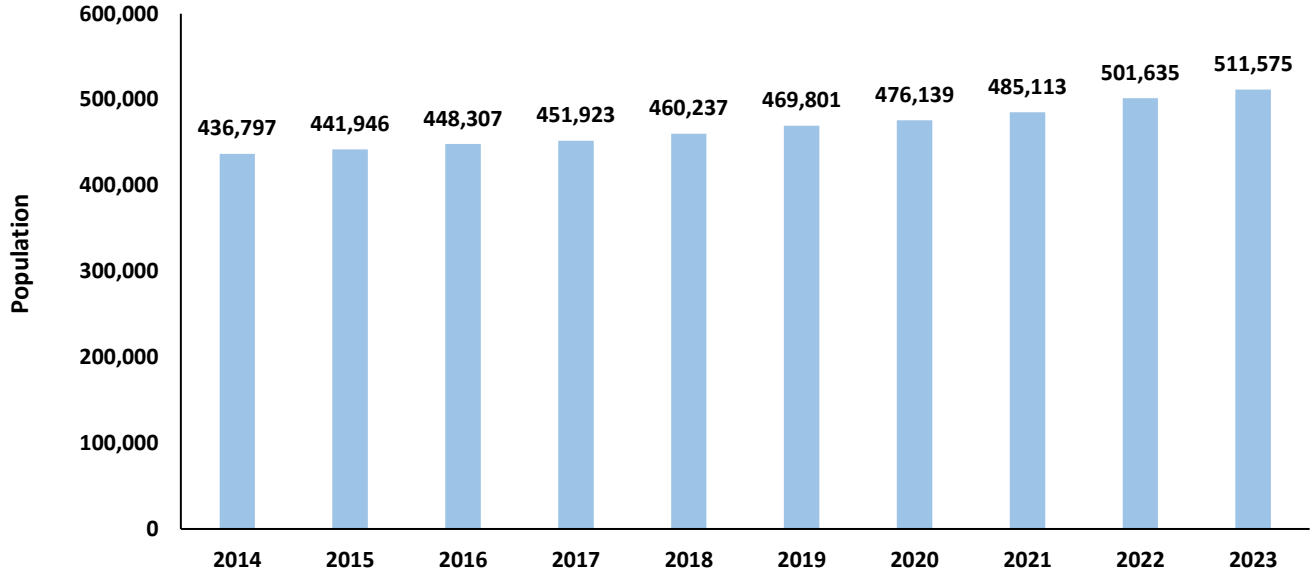
Table 1. Select Demographics for Washoe County and Nevada, 2023.

Population, Washoe County, 2023 estimate*	511,575
Population, Washoe County, 2014 estimate*	436,797
Population, Washoe County, percent change*	17.10%
Female persons, Washoe County, 2023 estimate*	255,190
Male persons, Washoe County, 2023 estimate*	256,385
Median household income, Washoe County (2023) **	$85,600
Median household income, Nevada (2023) **	$75,561
Per capita income in the past 12 months, Washoe County (2023)**	$46,857
Per capita income in the past 12 months, Nevada (2023)**	$39,963
Percent of persons below poverty level, Washoe County (2023) **	10.7%
Percent of persons below poverty level, Nevada (2023)**	12.6%
Percent uninsured, Washoe County (2023)**	10.0%
Percent uninsured, Nevada (2023)**	11.4%

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

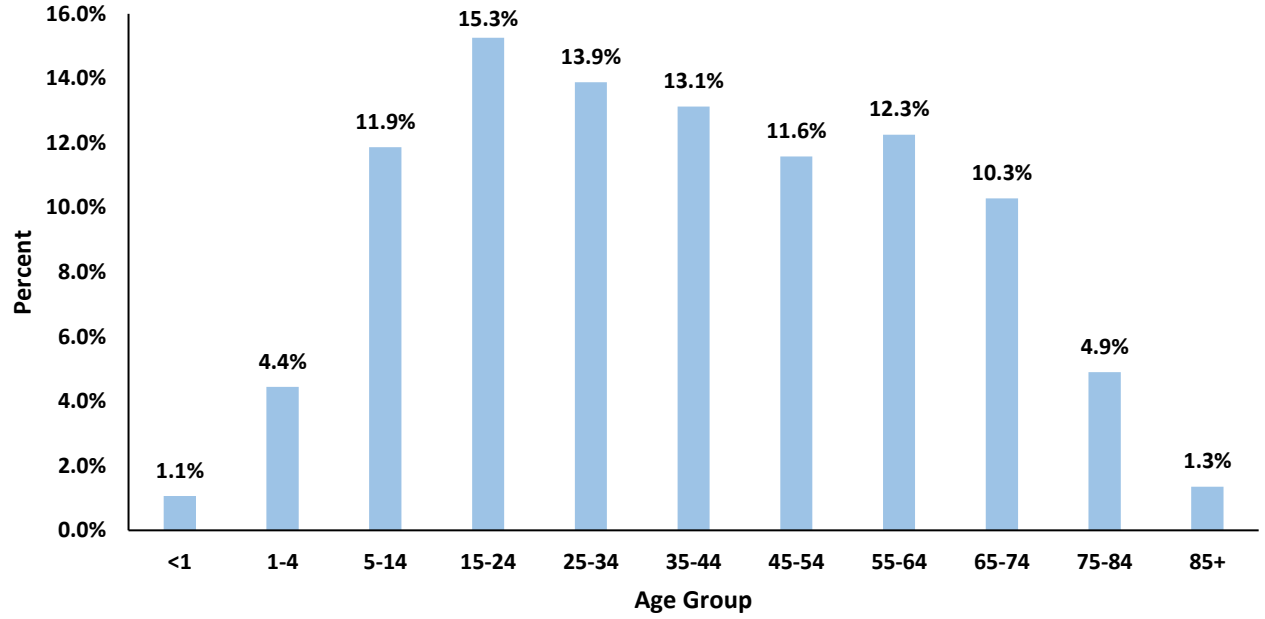
In 2023, the estimated population for Washoe County was 511,575, a 17.1% increase from the 2014 estimated population. The population was made up of approximately equal percent of females and males. The median household income was $85,600, higher than both the median household income of Nevada ($75,561), and the United States ($78,535). The percent of uninsured Washoe County residents in 2023 was 10.0%, which is lower than Nevada's percent (11.4%), but higher than the national percent (8.6%).

Figure 1. Washoe County Population, 2014-2023.



Source: Nevada State Demographer, Vintage 2023.

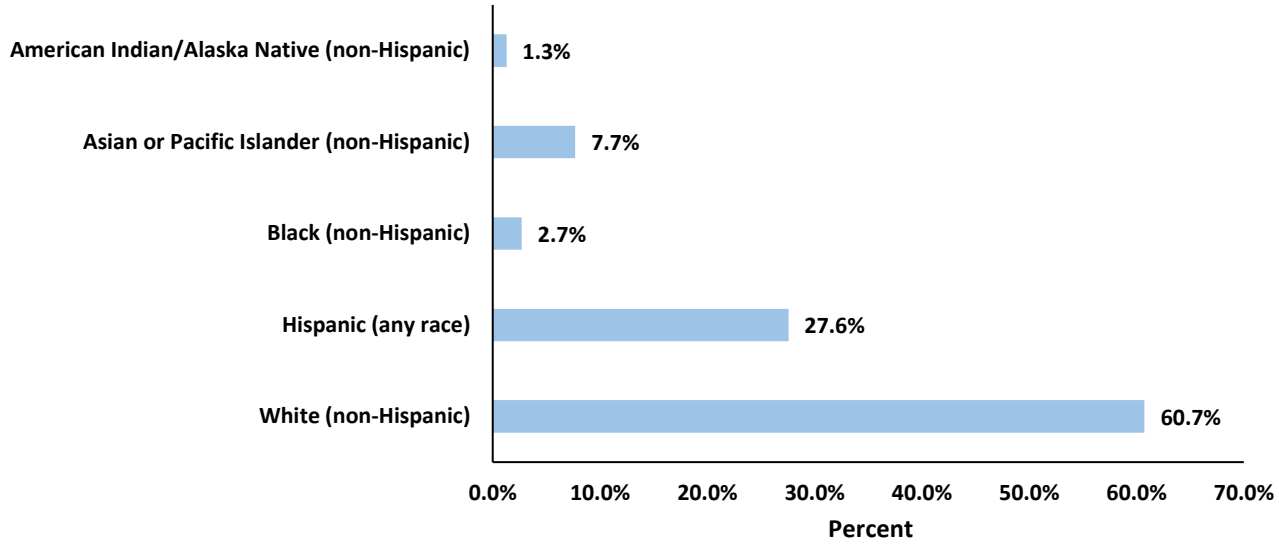
Figure 2. Washoe County Population by Age Group, 2023.



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

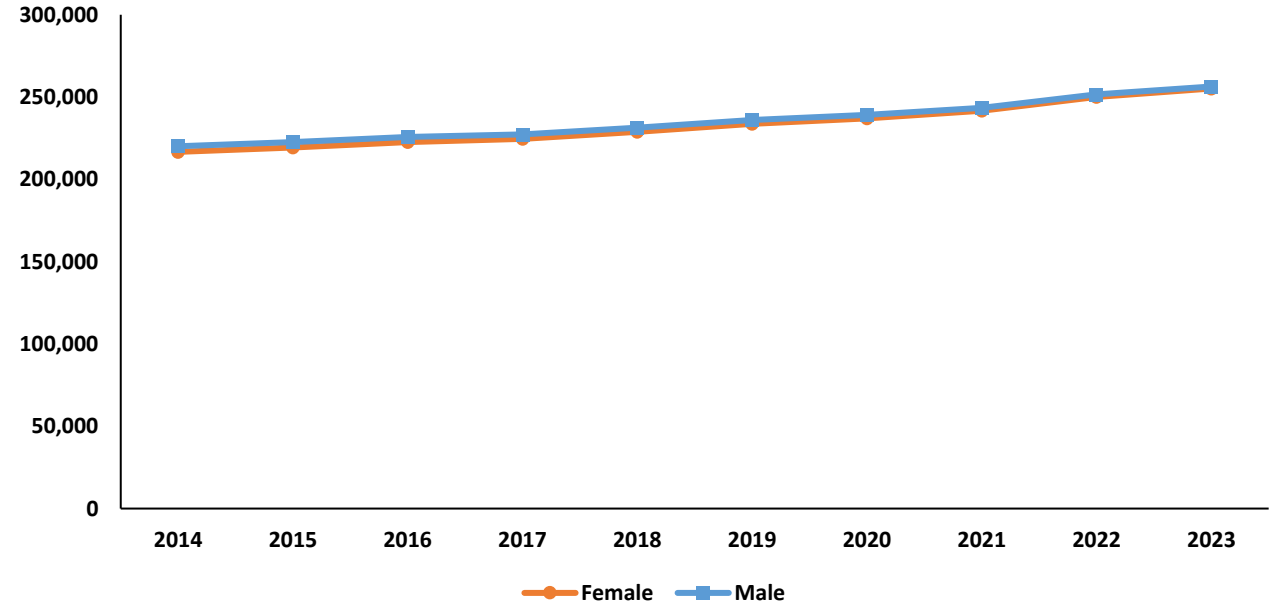
White non-Hispanics comprise 60.7% of Washoe County's population, followed by Hispanics (27.6%), Asian/Pacific Islander non-Hispanics (7.7%), Black non-Hispanics (2.7%), and American Indian/Alaska Native non-Hispanics (1.3%). The population consists of approximately equal percentages of males and females.

Figure 3. Washoe County Population by Race/Ethnicity, 2023.



Source: Nevada State Demographer, Vintage 2023.
Chart scaled to 70.0% to display differences among groups.

Figure 4. Washoe County Population Distribution by Sex, 2014-2023.



Source: Nevada State Demographer, Vintage 2023.

Mental Health

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

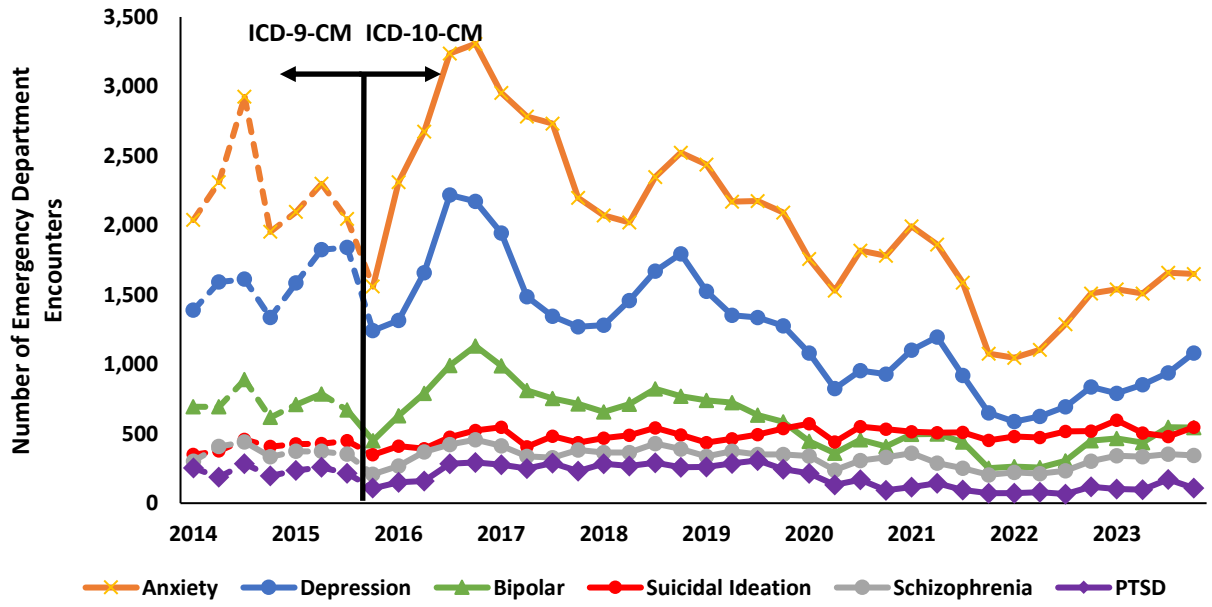
Hospital Emergency Department Encounters

The hospital emergency department billing data includes data for emergency room patients of all ages for Nevada's non-federal hospitals. There were 15,993 visits related to mental health disorders among Washoe County 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 6,358 and 3,663 encounters in 2023, respectively. Unlike the overall state trends, both have increased since the start of 2022 and are not lower than 2020 values.

For 2023, males had a higher prevalence of visits for schizophrenia (67.7%) and suicidal ideation (56.4%), whereas females had a higher prevalence of visits for anxiety (63.0%), depression (61.6%), bipolar disorder (59.2%), and PTSD (58.8%).

Figure 5. Mental Health-Related Emergency Department Encounters by Quarter and Year, Washoe County 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.

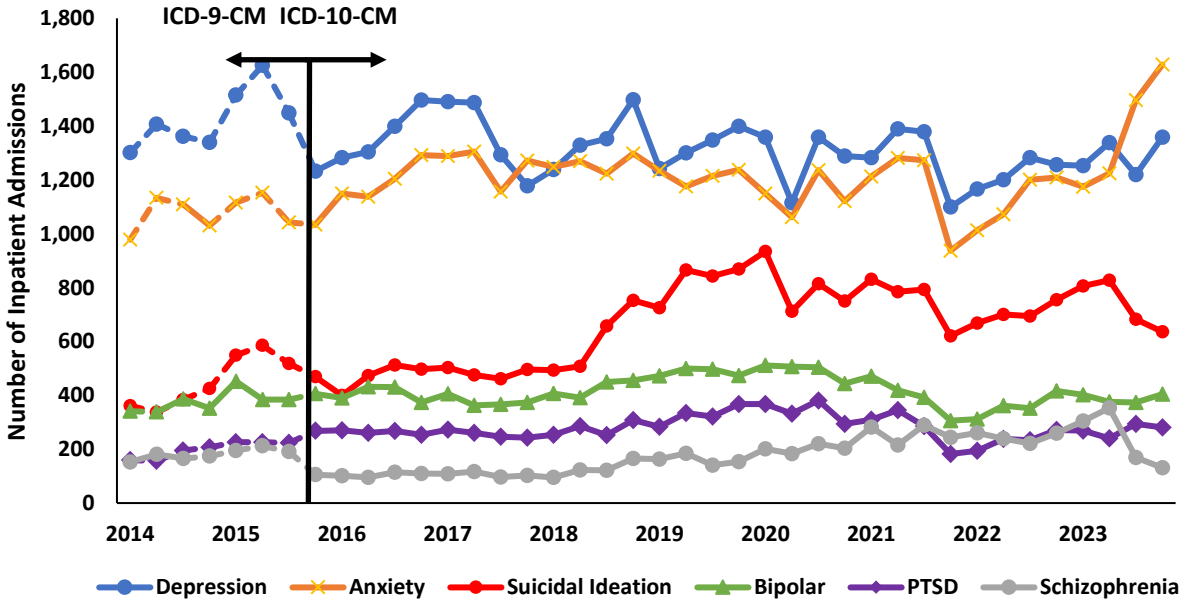
Hospital Inpatient Admissions

Hospital inpatient billing data include data for patients of all ages discharged from Nevada's non-federal hospitals. There were 17,238 inpatient admissions related to mental health disorders among Washoe County 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. Washoe County, in contrast with statewide data for Nevada, has consistently had more cases for depression than anxiety with an upward trend in 2023. In 2023, males had a higher prevalence of visits for schizophrenia (60.7%) and suicidal ideation (56.0%), whereas females had a higher prevalence of visits for anxiety (61.8%) depression (61.6%), bipolar (60.4%), and PTSD (59.7%).

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

Figure 6. Mental Health-Related Inpatient Admissions, by Quarter and Year, Washoe County Residents, 2014-2023.



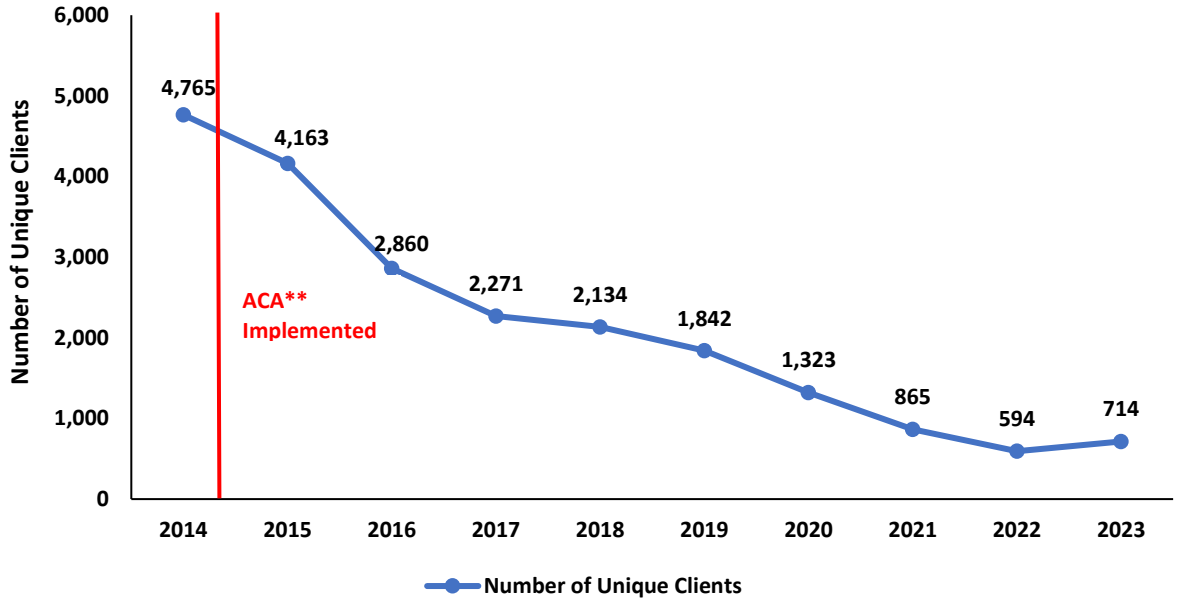
Source: Hospital Inpatient Billing.
Categories are not mutually exclusive.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

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 (DPBH), 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 facility services include inpatient acute psychiatric, mobile crisis, outpatient counseling, service coordination, and case management. Services are not denied if an individual does not have the ability to pay.

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

Figure 7. Unique Adult Clients Aged 18+* Served at State-Funded Mental Health Clinics, Washoe County Residents, 2014-2023.

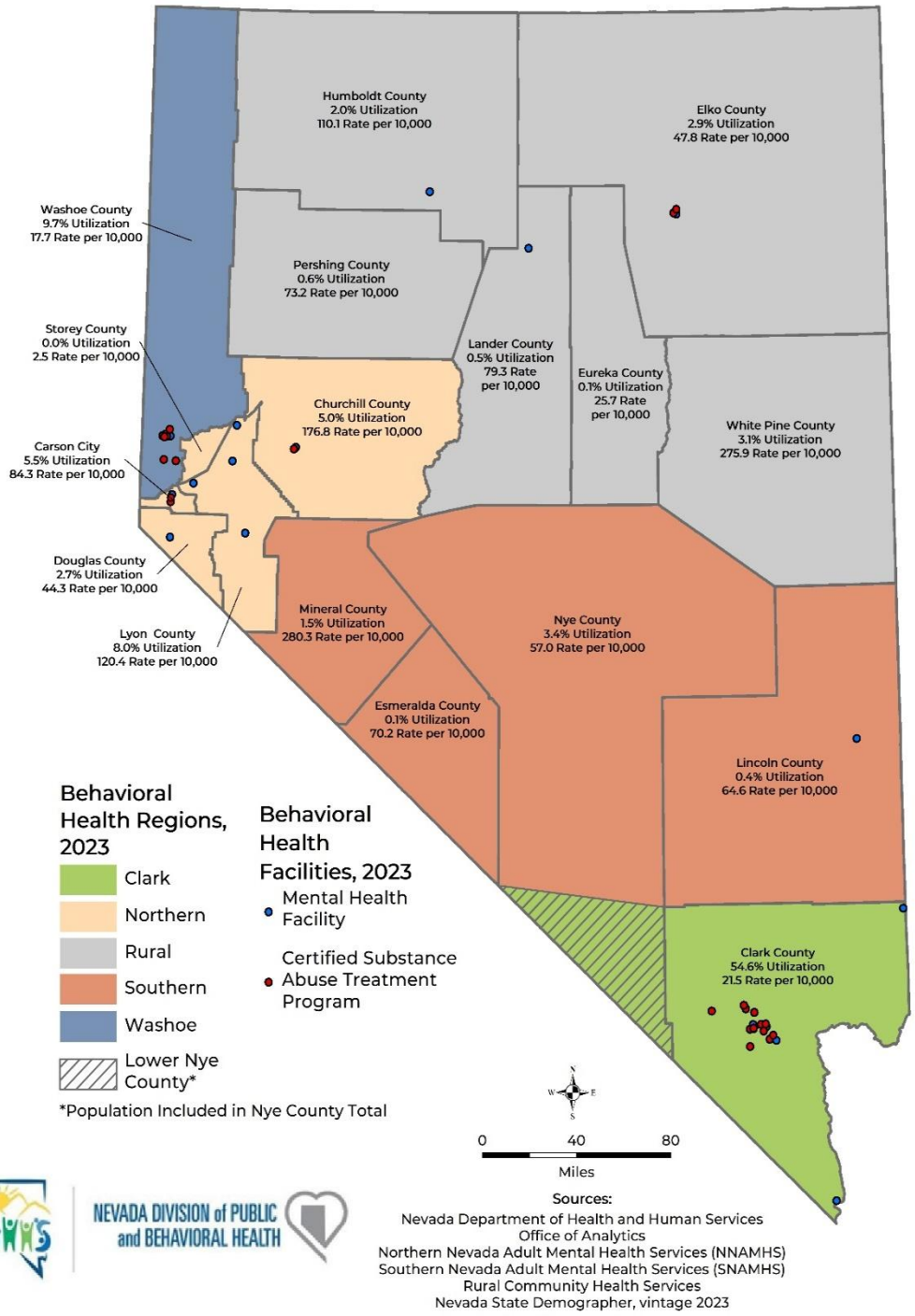


Source: Avatar
**A client is counted only once per year. Clients may be counted more than once across years.*
***Affordable Care Act.*

Of the Nevada residents accessing DPBH-funded adult mental health services in 2023, 9.7% lived in Washoe County.

Figure 8 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.

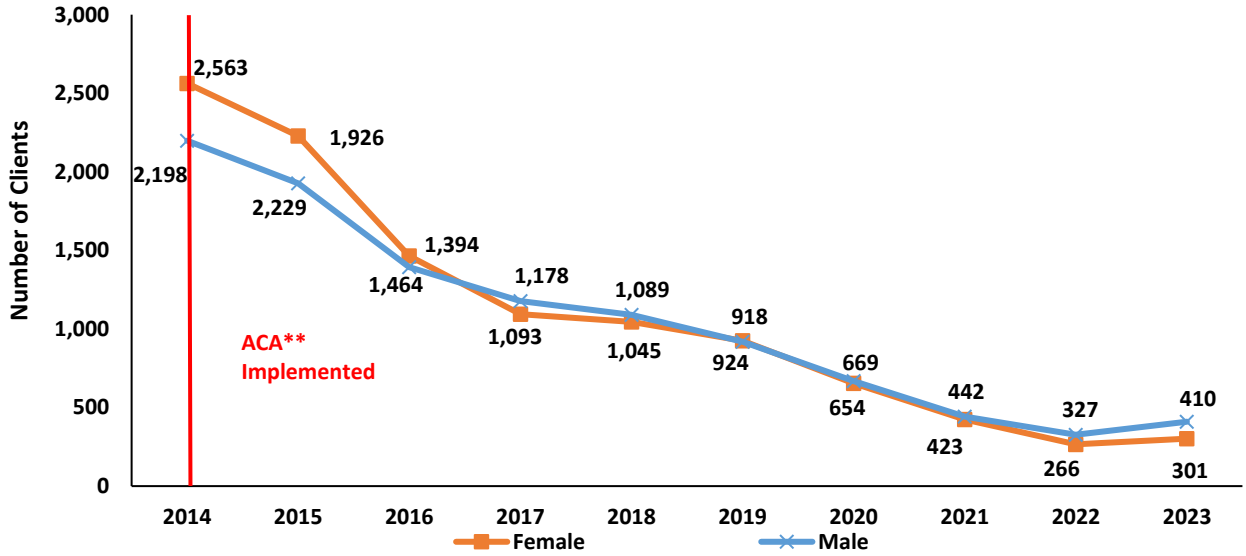
Figure 8. State-Funded Adult (Aged 18+*) Mental Health Clinic Utilization by County, 2023.



Source: Avatar
**A client is counted only once per year. Clients may be counted more than once across years.*
***Percent (%)**: Number of clients who utilize mental health services in that county, divided by total utilization.*
***Rate**: Number of clients who utilize mental health services in that county divided by county population per 10,000 population.*

Since 2017, the number of male clients and female clients have been comparable. In 2023, 21.1 per 100,000 of the Washoe County adult female population utilized the state-funded mental health clinics, compared to adult males at 29.9 per 100,000.

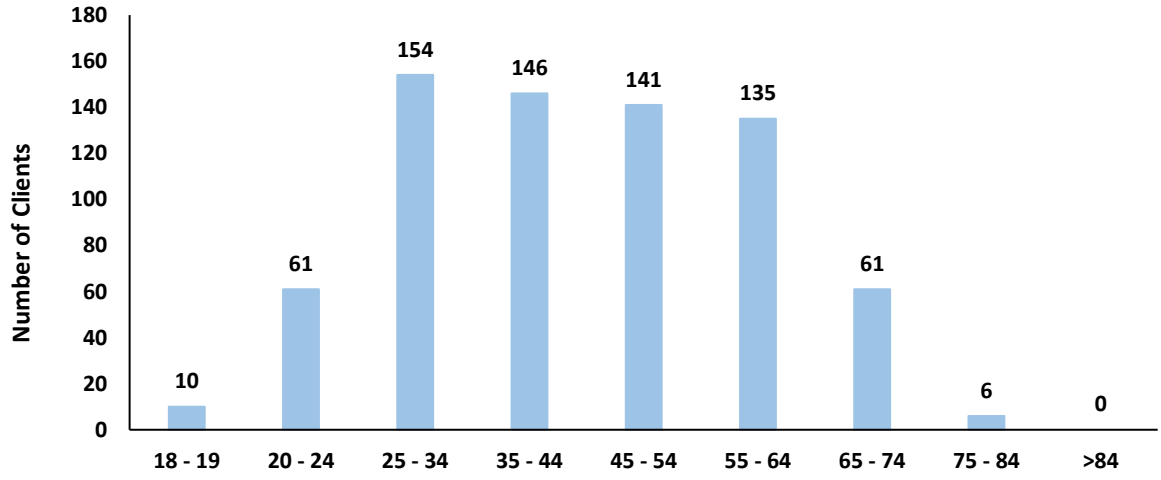
Figure 9. State-Funded Adult (Aged 18+*) Mental Health Clinic Utilization* by Sex, Washoe County Residents, 2014-2023.



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, utilization of services by Washoe County residents was fairly equal across the 25 to 64 age groups.

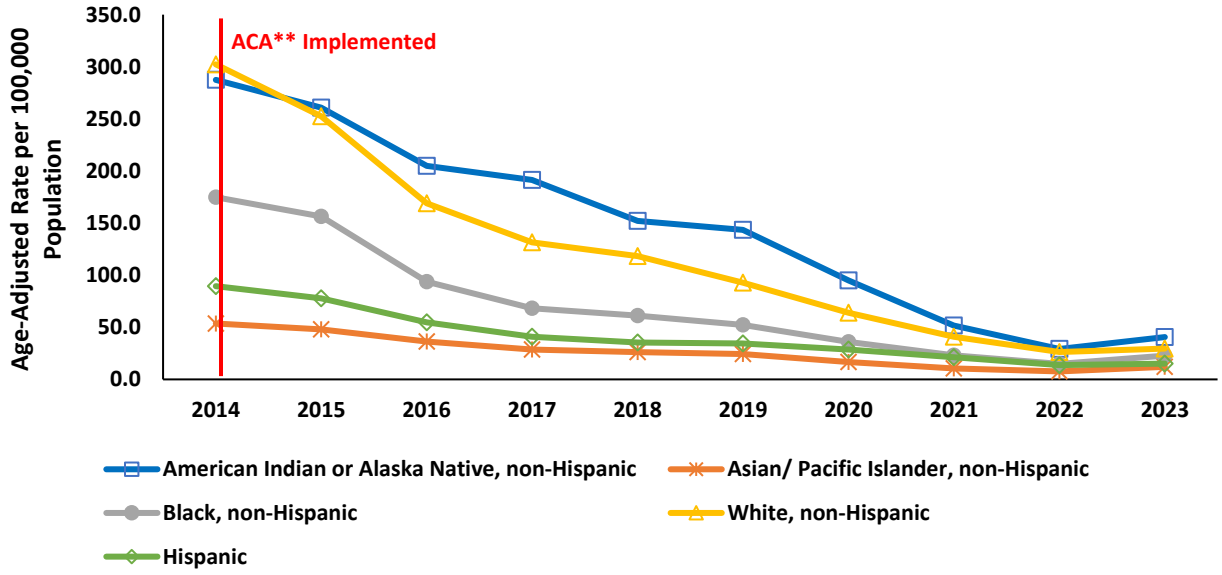
Figure 10. State-Funded Adult (Aged 18+*) Mental Health Clinic Utilization* by Age Group, Washoe County Residents, 2023.



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

Since 2017, the distribution of all racial and ethnic groups has remained relatively consistent. In 2023, in contrast to statewide trends, American Indian/Alaska Native, non-Hispanics (40.5 per 100,000) and White non-Hispanics (29.5 per 100,000) had the highest age-adjusted rates.

Figure 11. State-Funded Adult (Aged 18+*) Mental Health Clinic Utilization* by Race/Ethnicity, Washoe County 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 for Washoe County residents. In 2023, NNAMHS medication clinic increased by 270 people after a consistent decline for eight years.

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

Program	Year									
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
SNAMHS Medication Clinic - Adult	48	30	14	16	12	8	6	4	2	2
NNAMHS Medication Clinic - Adult	4,465	3,874	2,978	2,174	2,079	1,888	1,230	578	459	729
SNAMHS Inpatient Hospital - Adult	19	10	11	13	15	2	4	4	0	3
SNAMHS Ambulatory Service - Adult	4	5	2	2	0	0	1	1	0	0
SNAMHS Service Coordination - Adult	8	4	0	1	0	0	0	0	0	0
SNAMHS Outpatient Counseling - Adult	938	707	688	675	559	560	520	393	324	223

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

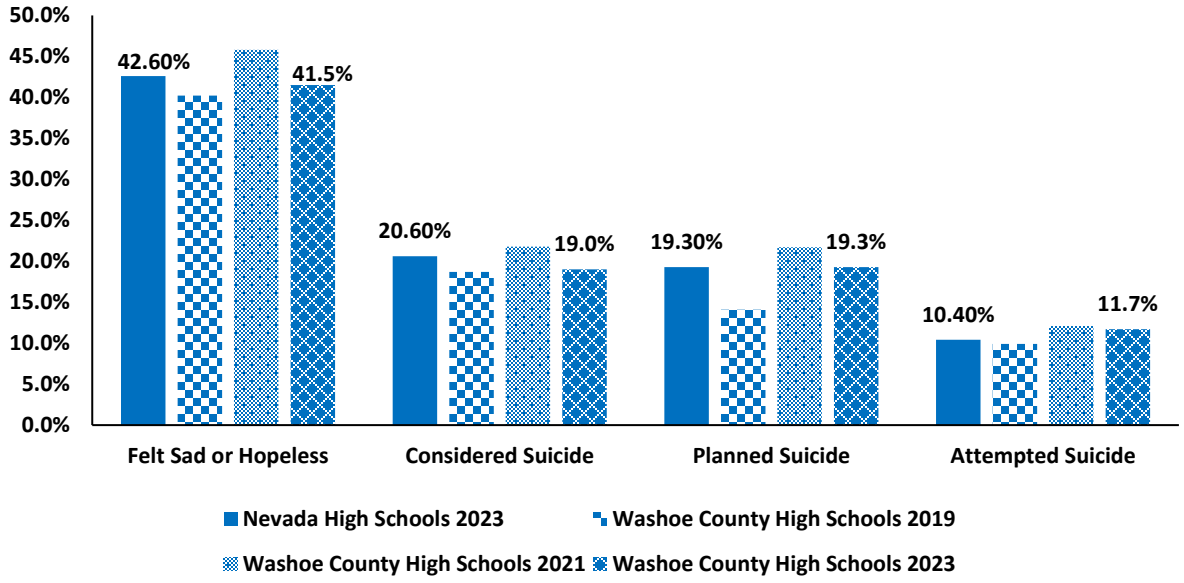
Youth Risk Behavior Survey

The YRBS monitors six categories of health-related behaviors that contribute to leading causes of death and disabilities among youth and adults. Nevada high school and middle school students are surveyed during the odd years. In 2023, 941 high school students and 1,978 middle school students participated in the YRBS in Washoe County. 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, go online to UNR YRBS.

The prevalence of all reported mental health outcomes for Washoe County high school students was highest in 2021, with notable declines in 2023. Despite these decreases, percentages in 2023 are higher than those in 2019. This may indicate that the declines may be part of the broader trend of recovery from elevated worse mental health outcomes during the COVID-19 pandemic.

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

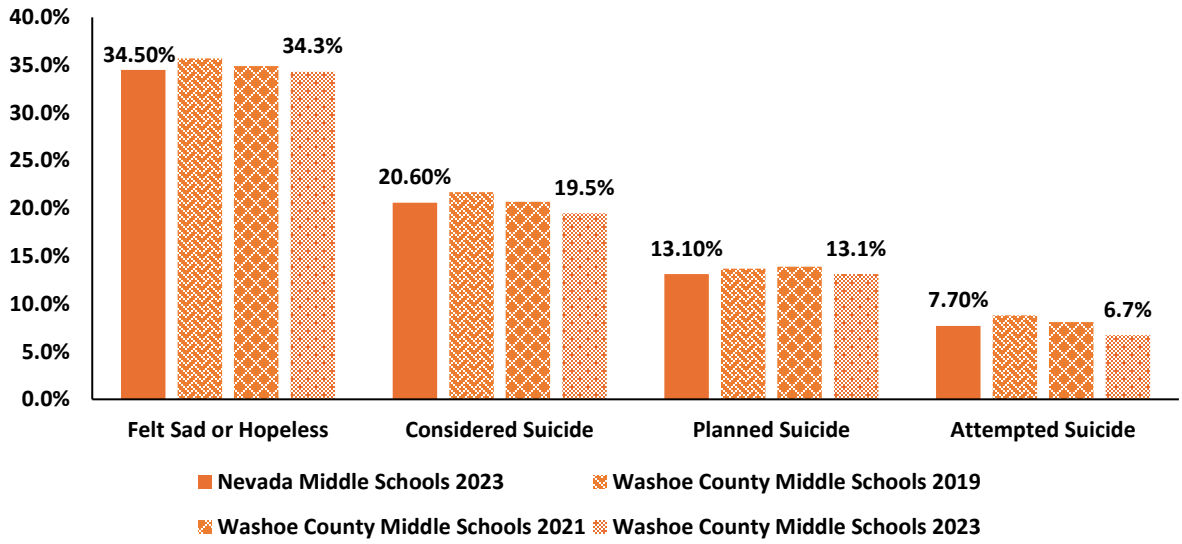
Figure 12. Mental Health Behaviors, Washoe County High School Students, 2019, 2021, 2023 and Nevada High School Students, 2023.



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

Mental health behaviors for Washoe County middle school students have remained relatively consistent between 2019 and 2023. Middle school students in Washoe County had lower outcome percentages than high school students in all measures except for those who considered suicide.

Figure 13. Mental Health Behaviors, Washoe County Middle School Students, 2019, 2021, 2023 and Nevada Middle School Students 2023.



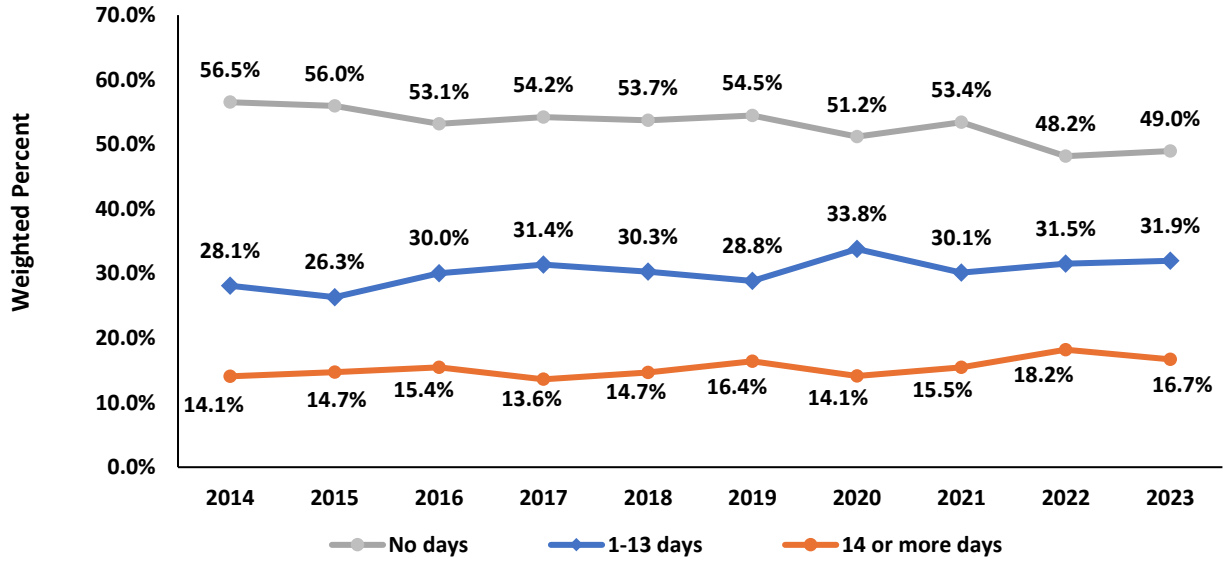
Source: Nevada Youth Risk Behavior Survey
Chart scaled to 40.0% to display differences among groups.

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, while "1-13 days" and "14 or more" days have increased. Adults who reported "14 or more days" have decreased by 1.5% in 2023 compared to 2022, which had a high of 18.2%.

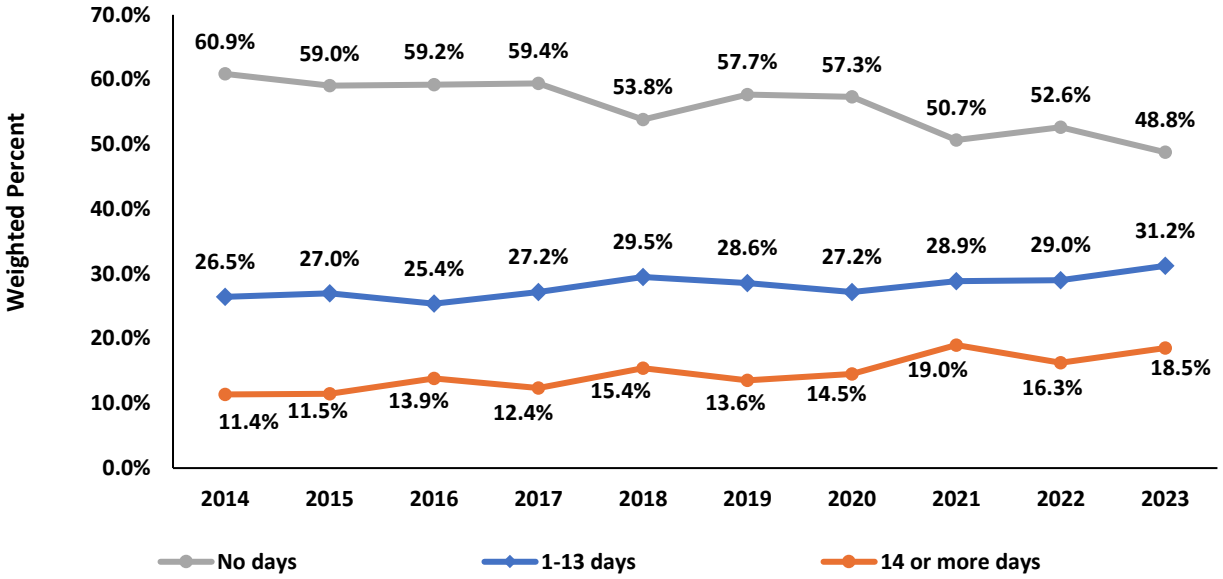
Figure 14. Percent of Adult BRFSS Respondents Who Experienced Poor Mental or Physical Health that Prevented Them from Doing Usual Activities by Days Affected in Past Month, Washoe County Residents, 2014-2023.



Source: Behavioral Risk Factor Surveillance System
Chart scaled to 70.0% to display differences among groups.
Frequent physical or mental distress is defined as feeling emotionally unhealthy, very sad, anxious, or troubled for 14 or more days out of the past 30 days.
Specific question asked in survey: "During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?"

Generally, adults who reported any number of days in which their mental health was considered "not good" has increased, while "no days" has decreased since 2014. The prevalence of adults who experienced "14 or more days" reached its peak in 2021 at 19.0%, an increase of 7.6% since 2014.

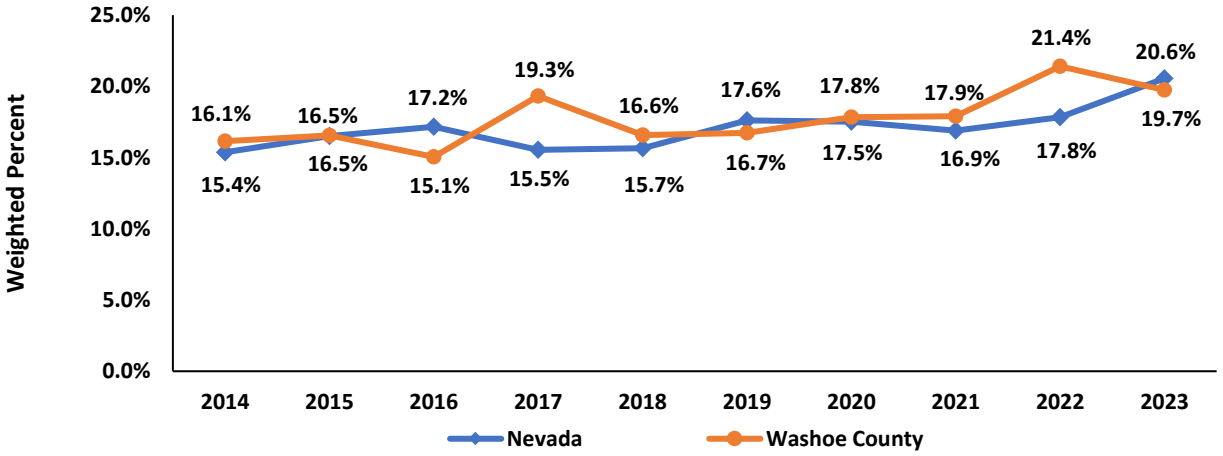
Figure 15. Percent of Adult BRFSS Respondents Whose Mental Health was Not Good by Number of Days Experienced in the Past Month, Washoe County Residents, 2014-2023.



Source: Behavioral Risk Factor Surveillance System
Chart scaled to 70.0% to display differences among groups.
Frequent mental distress is defined as feeling emotionally unhealthy, very sad, anxious, or troubled for 14 or more days out of the past 30 days.
Specific question asked in survey: "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"

The prevalence of those in Washoe County who reported having ever been told they have a depressive disorder by a doctor, nurse, or other health professional has been higher than the statewide average for most years since 2014 with peaks in 2017 (19.3%) and 2022 (21.4%).

Figure 16. Percent of Adult BRFSS Respondents Who Have Ever Been Told They Have a Depressive Disorder, Including Depression, Major/Minor Depression, or Dysthymia, Washoe County Residents, 2014-2023.



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

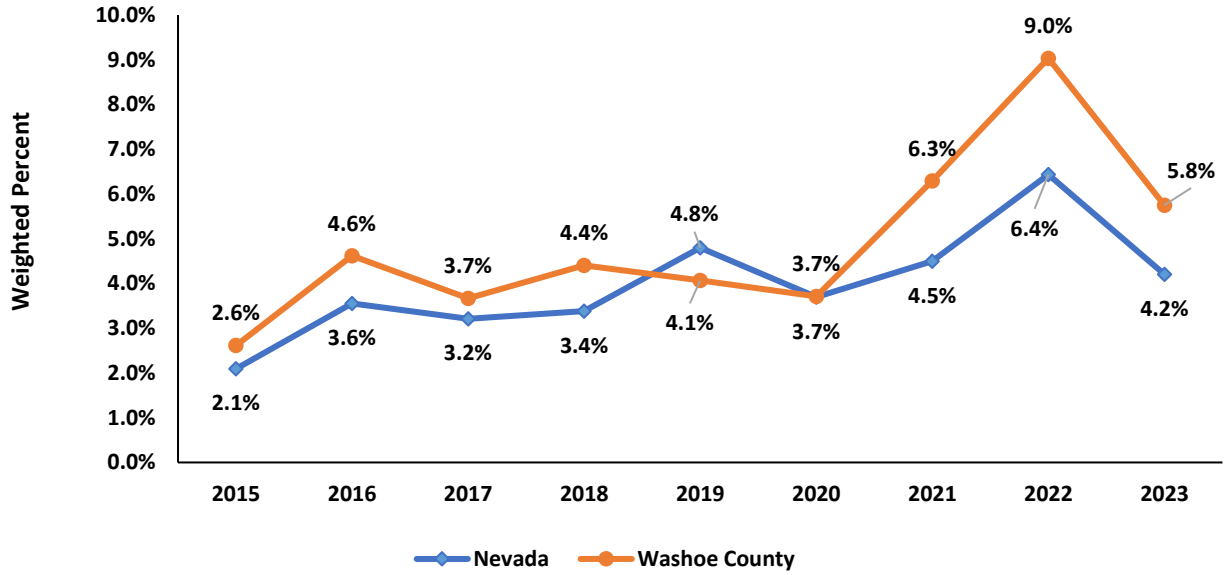
Suicide

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 counselor who can help to provide resources.

When asked "Have you seriously considered attempting suicide during the past 12 months?" 5.8% of adult Washoe County resident BRFSS respondents responded "yes" in 2023, a drop of 3.2% from the previous year. In 2022 there was a high of 9.0%, 3.5 times more than what was seen in 2015 (2.6%) and 1.4 times greater than what was seen statewide in 2022 (6.4%).

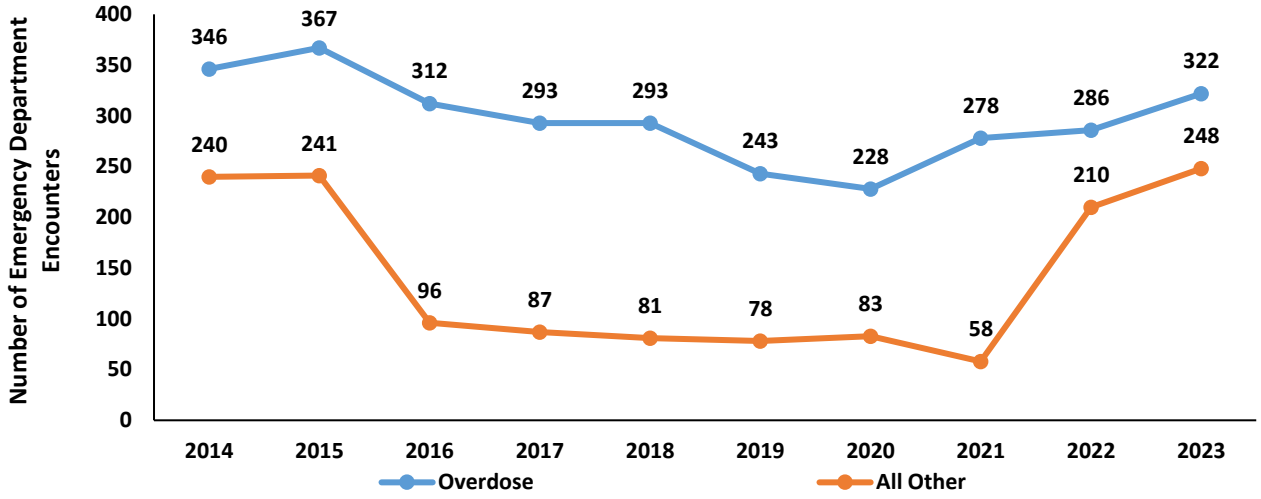
Figure 17. Percent of Adult BRFSS Respondents Who Have Seriously Considered Attempting Suicide, Washoe County Residents, 2015-2023.



Source: Behavioral Risk Factor Surveillance System
Chart scaled to 10.0% to display differences among groups.
Specific question asked in survey: "During the past 12 months have you ever seriously considered attempting suicide?"

Emergency department encounters related to suicide attempts (where the patient did not expire at the hospital) decreased between 2016 to 2021, before rising post-COVID pandemic. The most common method for attempted suicide is overdose (substance or drug poisoning). All other methods include cutting/piercing, firearms, hanging/strangulation/suffocation, and jumping from heights.

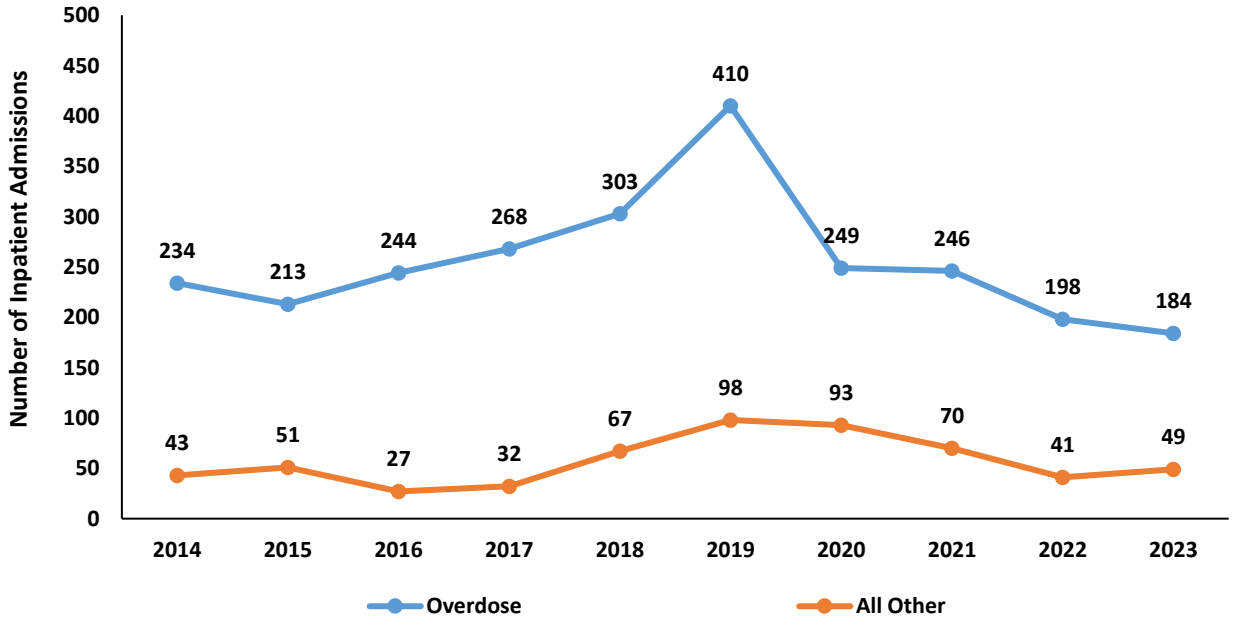
Figure 18. Suicide Attempt Emergency Department Encounters by Method, All Ages, Washoe County Residents, 2014-2023.



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 suicide attempts increased between 2014 and 2019 to a high of 410, followed by a decline through 2023.

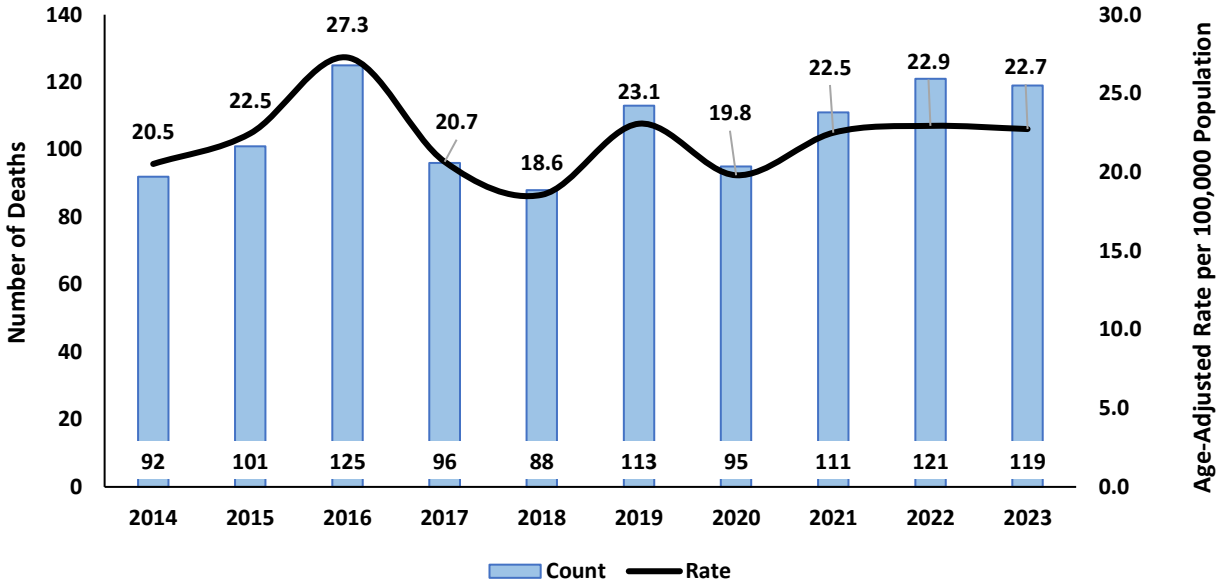
Figure 19. Suicide Attempt Inpatient Admissions by Method, All Ages, Washoe County Residents, 2014-2023.



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 Washoe County in 2023 was 22.7 per 100,000 population. The highest rate was in 2016, at 27.3 per 100,000 population, while the lowest rate was in 2018, at 18.6 per 100,000 population. The national age-adjusted rate in 2022, the most recent year with complete CDC data, was 14.2 per 100,000 population, compared to 20.0 per 100,000 among Nevada residents.

Figure 20. Number of Suicides and Rates, All Ages, Washoe County Residents, 2014-2023.



Source: Nevada Electronic Death Registry System

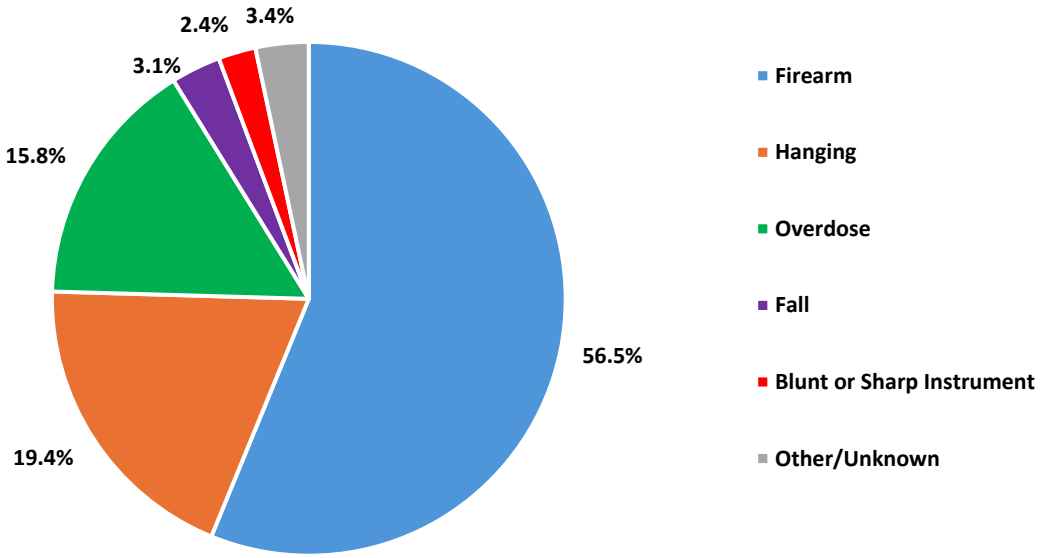
National Violent Death Reporting System

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 734 deaths among Washoe County residents reported in the Nevada Violent Death Reporting System (NVDRS). Of those deaths, 68.9% (n=506) were suicides, 17.6% were homicides, 1.8% were legal interventions, and the remainder were categorized as unintentional involving firearms or undetermined.

Among the 506 suicides, the method was firearms in 56.5% of cases (n=286), 19.4% hanging/strangulation/suffocation, 15.8% overdose, 3.1% fall, 2.4% blunt/sharp instrument, and 3.4% other/unknown. About 76% of persons were male and 24% were female.

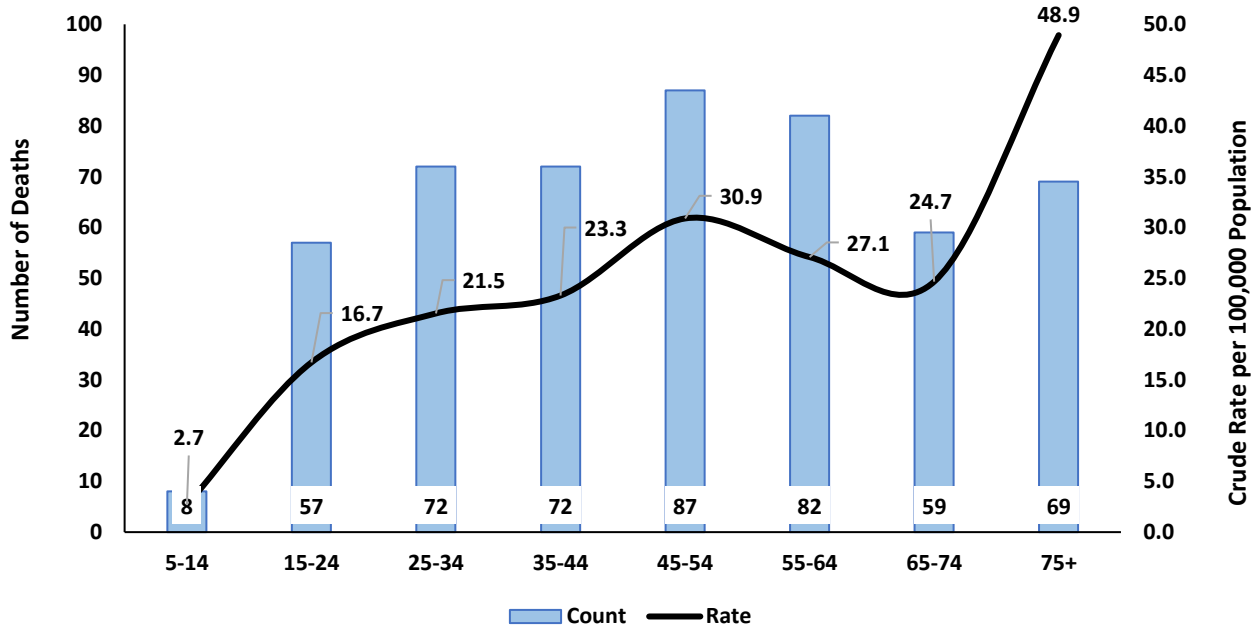
Figure 21. Method of Suicide Deaths, Washoe County Residents, 2018-2022.



Source: Nevada Violent Death Reporting System

Suicide rates increase until the 45-54 age group, decrease afterward, and then sharply increase among those aged 75 and older.

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



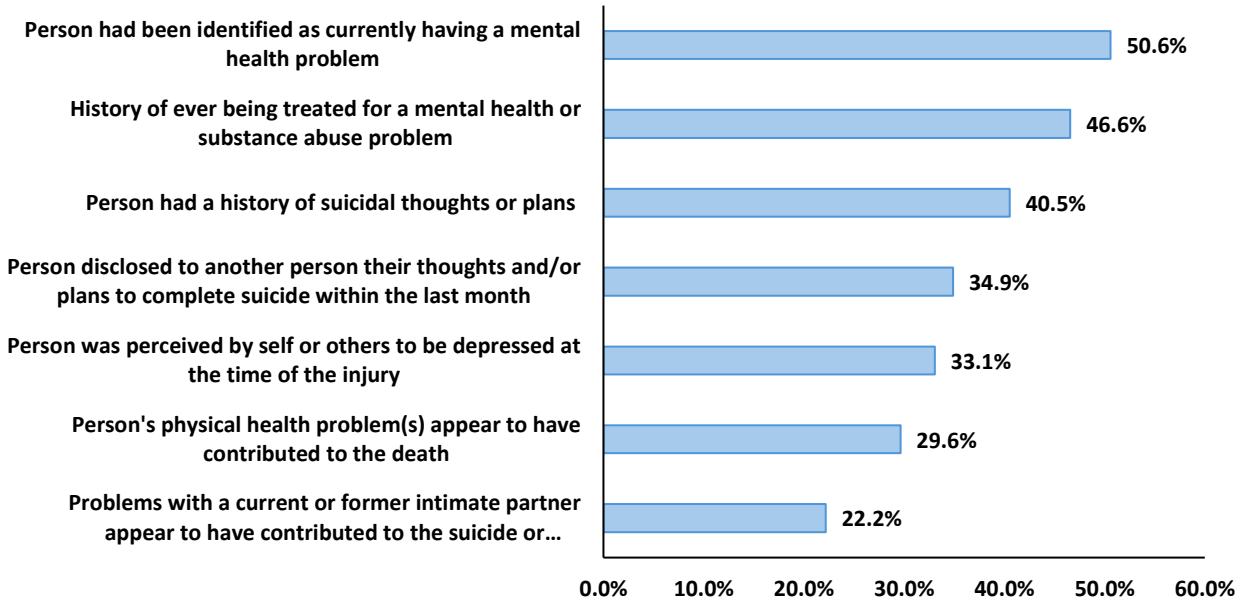
Source: Nevada Violent Death Reporting System

Of the 506 suicides among Washoe County residents from 2018-2022 that were entered into NVDRS, 98.0% (n=496) had circumstantial information available.

More than 50% of those suicides involved persons reported to have a mental health problem; 46.6% had a history of ever being treated for a mental health or substance abuse problem; 40.5% had a history of suicidal thoughts or plans; 34.9% disclosed to another person their thoughts and/or plans to complete suicide within the last month; 33.1% were perceived by self or others to be depressed at the time of injury; 29.6% had a physical health problem(s) that appeared to contribute to the death; and 22.2% had problems with a current or former intimate partner that appeared to contribute to the death.

The percent of Washoe County residents who reported a mental health problem (50.6%) is higher than that of Nevadans overall (40.3%). Similarly, the percentage of Washoe County individuals with a history of mental health or substance abuse treatment (46.6%) is substantially higher than the statewide rate of 28.1%.

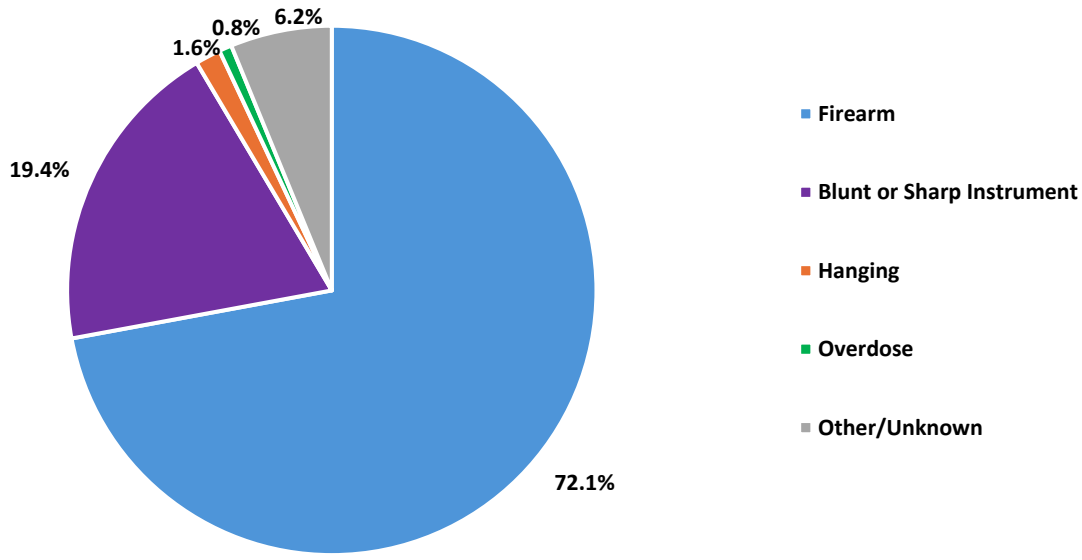
Figure 23. Circumstances Among Suicide Deaths, Washoe County Residents, 2018-2022.



Source: Nevada Violent Death Reporting System
Chart scaled to 60.0% to display differences among groups.

Of the 129 homicides among Washoe County residents from 2018-2022, the method was firearms in 72.1% of cases, 19.4% blunt/sharp instrument, 1.6% hanging, 0.8% overdose, and 6.2% other/unknown. Males accounted for 77.5% of homicide victims, and 22.5% were females.

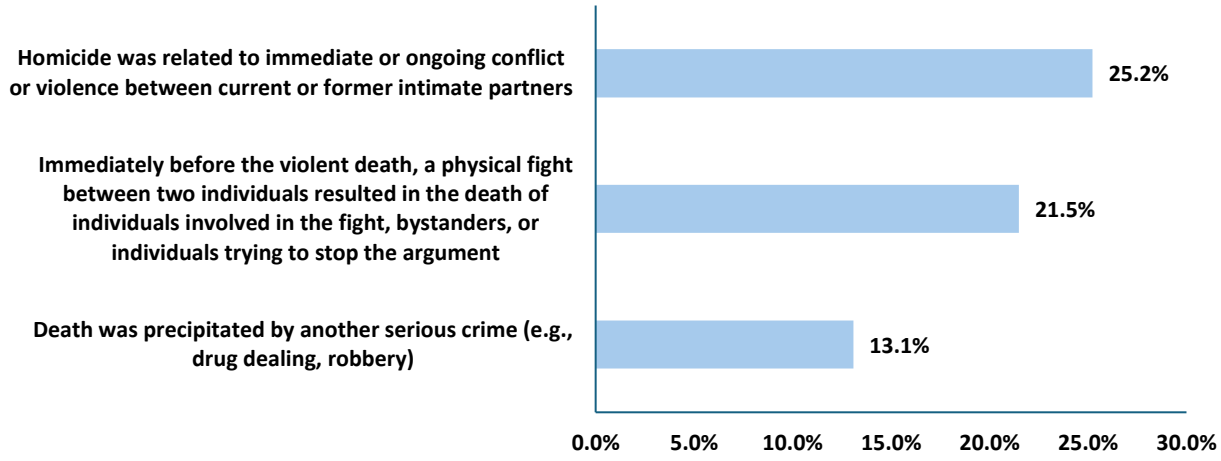
Figure 24. Method of Homicide Deaths, Washoe County Residents, 2018-2022.



Source: Nevada Violent Death Reporting System

Of the 129 homicides among Washoe County residents from 2018-2022 that were entered into NVDRS, 82.9% (n=107) had circumstantial information available. Of those homicides, 25.2% were related to ongoing conflict or violence between current or former intimate partners, 21.5% involved a physical fight immediately before the homicide, and 13.1% were precipitated by another serious crime, such as drug dealing or robbery.

Figure 25. Circumstances Among Homicide Deaths, Washoe County Residents, 2018-2022.



Source: Nevada Violent Death Reporting System
Chart scaled to 30.0% to display differences among groups.

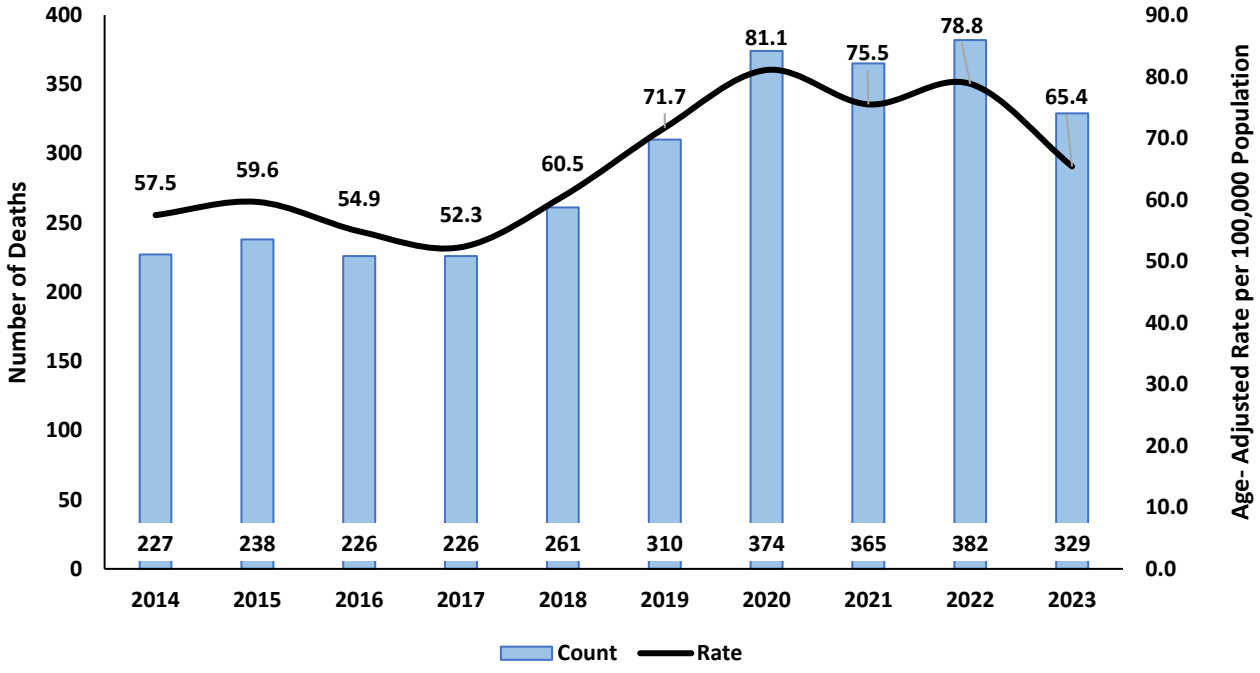
Mental Health-Related Deaths

Mental health-related deaths are deaths with the following ICD-10 code groups listed as a contributing cause of death (F00-F99 excluding F10-F19):

- Organic, including symptomatic, mental disorders
- Schizophrenia, schizotypal and delusional disorders
- Mood [affective] disorders
- Neurotic, stress-related and somatoform disorders
- Behavioral syndromes associated with physiological disturbances and physical factors
- Disorders of adult personality and behavior
- Intellectual disabilities
- Disorders of psychological development
- Behavioral and emotional disorders with onset usually occurring in childhood and adolescence
- Unspecified mental disorder

Mental health-related deaths in Washoe County for 2023 occurred at an age-adjusted rate of 65.4 per 100,000 population, with a death count of 329 persons. This rate is substantially higher than the rate for the state in total of 54.5 per 100,000, and the rate has generally increased over the reporting period.

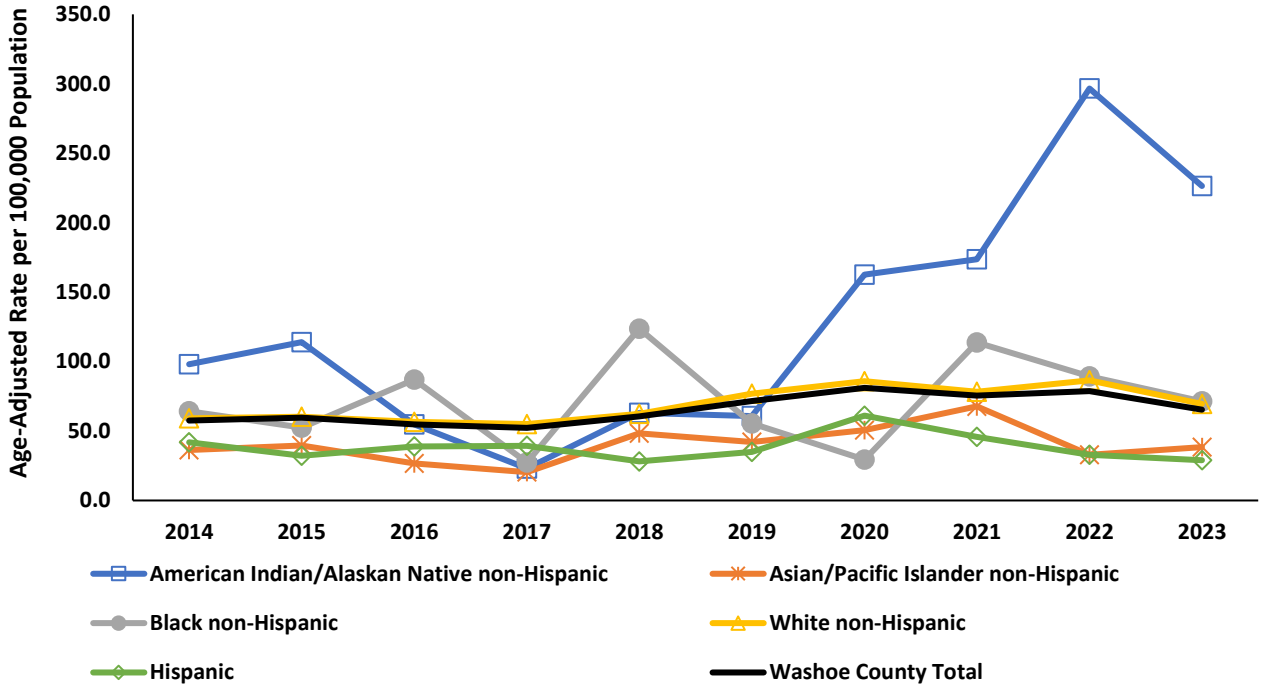
Figure 26. Mental Health-Related Deaths and Rates, Washoe County Residents, 2014-2023.



Source: Nevada Electronic Death Registry System.

From 2014 to 2023, there were no statistically significant differences in age-adjusted mental health-related death rates among race/ethnicities. Note that the rate fluctuations among the American Indian/Alaska Native non-Hispanic population is a result of high volatility due to the relatively low population of this demographic in the state and should not be taken as a significant change from the other years in the reporting period.

Figure 27. Mental Health-Related Death Rates by Race/Ethnicity, Washoe County 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 such as heroin to prescription opioids. This was, at least partially, caused by the over-prescription of opioids for pain management.

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

In 2017, the U.S. Department of Health and Human Services (HHS) officially declared the opioid crisis a public health emergency. In response to this crisis, Nevada introduced Assembly Bill (AB) 474, which was approved by the Legislature and Gov. Brian Sandoval and 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] AB 474 has led to measurable outcomes: Figures 29 and 30 below show the sharp decline in the number and rate of both opioid and controlled substance prescriptions in Washoe County since 2017. These 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.

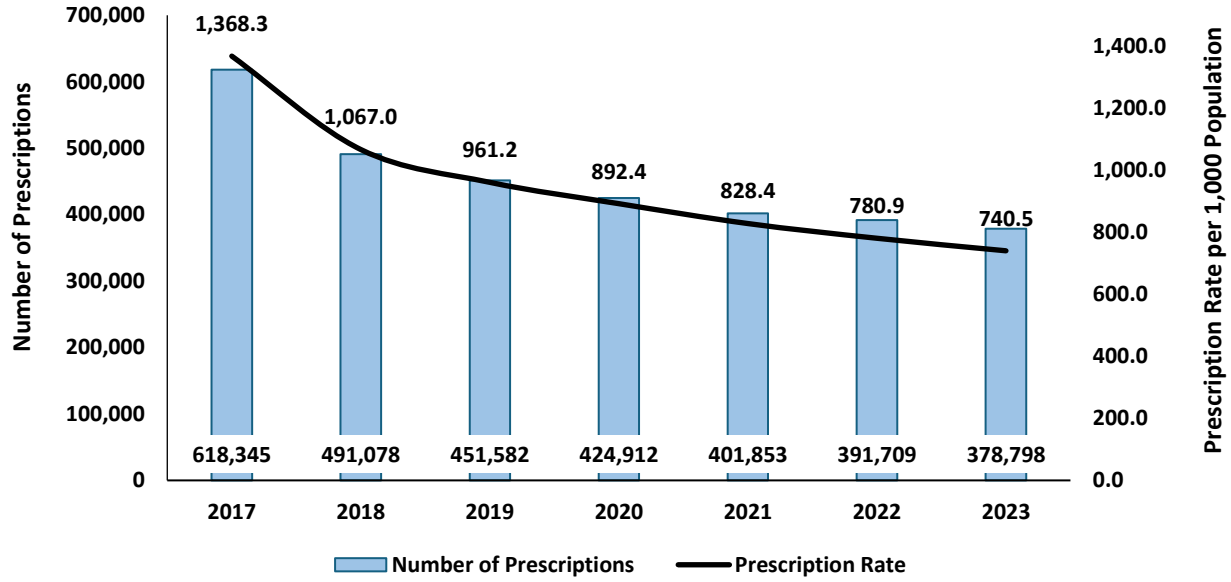
In addition to opioids, Nevada's PDMP tracks information about all Schedule II through V prescriptions dispensed to patients in the state. These drugs are classified as having accepted medical use and, at minimum, a low potential for abuse and risk of dependence. Schedule I drugs, such as ecstasy, heroin, 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] DPBH web page - Prescription Drug Abuse Prevention

PDMP total prescriptions among Washoe County residents have decreased markedly from a rate of 1,368.3 per 1,000 population in 2017 to 740.5 per 1,000 population in 2023.

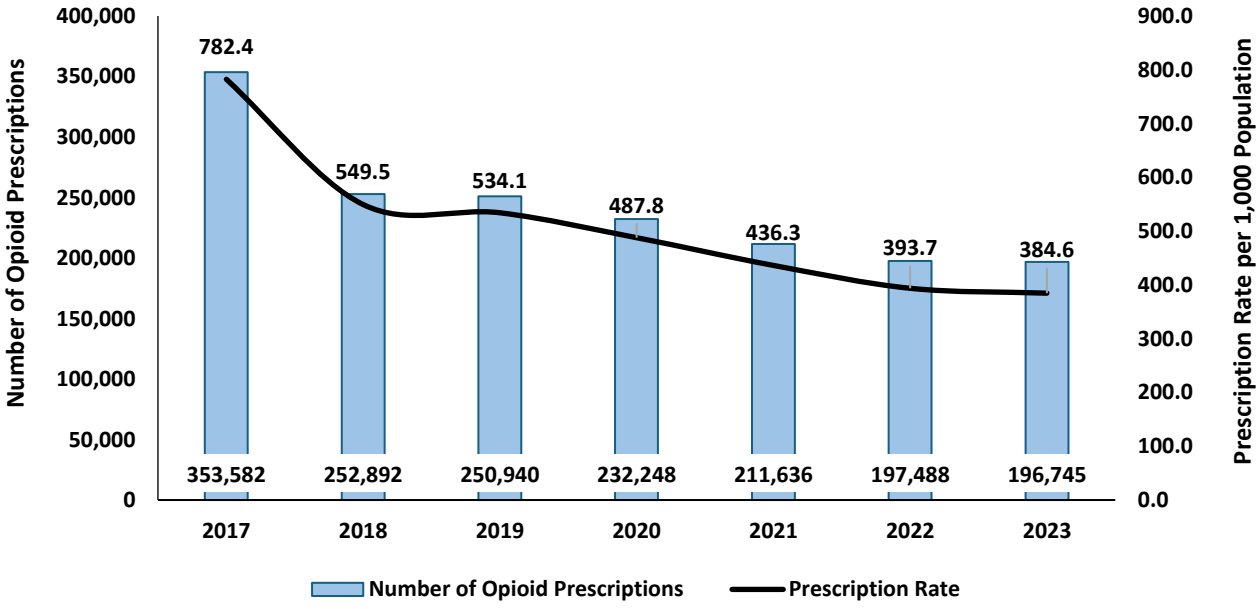
Figure 28. Total Prescriptions and Rates, Washoe County Residents 2017-2023.



Source: Prescription Drug Monitoring Program

Mirroring total prescription trends, total opioid prescriptions have decreased from a rate of 782.4 per 1,000 population in 2017 to 384.6 per 1,000 population in 2023.

Figure 29. Total Opioid Prescriptions and Rates, Washoe County Residents 2017-2023.

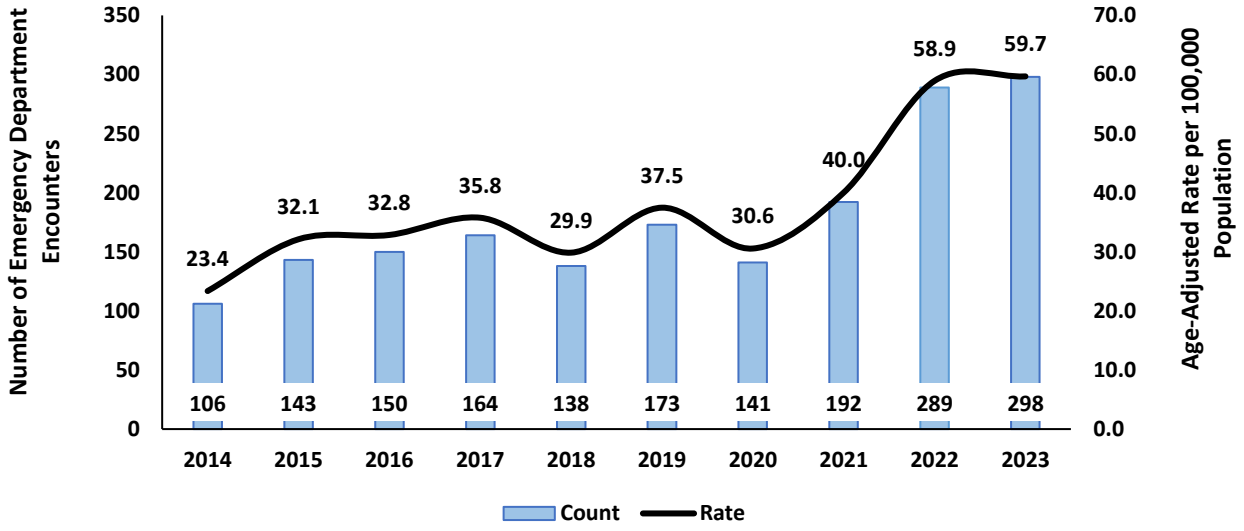


Source: Prescription Drug Monitoring Program

Hospital Emergency Department Encounters

While total opioid prescriptions among Washoe County residents decreased since 2017, opioid overdose emergency department encounters have notably increased since 2021, with the highest rate in 2023, at 59.7 per 100,000 population. This trend may suggest that there are other factors driving opioid misuse.

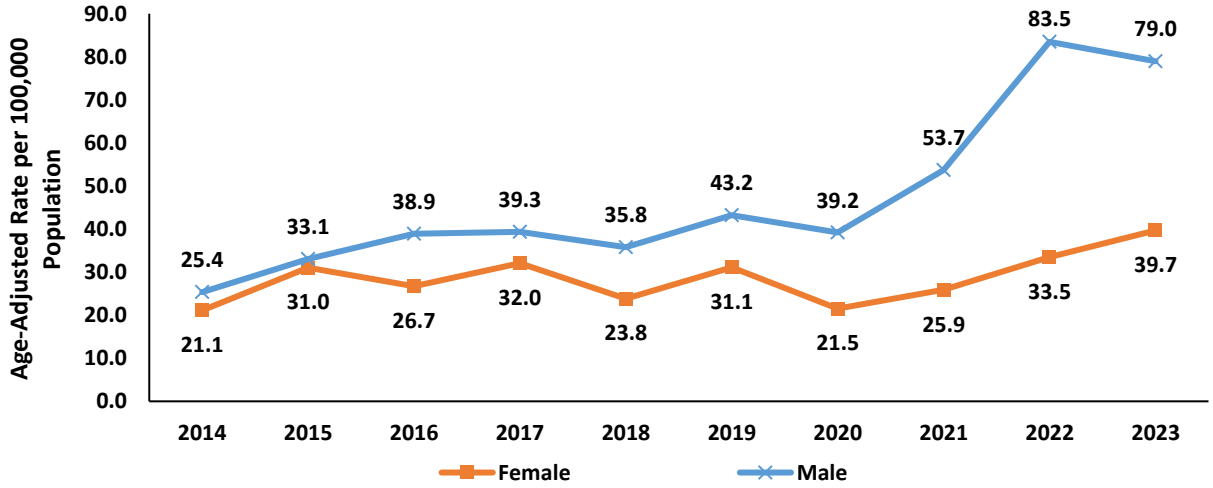
Figure 30. Opioid Overdose Emergency Department Encounters and Rates by Year, Washoe County Residents, 2014-2023.



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 females and males remained relatively close and stable until 2019. Starting in 2020 there is a significant increase in the rate for males with a high of 83.5 per 100,000 in 2022, and small decrease down to 79.0 in 2023.

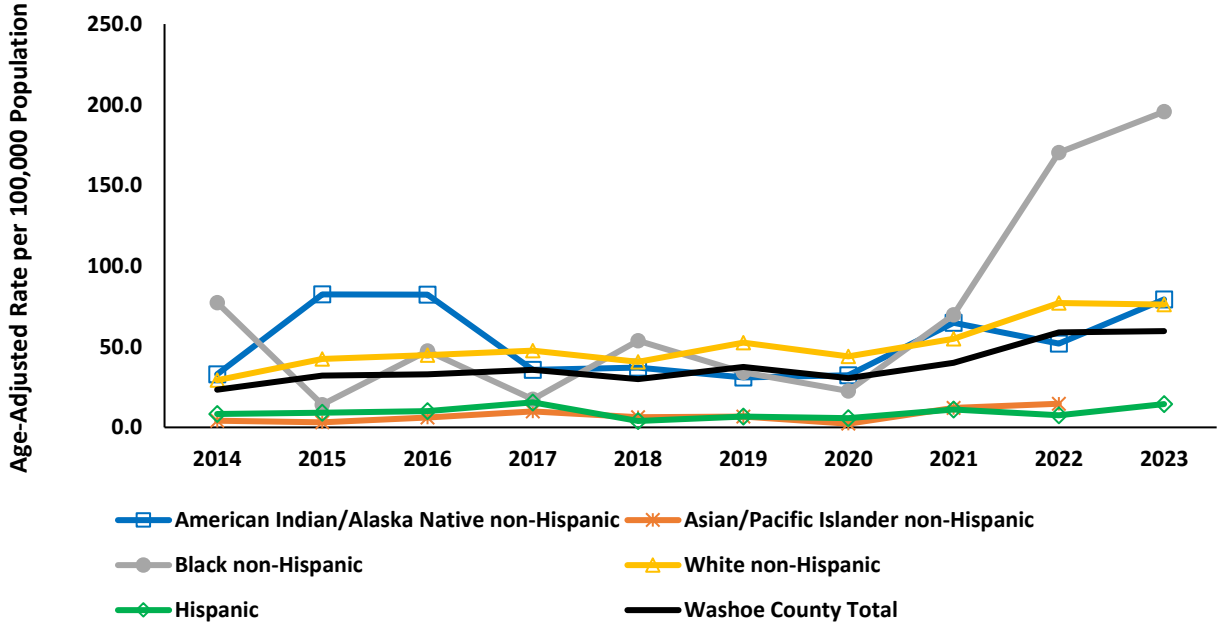
Figure 31. Opioid Overdose Emergency Department Encounter Rates by Year and Sex, Washoe County Residents, 2014-2023.



Source: Hospital Emergency Department Billin
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 among White non-Hispanics have been consistently higher than the overall Washoe County rate. The rates among Black non-Hispanics saw a statistically significant increase from 2021 to 2023.

Figure 32. Opioid Overdose Emergency Department Encounter Rates by Year and Race/Ethnicity, 2014-2023.

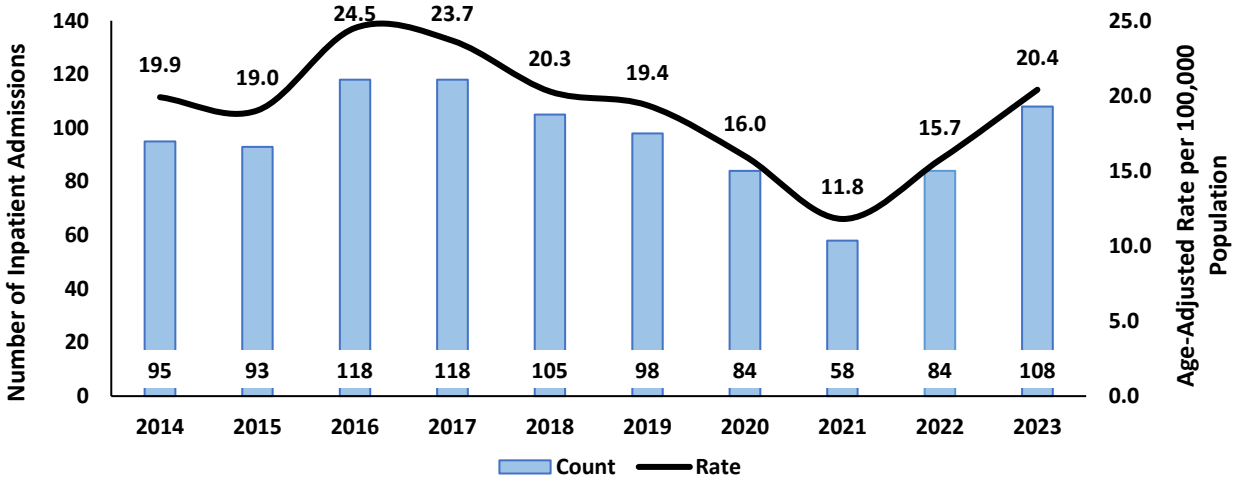


Source: Hospital Emergency Department Billing
Categories are not mutually exclusive.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Hospital Inpatient Admissions

Opioid-related inpatient admission rates decreased from 2016 to 2021 before increasing beginning in 2022. This is indicative of an increase in cases involving complications requiring extended care.

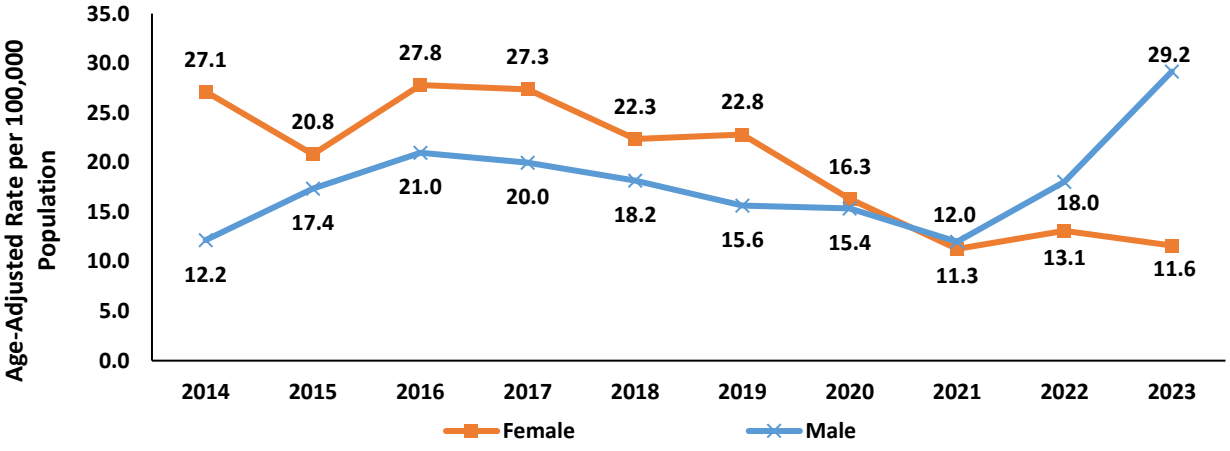
Figure 33. Opioid Overdose Inpatient Admissions and Rates by Year, Washoe County Residents, 2014-2023.



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.

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

Figure 34. Opioid Overdose Inpatient Admission Rates by Year and Sex, Washoe County Residents, 2014-2023.



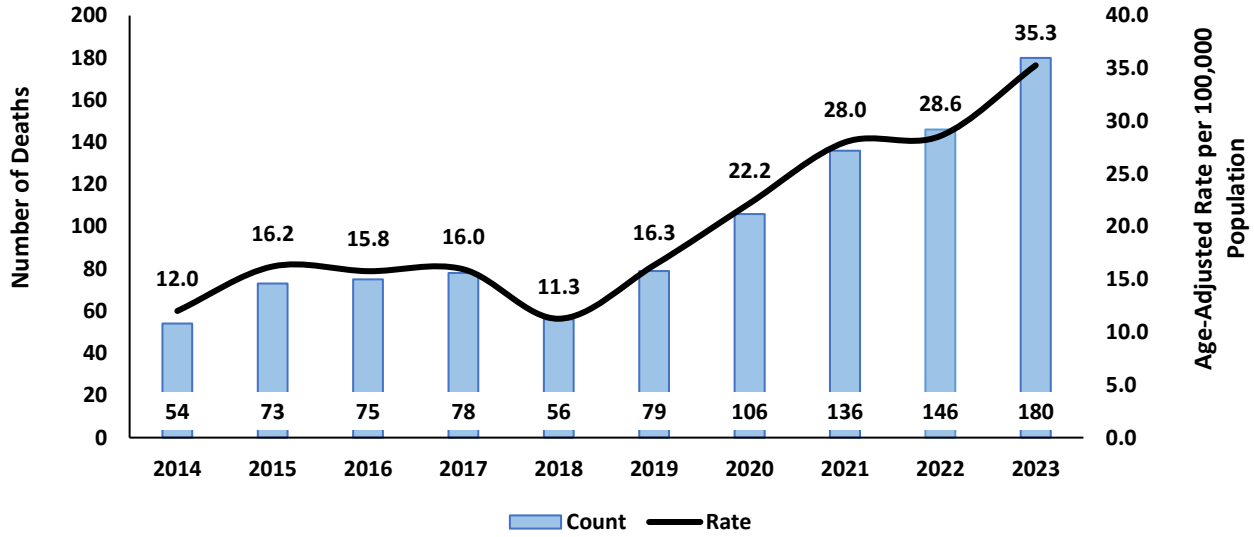
Source: Hospital Inpatient Billing
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Consistent with opioid overdose emergency room encounters, the rates among White non-Hispanics have been consistently higher than the overall Washoe County rate. Due to volatility in rates of opioid overdose inpatient admissions by race/ethnicity because of the relatively smaller populations in Washoe County, the associated figure has been omitted.

Opioid Overdose Deaths

Opioid overdose deaths have significantly increased from 2018 to 2023, mirroring the rise in emergency room encounters starting in 2021 and inpatient admissions starting in 2022. This sharp increase may reflect a worsening opioid epidemic, with the rise of emergency room encounters providing an early indicator of overdose trends.

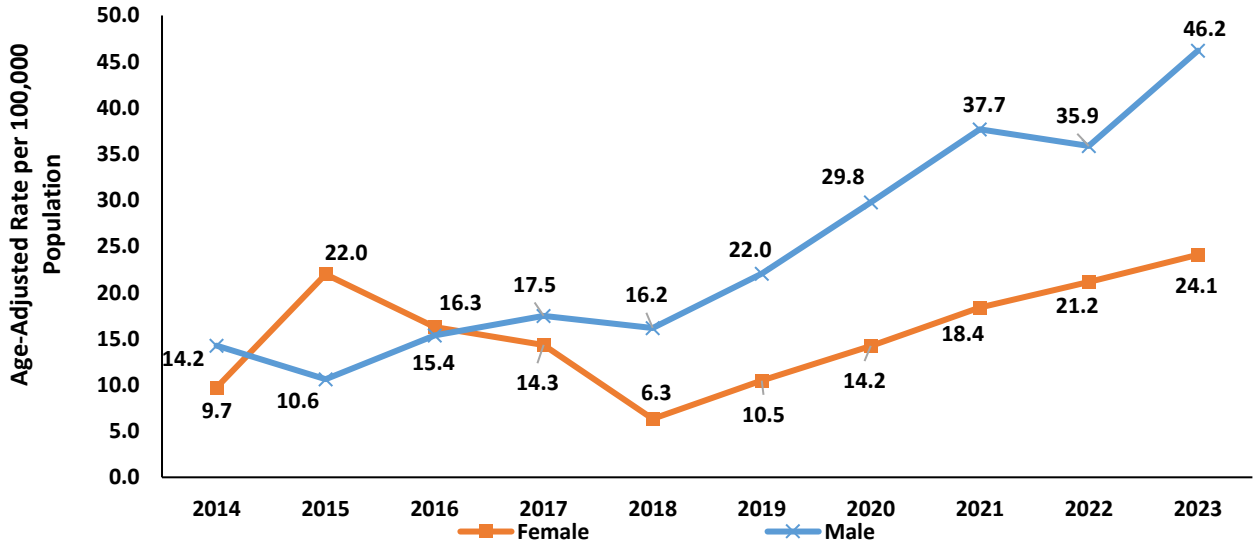
Figure 35. Opioid Overdose Deaths and Rates, Washoe County Residents, 2014-2023.



Source: Nevada Electronic Death Registry System

Opioid overdose death rates have increased for both sexes consistently since 2018. This suggests that the opioid crisis has worsened for both, but that males have been disproportionately affected.

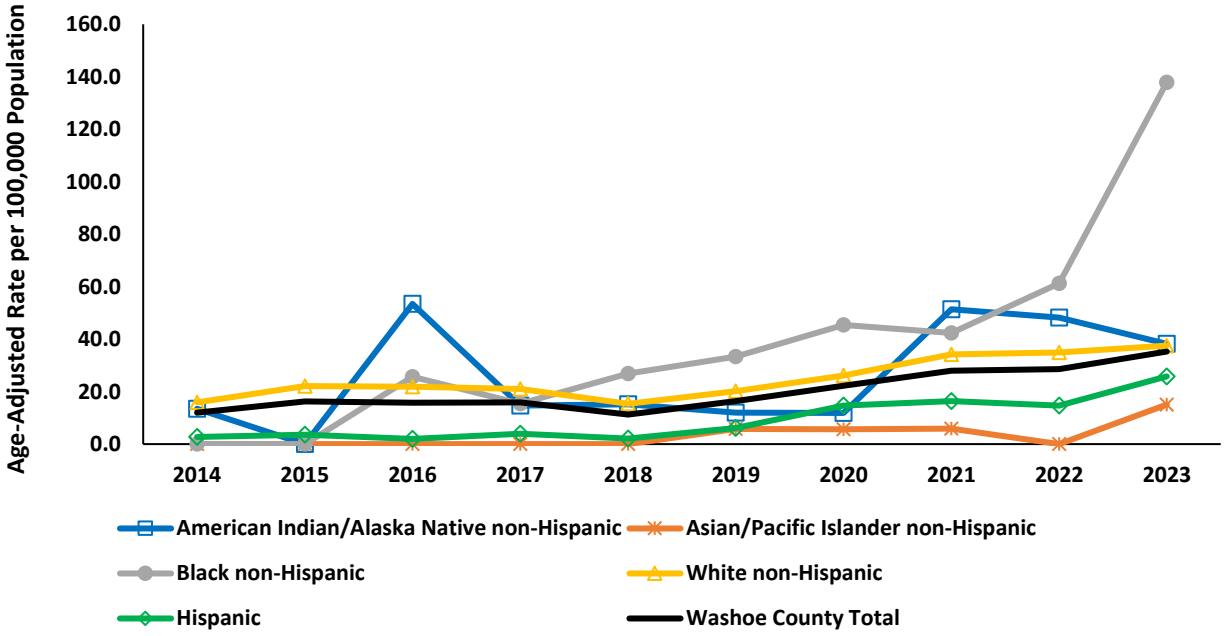
Figure 36. Opioid Overdose Death Rates by Sex, Washoe County Residents, 2014-2023.



Source: Nevada Electronic Death Registry System

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

Figure 37. Opioid Overdose Death Rates by Race/Ethnicity, Washoe County Residents, 2014-2023.



Source: Nevada Electronic Death Registry System

Stimulants

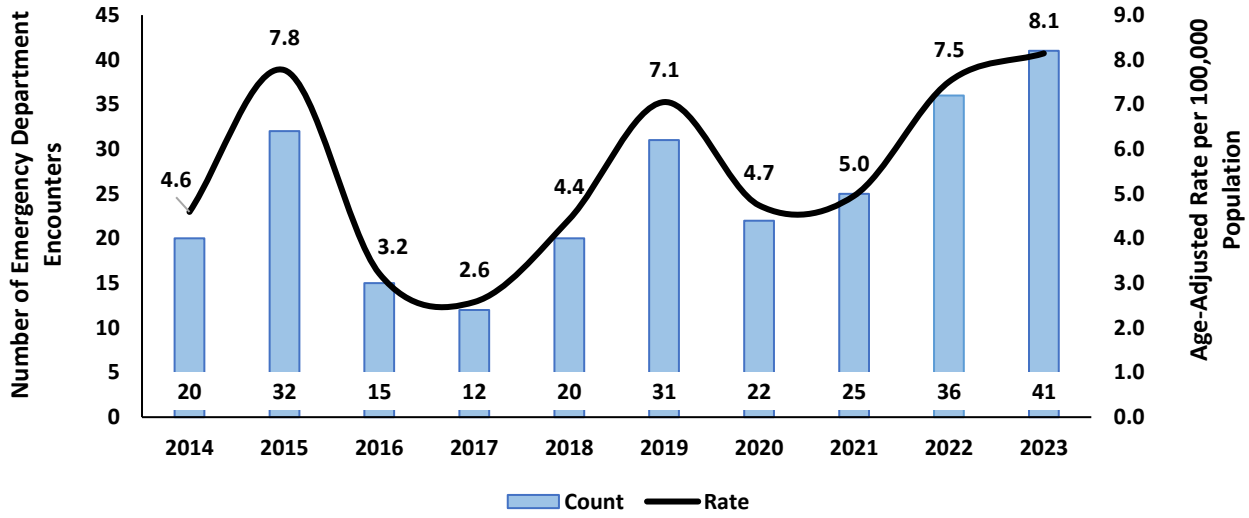
Stimulants are a class of drugs that accelerate communication between the brain and body, often making individuals feel more awake, alert, confident, or energetic. They include legal substances such as caffeine, prescription medications such as dexamphetamines, Adderall, and methylphenidate (Ritalin),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

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

Hospital Emergency Department Encounters

The rate of stimulant overdose emergency department encounters has fluctuated notably year-over-year, with peaks in 2015, 2019 and 2022-2023. The number of stimulant overdoses is relatively small compared to opioids.

Figure 38. Stimulant Overdose Emergency Department Encounters and Rates by Year, Washoe County Residents, 2014-2023.

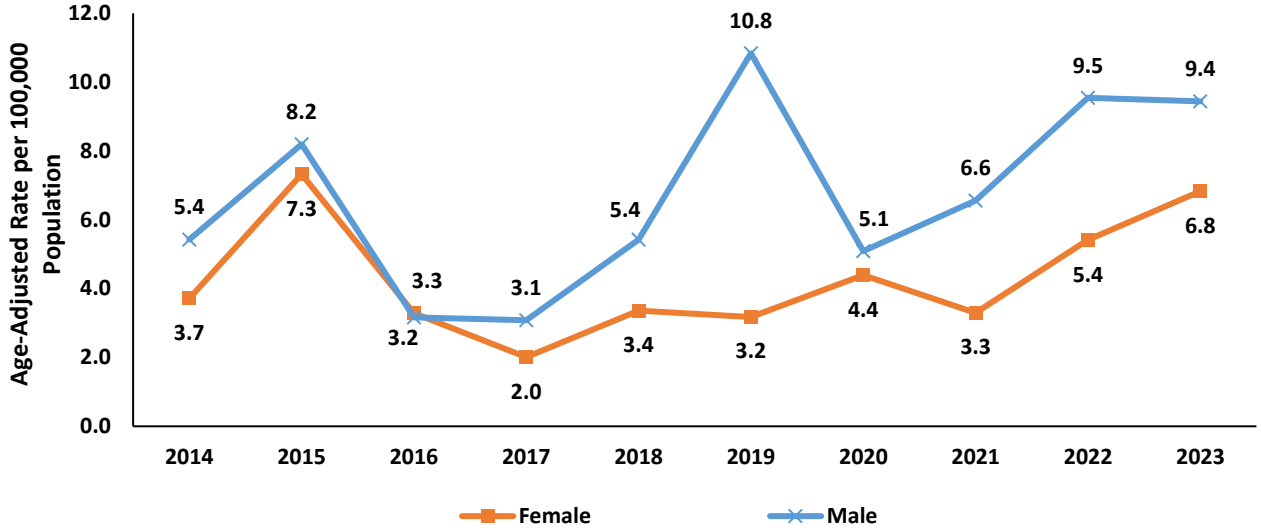


Source: Hospital Emergency Department Billing
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Males have had a higher rate of stimulant overdose emergency department encounters compared to females for all years from 2014-2023, with the exception of 2016.

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

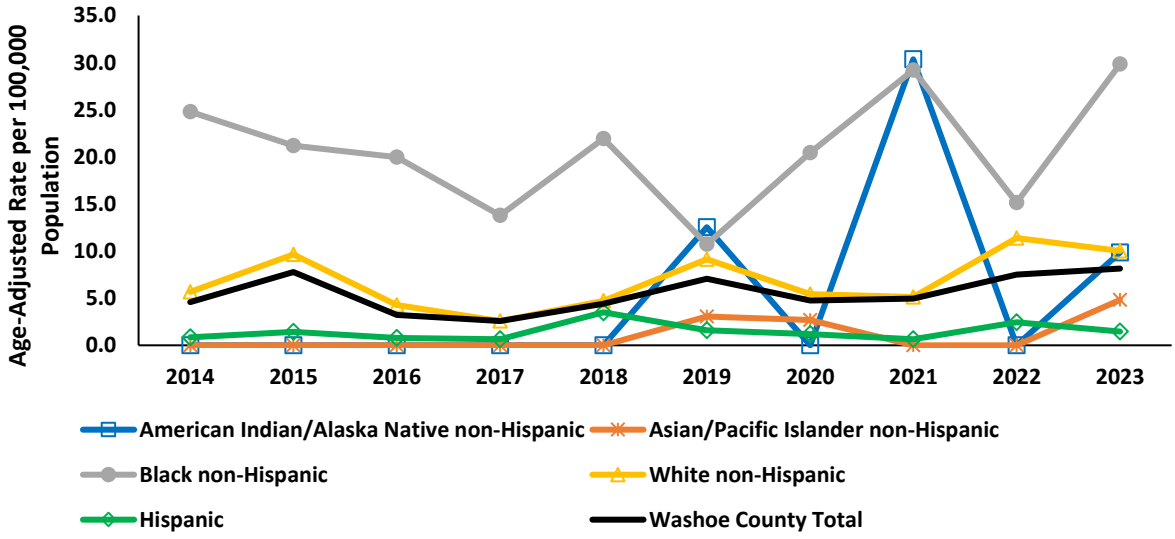
Figure 39. Stimulant Overdose Emergency Department Encounter Rates by Year and Sex, Washoe County Residents, 2014-2023.



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.

Similar to opioids, White non-Hispanics and Black non-Hispanics experience higher rates of stimulant overdose-related emergency room encounters compared to the overall Washoe County rates. However, unlike opioids, Black non-Hispanics have a higher rate of these encounters than White non-Hispanics. Note that the rate fluctuations among the American Indian/Alaska Native non-Hispanic population is a result of high volatility due to the relatively low population of this demographic in the state and should not be taken as a significant change from the other years in the reporting period.

Figure 40. Stimulant Overdose Emergency Department Encounter Rates by Year and Race/Ethnicity, Washoe County Residents, 2014-2023.

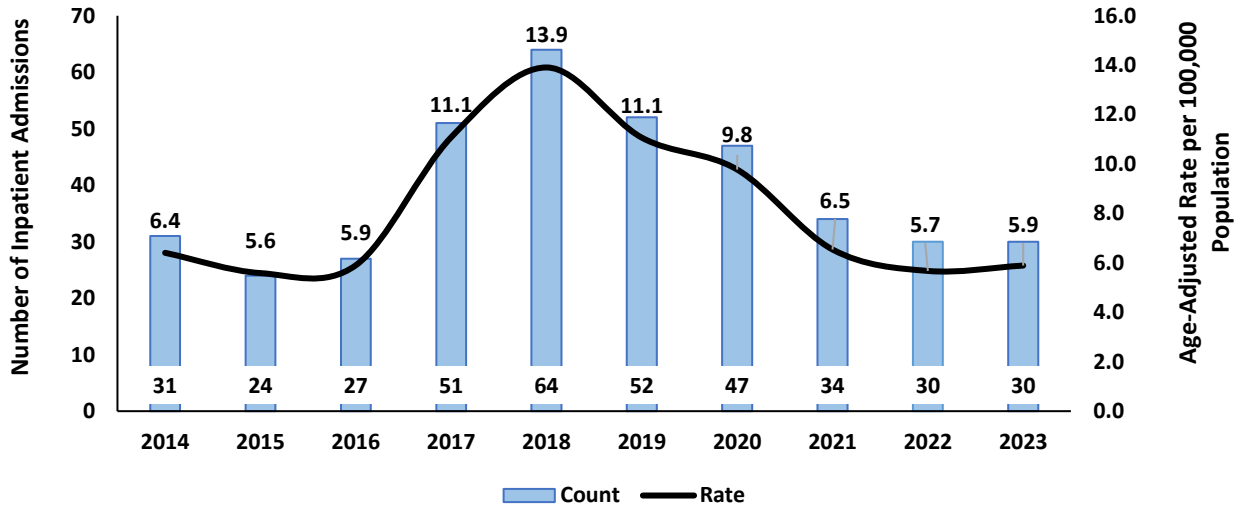


Source: Hospital Emergency Department Billing
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Hospital Inpatient Admissions

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

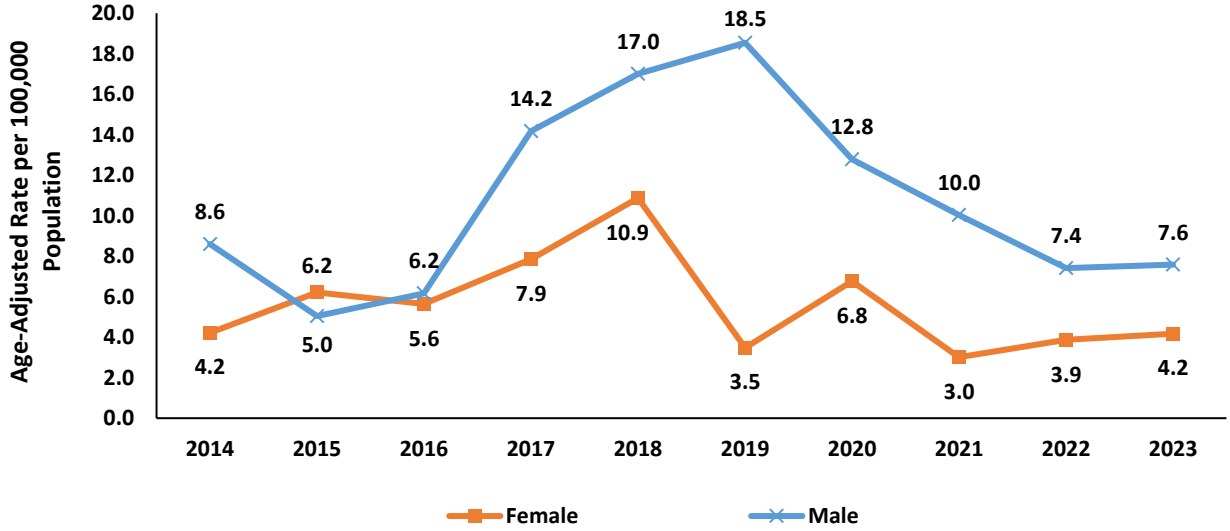
Figure 41. Stimulant Overdose Inpatient Admissions and Rates by Year, Washoe County Residents, 2014-2023.



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.

From 2017 to 2023, males had consistently higher stimulant overdose inpatient admission rates compared to females. Rates for both sexes experienced an increase in 2018, followed by a decrease to rates below the 2014 level.

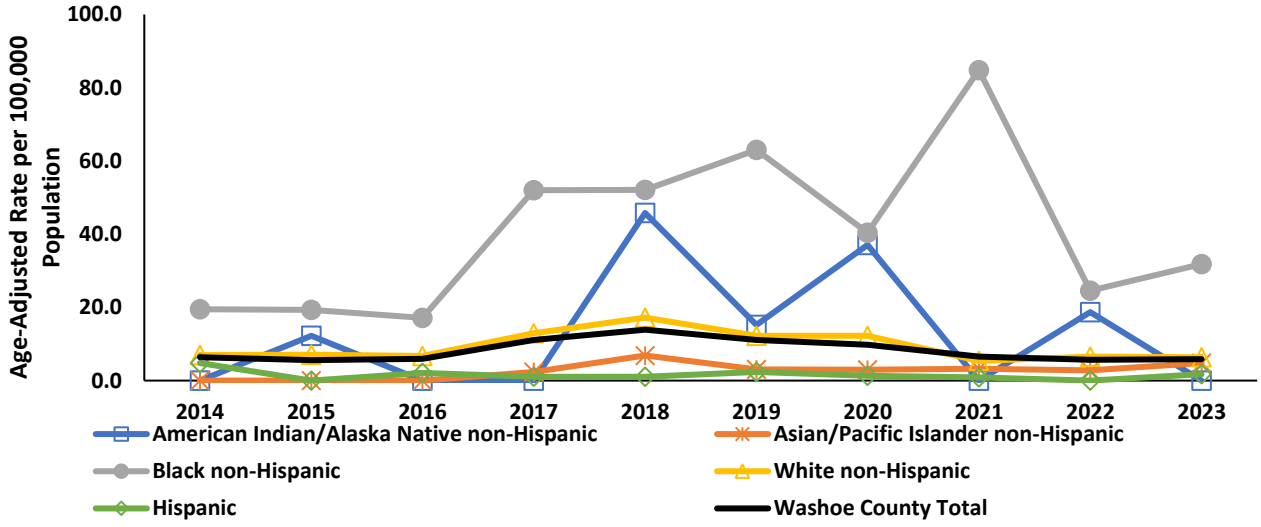
Figure 42. Stimulant Overdose Inpatient Admission Rates by Year and Sex, Washoe County Residents, 2014-2023.



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 rates of stimulant overdose inpatient admissions among Black non-Hispanics are significantly higher than the rates of both White non-Hispanics and Washoe County totals for all years 2014-2023. Note that the rate fluctuations among the American Indian/Alaska Native non-Hispanic population is a result of high volatility due to the relatively low population of this demographic in the state and should not be taken as a significant change from the other years in the reporting period.

Figure 43. Stimulant Overdose Inpatient Admission Rates by Year and Race/Ethnicity, Washoe County Residents, 2014-2023.

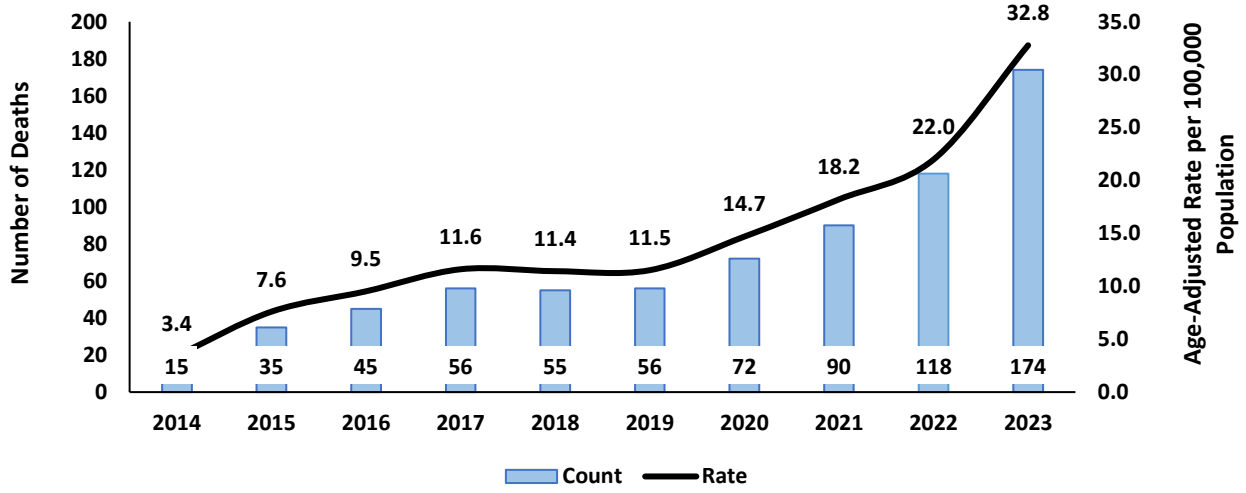


Source: Hospital Inpatient Billing
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Stimulant Overdose Deaths

The rates of stimulant-related overdose deaths have steadily increased since 2014, resulting in an 865% overall increase from 2014 to 2023. Methamphetamine toxicity was a contributing factor in the majority of deaths.

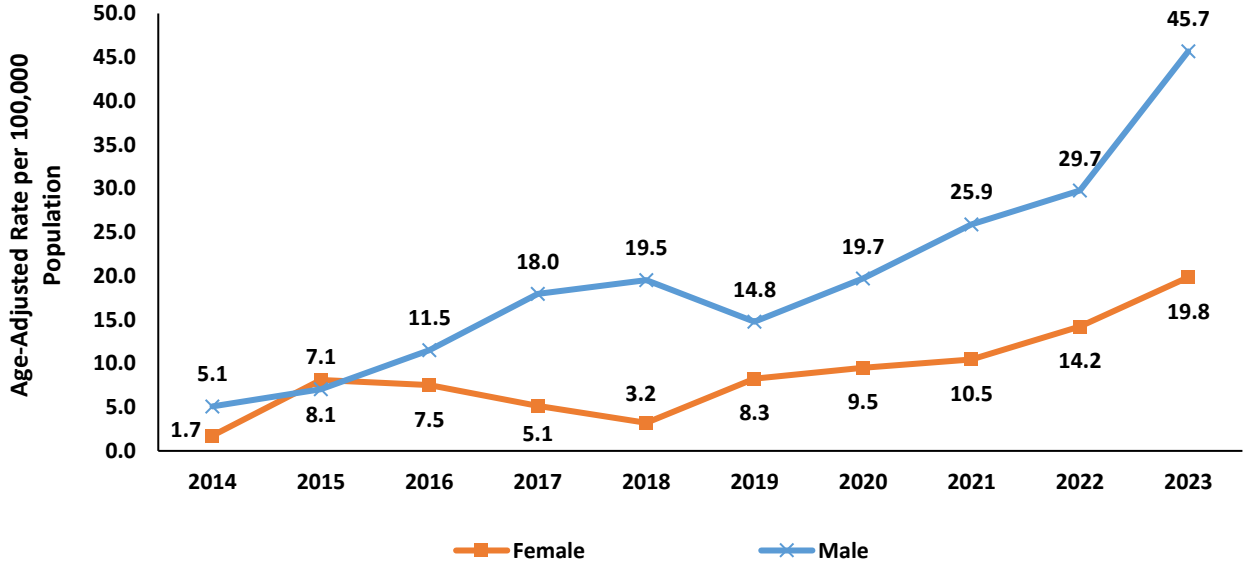
Figure 44. Stimulant Overdose Deaths and Rates, Washoe County Residents, 2014-2023.



Source: Nevada Electronic Death Registry System

Since 2014, stimulant overdose death rates have increased among both males and females, with a slight decrease in male rates observed in 2019. Throughout the period from 2017 to 2023, male rates remained consistently and considerably higher than female rates.

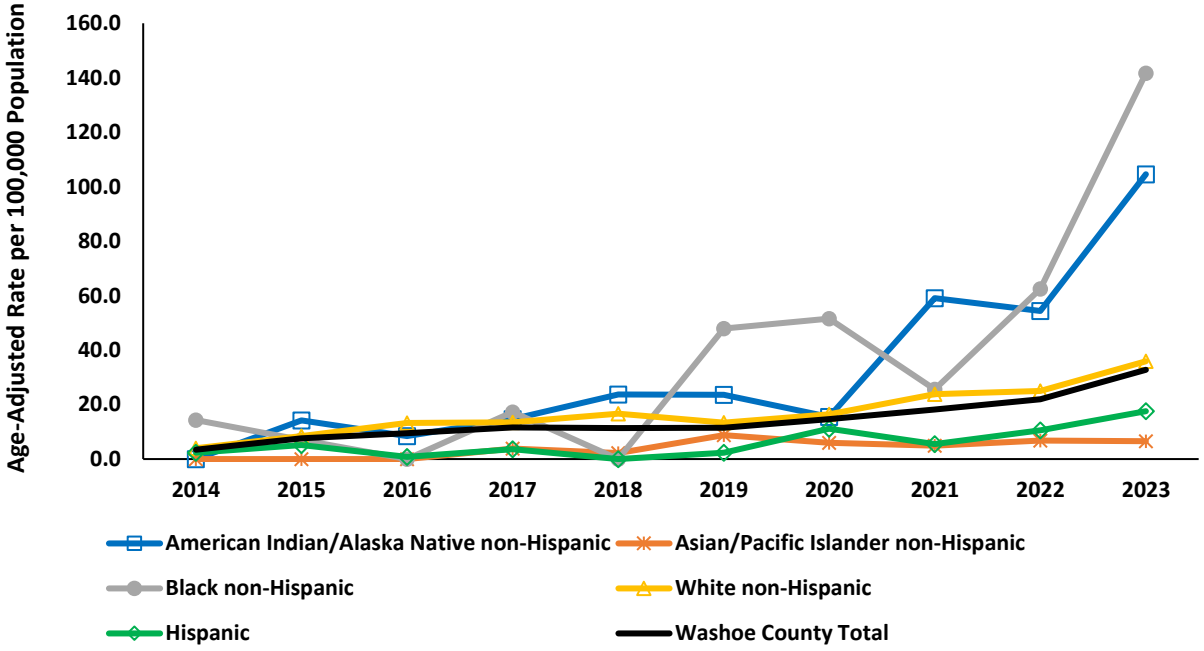
Figure 45. Stimulant Overdose Death Rates by Sex, Washoe County Residents, 2014-2023.



Source: Nevada Electronic Death Registry System

The stimulant overdose death rate for all race/ethnicity groups has increased since 2014.

Figure 46. Stimulant Overdose Death Rates by Race/Ethnicity, Washoe County Residents, 2014-2023.



Source: Nevada Electronic Death Registry System

Alcohol

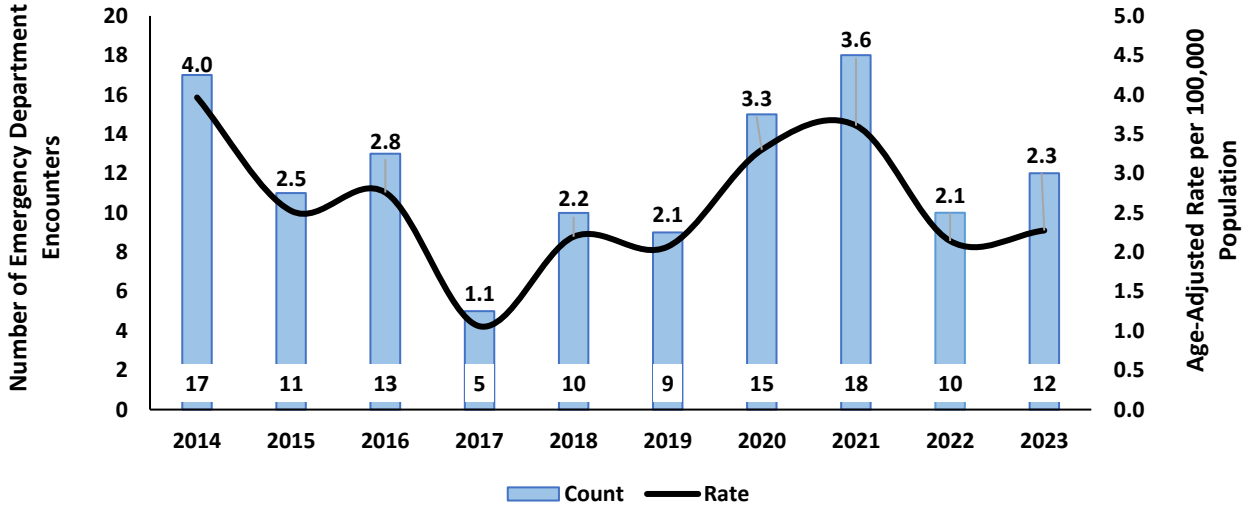
According to research from the CDC, alcohol misuse causes roughly 178,000 deaths each year in the United States and shortens lives by an average of 24 years.[4] About two-thirds of those deaths are from chronic conditions developed from long-term alcohol use, while the other one-third result from binge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

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

Overdoses

The rates for alcohol overdose emergency department encounters have remained consistent, fluctuating from a high of 4.0 per 100,000 population in 2014 to a low of 1.1 per 100,000 and back up to 3.6 in 2021.

Figure 47. Alcohol Overdose Emergency Department Encounters and Rates by Year, Washoe County Residents, 2014-2023.



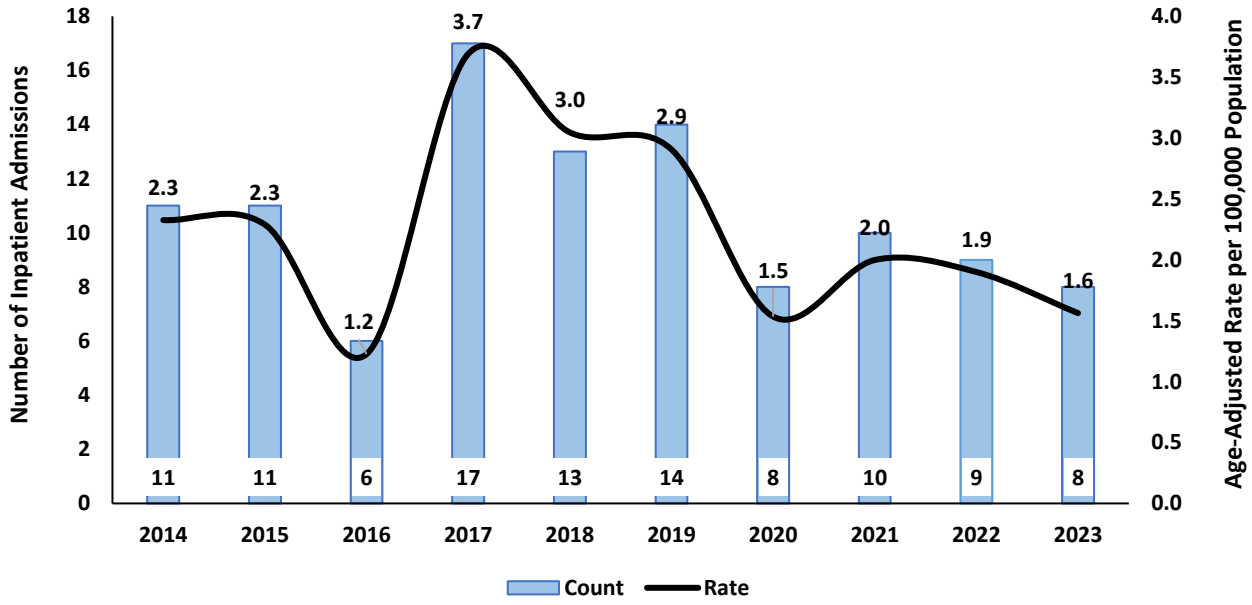
Source: Hospital Emergency Department Billing
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

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

Due to the small total number of emergency department encounters in the reporting period, rates by demographic breakout have been omitted.

Hospital inpatient admissions due to alcohol overdoses have been decreasing since 2017. The rate per 100,000 in 2016 was the lowest in the reporting period at 1.2 per 100,000 population; the highest was 3.7 in 2017; and then a gradual decline to 1.6 in 2023.

Figure 48. Alcohol Overdose Inpatient Admissions and Rates by Year, Washoe County 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 the small total number of emergency department encounters in the reporting period, rates by demographic breakout have been omitted.

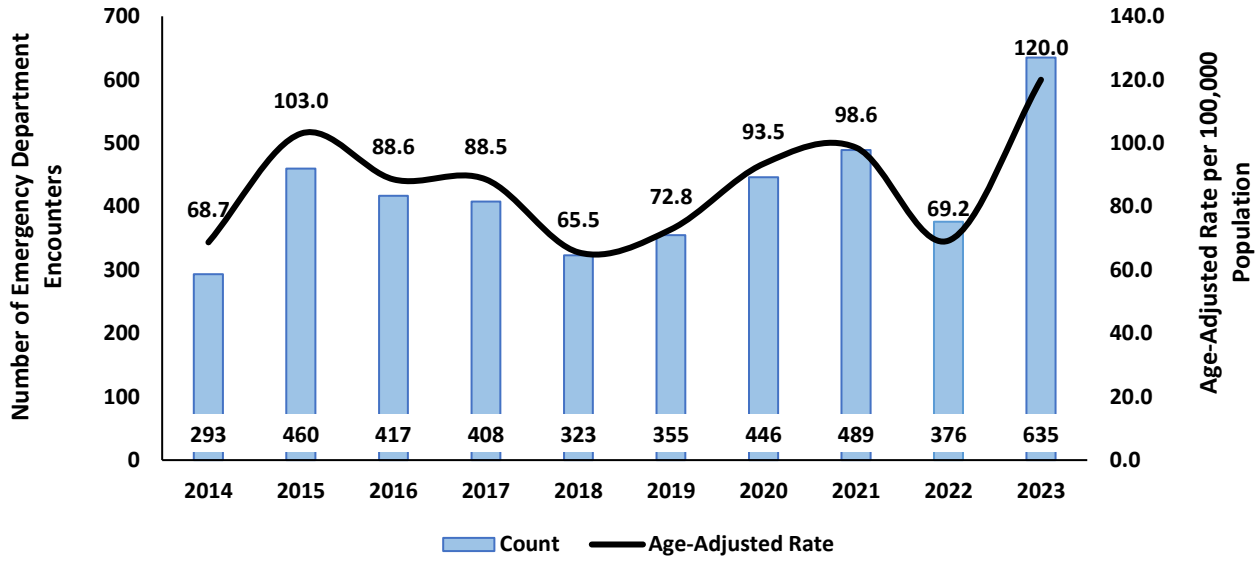
Chronic Alcohol Conditions

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 fluctuated throughout the reporting period with a low of 65.5 per 100,00 in 2018 and a high of 120.0 per 100,000 population in 2023.

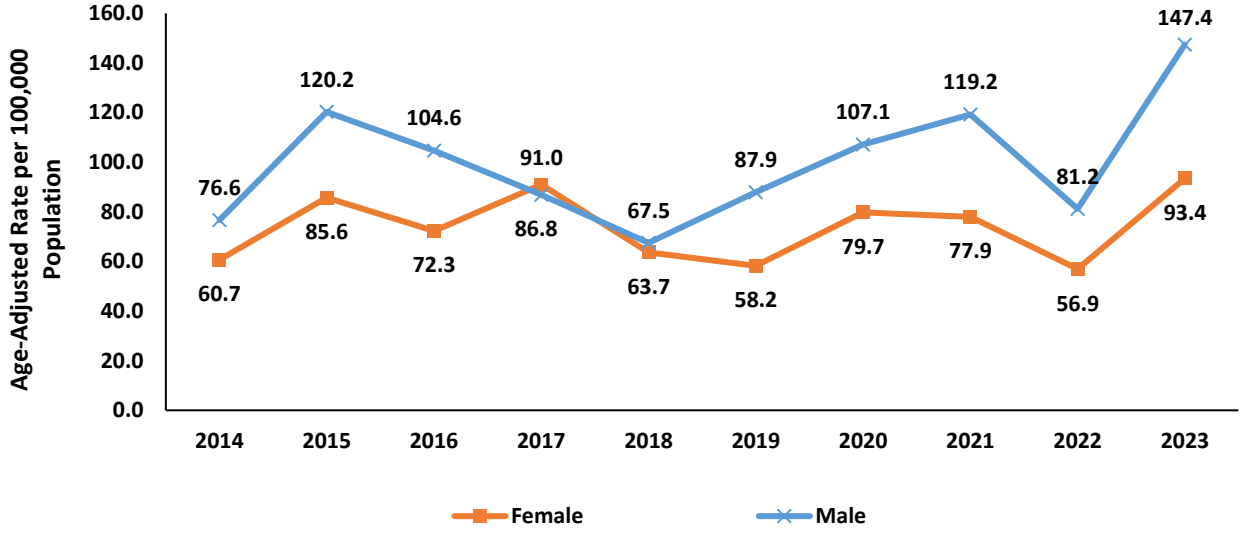
Figure 49. Chronic Alcohol Diseases Emergency Department Encounters and Rates by Year, Washoe County Residents, 2014-2023.



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

The rates of emergency department encounters for alcohol-related diseases in Washoe County between 2014 and 2023 for both females and males have been largely comparable, with the rate for men being slightly higher on average.

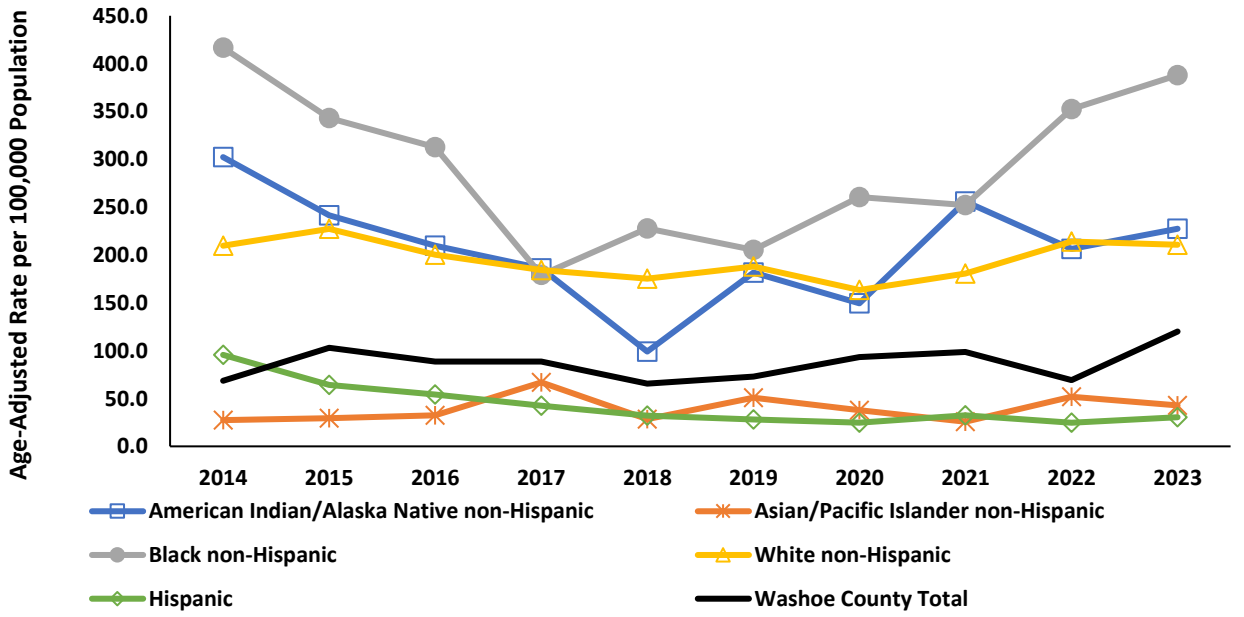
Figure 50. Chronic Alcohol Diseases Emergency Department Encounter Rates by Year and Sex, Washoe County Residents, 2014-2023.



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 chronic alcohol disease-related emergency department encounters is significantly higher for Black non-Hispanics, White non-Hispanics, and American Indian/Alaska Natives than for Washoe County as a whole; the rates for the Hispanic and Asian/Pacific Islander non-Hispanic populations in Washoe are lower than the county as a whole.

Figure 51. Chronic Alcohol Diseases Emergency Department Encounter Rates by Year and Race/Ethnicity, Washoe County Residents, 2014-2023.

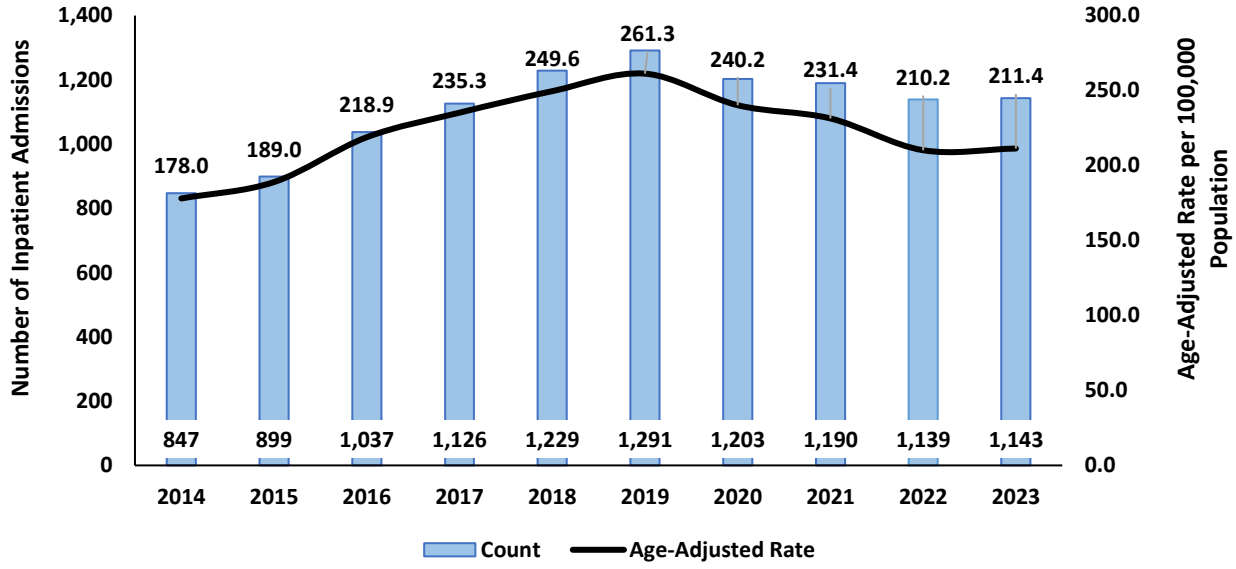


Source: Hospital Emergency Department Billing
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Hospital Inpatient Admissions

Inpatient admissions for chronic alcohol-related diseases increased between 2014 and 2019 to a high of 261.3 per 100,000 before declining through 2023.

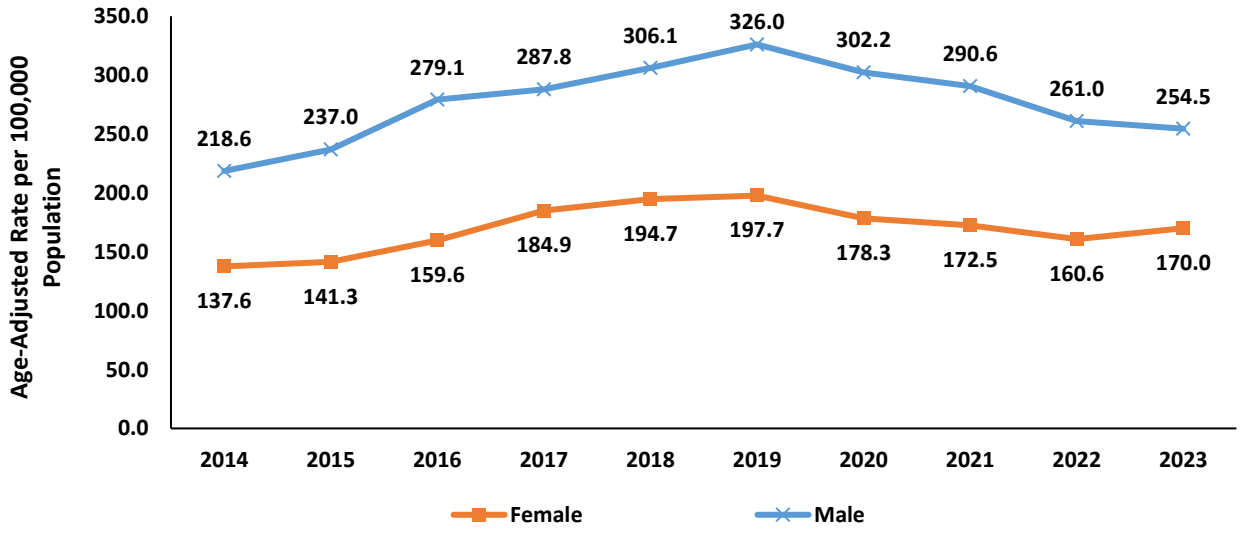
Figure 52. Chronic Alcohol Diseases Inpatient Admissions and Rates by Year, Washoe County Residents, 2014-2023.



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 for men has remained significantly higher than that of women for the duration of the reporting period.

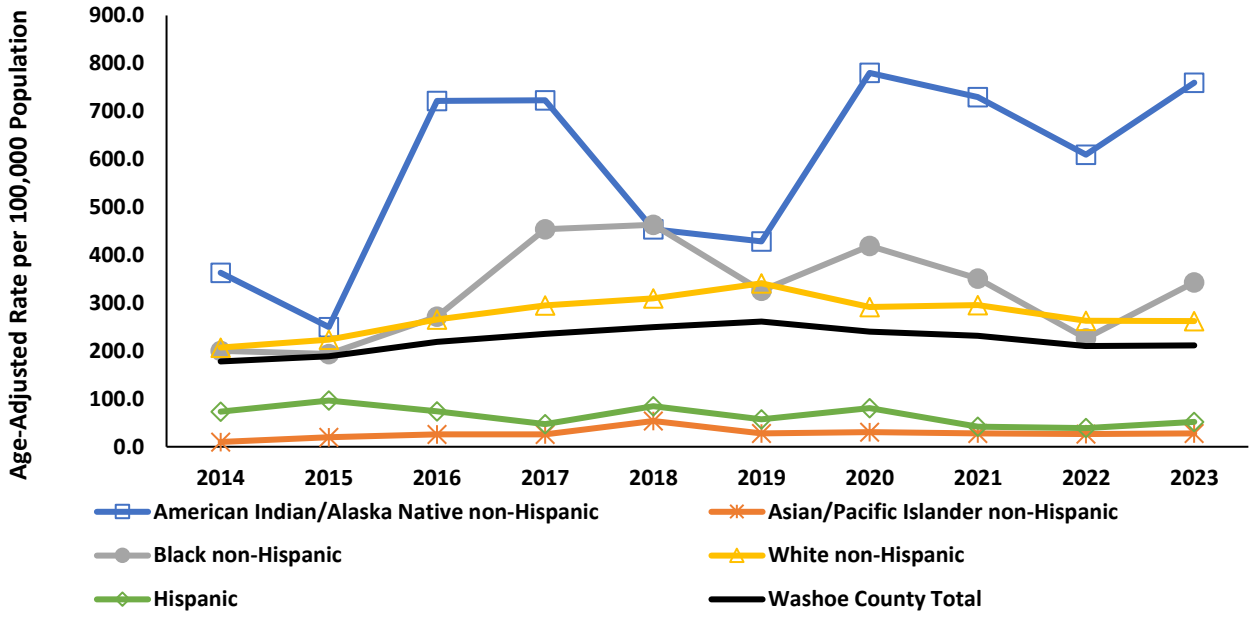
Figure 53. Chronic Alcohol Diseases Inpatient Admission Rates by Year and Sex, Washoe County Residents, 2014-2023.



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.

American Indian/Alaska Native non-Hispanics had a rate of inpatient admissions that was consistently higher than the total rate for Washoe County in all years of the reporting period. Black non-Hispanics and White non-Hispanics also had rates higher than the county in total.

Figure 54. Chronic Alcohol Diseases Inpatient Admission Rates by Year and Race/Ethnicity, Washoe County Residents, 2014-2023.

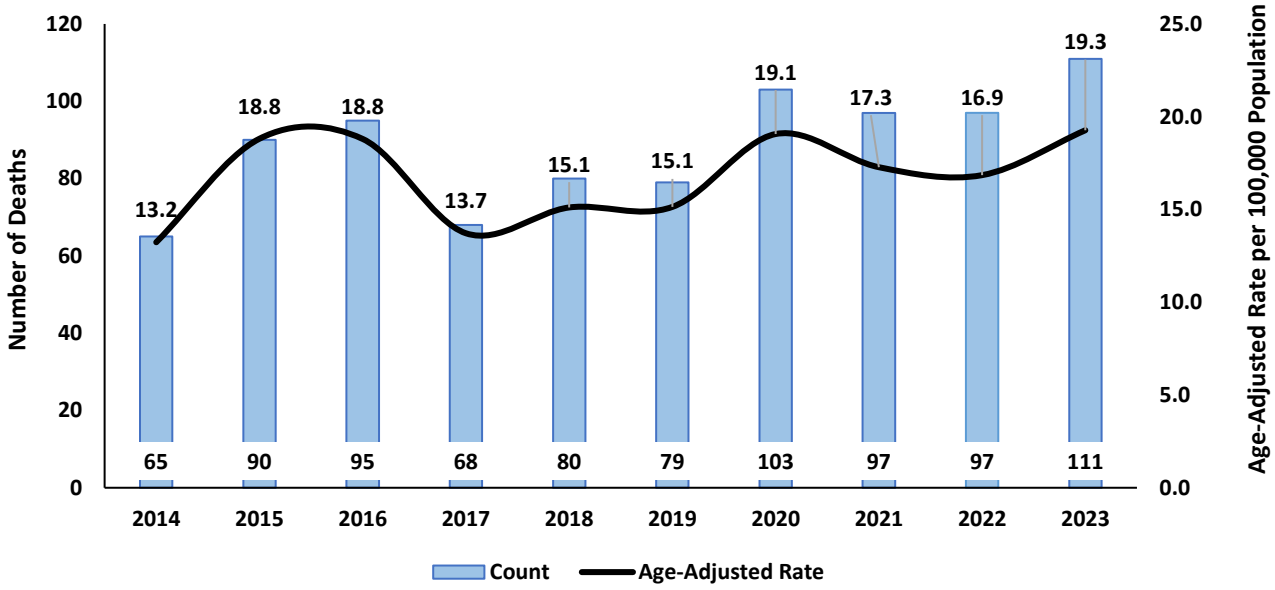


Source: Hospital Inpatient Billing
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Chronic Alcohol Diseases Deaths

Deaths related to chronic diseases from alcohol increased markedly in 2020 to 19.1 per 100,000, and remained elevated in the years following the height of the COVID-19 pandemic.

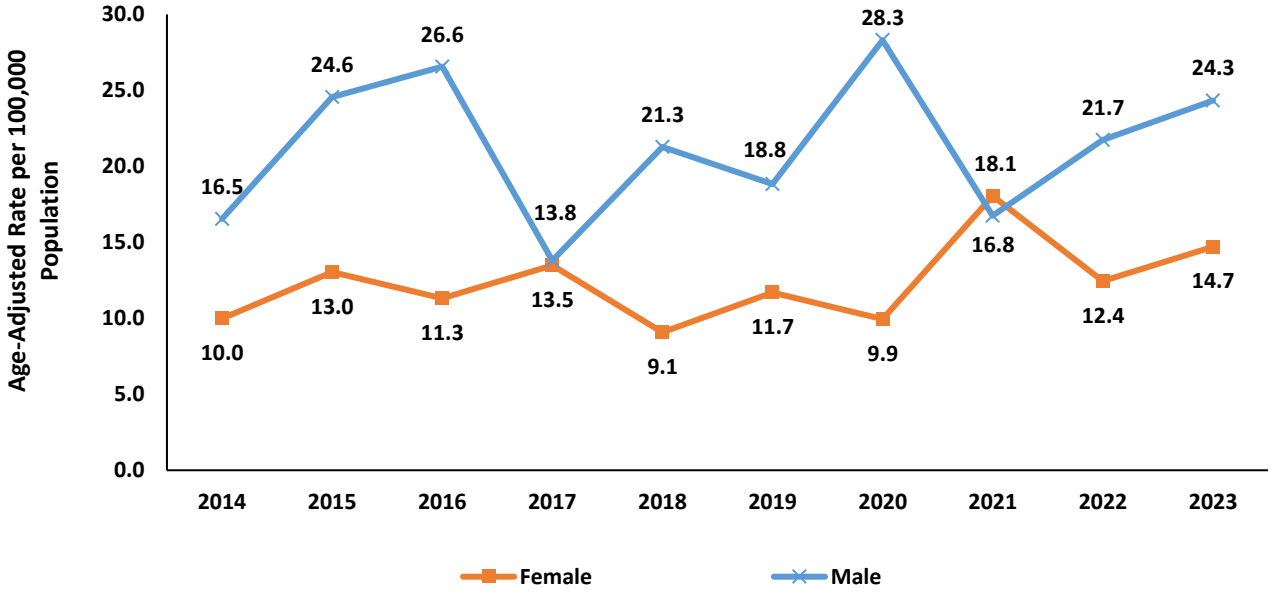
Figure 55. Chronic Alcohol Diseases Deaths and Rates, All Ages, Washoe County Residents, 2014-2023.



Source: Nevada Electronic Death Registry System

As with hospital visits, the rate of deaths from these conditions is higher for men, on average, than it is for women. The peak rates for men per 100,000 were 26.6 and 28.3 in 2016 and 2020 respectively; the peak rates for women were one year behind the men, at 13.5 in 2017 and 16.8 in 2021.

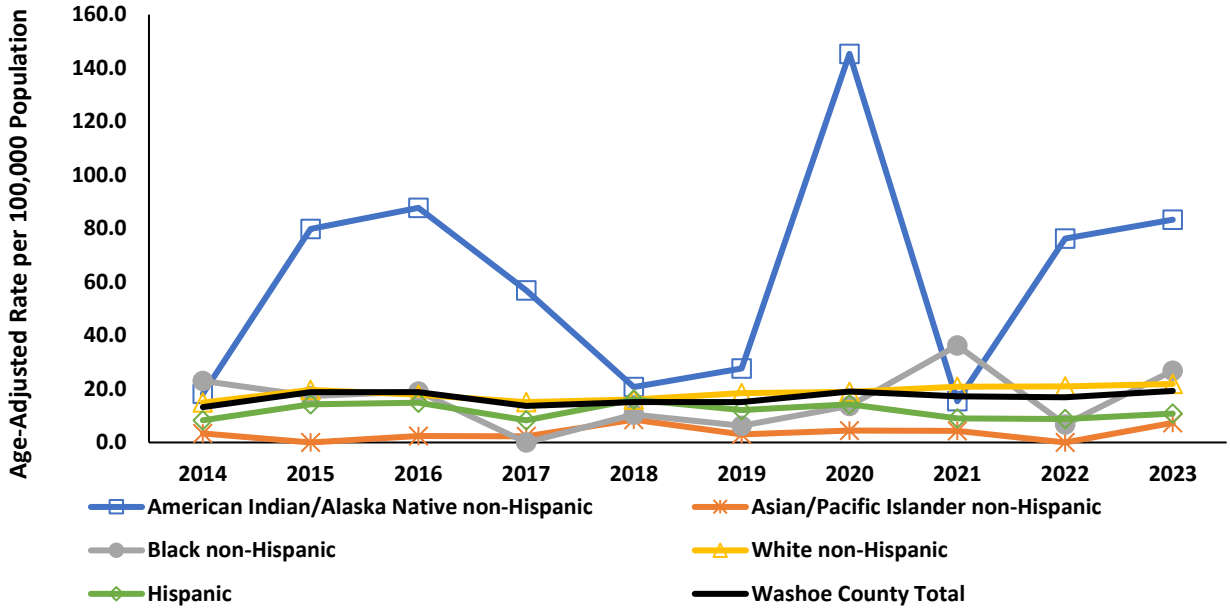
Figure 56. Chronic Alcohol Diseases Death Rates by Sex, Washoe County Residents, 2014-2023.



Source: Nevada Electronic Death Registry System

While it should again be noted that the relatively small population of indigenous people in the Washoe County population can lead to volatility in rates per 100,000, the rate of death for this demographic due to these chronic conditions is higher than Washoe County as a whole for all years except 2021.

Figure 57. Chronic Alcohol Diseases Death Rates by Race/Ethnicity, Washoe County Residents, 2014-2023.



Source: Electronic Death Registry System

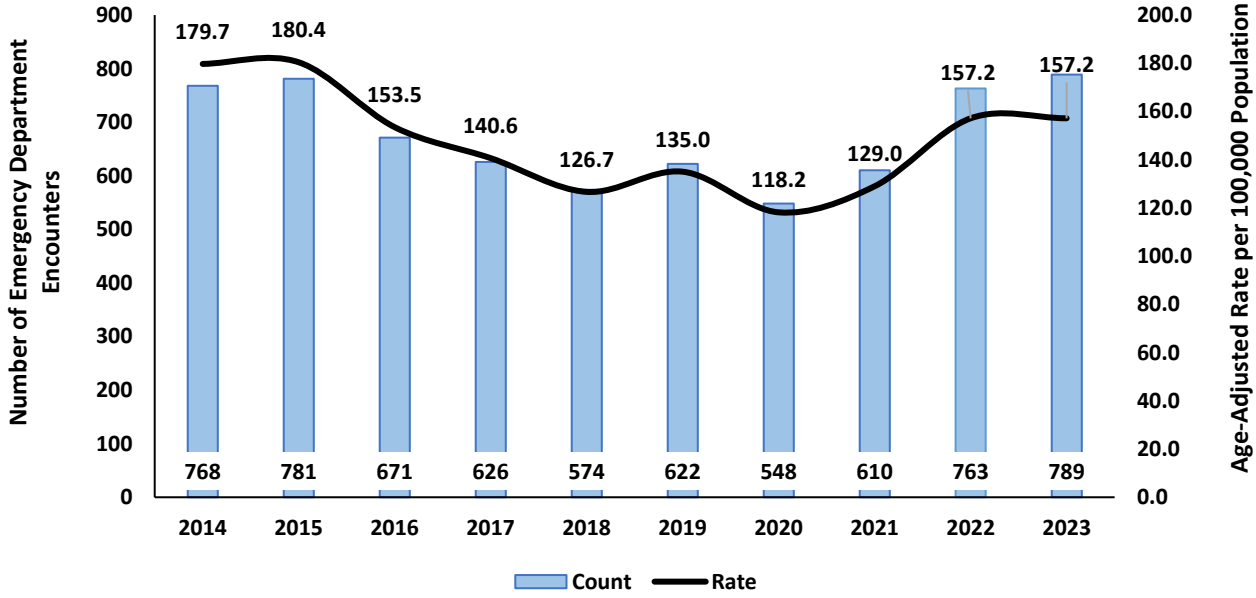
Alcohol- and/or Drug-Related Overdoses

This section combines alcohol with all other substances including opioids, stimulants, hallucinogens, and other prescription medications to present a broader picture of overdose-related hospitalizations and deaths in Washoe County.

Hospital Emergency Department Encounters

The rate overdoses in emergency departments in Washoe County decreased between 2015 and 2020, followed by a notable increase in the years following the COVID-19 pandemic.

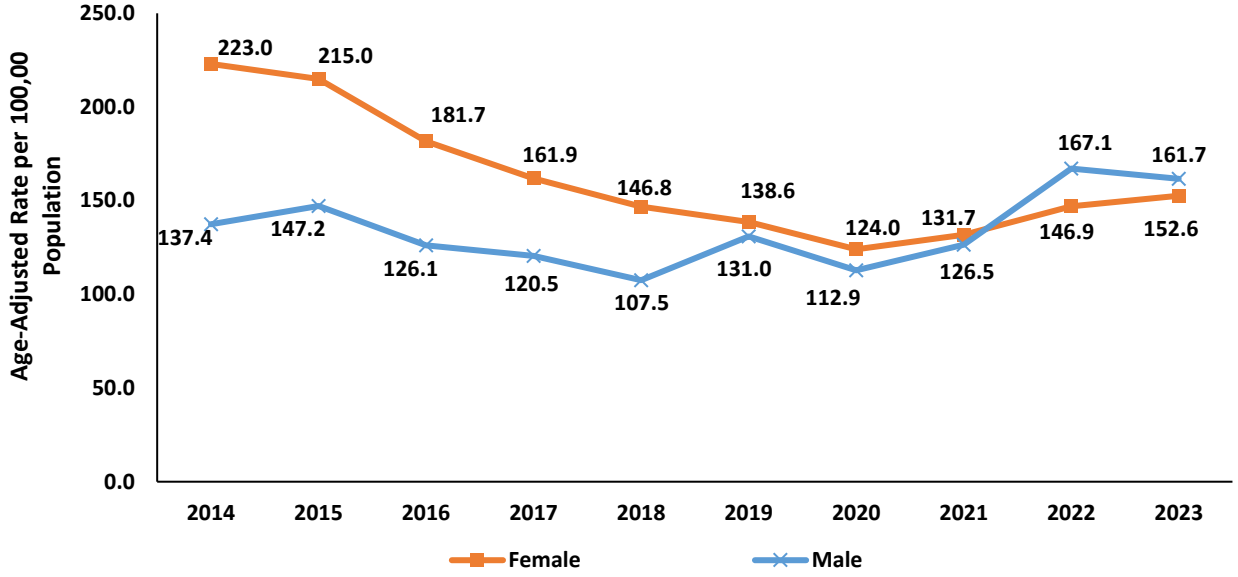
Figure 58. Alcohol- and/or Drug-Related Overdose Emergency Department Encounters and Rates by Year, Washoe County Residents, 2014-2023.



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.

From 2014 to 2021, females consistently had higher rates of alcohol- and drug-related overdose emergency department encounters compared to males. This changed in 2022, when males surpassed females with a rate of 167.1 compared to 146.9 per 100,000 population.

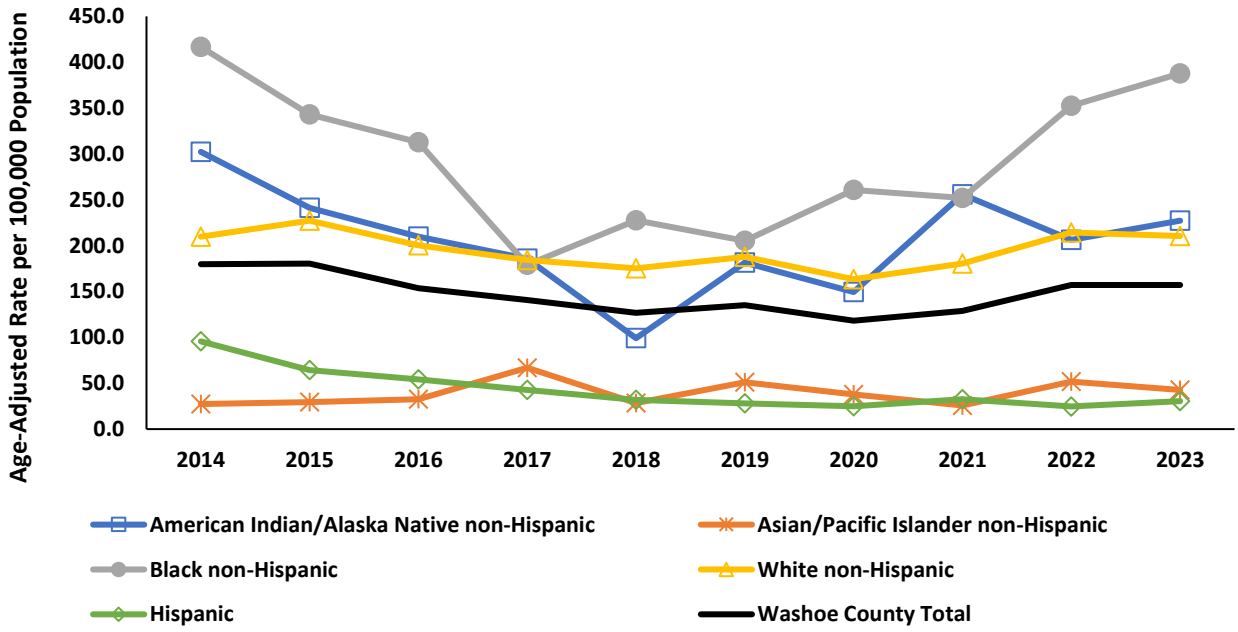
Figure 59. Alcohol- and/or Drug-Related Overdose Emergency Department Encounter Rates by Year and Sex, Washoe County Residents, 2014-2023.



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.

Black non-Hispanic and White non-Hispanic populations consistently had higher rates of alcohol- and drug-related overdose emergency department encounters compared to Washoe County across all years of the reporting period. American Indian/Alaskan Natives also had elevated rates in all years except 2018.

Figure 60. Alcohol- and/or Drug-Related Overdose Emergency Department Encounter Rates by Year and Race/Ethnicity, Washoe County Residents, 2014-2023.

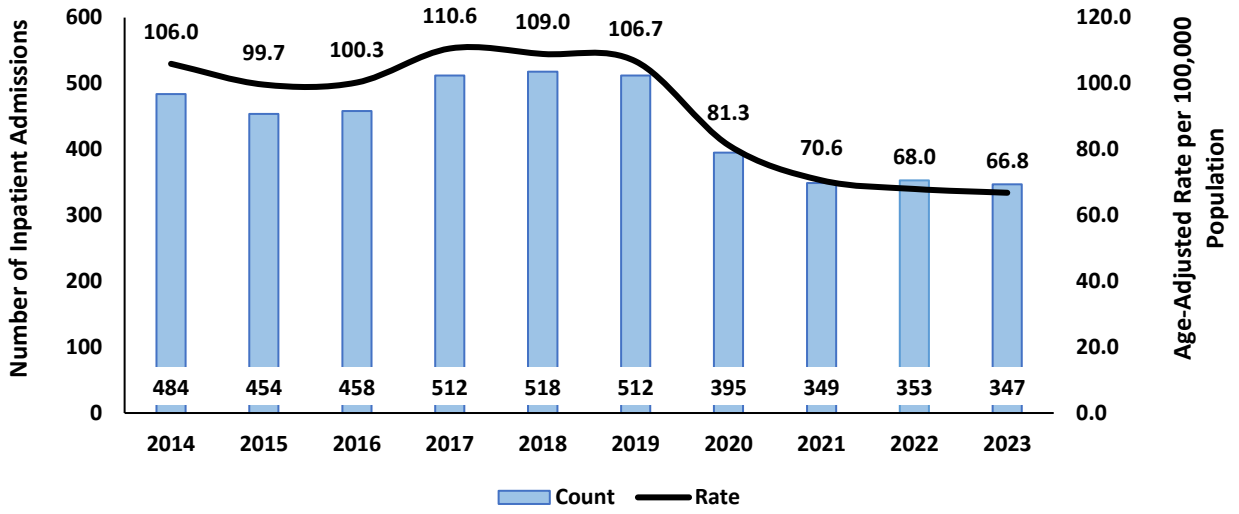


Source: Hospital Emergency Department Billing
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Hospital Inpatient Admissions

The rate of alcohol- and drug-related overdose inpatient admissions had experienced a downward trend since 2017's rate of 110.6, with the lowest rate occurring in 2023 at 66.8 per 100,000 population.

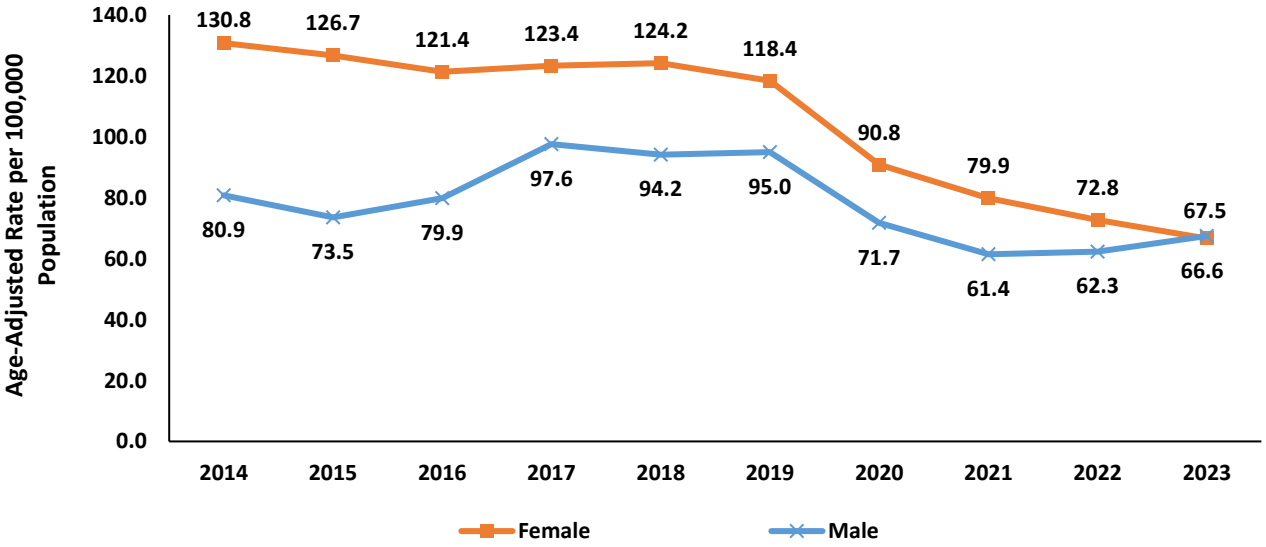
Figure 61. Alcohol- and/or Drug-Related Overdose Inpatient Admissions and Rates by Year, Washoe County Residents, 2014-2023.



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.

Following the same trend as emergency department encounters, females consistently had higher rates of alcohol- and drug-related inpatient admissions compared to males, with males surpassing females in 2023 (67.5 and 66.6 per 100,000 population, respectively).

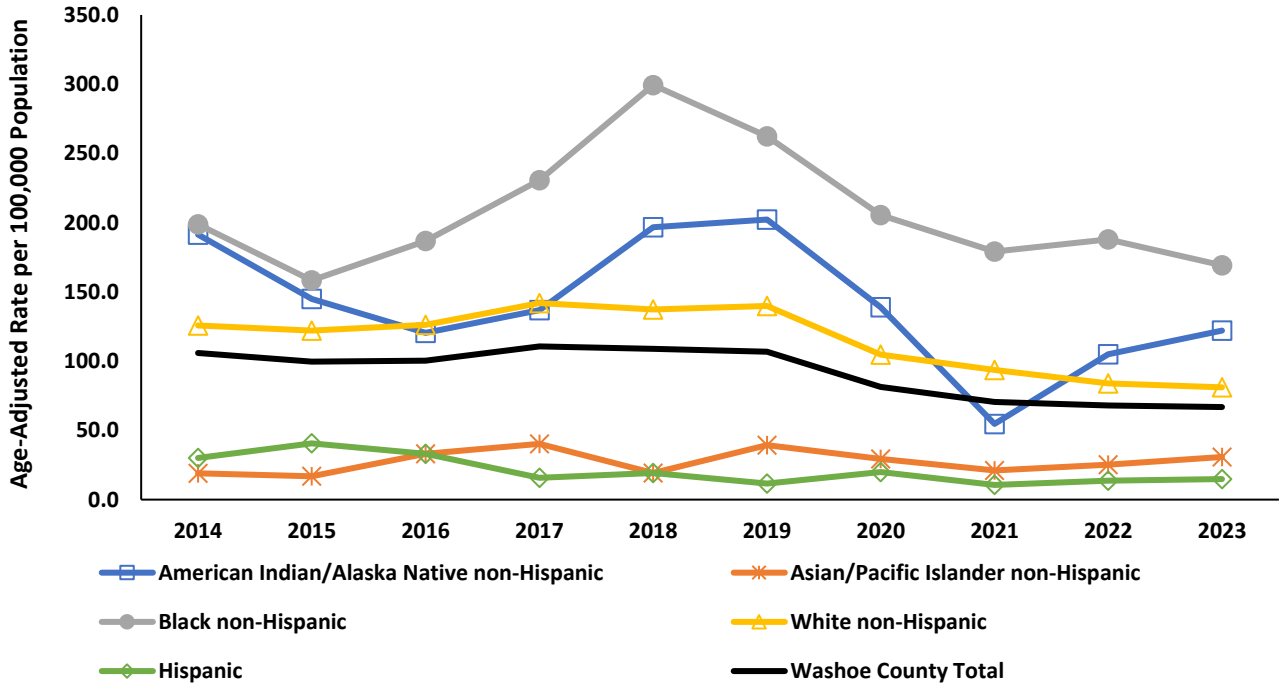
Figure 62. Alcohol- and/or Drug-Related Overdose Inpatient Admission Rates by Year and Sex, Washoe County Residents, 2014-2023.



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.

Following the same trend as emergency department encounters, Black non-Hispanic and White non-Hispanic populations consistently had higher rates of alcohol- and drug-related overdose inpatient admissions compared to Washoe County overall. American Indian/Alaska Native non-Hispanics also had higher rates than the county for all years except 2021. Hispanic and Asian/Pacific Islander non-Hispanic rates were well below the overall county rate from 2014 through 2023.

Figure 63. Alcohol- and/or Drug-Related Overdose Inpatient Admission Rates by Year and Race/Ethnicity, Washoe County Residents, 2014-2023.

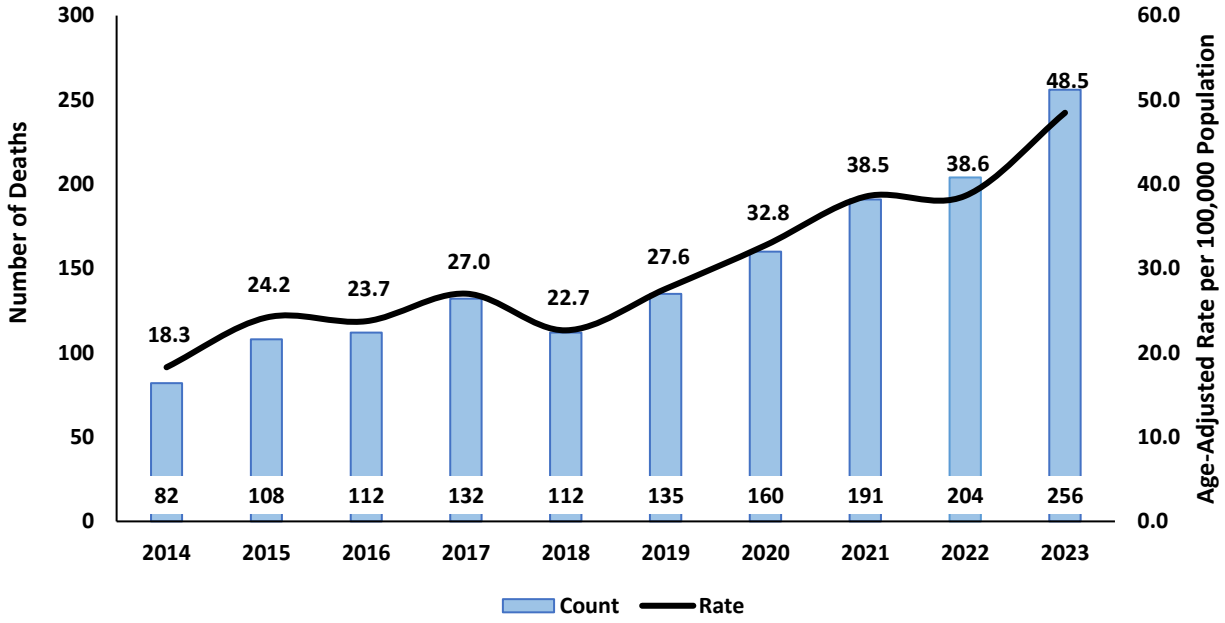


Source: Hospital Inpatient Billing
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Alcohol- and/or Drug-Related Overdose Deaths

This section includes deaths of all ages where alcohol overdose or drug overdose is listed as the primary cause of death. In 2023, there were 256 such deaths in Washoe County, the highest count and rate in the reporting period. Both the number of these deaths and the age-adjusted rate have been increasing since 2018.

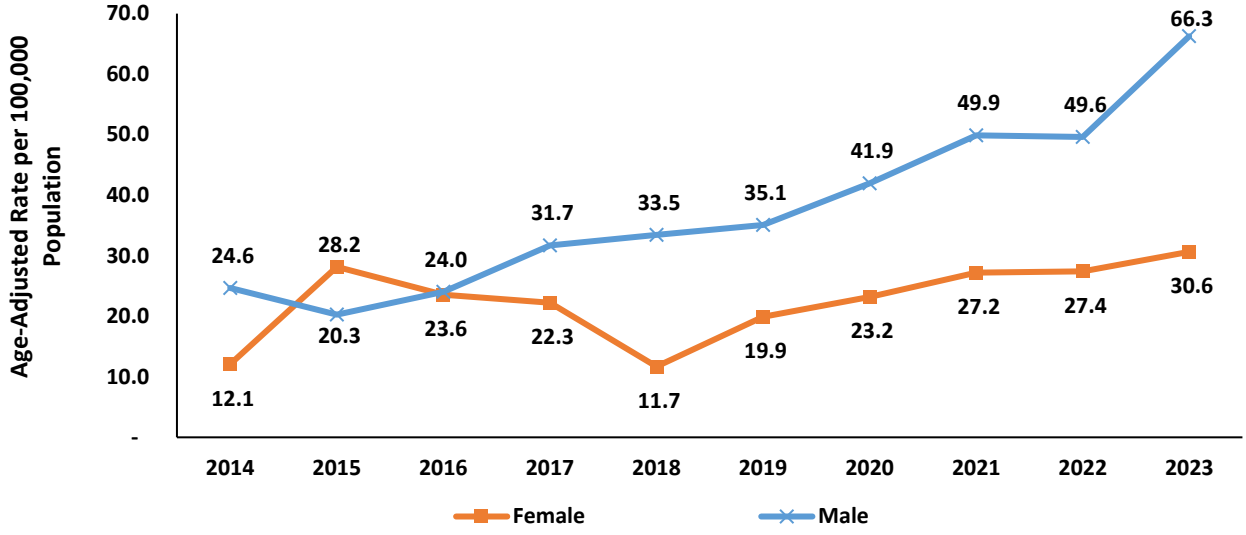
Figure 64. Alcohol- and/or Drug-Related Overdose Deaths and Rates, Washoe County Residents, 2014-2023.



Source: Electronic Death Registry System

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

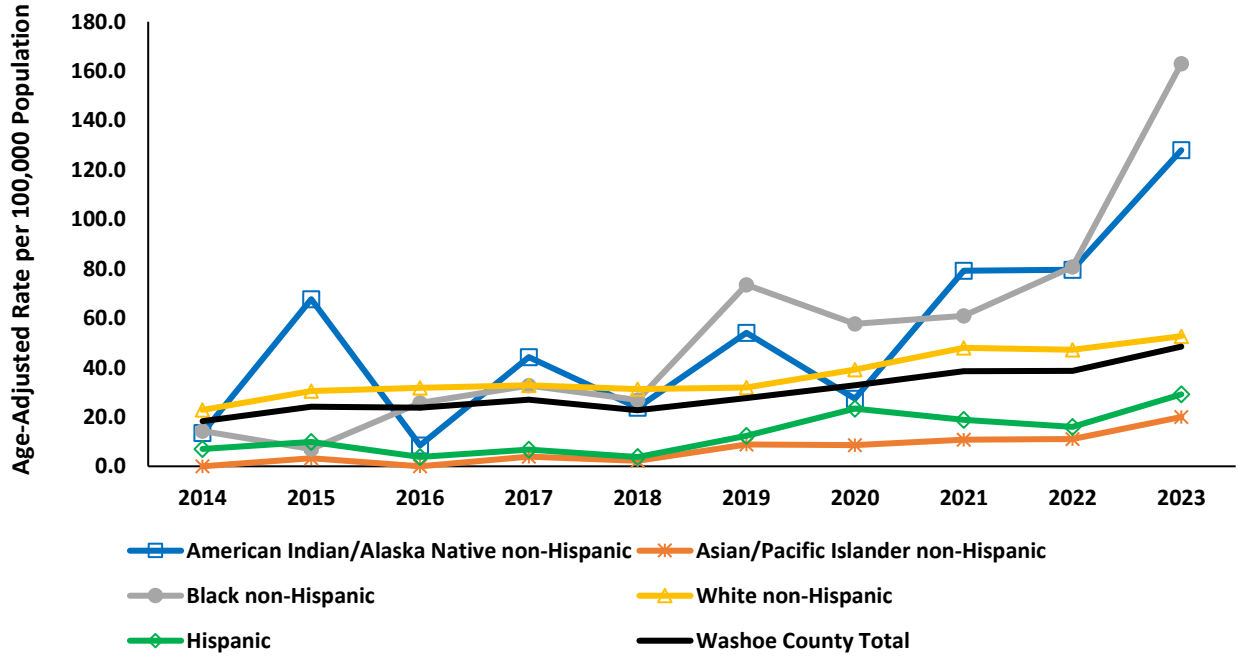
Figure 65. Overdose Death Rates by Sex, Washoe County Residents, 2014-2023.



Source: Electronic Death Registry System

All race/ethnicities experienced an overdose death rate increase from 2014-2023. The rates among White non-Hispanics have been higher than the Washoe County total rates for all years. This has also been the case for Black non-Hispanics since 2016.

Figure 66. Overdose Death Rates by Race/Ethnicity, Washoe County Residents, 2014-2023.



Source: Electronic Death Registry System

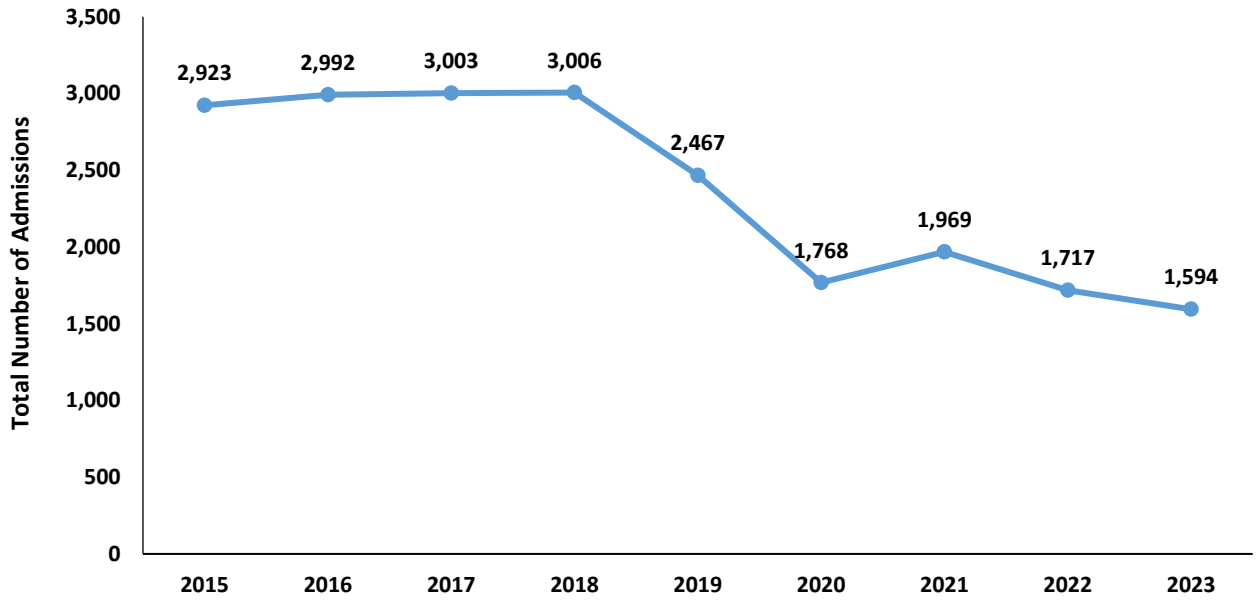
Substance Use Treatment Centers

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

The number of admissions to Nevada state-funded substance use treatment facilities in Washoe County has declined since 2015.

In 2021, Medicaid reduced copayment requirements for opioid use disorder (OUD) medications and expanded coverage to include all states covering buprenorphine, oral naltrexone, and injectable naltrexone. Additionally, utilization management policies, such as quantity limits and prior authorizations, were decreased. These changes from 2017 through 2021, along with policies from the Affordable Care Act, the Obama administration, and the 2018 SUPPORT Act, have significantly expanded Medicaid's role in substance use disorder (SUD) care.[7] Due to the prevalence of Medicaid utilization at these facilities, there was a notable increase in admissions in 2022 and 2023 statewide, however these increases were not seen in Washoe County.

Figure 67. Total Number of Admissions in State-Funded Washoe County Substance Abuse Treatment Facilities, Washoe County Facilities, 2015-2023.

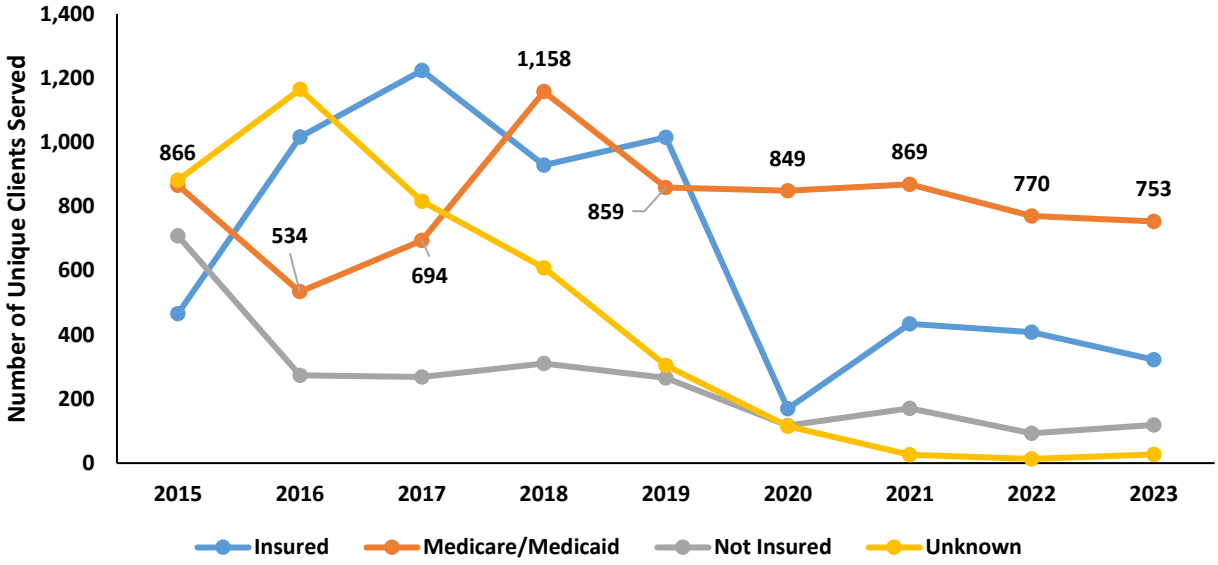


Data Source: Treatment Episode Data Sets

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

[7] SAMHSA - Medicaid Coverage of Medications, OUD

Figure 68. Insurance Coverage for Individuals Admitted in a Substance Use Treatment Facility, Washoe County Facilities, 2015-2023.

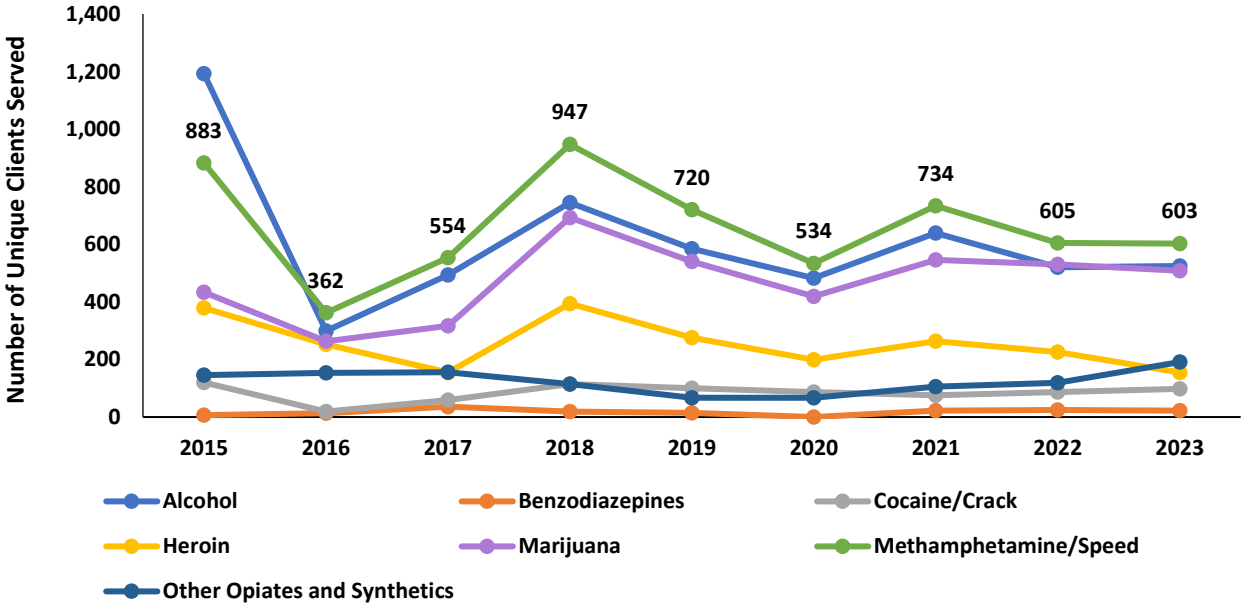


Data Source: Treatment Episode Data Sets

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

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

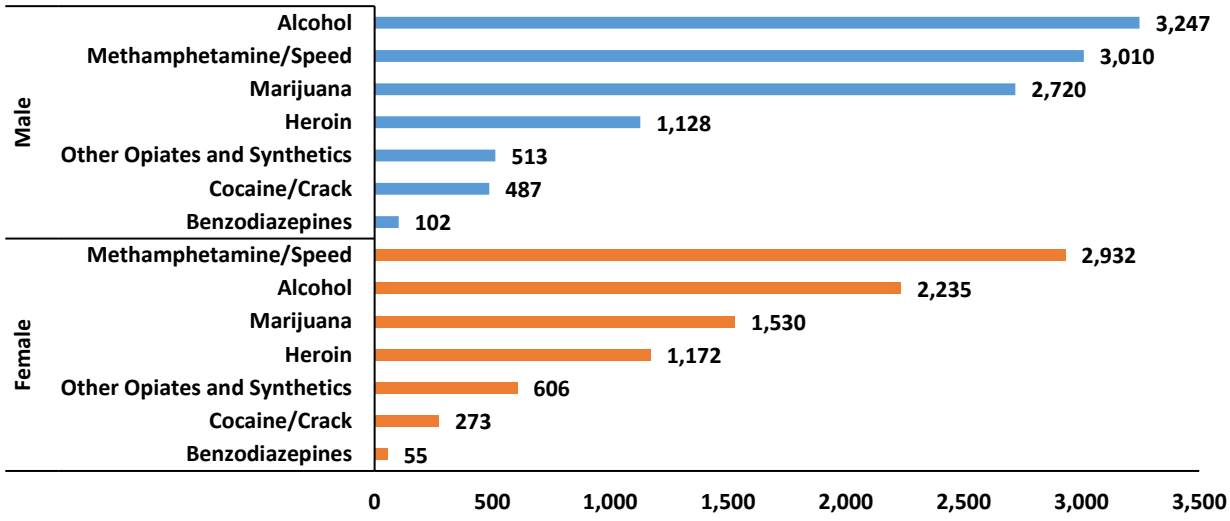
Figure 69. Primary Substance Used for Clients at Adult Substance Abuse Treatment Centers, Washoe County Facilities, 2015-2023.



Data Source: Treatment Episode Data Sets

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

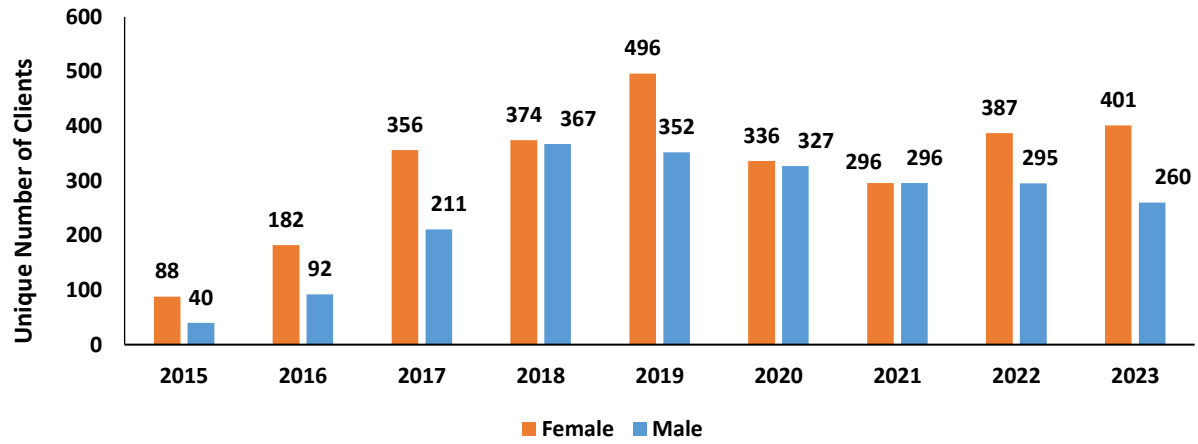
Figure 70. Primary Substance Used for Clients at Adult Substance Abuse Treatment Centers by Gender, Washoe County Facilities, 2015-2023.



Data Source: Treatment Episode Data Sets

Co-occurring mental health disorders are frequently observed among individuals admitted to substance use treatment facilities. As illustrated in the figure below, there has been a notable increase in the number of admissions involving individuals with co-occurring disorders within the state. The graph below shows that females were admitted with a co-occurring disorder more than men, which is the opposite trend of the state as a whole.

Figure 71. Individuals Admitted to a Substance Use Treatment Facility with a Co-occurring Mental Health Disorder by Sex, Washoe County Facilities, 2015-2023.



Data Source: Treatment Episode Data Sets

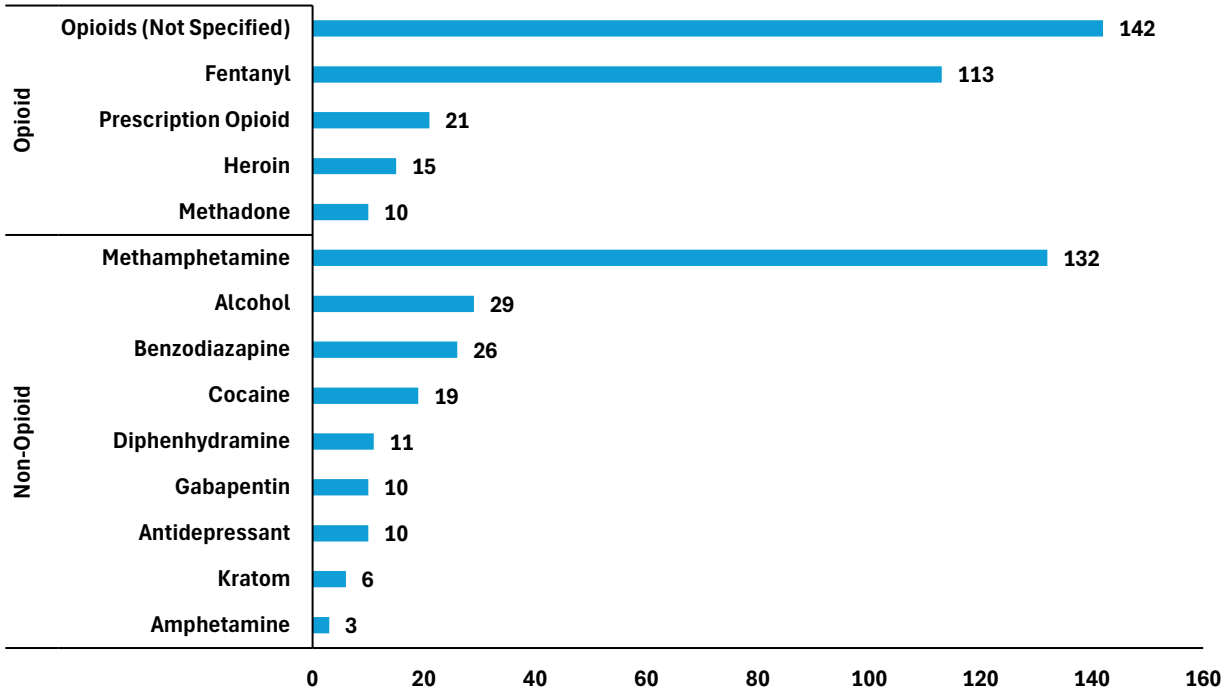
SUDORS

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

Of the 223 total drug overdose deaths of unintentional/undetermined intent among Washoe County residents in 2022, decedents were mostly male, white, and were a high school graduate or had a completed GED. Note, overdose death counts do not match the Office of Analytics SUDORS dashboard, as counts on the dashboard are based on county of incidence, while counts in this report are based on county of residence.

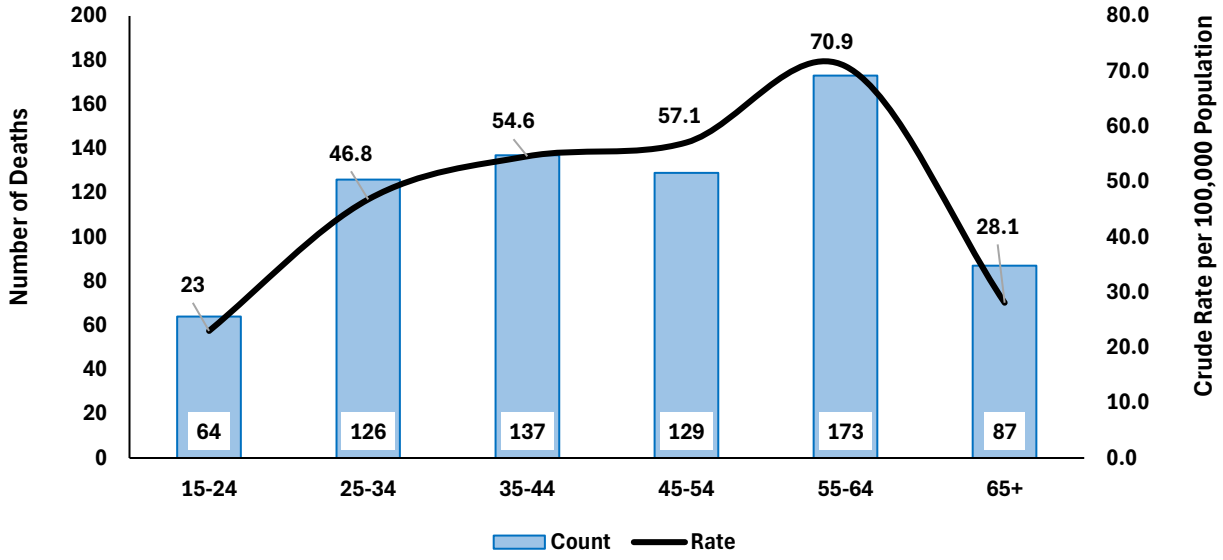
Overdose deaths have risen from 123 in 2019 to 223 in 2022. This represents an increase from around 26 such deaths per 100,00 population to a rate of over 44 per 100,000. Opioids were listed in the cause of death for over half of cases (type not specified, 63%); fentanyl was listed in about 50% of cases; prescription opioids were listed in the cause of death in 9% of cases; heroin was listed in about 8% of cases; methamphetamine was also listed as one of the substances in the cause of death in over half of cases reported.

Figure 72. Substances Listed in the Cause of Death Among Unintentional/Undetermined Overdose Deaths, Washoe County Residents, 2022.



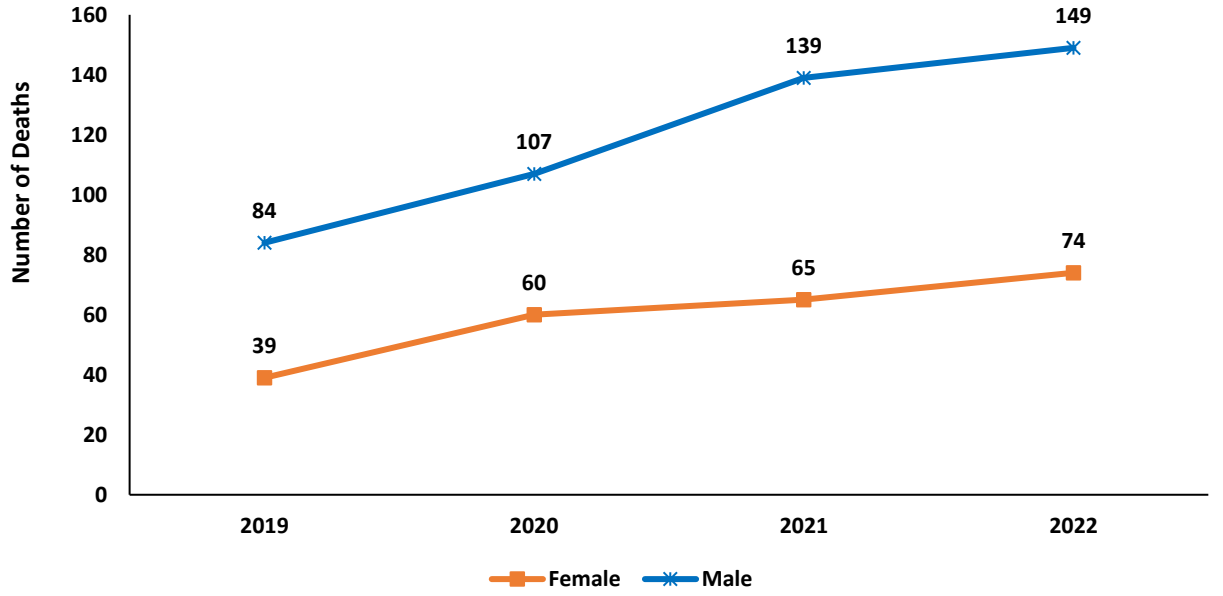
Source: SUDORS

Figure 73. Total Number of Unintentional/Undetermined Overdose Deaths and Rates by Age Group, Washoe County Residents, 2019-2022.



Source: SUDORS

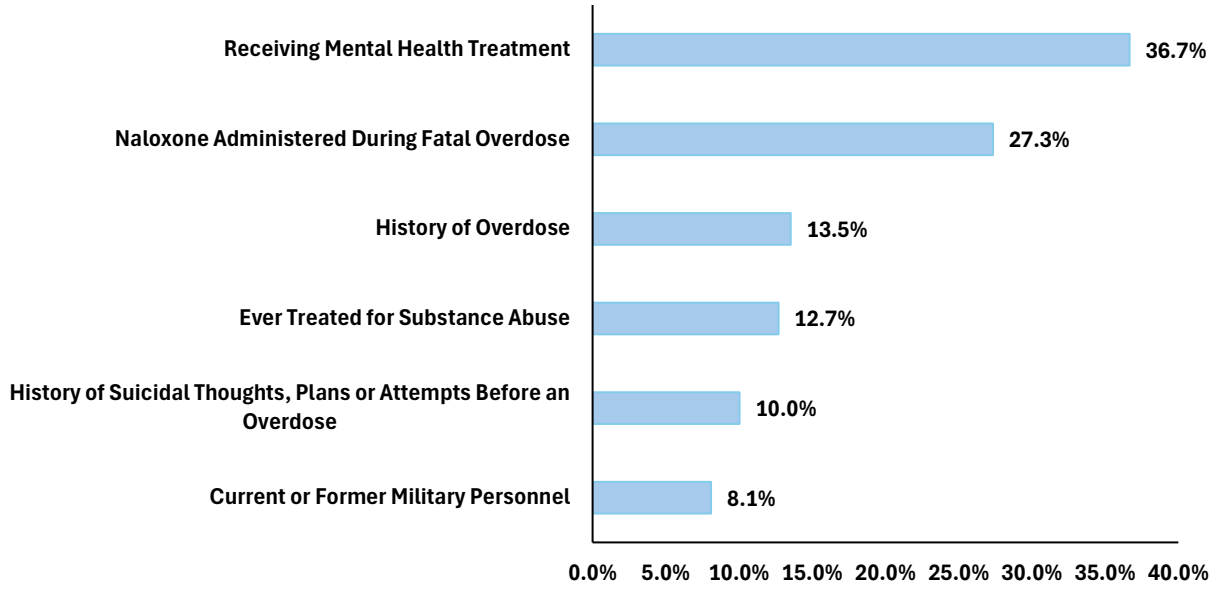
Figure 74. Total Number of Unintentional/Undetermined Overdose Deaths by Sex, Washoe County Residents, 2019-2022.



Source: SUDORS

Over 37% of persons in the SUDORS dataset had been receiving mental health treatment services, and 27% had naloxone administered during the fatal overdose. About 14% of cases had a documented prior history of overdose.

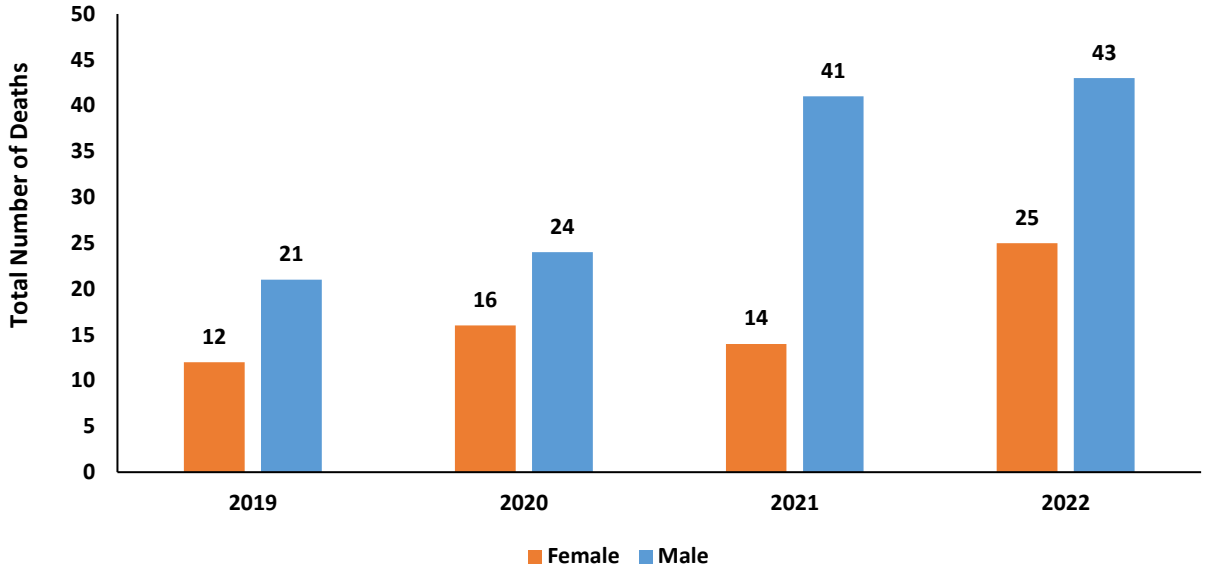
Figure 75. Circumstances Preceding Unintentional/Undetermined Overdose Deaths, Washoe County Residents, 2019-2022.



Source: SUDORS
Chart scaled to 40.0% 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 in Washoe County were nearly twice as likely to have naloxone administered at the scene before dying from an unintentional/undetermined overdose compared to females from 2019-2022.

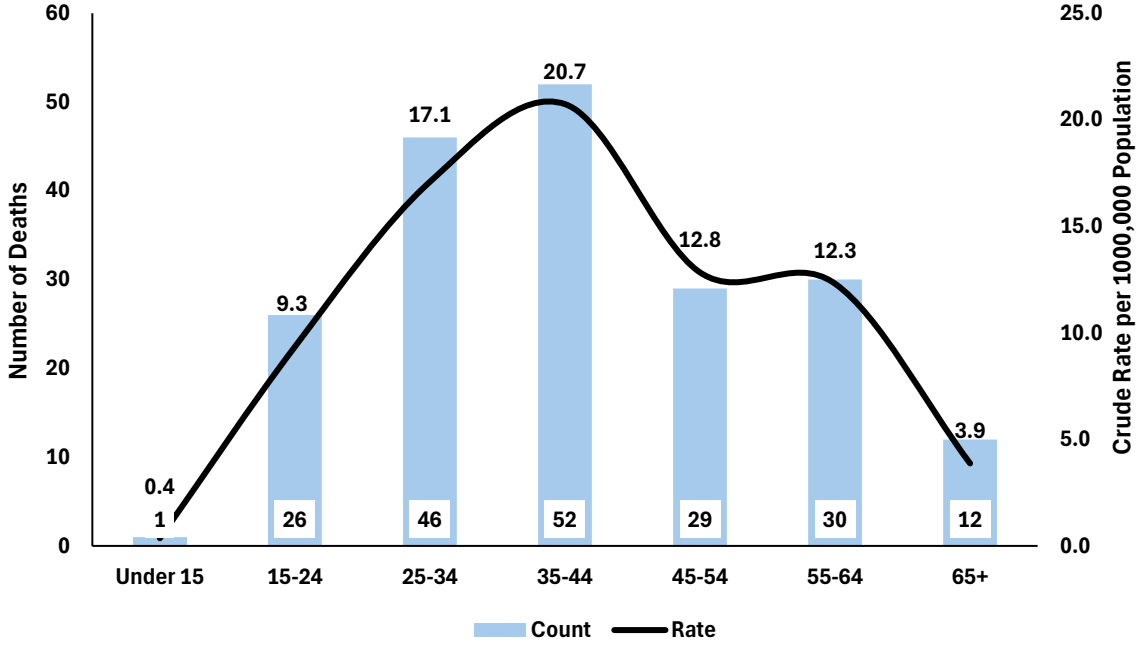
Figure 76. Naloxone Administered at the Scene Among Unintentional/Undetermined Overdoses Deaths by Sex, Washoe County Residents, 2019-2022.



Source: SUDORS

The combined 25-44 age groups comprise the highest number of deaths and the highest rate of naloxone administered. This group accounts for roughly half of such deaths in Washoe County from 2019-2022.

Figure 77. Naloxone Administered Among Unintentional/Undetermined Overdose Deaths by Rate and Age Group, Washoe County Residents, 2019-2022.



Source: SUDORS

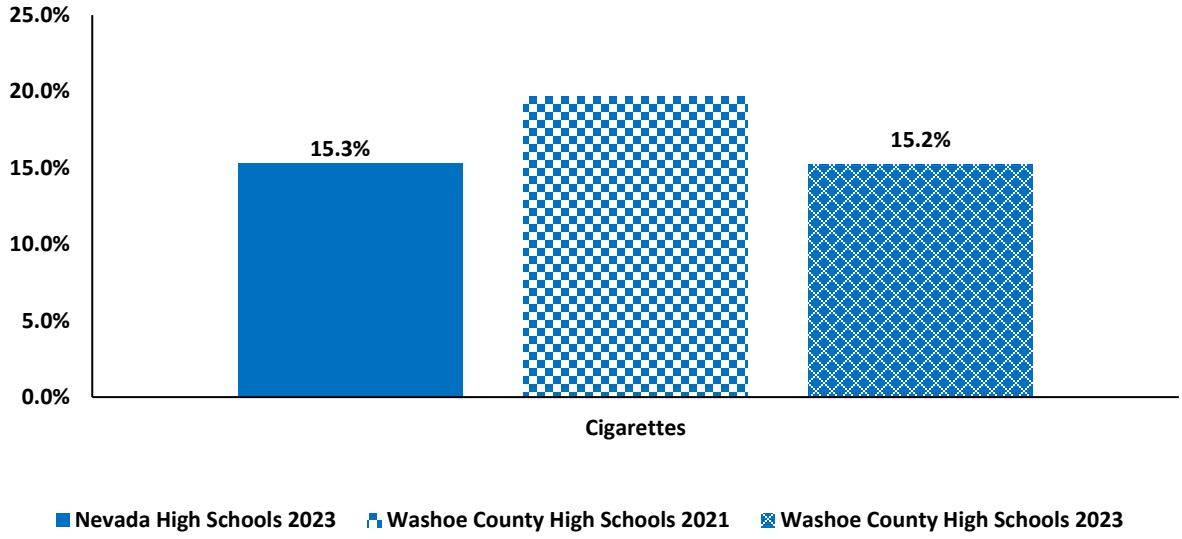
Youth Risk Behavior Survey

The Youth Risk Behavior Survey (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, 941 high school students and 1,978 middle school students participated in the YRBS in Washoe County. 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.

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

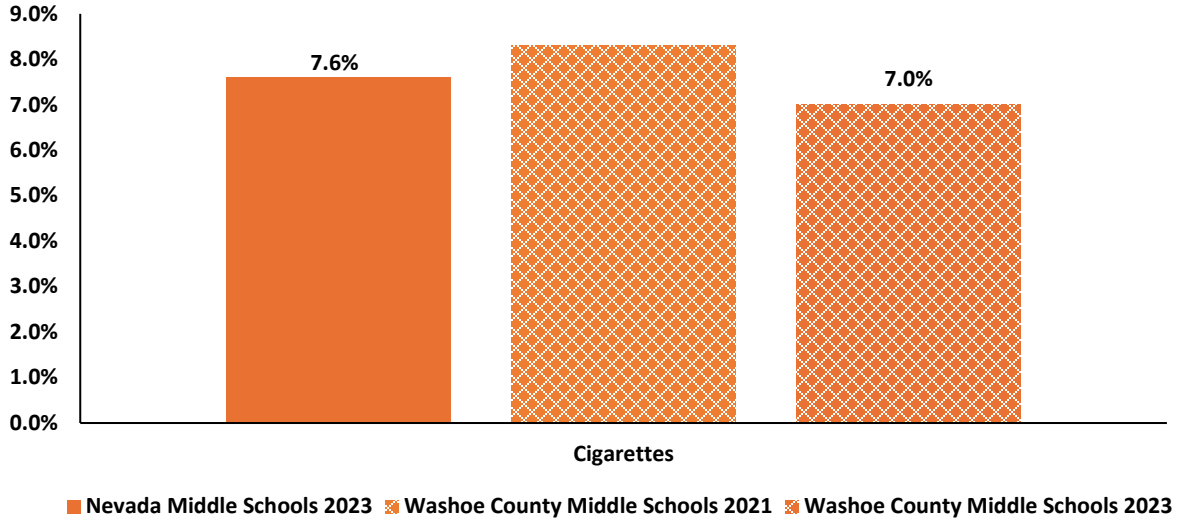
Washoe County high school students in 2023 had a similar percent for ever having ever tried cigarettes compared to Nevada at 15.2% and 15.3%, respectively. The middle school students in Washoe County had a lower percent for ever trying cigarettes at 7.0% compared to Nevada at 7.6%.

Figure 78a. Percent of Respondents Who Have Ever Tried Cigarette Smoking*, Washoe County High School Students, 2021, 2023, and Nevada High School Students, 2023.



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

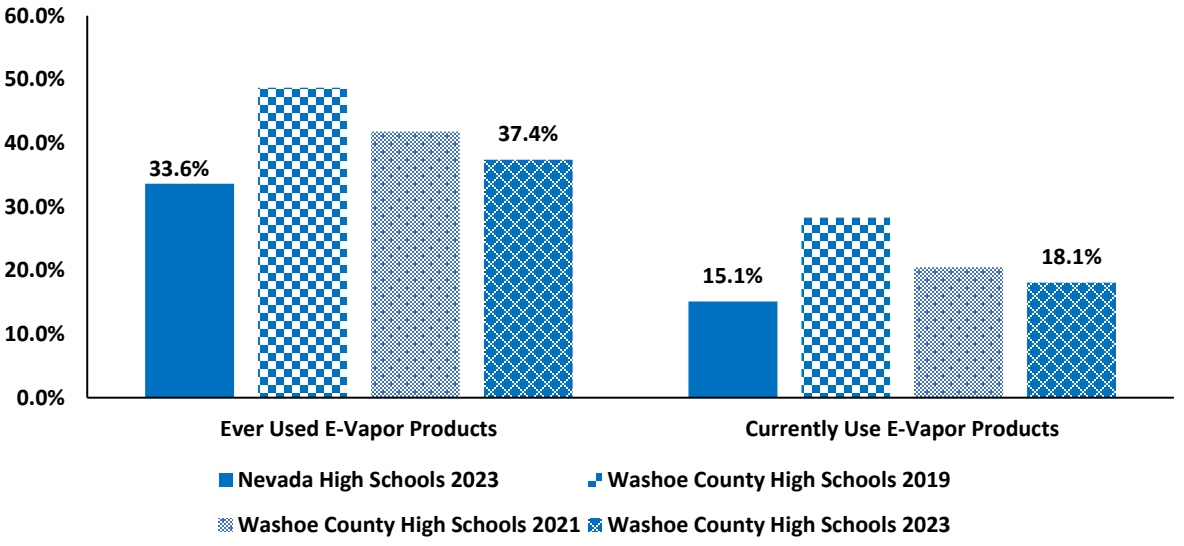
Figure 78b. Percent of Respondents Who Have Ever Tried Cigarette Smoking*, Washoe County Middle School Students, 2021, 2023, and Nevada Middle School Students, 2023.



Source: Nevada Youth Risk Behavior Survey
Chart scaled to 9.0% to display differences among groups.

Washoe County high school students have a higher percent for ever using an e-vapor product than Nevada in 2023 (37.4% and 33.6%, respectively) and currently using electronic vapor (e-vapor) products than Nevada in 2023 (18.1% and 15.1%, respectively).

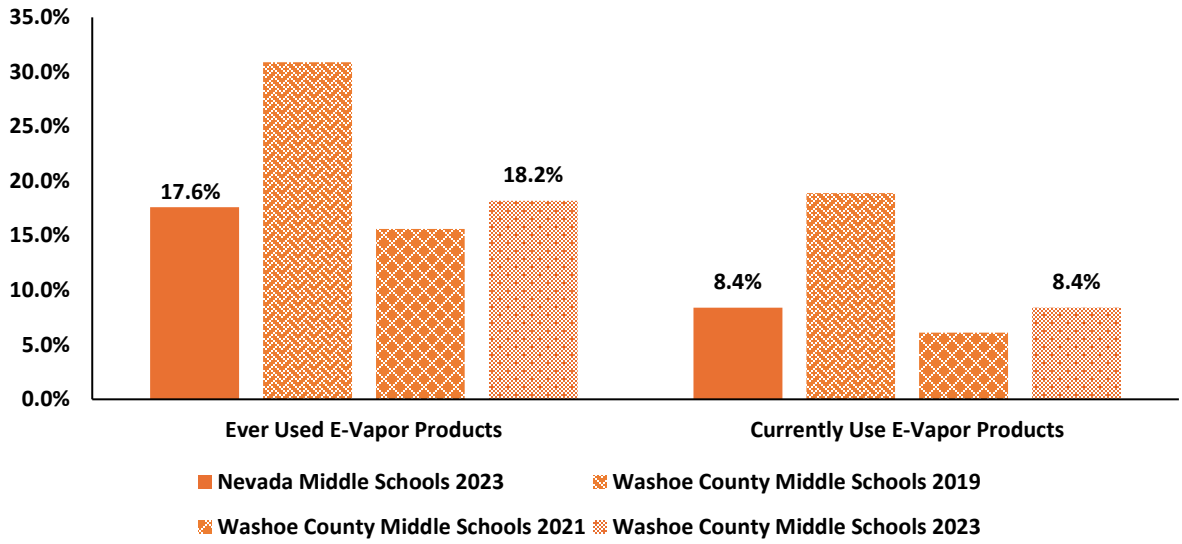
Figure 79a. Electronic Vapor Product* Use, Washoe County High School Students, 2019, 2021, 2023, and Nevada High School Students, 2023.



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'.*

Washoe County middle school students have a higher percent for ever using an e-vapor product than Nevada in 2023 (18.2% and 17.6%, respectively) and the same percent of students currently using electronic vapor (e-vapor) products than Nevada in 2023 (8.4%, respectively).

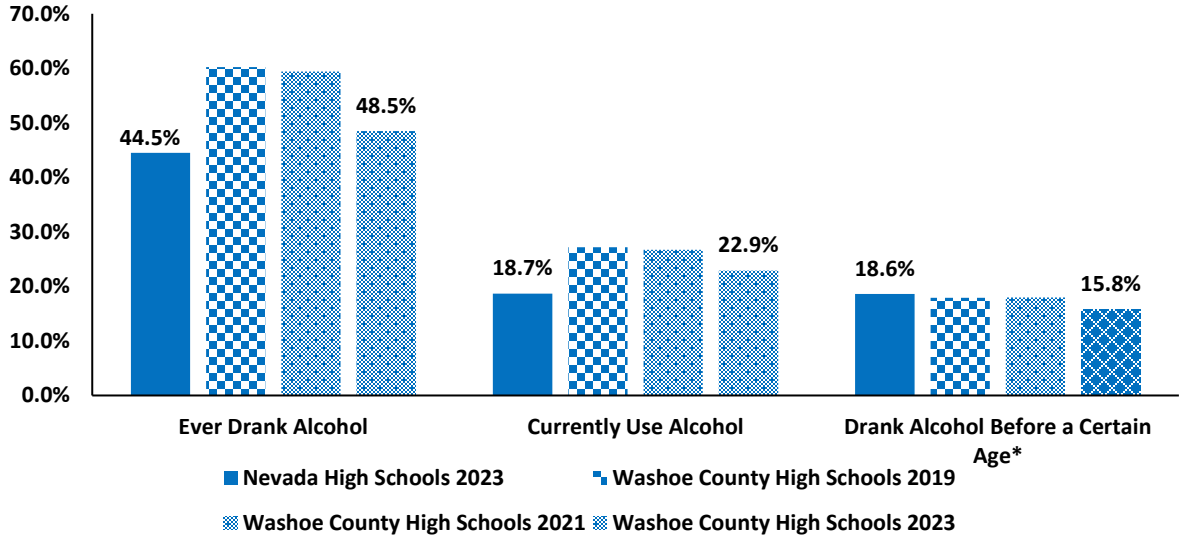
Figure 79b. Electronic Vapor Product* Use, Washoe County Middle School Students, 2019, 2021, 2023, and Nevada Middle School Students, 2023.



Source: Nevada Youth Risk Behavior Survey
Chart scaled to 35.0% to display differences among groups.
**Includes e-cigarettes, vapes, vape pens, e-cigars, e-hookahs, hookah pens, and mods such as 'JUUL', 'SMOK', 'Suorin', 'Vuse', and 'blu'.*

The percent of ever drank alcohol, currently drink alcohol, and drank alcohol before a certain age among Washoe County high school students has steadily declined from 2019 to 2023. The percent of those who ever drank alcohol and currently drink alcohol among Washoe County high school students are higher than Nevada high school students in 2023. The percent of those who drank before a certain age was lower in Washoe County high school students compared to Nevada high school students.

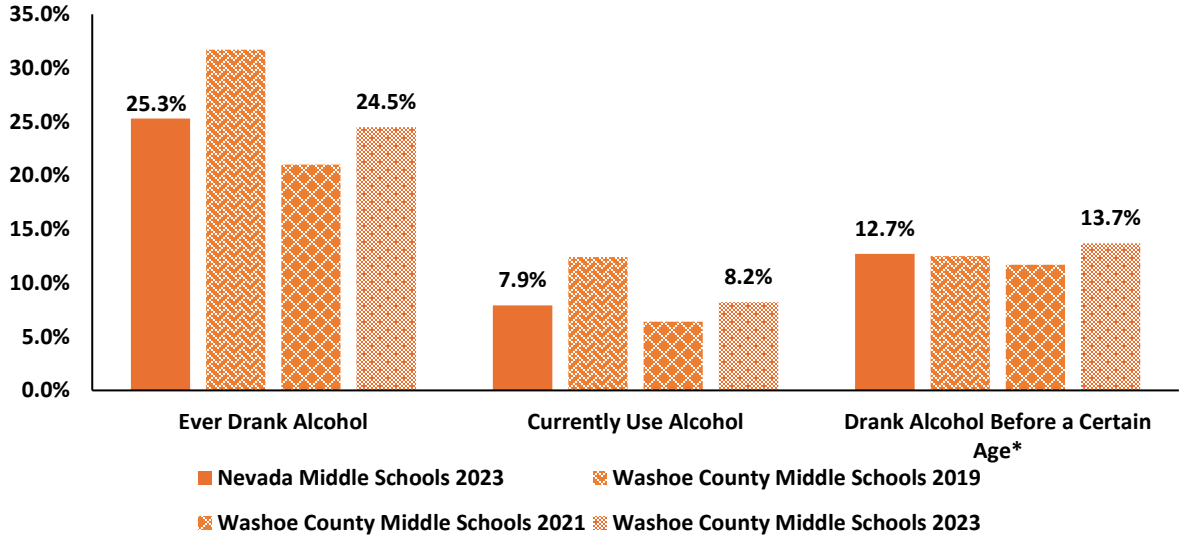
Figure 80a. Alcohol Use, Washoe County High School Students, 2019, 2021, 2023, and Nevada High School Students, 2023.



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

The percent of ever drank alcohol, currently use alcohol, and drank alcohol before certain age among Washoe County middle school students decreased significantly from 2019 to 2021 before increasing in 2023. Washoe County middle school student percents for currently drink alcohol and drank before a certain age are both higher than Nevada middle school student percents.

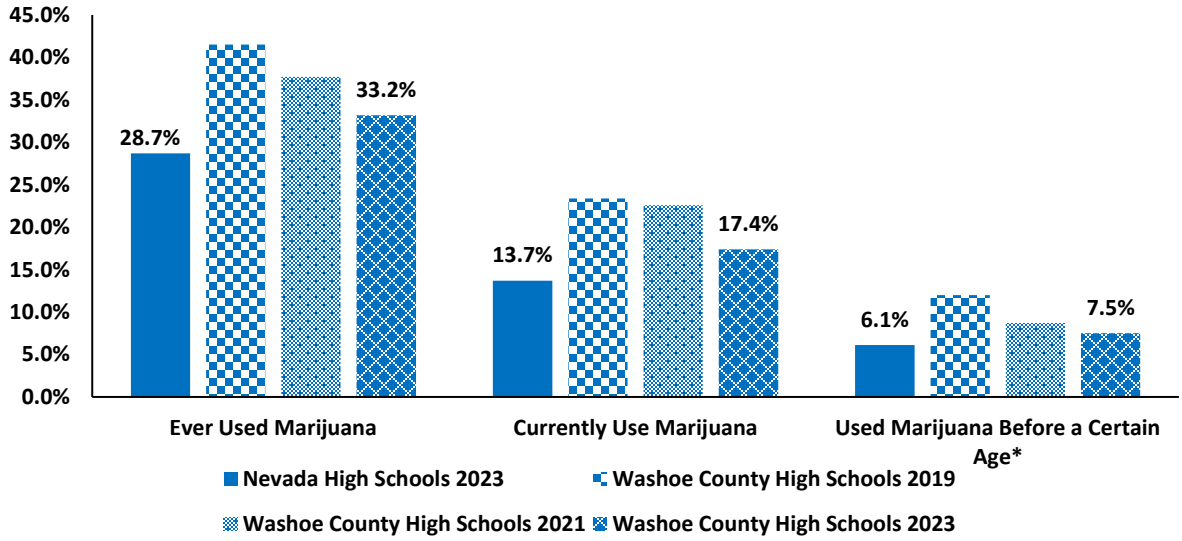
Figure 80b. Alcohol Use, Washoe County Middle School Students, 2019, 2021, 2023, and Nevada Middle School Students, 2023.



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 percent of Washoe County high school students who have reported to have ever used marijuana, currently use marijuana, or used marijuana before a certain age has decreased from 2019 to 2023. The percents of Washoe County high school students who have reported to have ever used marijuana, currently use marijuana, or used marijuana before a certain age in 2023 are higher than Nevada high school percents.

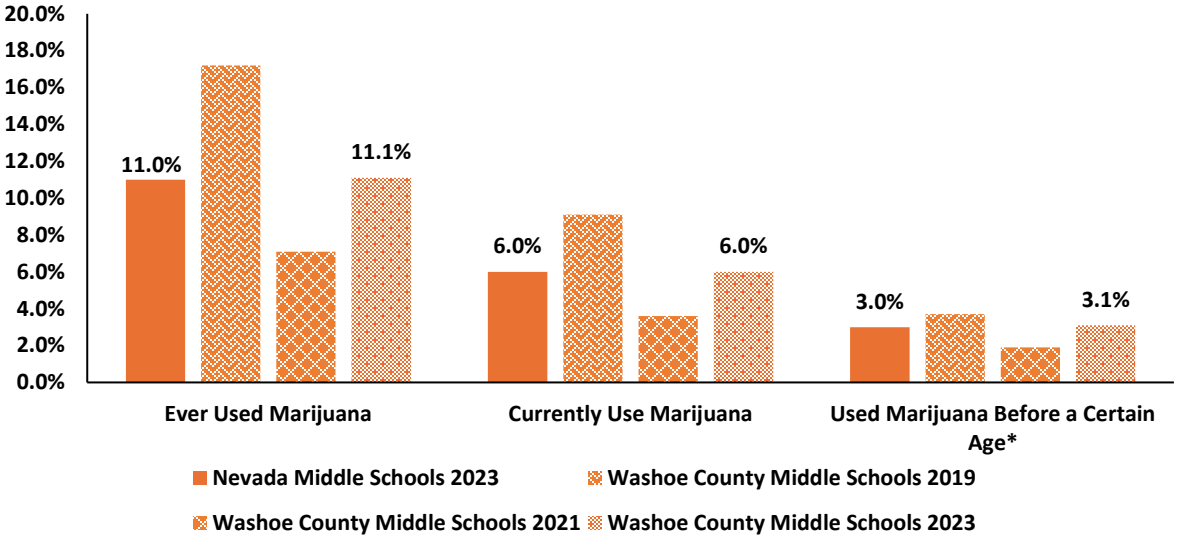
Figure 81a. Marijuana Use, Washoe County High School Students, 2019, 2021, 2023, and Nevada High School Students 2023.



Source: Nevada Youth Risk Behavior Survey
Chart scaled to 45.0% to display differences among groups.
**Among high school students, if they ever used marijuana before age 13.*

The percent of Washoe County 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 percents in 2023 for ever used marijuana, who currently use marijuana, and used marijuana before a certain age were within 1.0% of 2023 Nevada middle school percents.

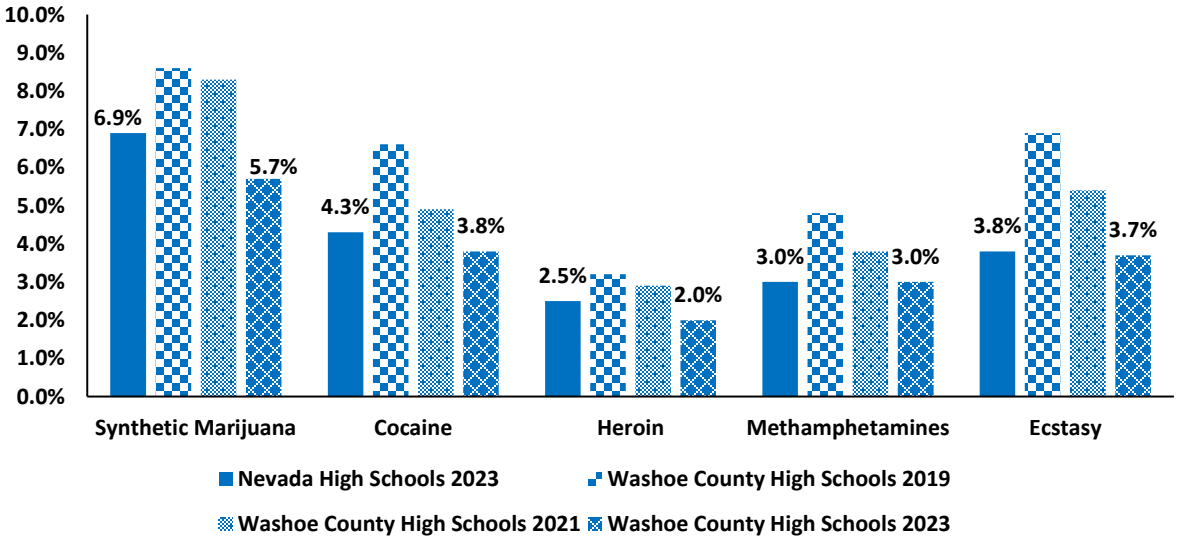
Figure 81b. Marijuana Use, Washoe County Middle School Students, 2019, 2021, 2023, and Nevada Middle School Students, 2023.



Source: Nevada Youth Risk Behavior Survey
Chart scaled to 20.0% to display differences among groups.
**Among middle school students, if they ever used marijuana before age 11.*

Of the illicit drugs listed in the figure below, lifetime drug use percents among Washoe County high school students in 2023 was highest with synthetic marijuana use (5.7%), which is lower than the Nevada high school student percent (6.9%). Lifetime percent use of cocaine, heroin, and ecstasy among Washoe County high school students are all slightly lower than Nevada High school students in 2023, while the percent of lifetime use of methamphetamines was the same.

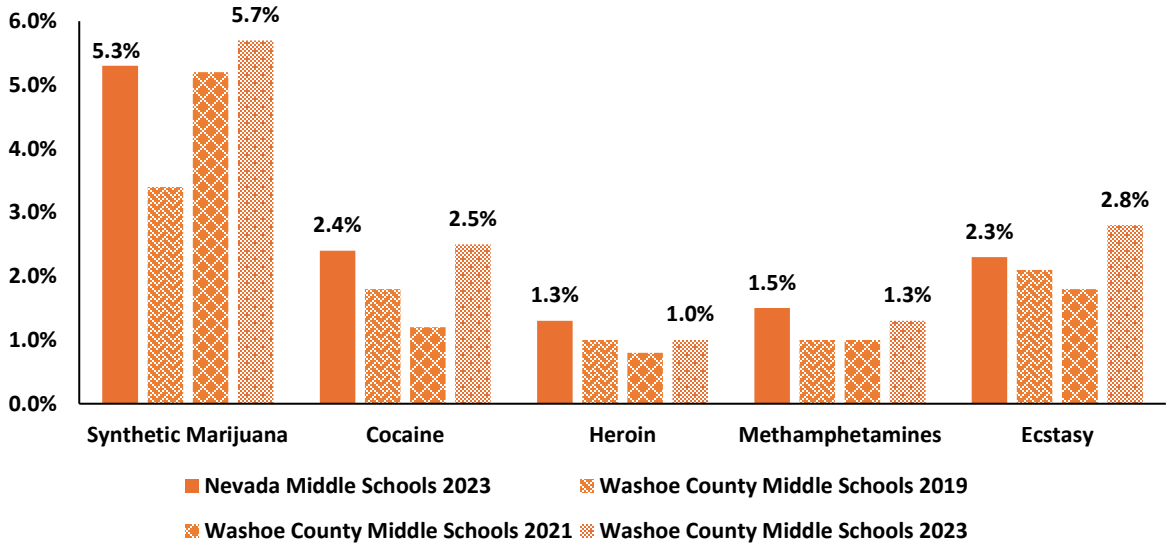
Figure 82a. Lifetime Drug Use, Washoe County High School Students, 2019, 2021, 2023, and Nevada High School Students, 2023.



Source: Nevada Youth Risk Behavior Survey
Chart scaled to 10.0% to display differences among groups.

Lifetime percent drug use among Washoe County middle school students was highest in 2023 for synthetic marijuana (5.7%), cocaine (2.5%), methamphetamines (1.3%), and ecstasy (2.8%). Washoe County middle school student percent of lifetime use for all illicit drugs listed for 2023 was within 1.0% of Nevada middle school student percents.

Figure 82b. Lifetime Drug Use, Washoe County Middle School Students, 2019, 2021, 2023 and Nevada Middle School Students, 2023.



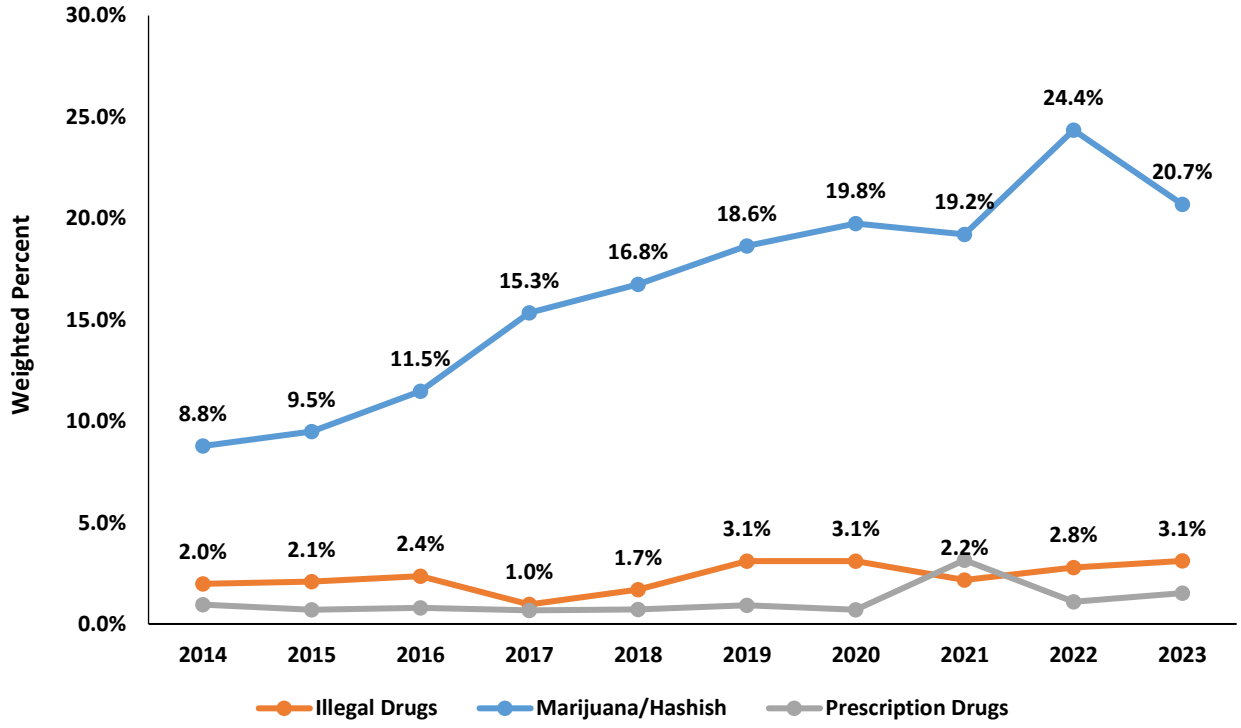
Source: Nevada Youth Risk Behavior Survey
Chart scaled to 6.0% to display differences among groups.

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, 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 increased substantially since 2014. In 2023, 20.7% of respondents reported to have used marijuana in the past 30 days, up from 8.8% in 2014 and a high of 24.4% in 2022. Self-reported use of marijuana has increased, as expected, since recreational marijuana use was legalized in Nevada in 2017. Of Washoe County residents surveyed in 2023, 1.1% (on average) used prescription drugs to get high in the last 30 days and 2.3% used other illegal drugs to get high in the last 30 days.

Figure 83. Percent of Adult BRFSS Respondents Who Used Marijuana/Hashish, Illegal Substances, or Painkillers to Get High in the Last 30 Days, Washoe County Residents, 2014-2023.



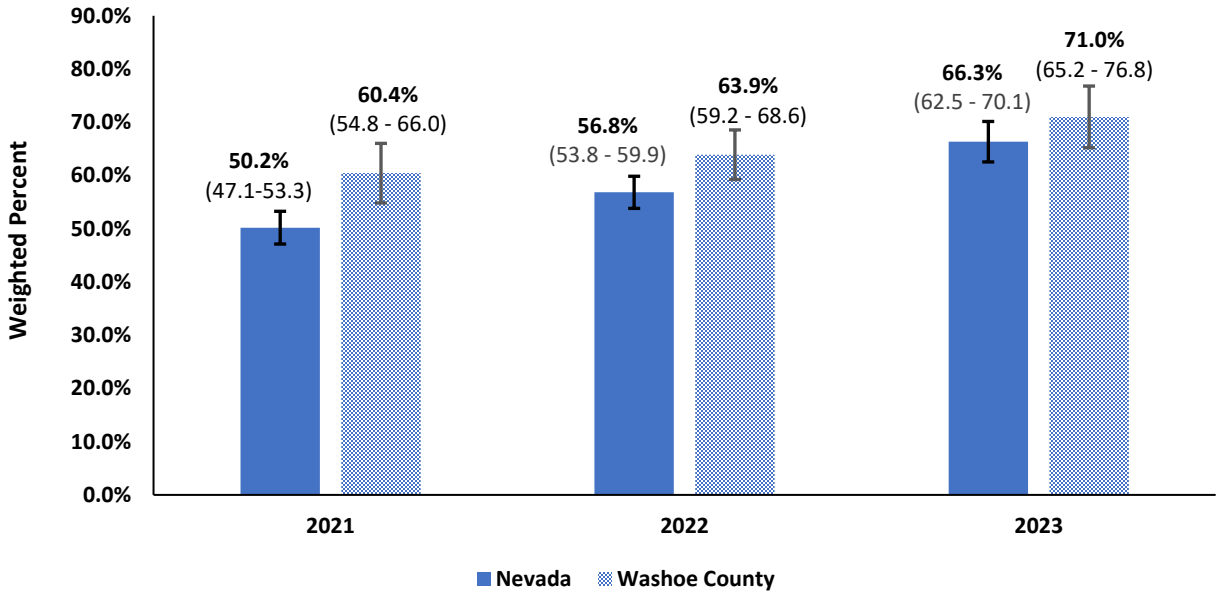
Source: Behavioral Risk Factor Surveillance System
Chart scaled to 30.0% to display differences among groups.
Specific question asked in survey: "During the past 30 days, on how many days did you use marijuana or hashish/any other illegal drug/ prescription drugs without a doctor's order, just to "feel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

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

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

In Washoe County, reported Narcan knowledge has increased by 10.6% since 2021 (the first year the question was added to BRFSS).

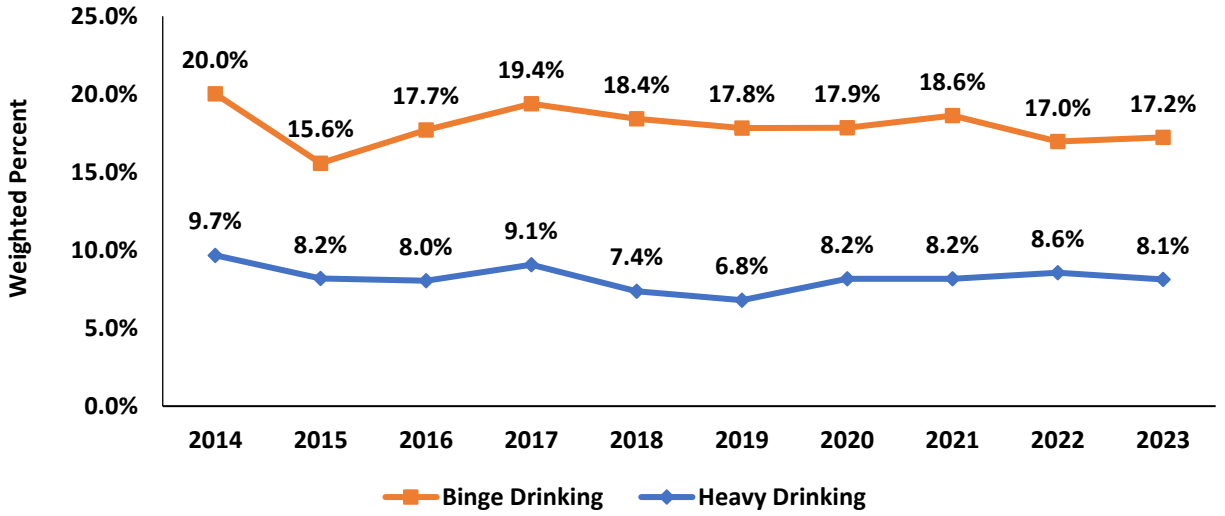
Figure 84. Percentage of BRFSS Respondents who Reported Knowing what Narcan is, Washoe County Residents, 2021-2023.



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 day. Both reported heavy drinking and binge drinking as highest in 2014, and rates have remained consistent throughout the reporting period.

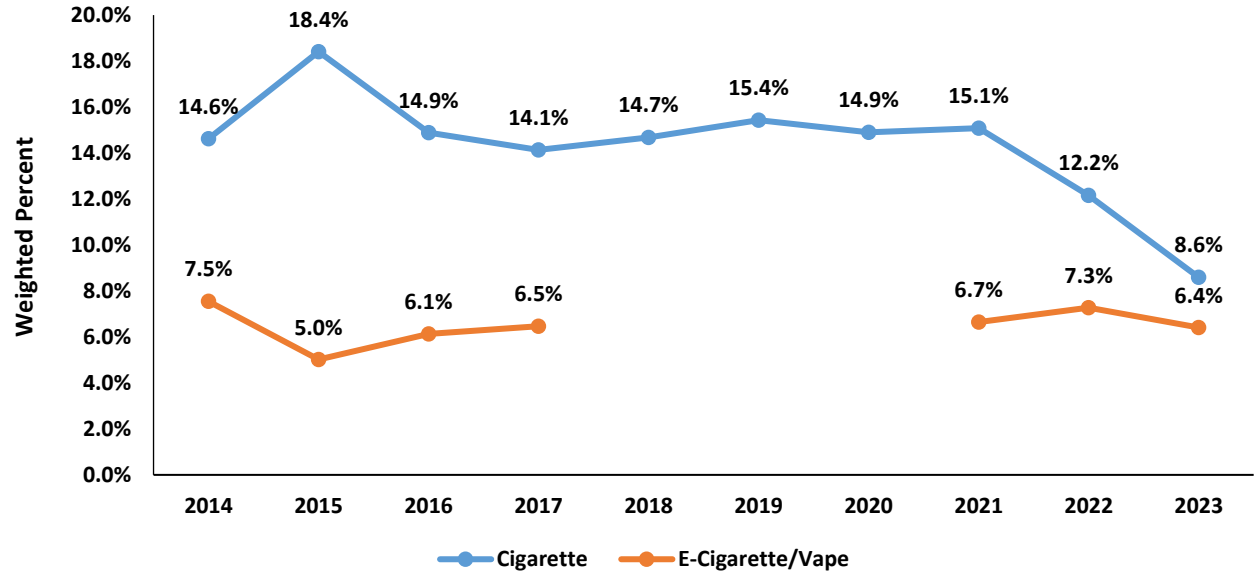
Figure 85. Percent of Adult BRFSS Respondents Who are Considered Binge Drinkers or Heavy Drinkers, Washoe County Residents, 2014-2023.



Source: Behavioral Risk Factor Surveillance System
Chart scaled to 25.0% to display differences among groups.

In 2023, 8.6% of adults were current cigarette smokers, which has decreased substantially since 2014 at 14.6%. From 2018 through 2020, the e-cigarette use question was asked differently compared to years prior, thus had to be excluded from the graph.

Figure 86. Percent of Adult BRFSS Respondents Who are Current Cigarette or E-Cigarette Smokers, Washoe County Residents, 2014-2023.



Source: Behavioral Risk Factor Surveillance System
Chart scaled to 20.0% to display differences among groups.
E-cigarette use was not collected in 2018-2020.
Current cigarette smokers are defined as individuals who have smoked at least 100 cigarettes in their lifetime and currently smoke. Current e-cigarette smokers are defined as individuals who currently have smoked on at least one day in the past 30 days or who currently report using e-cigarettes or other electronic "vaping" products every day or some days.

Youth

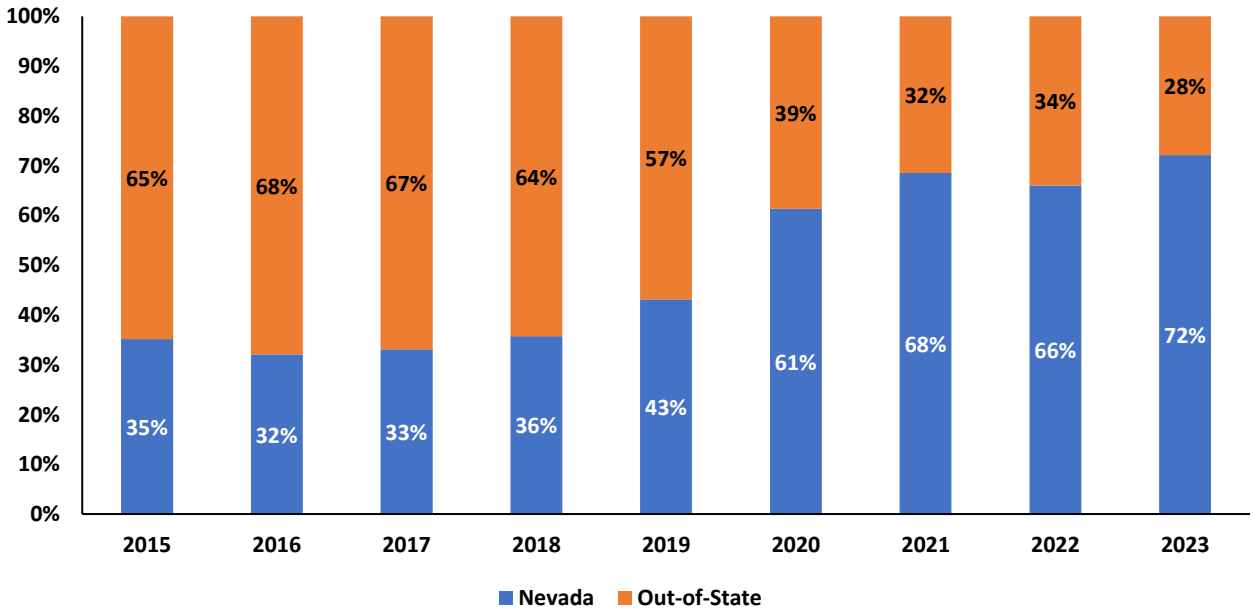
This section focuses on other factors that affect youth not directly related to substance use or mental health.

Medicaid: Residential Treatment Centers

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

Since 2015 the percent of Washoe County children admitted to facilities in Nevada (rather than out-of-state facilities) has increased by nearly 40%. This reflects statewide efforts to keep the treatment of Nevada youth in-state.

Figure 87. Medicaid-Funded Residential Treatment Center Placement for Washoe County 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 Washoe County Children, 2015-2023.

Year	Provider State Category			
	Nevada	Out-of-State	Nevada %	Out-of-State %
2015	70	129	35.2%	64.8%
2016	59	125	32.1%	67.9%
2017	50	101	33.1%	66.9%
2018	40	72	35.7%	64.3%
2019	47	62	43.1%	56.9%
2020	73	46	61.3%	38.7%
2021	100	46	68.5%	31.5%
2022	68	35	66.0%	34.0%
2023	75	29	72.1%	27.9%

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.

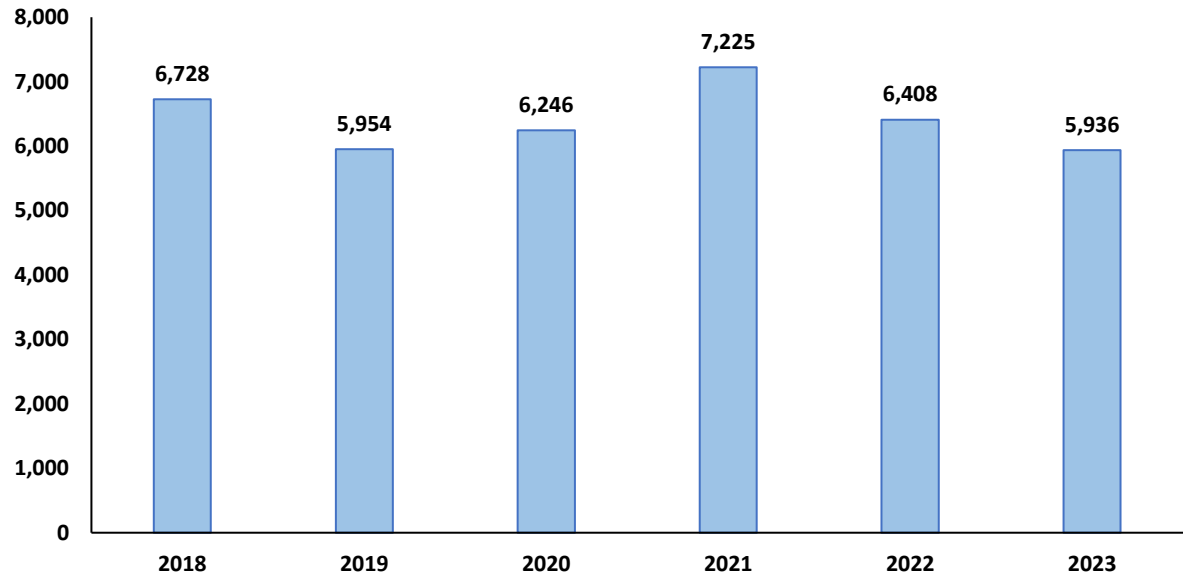
Child Protective Services

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.[8]

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

In the reporting period 2018-2023, CPS in Washoe County considered 38,497 reports. The prevalence of reported cases is relatively consistent year over year.

Figure 88. Child Protective Services Reports Received, Washoe County, 2018-2023.



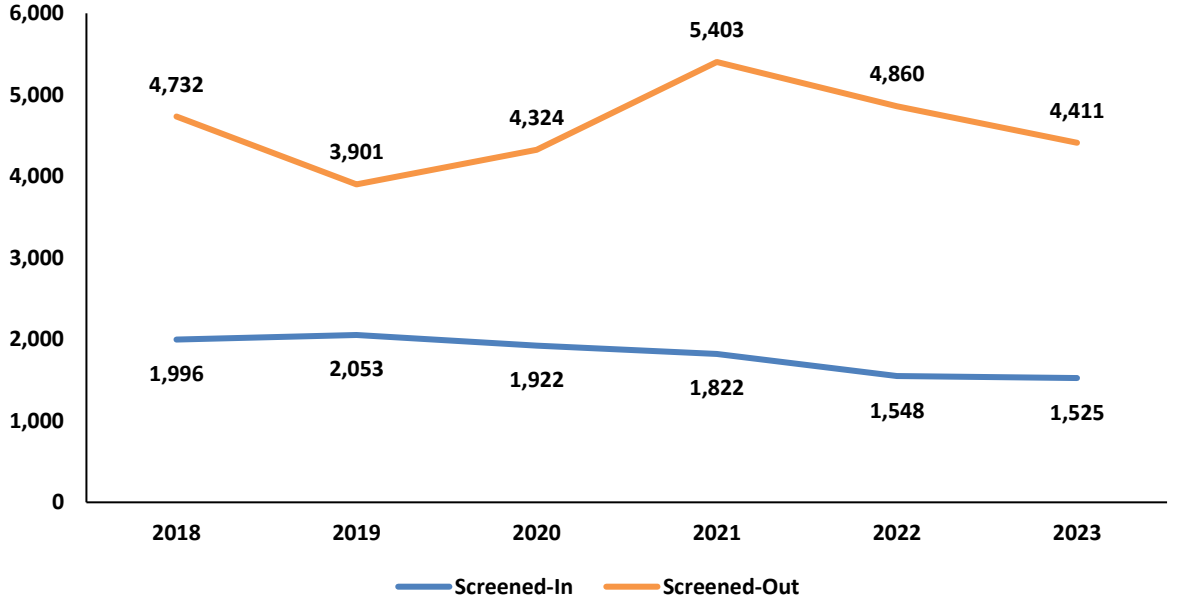
Source: UNITY Database

For each report, a screening decision is made as to 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 38,497 reports made between 2018 and 2023, roughly 28% (n=10,866) were screened-in, resulting in agency response.

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

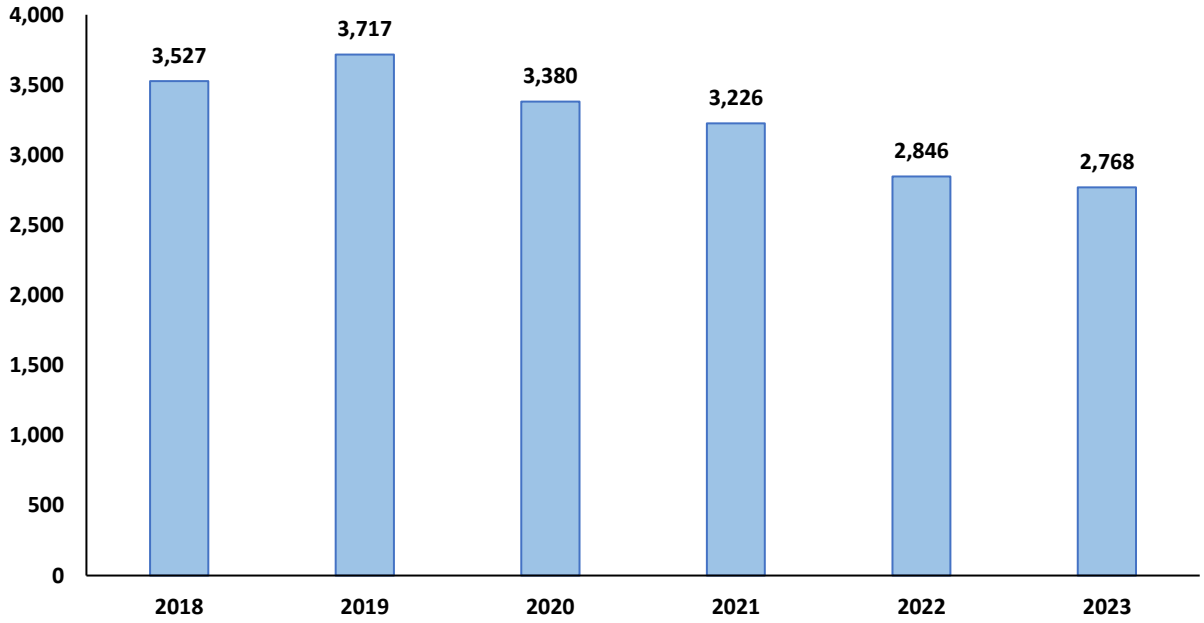
Figure 89. Child Protective Services Reports Received by Screening Decision, Washoe County, 2018-2023.



Source: UNITY Database

During the reporting period, the nearly 11,000 screened-in reports involved 19,464 Washoe County youth — an average of about 3,200 per year resulting in a CPS investigation, assessment, or response. These counts are distinct by year; some youth may be counted more than once in the reporting period (2018-2023) if they appeared on screened-in reports in more than one year.

Figure 90. Unique Washoe County Youth Screened-In, 2018-2023.



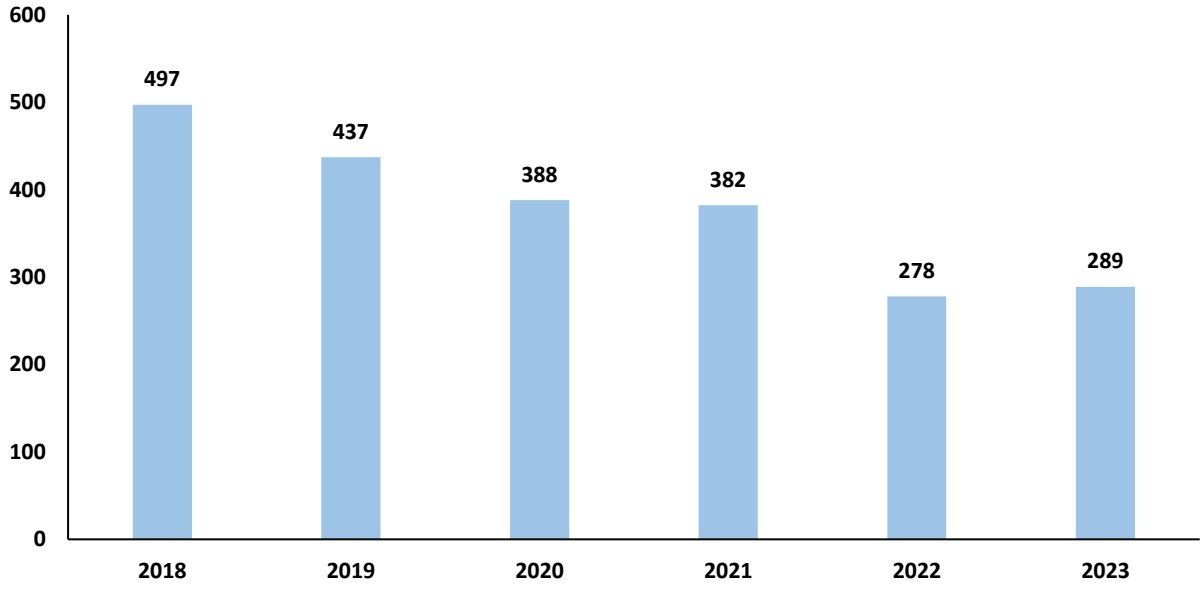
Source: UNITY Database

Foster Care

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

From 2018 to 2023, a total of 2,164 unique youth were served in the foster care system in Washoe County, accounting for 2,271 entries. Some youth entered, exited, and later re-entered the foster care system, with each entry counted separately. Since the COVID pandemic in 2020, the number of entries has decreased, averaging 334 per year between 2020 and 2023.

Figure 91. Foster Care Entries, Washoe County, 2018-2023.



Source: UNITY Database

From 2018 to 2023, parental substance abuse and neglect are the primary drivers of Washoe County youth being placed into foster care, with counts of 301 and 212 respectively in 2023.

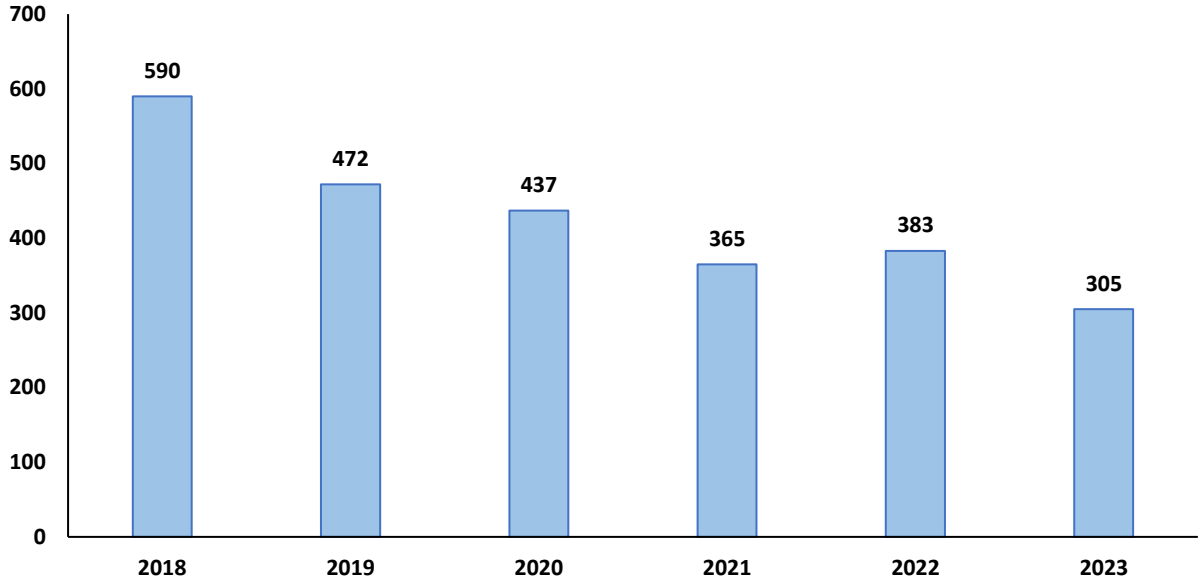
Table 4. Top Reasons for Foster Care Entries, Washoe County, 2018-2023.

Entry Reason	2018	2019	2020	2021	2022	2023
Parental substance abuse	187	209	242	354	253	301
Neglect	275	257	261	267	198	212
Incarceration of parent(s)	174	168	128	136	97	70
Inadequate housing	85	77	60	99	115	102
Domestic violence	74	68	78	79	67	77
Abuse	50	26	39	29	37	17
All other	98	85	71	152	132	151

Source: UNITY Database

The number of exits from the Washoe County foster care system decreased commensurate with entries to the system throughout the reporting period.

Figure 92. Foster Care Exits, Washoe County, 2018-2023.



Source: UNITY Database

Reunification with family is the most common outcome for youth leaving foster care, accounting for roughly 46% of exits.

Table 5. Reason for Foster Care Exits, Washoe County, 2018-2023.

Exit Reason	2018	2019	2020	2021	2022	2023
Reunification	333	248	243	208	247	141
Adoption	218	172	142	92	95	110
Aged out	22	27	28	27	20	26
Guardianship	7	16	10	31	15	25
Transfer to another agency	7	7	12	2	6	1
All other	0	1	1	1	0	1
Total	590	472	437	365	383	305

Source: UNITY Database

Youth Suicide

Suicide was the leading cause of death for Washoe County residents aged 10-17, accounting for 28% of deaths in that age group from 2014 to 2023. It was the second leading cause of death for Washoe County residents aged 18-24 (behind non-transport accidents), and includes accidental drug overdoses and firearms-related incidents.

Emergency department encounters for attempted suicides saw pronounced increases in the years immediately following the COVID-19 pandemic, reaching a high in 2023 with 181 such encounters for Washoe County residents aged 18 or younger. This represents a rate of 154.3 per 100,000 population.

The rate for deaths by suicide was also higher in 2023 than any other year in the reporting period with a rate of 6.8 per 100,000 for those 18 and younger.

Table 6. Suicide and Suicide Attempts and Rates by Year, 18 Years of Age and Younger, Washoe County Residents 2014-2023.

Year	Suicide Attempts				Suicides	
	Emergency Department Encounters		Inpatient Admissions			
	N	Rate	N	Rate	N	Rate
2014	116	106.5	30	27.5	3	2.8
2015	151	137.5	49	44.6	5	4.6
2016	103	92.8	47	42.3	3	2.7
2017	99	89.0	52	46.8	3	2.7
2018	101	89.4	82	72.6	4	3.5
2019	81	70.4	103	89.6	6	5.2
2020	97	84.0	93	80.5	5	4.3
2021	111	96.8	83	72.4	5	4.4
2022	153	130.7	51	43.6	5	4.3
2023	181	154.3	48	40.9	8	6.8

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

Table 7. Top Causes of Death, Ages 10-17 and 18-24, Washoe County Residents 2014-2023.

Youth Deaths Age 10-17				
Rank	Leading Cause of Death	N.	% of Total Deaths	Crude Rate
1	Intentional self-harm (suicide)	37	28.0%	7.5
2	Transport accidents	23	17.4%	4.7
3	Assault (homicide)	19	14.4%	3.8
4	Non-transport accidents	16	12.1%	3.2
5	All other	37	28.0%	7.5
	Total	**132**		
Young Adult Deaths Age 18-24				
Rank	Leading Cause of Death	N.	% of Total Deaths	Crude Rate
1	Non-transport accidents	94	26.3%	19.9
2	Intentional self-harm (suicide)	71	19.8%	15.0
3	Transport accidents	64	17.9%	13.5
4	Assault (homicide)	39	10.9%	8.2
5	All other	90	25.1%	19.0
	Total	**358**		

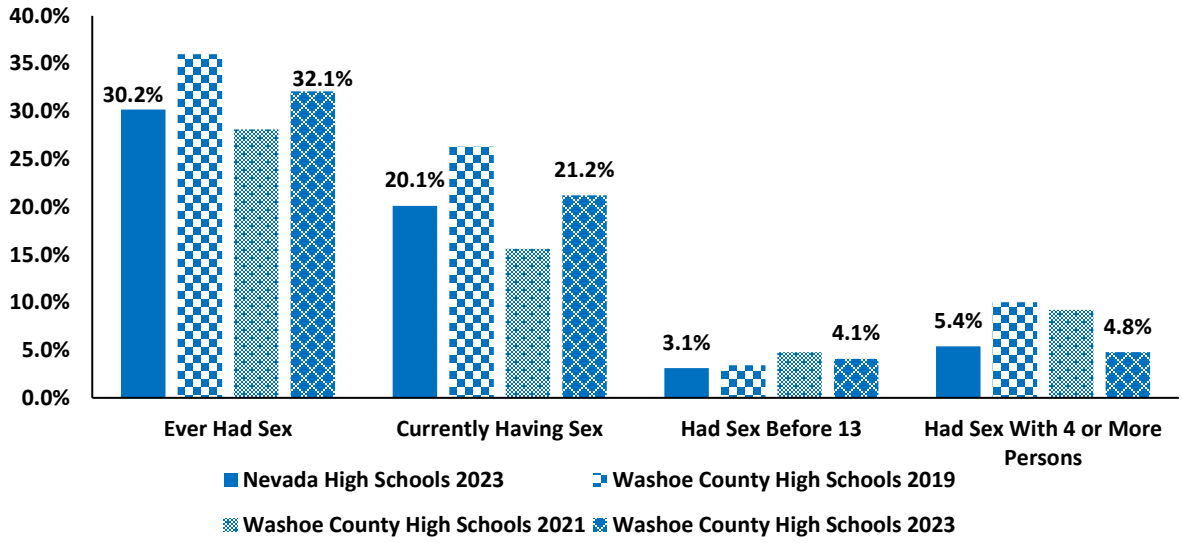
Source Electronic Death Registry System
Crude rate 100,000 age-specific population.

Youth-Reported Sexual Behaviors, Violence, and Safety

According to YRBS data, from 2019 to 2021 there was a decrease in the percent of Washoe County High School students that ever-had sex, are currently having sex, and had sex with four or more persons.

From 2021 to 2023, there was an increase in the percent of Washoe County High School students who reported ever having sex and are currently having sex.

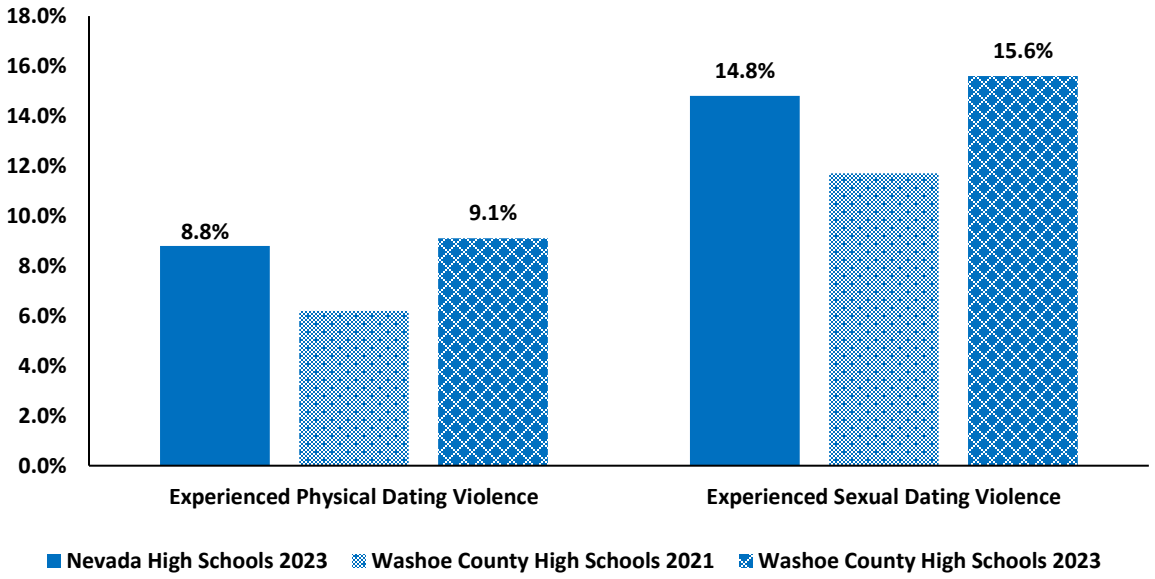
Figure 93. Sexual Behaviors Among Washoe County High School Students, 2019, 2021, 2023 and Nevada High School Students, 2023.



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

The percent of Washoe County High School students who reported physical dating violence or sexual dating violence increased from 2021 to 2023 and was slightly higher than the reported percents statewide for both categories.

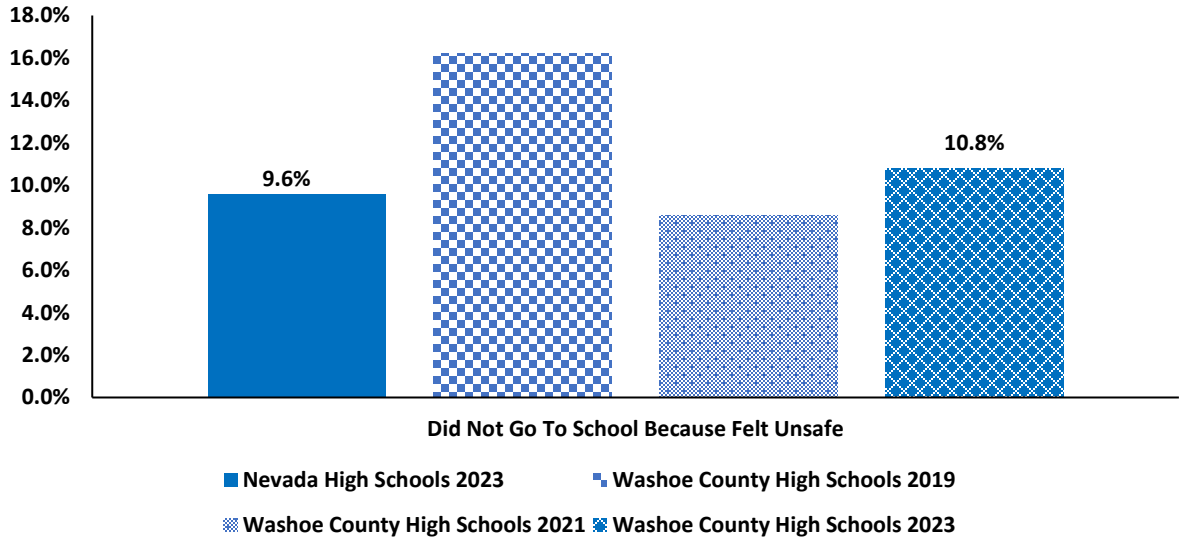
Figure 94. Sexual Violence Among Washoe County High School Students 2021, 2023 and Nevada High School Students, 2023.



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

Between 2019 and 2023 the percent of Washoe County students who reported not going to school because they felt unsafe decreased by roughly 5%. At 10.8% this is elevated from 2021 (8.6%) and slightly higher than the percent reported statewide (9.6%).

Figure 95. Violence Among Washoe County High School Students, 2019, 2021, 2023 and Nevada High School Students, 2023



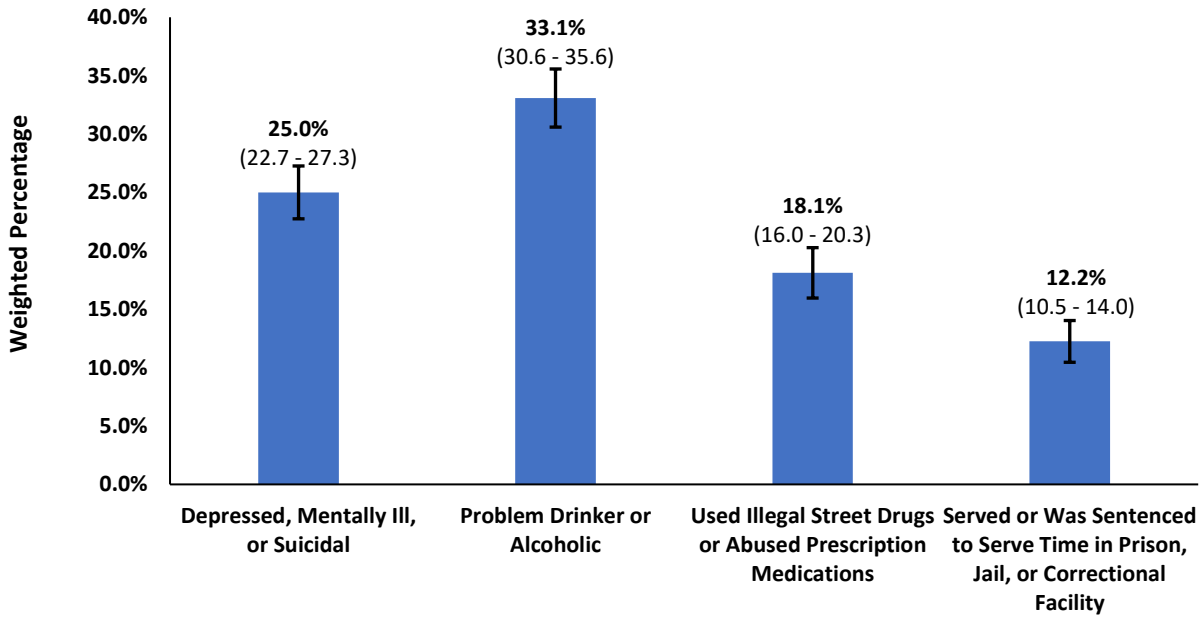
Source: Nevada Youth Risk Behavior Survey
Chart scaled to 18.0% to display differences among groups

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.[9] Prevention of ACEs is vital to reducing negative health outcomes in the community.

Between 2019-2023, 33.1% of adults state that, before the age of 18, they lived with someone who was a problem drinker or alcoholic, and 25.0% reported living with someone who was depressed, mentally ill, or suicidal. These early exposures (ACEs) may be associated with increased adverse health outcomes later in life.

Figure 96. Adult BRFSS Respondents Who, During Childhood, Lived with Others Who Had Certain Conditions, Washoe County Residents, 2019-2023.

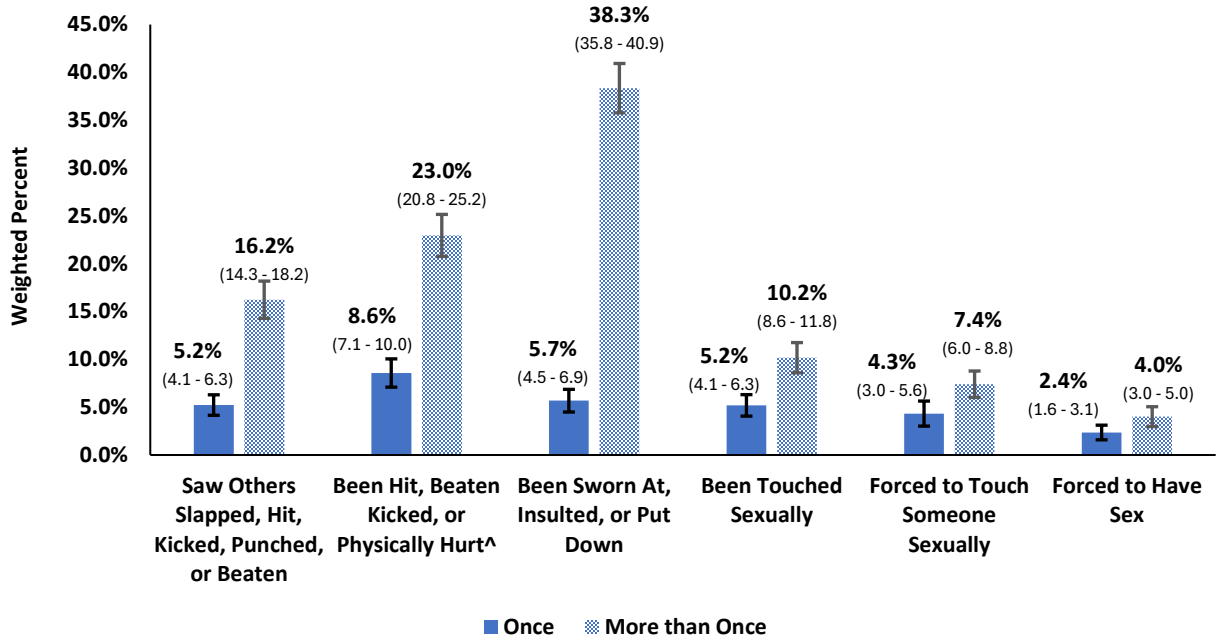


Source: Behavioral Risk Factor Surveillance System
Chart scaled to 40.0% to display differences among groups.
Childhood refers to before the age of 18.
Questions: "Did you live with anyone who was depressed, mentally ill, or suicidal?"
"Did you live with anyone who was a problem drinker or alcoholic?"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

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

Using combined data from 2019-2023, 44.0% of adults reported that, before the age of 18, they had been sworn at, insulted, or put down at least once; 31.6% were "hit, beaten, kicked, or physically hurt" (not including spanking) at least once; and 15.4% of adults had been touched sexually at least once.

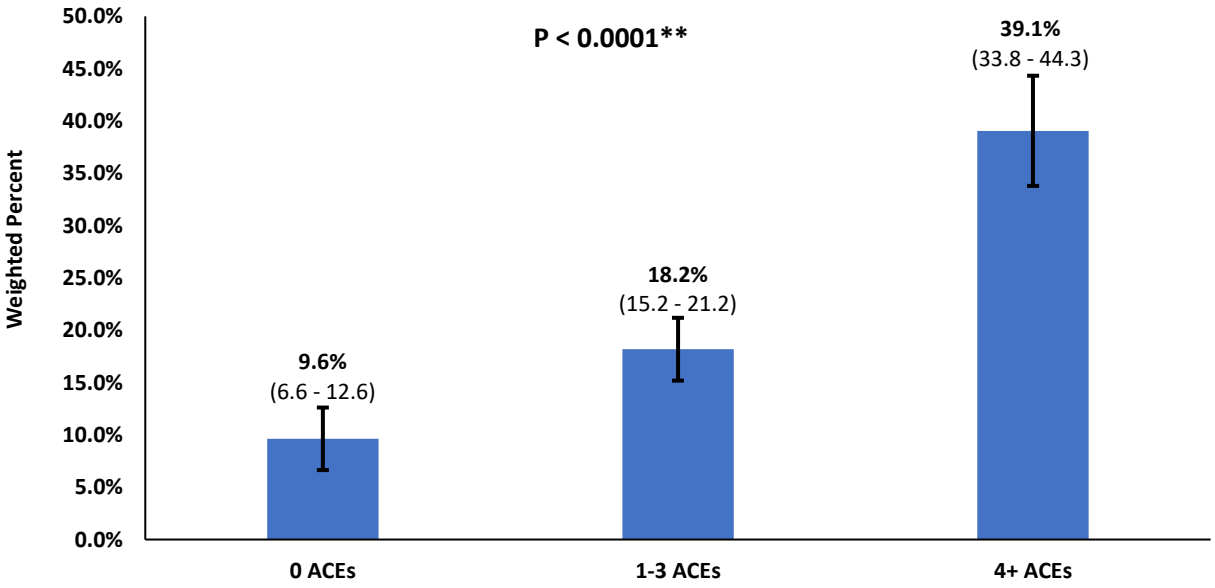
Figure 97. Adult BRFSS Respondents with Adverse Childhood Experiences, Washoe County Residents, 2019-2023.



Source: Behavioral Risk Factor Surveillance System
Chart scaled to 45.0% to display differences among groups.
Childhood refers to before the age of 18.
Questions: "How often did your parents or adults in your home ever slap, hit, kick, punch or beat each other up?"
"Before age 18, how often did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?"
"How often did a parent or adult in your home ever swear at you, insult you, or put you down?"
"How often did anyone at least 5 years older than you or an adult, touch you sexually?"
"How often did anyone at least 5 years older than you or an adult, try to make you touch them sexually?"
"How often did anyone at least 5 years older than you or an adult, force you to have sex?"
^Does not include spanking.
**Someone at least 5 years older than you or an adult.*
95% Confidence Intervals.

Higher exposure to ACEs is significantly associated with a greater prevalence of depression among adults. Among adult Washoe County residents who reported experiencing at least four ACEs, 39.1% also reported having depression, compared to just 9.6% of those reporting depression who experienced no ACEs.

Figure 98. Percentage of BRFSS Respondents Who Reported Having Depression, by Number of Adverse Childhood Events, Washoe County 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.*

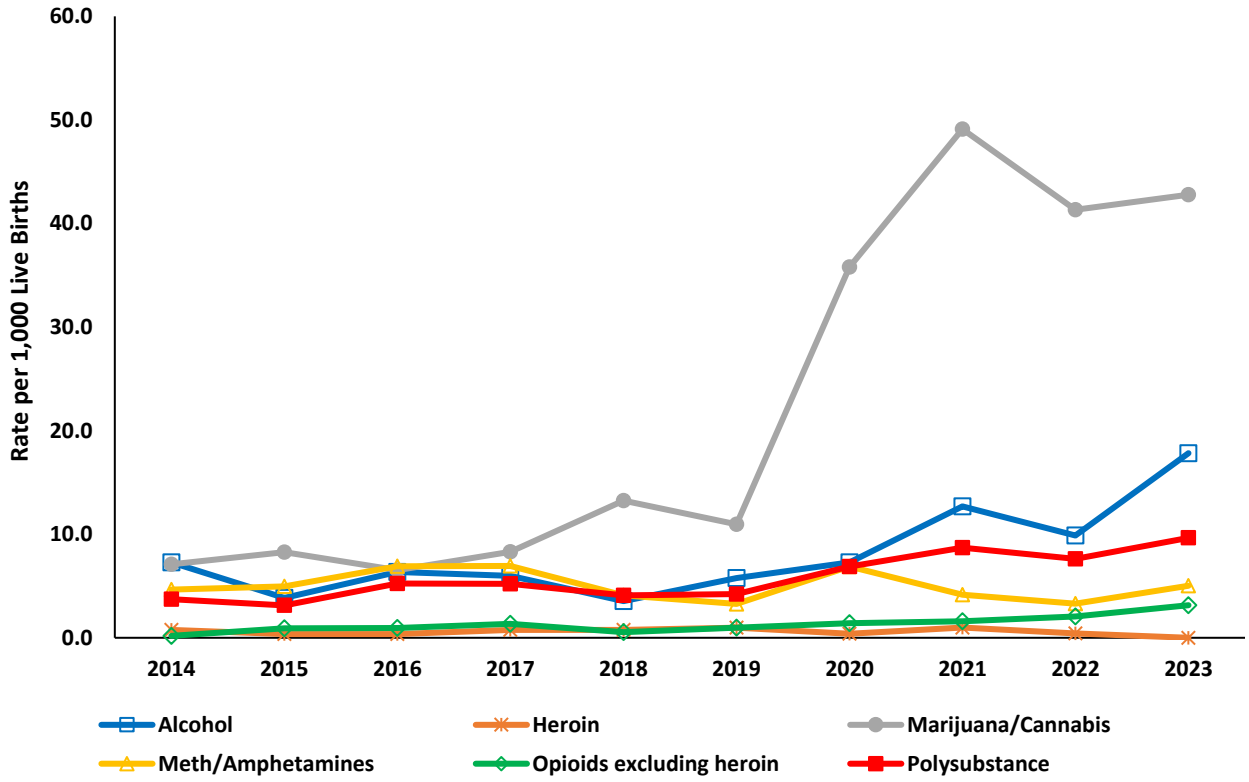
Maternal and Child Health

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 5,153 live births per year to Washoe County residents between 2014 and 2023. In 2023, 204 birth certificates indicated marijuana use, 85 indicated alcohol use, 46 indicated polysubstance (more than one substance) use, 24 indicated meth/amphetamine use, and 15 indicated opiate use.

Of the self-reported substance use during pregnancy among Washoe County residents who gave birth between 2014 and 2023, the highest rate was with marijuana use in 2021, at 49.1 per 1,000 live births. Alcohol use increased from a low of 3.9 per 1,000 births to a high of 17.8 per 10,000 live births, and polysubstance use (more than one substance) has increased from 3.7 per 1,000 live births in 2014 to a high 9.6 per 1,000 live births in 2023. The rate of self-reported meth/amphetamine and opioids excluding heroin use has remained fairly steady over the 10-year period. The substance categories are mutually exclusive, with any instance of multiple substance classified as polysubstance use.

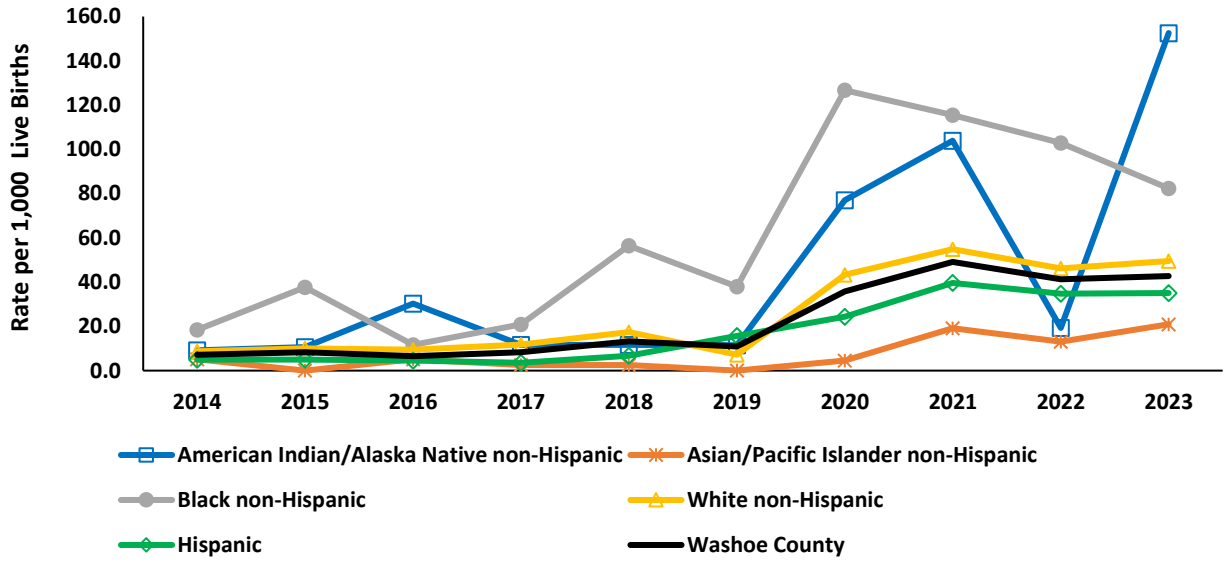
Figure 99. Self-Reported Prenatal Substance Use Birth Rates for Select Substances, Washoe County Residents, 2014-2023.



Source: Nevada Electronic Birth Registry System

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

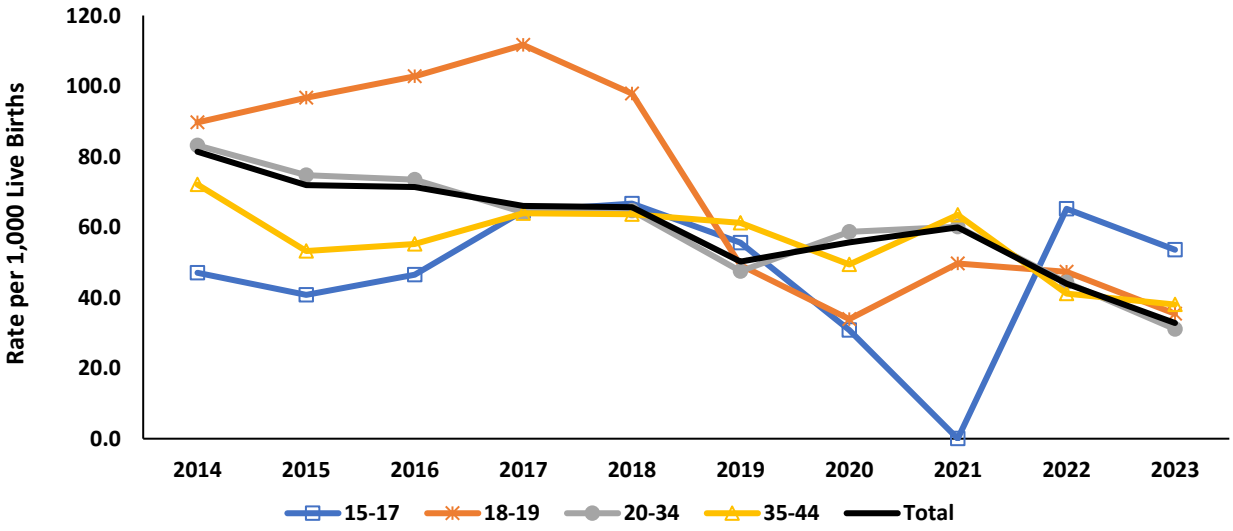
Figure 100. Self-Reported Prenatal Marijuana Use Birth Rates by Race/Ethnicity, Washoe County Residents, 2014-2023.



Source: Nevada Electronic Birth Registry System.

Self-reported tobacco use during pregnancy has fluctuated over the years but shows an overall decline across all age groups. The rates among the 15-17 age group fluctuate greatly due to small populations and are not statistically significant.

Figure 101. Self-Reported Prenatal Tobacco Use Birth Rates by Maternal Age, Washoe County Residents, 2014-2023.

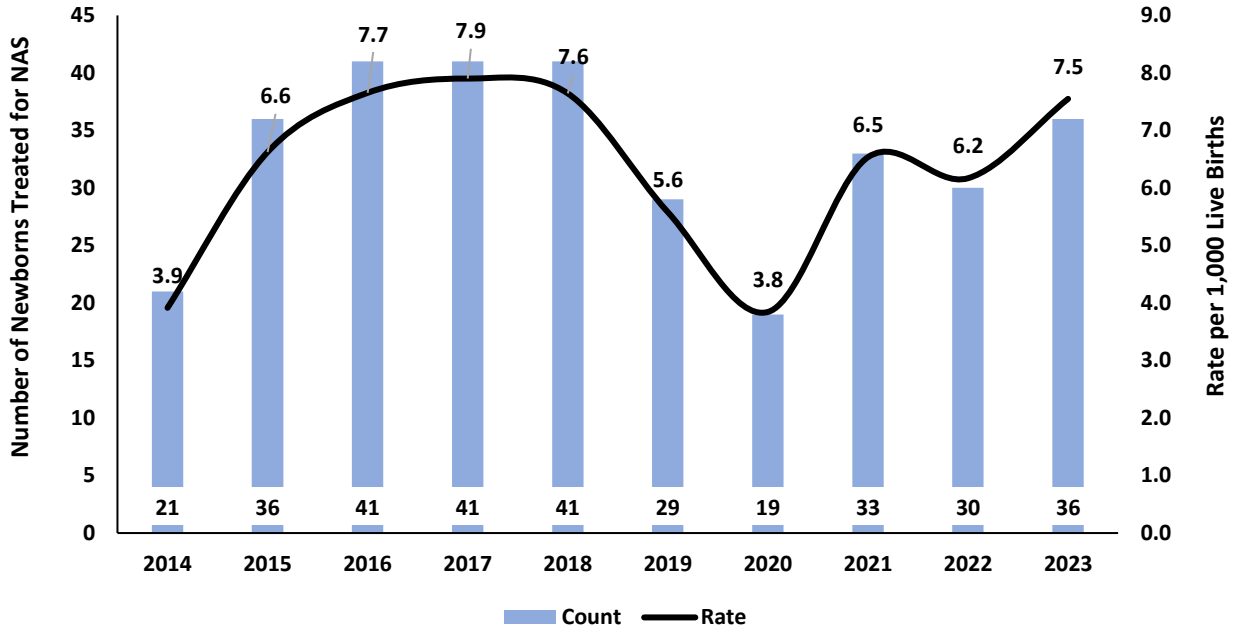


Source: Nevada Electronic Birth Registry System

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 2017, with 41 admissions and a rate of 7.9 per 1,000 live births; the number dipped to 19 (rate of 3.8 per 1,000) in 2020; and climbed back to 36 (rate of 7.5 per 1,000) in 2023.

Figure 102. Neonatal Abstinence Syndrome, Washoe County 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 the small total number of cases of NAS in the reporting period, rates by demographic breakout have been omitted.

Lesbian, Gay, Bisexual, and Transgender Health

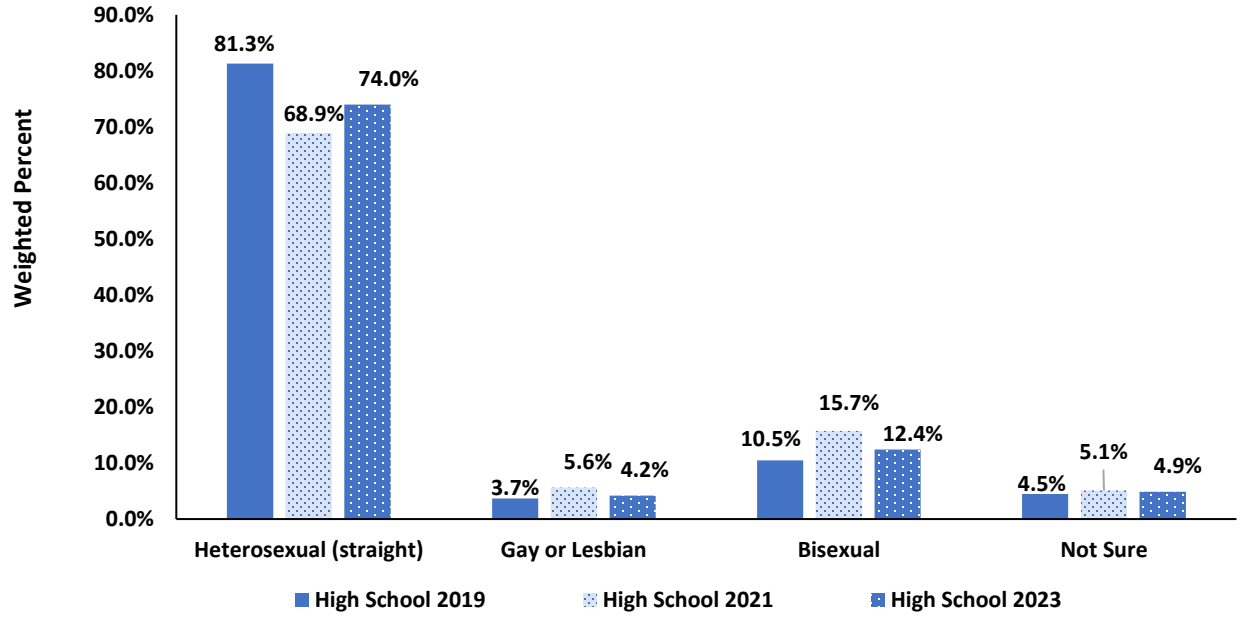
Those who identify as LGBT are part of a vulnerable community that may face unique or worse health outcomes. This is especially important when considering LGBT youth who may be most at risk for health disparities. This section exists to better understand the unique risk factors that exist for this population.

Causes of Death and Disabilities

The YRBS monitors six categories of health-related behaviors that contribute to leading causes of death and disabilities among youth. LGB youth included in this report identify as gay or lesbian, bisexual, or not sure. For more detail information about YRBS and sexual orientation and gender identity, the University of Nevada, Reno, produced a Sexual and Gender Minority Special Report using 2019 data.

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

Figure 103. Sexual Orientation, Nevada High School Population, 2019, 2021, and 2023.



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

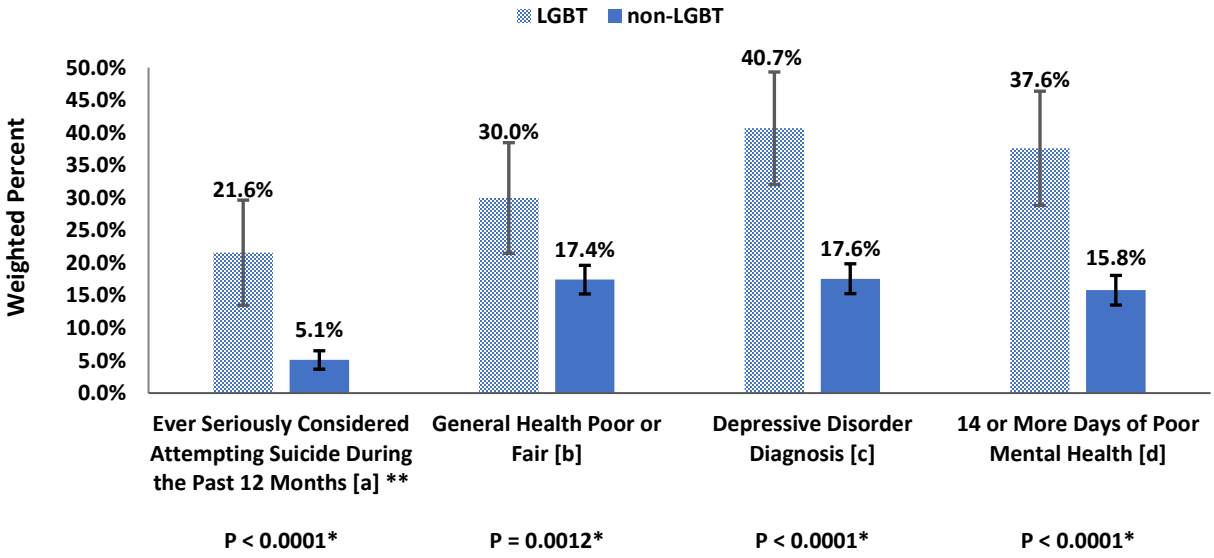
Substance Use in LGBT Community

The BRFSS collects information on adult 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, alcohol use, and e-cigarette use.

Those in the LGBT community are considered a vulnerable community and may have worse health outcomes when compared to the non-LGBT population. A more in-depth look at health outcomes is vital to ensure these health disparities are addressed and analyzed. LGBT data include adults in Washoe County that reported being lesbian, gay, bisexual, other, and/or transgender (n=221). The non-LGBT comparison group consists of 1,966 Washoe County adults.

Adults who are part of the LGBT community were significantly more likely to report having any mental health behavior compared to non-LGBT adults from 2021-2023. LGBT adults were four times as likely to report seriously considering attempting suicide within the past 12 months and 2.3 times as likely to have a depressive disorder compared to non-LGBT adults.

Figure 104. Mental Health Behaviors, by LGBT and non-LGBT, Washoe County Residents, 2021-2023.

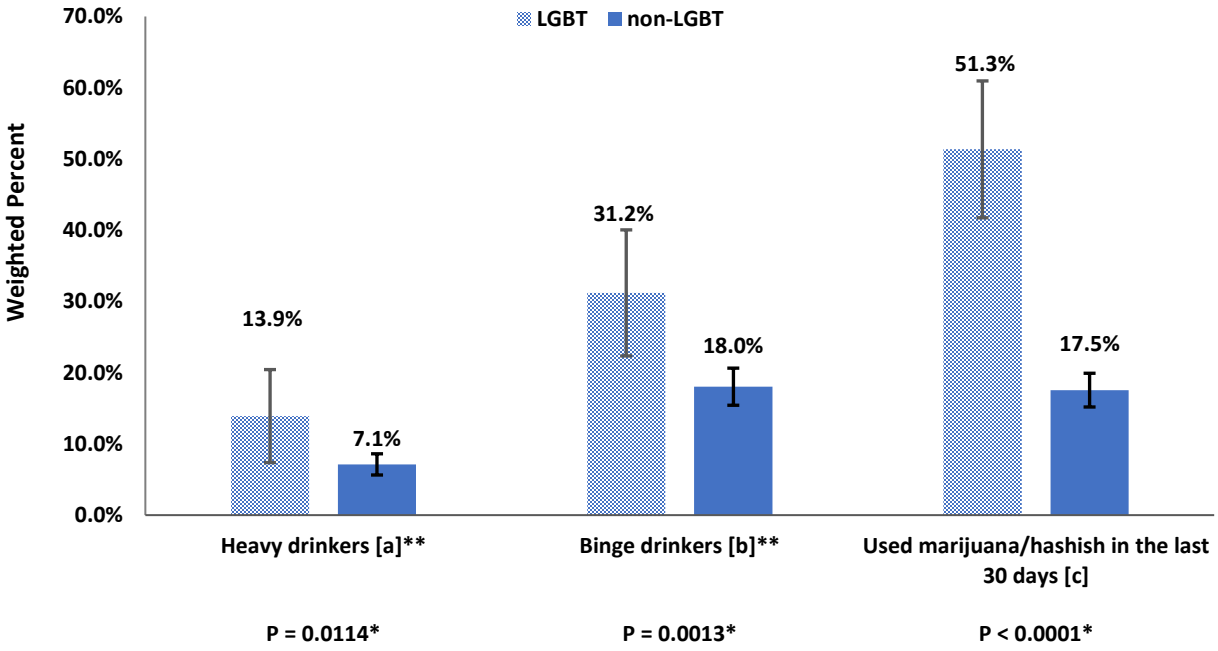


Source: Behavioral Risk Factor Surveillance System
Chart scaled to 50.0% to display differences among groups.
***Cell size small, take caution with interpretation*
** Significant (P < 0.05).*
95% Confidence Intervals

a. LGBT (13.5 - 29.6), non-LGBT (3.7 - 6.5)
b. LGBT (21.5 - 38.5), non-LGBT (15.2 - 19.6)
c. LGBT (32.0 - 49.3), non-LGBT (15.3 - 19.9)
d. LGBT (28.8 - 46.4), non-LGBT (13.5 - 18.1)

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

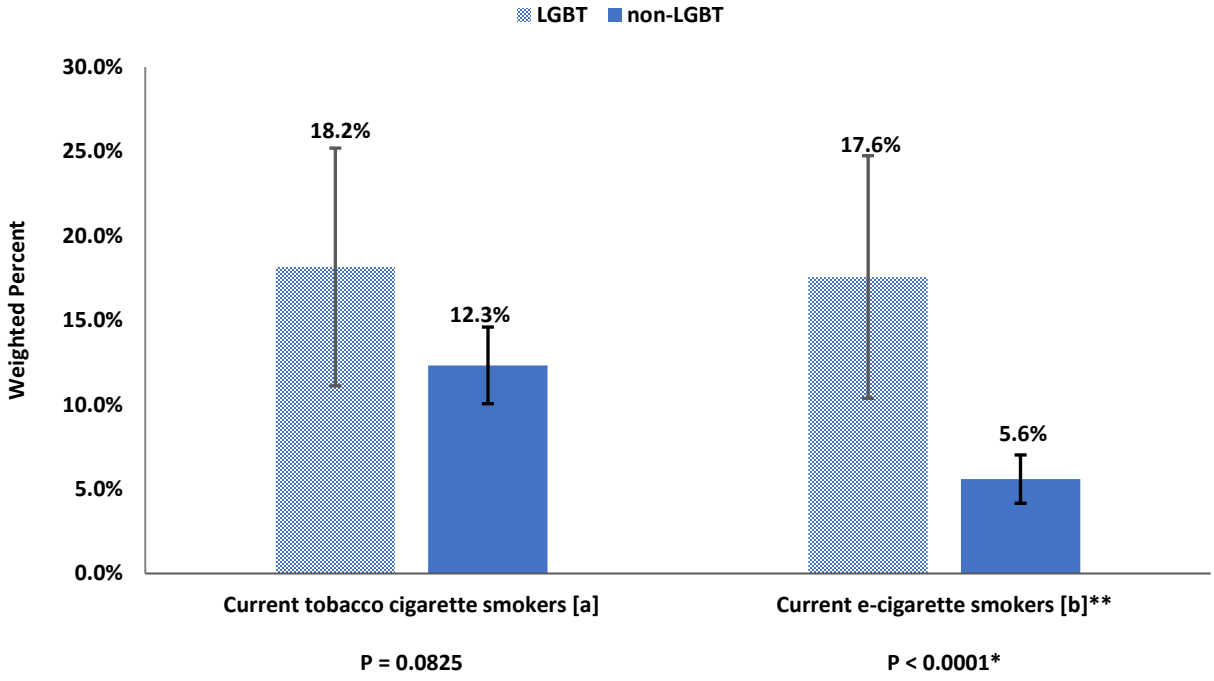
Figure 105. Substance Use-Related Risk Factors, by LGBT and non-LGBT, Washoe County Residents, 2021-2023.



Source: Behavioral Risk Factor Surveillance System
Chart scaled to 70.0% to display differences among groups.
***Cell size small, take caution with interpretation*
** Significant (P < 0.05).*
95% Confidence Intervals
a. LGBT (7.4 - 20.4), non-LGBT (5.6 - 8.6)
b. LGBT (22.3 - 40.0), non-LGBT (15.4 - 20.6)
c. LGBT (41.7 - 61.0), non-LGBT (15.2 - 19.9)

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

Figure 106. Current Cigarette Smokers, by LGBT and non-LGBT, Washoe County Residents, 2021-2023.



Source: Behavioral Risk Factor Surveillance System
Chart scaled to 30.0% to display differences among groups.
***Cell size small, take caution with interpretation*
** Significant (P < 0.05).*
95% confidence intervals
a. LGBT (11.1 - 25.2), non-LGBT (10.1 - 14.6)
b. LGBT (10.4 - 24.7), non-LGBT (4.2 - 7.0)

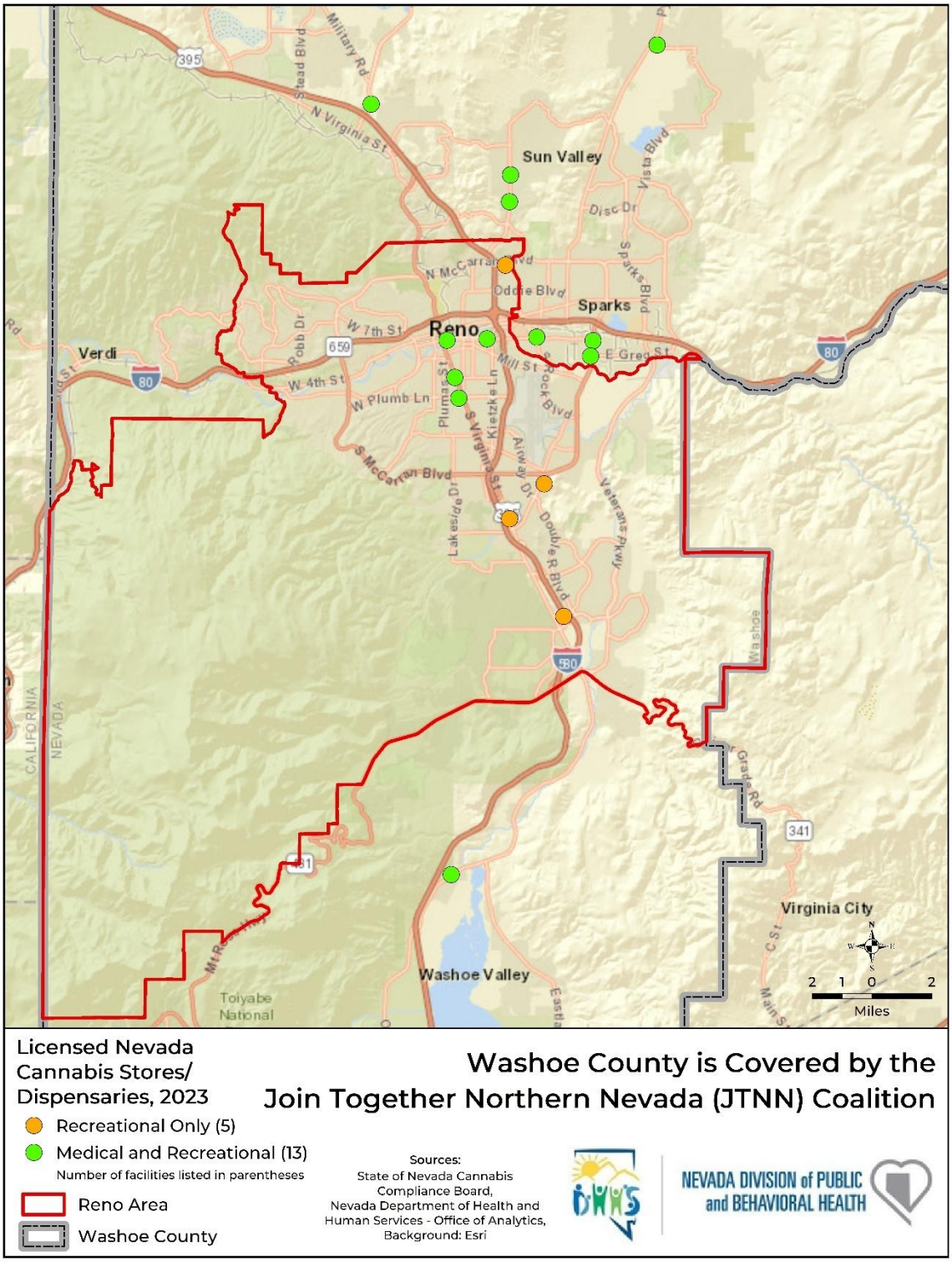
Cannabis

Legal Cannabis in Nevada

Legislation to allow licensed cannabis sales in Nevada was approved in 2013, the first medical cannabis dispensary opened in Nevada in 2017, and cannabis became legal for recreational use in Nevada on Jan. 1, 2017. Figure 107 below displays the locations of the Nevada licensed cannabis dispensaries in Washoe County. Licensing is managed by the State of Nevada Cannabis Compliance Board (see NV CCB for more information). Note that there are tribal cannabis establishments in Nevada; these establishments are not licensed through the State of Nevada Cannabis Compliance Board and therefore are not shown on the maps.

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

Figure 107. Washoe County, Nevada Licensed Cannabis Dispensary Locations.



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-digit. In hospital billing data, the ICD codes are provided in the diagnosis fields, while for mortality data the ICD codes are 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