Behavioral Health Wellness and Prevention 2022 Epidemiologic Profile: Rural Region, Nevada

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

April 2023

Department of Health and Human Services

Office of Analytics

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For more information on this report, please contact data@dhhs.nv.gov

Executive Summary

Purpose

This report is intended to provide an overview of behavioral health in Nevada for public health authorities, Nevada legislators, behavioral health boards and the public. The analysis can be used to identify issues of concern and areas that may need to be addressed.

Data Sources

Behavioral Risk Factor Surveillance System (BRFSS)
BRFSS is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, chronic health conditions, and use of preventive services. More than 400,000 adults are interviewed each year, making the BRFSS the largest telephone health survey in the world. For many states, the BRFSS is the only available source of timely and accurate data on health-related behaviors. The survey consists of a set of federally grant funded core questions and states may include and pay for their own questions in the survey. While the survey's focus is chronic disease and injury, topics covered by the survey include car safety, obesity, and exercise among many others. Since state-added questions are not asked nationwide, these questions are not comparable.

Hospital Emergency Department Billing (HEDB)
The Hospital Emergency Department Billing data provides health billing data for emergency room patients for Nevada's non-federal hospitals. NRS 449.485 mandates all hospitals in Nevada to report all patients discharged in a form prescribed by the director of the Department of Health and Human Services. The data are collected using a standard universal billing form. The data in this report are for patients who used emergency room and inpatient services. The data includes demographics such as age, gender, race/ethnicity and uses International Classification of Diseases-9-Clinical Modification (ICD-9-CM) diagnoses codes and International Classification of Diseases-10-Clinical Modification (ICD-10-CM) diagnoses (up to 33 diagnoses respectively). ICD-10-CM diagnoses codes replaced ICD-9-CM diagnoses codes in the last quarter of 2015. Therefore, data prior to the last quarter in 2015 may not be directly comparable to data thereafter. In addition, the data includes billed hospital charges, procedure codes, length of hospital stay, discharge status, and external cause of injury codes. The billing data information is for billed charges and not the actual payment received by the hospital.

Hospital Inpatient Billing (HIB)
The Hospital Inpatient Billing data provides health billing data for patients discharged from Nevada's non-federal hospitals. NRS 449.485 mandates all hospitals in Nevada to report information as prescribed by the director of the Department of Health and Human Services. The data are collected using a standard universal billing form. The data is for patients who spent at least 24 hours as an inpatient, but do not include patients who were discharged from the emergency room. The data includes demographics such as age, gender, race/ethnicity and uses International Classification of Diseases-9-Clinical Modification (ICD-9-CM) diagnoses codes and International Classification of Diseases-10-Clinical Modification (ICD-10-CM) diagnoses (up to 33 diagnoses respectively). ICD-10-CM diagnoses codes replaced ICD-9-CM

diagnoses codes in the last quarter of 2015. Therefore, data prior to the 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.

Monitoring the Future Survey
Since 1975 Monitoring the Future Survey has measured alcohol and drug use and related attitudes among adolescent students nationwide. Survey participants report their drug use behaviors across three-time periods: lifetime, past year, and past month. Students from both public and private schools participate in the survey. The survey is funded by the National Institute on Drug Abuse (NIDA), a component of the National Institutes of Health (NIH) and conducted by the University of Michigan.
For more information: Monitoring the Future

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

Nevada State Demographer – Nevada Population Data
The Nevada State Demographer's office is funded by the Nevada Department of Taxation and is part of the Nevada Small Business Development Center. It is responsible for conducting annual population estimates for Nevada's counties, cities, and towns.

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

Substance Abuse and Mental Health Data
The National Survey of Drug Use and Health (NSDUH) is a survey on the use of illicit drugs, alcohol, tobacco, and mental health issues in the United States. The study includes those who are 12 years of age or older at the time of the survey. It is conducted annually by the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency within the US Department of Health and Human Services that focuses on behavioral health. For more information on the survey: SAMHSA NSDUH

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

Web-Enabled Vital Records Registry Systems (WEVRRS)

Statewide births and deaths are collected by the Office of Vital Records, in the Division of Public and Behavioral Health. WEVRRS is a software utilized by physicians, registered nurses, midwives, informants or funeral directors, and other individuals to collect and consolidate birth and death-related information.

Youth Risk Behavior Survey (YRBS)

The 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, little over 30 high schools from Nevada were 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 contracted 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; these include:

1. Behaviors that contribute to unintentional injuries and violence
2. Sexual behaviors that contribute to human immunodeficiency virus (HIV) infection, other sexually transmitted diseases, and unintended pregnancy
3. Tobacco use
4. Alcohol and other drug use
5. Unhealthy dietary behaviors
6. Physical inactivity

Nevada is among the 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, these include:

1. Behaviors that contribute to unintentional injuries and violence
2. Tobacco use
3. Alcohol and other drug use
4. Unhealthy dietary behaviors
5. Physical inactivity

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

Terminology

Age-Adjusted Rate

A rate is a measure of the frequency of a specific event over a given period, divided by the total number of people within the population over the same period of time. An age-adjusted rate is a rate that has been adjusted, or weighted, to the same age distribution as a "standard" population. Throughout this report, rates are adjusted to the 11 standard age groups of the U.S. population in the year 2000 (Census table P25-1130 Population Projections and Standard Age Groups). 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.

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.

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 the data as they were in the source data. Every effort has been made to be inclusive and equitable across every demographic to provide a fair and accurate representation of the people of Nevada. We recognize the terms “female” and “woman” do not include all birthing people but used as descriptors presented in source data.

Demographic Snapshot

Figure 1. Select Demographics for Rural Region, 2021.

	Rural Region
Population, 2021 estimate*	96,110
Population, 2012 estimate*	94,345
Population, percentage change*	1.9%
Male persons, 2021 estimate*	50,518 (52.6%)
Female persons, 2021 estimate*	45,592 (47.4%)
Median household income, Rural Region (2017-2021)**	$67,236
Per capita income in the past 12 months, Rural Region (2017-2021)**	$31,386
Persons in poverty, percent, Rural Region (2017-2021)**	12.8%
With a disability, under the age 65 years, percent, Rural Region (2017-2021)**	10.9%
Land area in square miles, Rural Region (2021)**	50,839 sq miles

*Source: *Nevada State Demographer, Vintage 2020 and **US Census Bureau.*

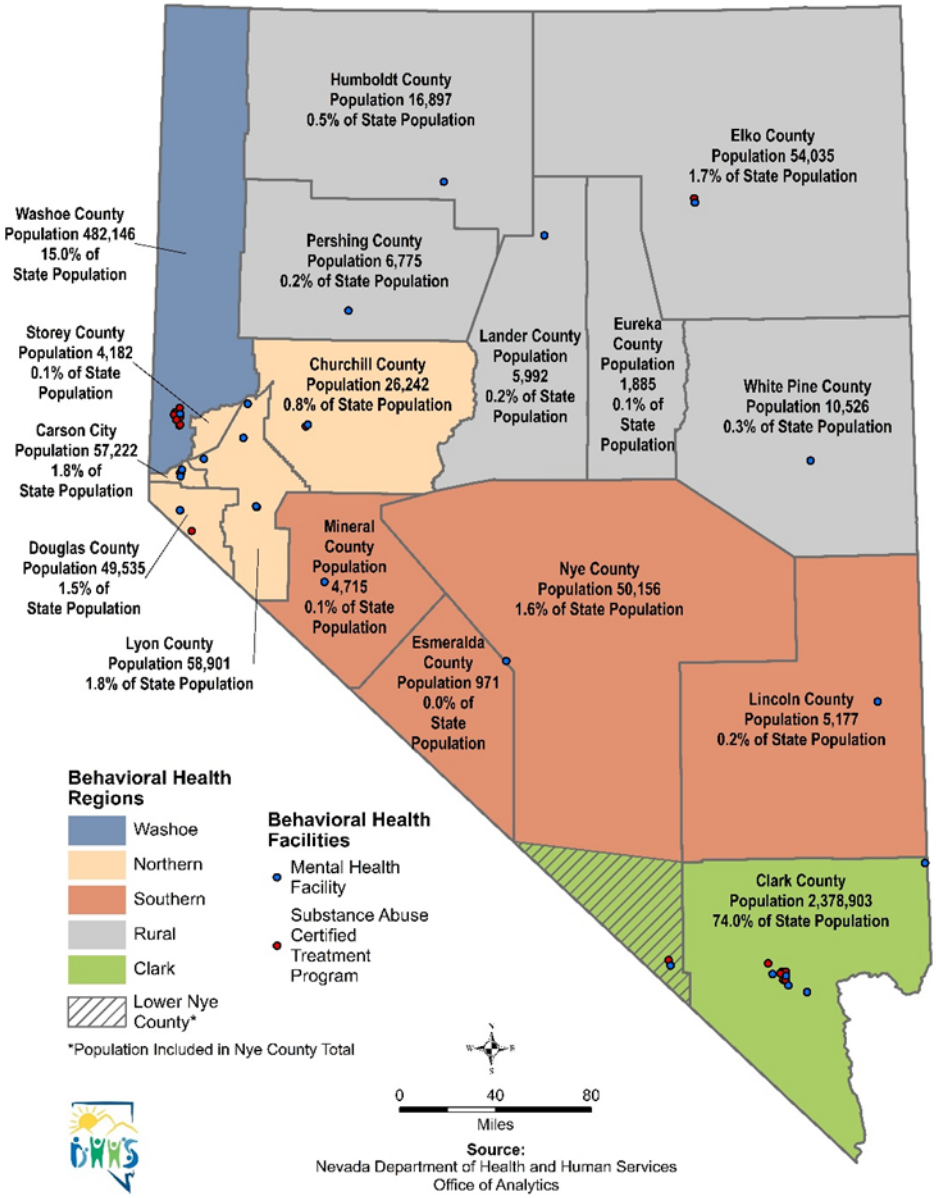
In 2021, the estimated population for the Rural Region was 6,110, a 1.9% increase from the 2012 estimated population. The population is comprised of 52.6% males and 47.4% females. The median household income was $67,236 and 12.8% were living at or below the poverty line.

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

With 74.1% of Nevada's population living in Clark County, it is the most populous area in the state, with an estimated 2,378,903 persons. Esmeralda County is the least populous county, with less than one percent of Nevada's population, an estimated 971 persons.

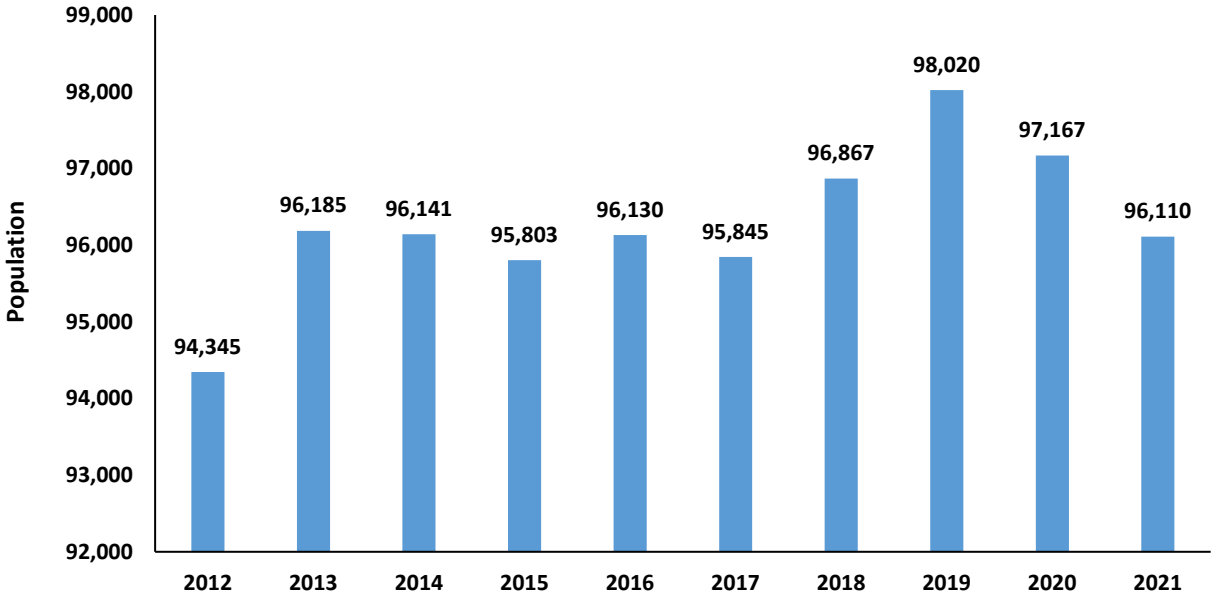
Figure 2 below shows the population for each of Nevada's 17 counties, the percent of Nevada population each county represents, the behavioral health regions, and the locations of mental health and substance abuse facilities.

Figure 2. Nevada Population Distribution by County, 2021.



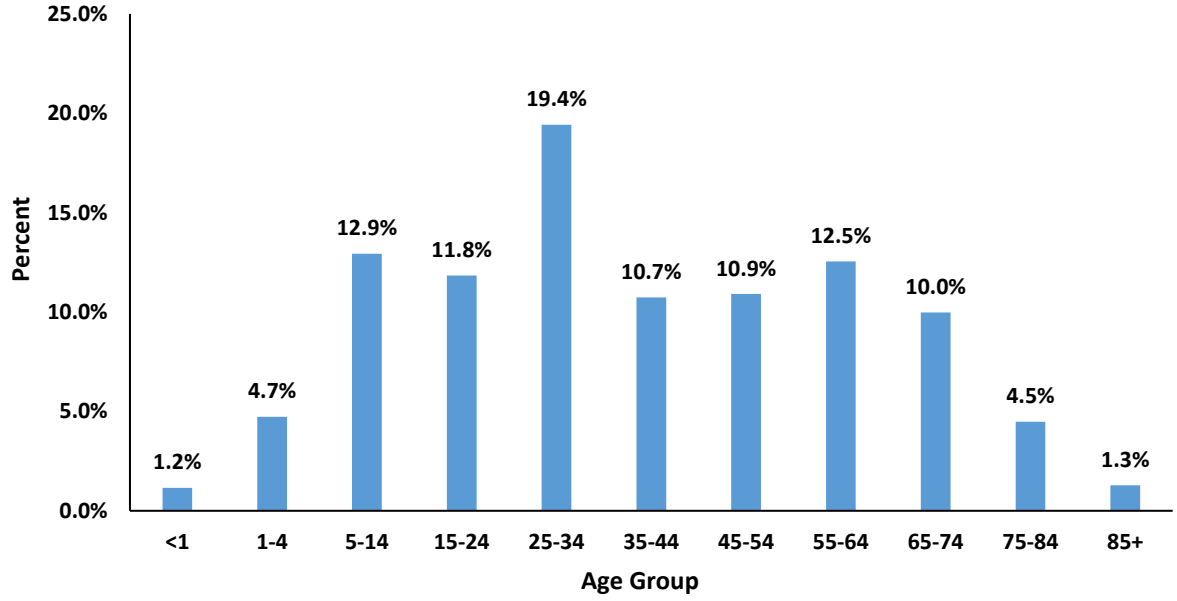
Source: Nevada State Demographer, Vintage 2020.
***Clark Region**: Clark County and southern Nye County.*
***Northern Nevada Region:** Carson City, Churchill, Douglas, Lyon, and Storey Counties.*
***Rural Nevada Region:** Elko, Eureka, Humboldt, Lander, Pershing, and White Pine Counties.*
***Southern Nevada Region:** Esmeralda, Lincoln, Mineral, and northern Nye Counties.*
***Washoe Region**: Washoe County.*
**Nye County: Northern Nye County is included in the Southern Region and southern Nye County is in part of Clark County Region. For data purposes, Nye County data is included in the Southern Nevada Region Report and not in the Clark County Region report.*

Figure 3. Rural Region Population, 2012-2021.



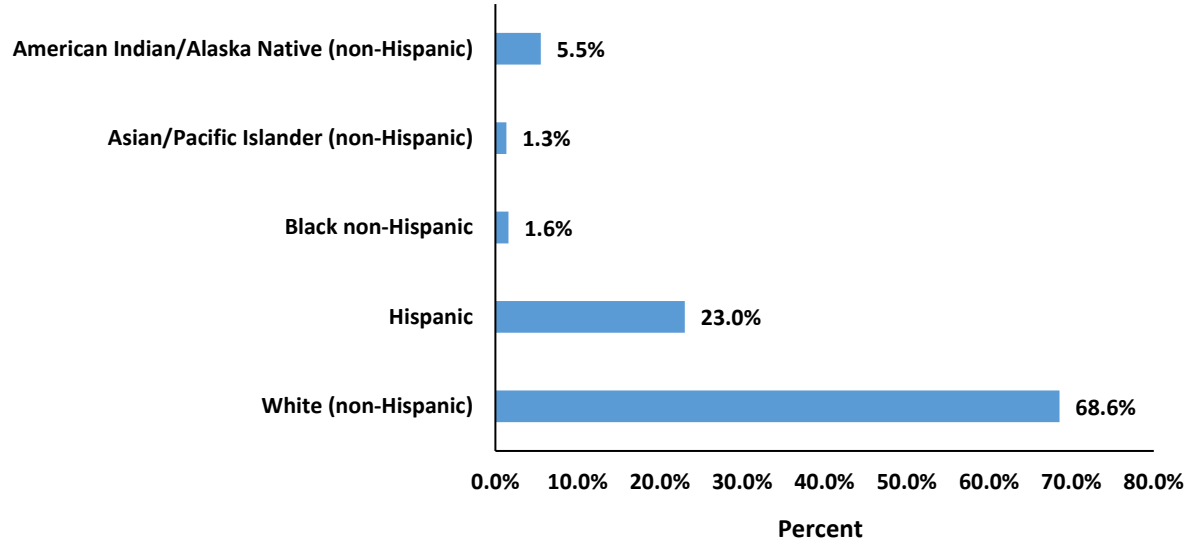
Source: Nevada State Demographer, Vintage 2020.
Chart scaled to display differences among groups.

Figure 4. Rural Region Population by Age Group, 2021.



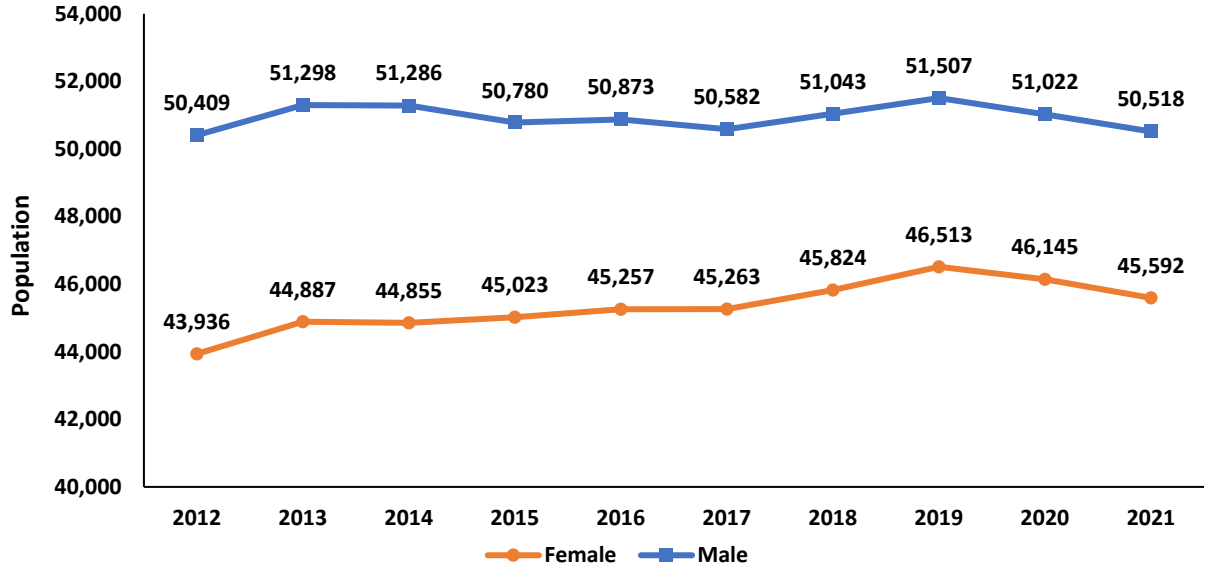
Source: Nevada State Demographer, Vintage 2020.
Chart scaled to 25.0% to display differences among groups.

Figure 5. Rural Region Population by Race/Ethnicity, 2021.



Source: Nevada State Demographer, Vintage 2020.
Chart scaled to 80.0% to display differences among groups.

Figure 6. Rural Region Population Distribution by Sex, 2012-2021.



Source: Nevada State Demographer, Vintage 2020.
Chart scaled to display differences among years.

The Rural Region's highest percent is among the 25-34 age group (19.4%), followed by the 5-14 age group (12.9%), and the 55-64 age group (12.5%).

White non-Hispanics comprise 68.6% of the Rural Region's population, followed by Hispanic, any race (23.0%), American Indian/Alaska Native (5.5%), Black non-Hispanic (1.6%), and Asian/Pacific Islander non-Hispanic (1.3%).

Mental Health

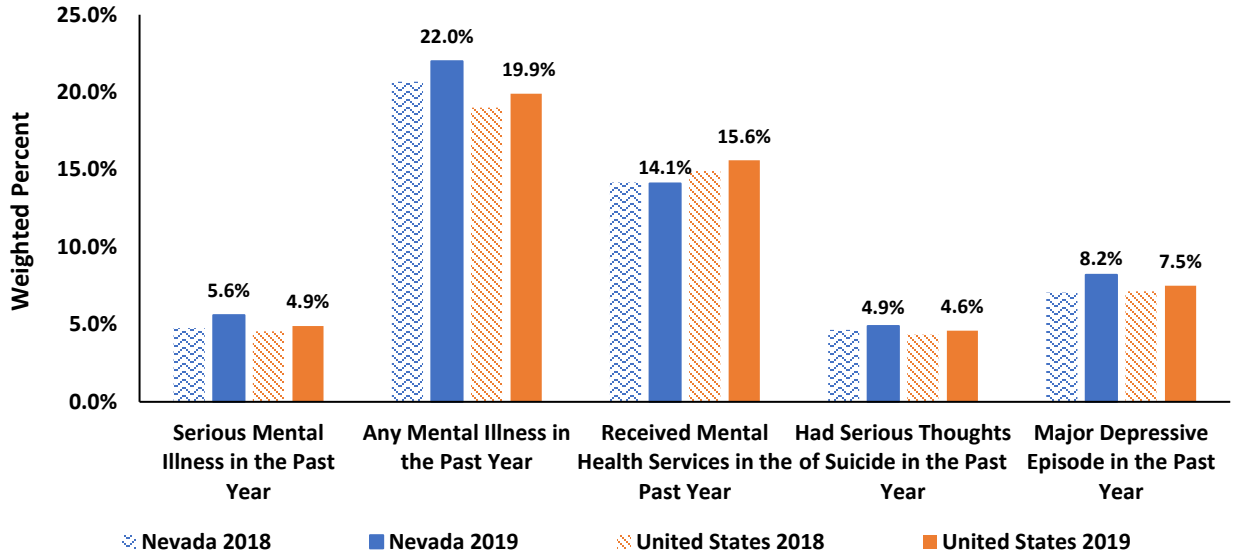
Mental health data are collected by numerous data sources in Nevada, including YRBS, BRFSS, hospital billing, state-funded mental health facilities, and vital records.

National Survey of Drug Use and Health

The Substance Abuse and Mental Health Services Administration (SAMHSA) sponsors the National Survey on Drug Use and Health (NSDUH). The survey tracks trends of illicit drug, alcohol, and tobacco use, as well as mental health issues throughout the United States.

According to SAMHSA's website, state data tables and reports from the 2019-2020 NSDUH "are no longer available due to methodological concerns with combining the 2019 and 2020 data". Therefore, data in Figure 7 below are from the 2017-2018 and 2018-2019 NSDUH state reports. For more information, please visit SAMHSA 2019-2020 State Reports

Figure 7. Percent of Mental Health Measures, Aged 18+, Nevada and the United States, 2018-2019.



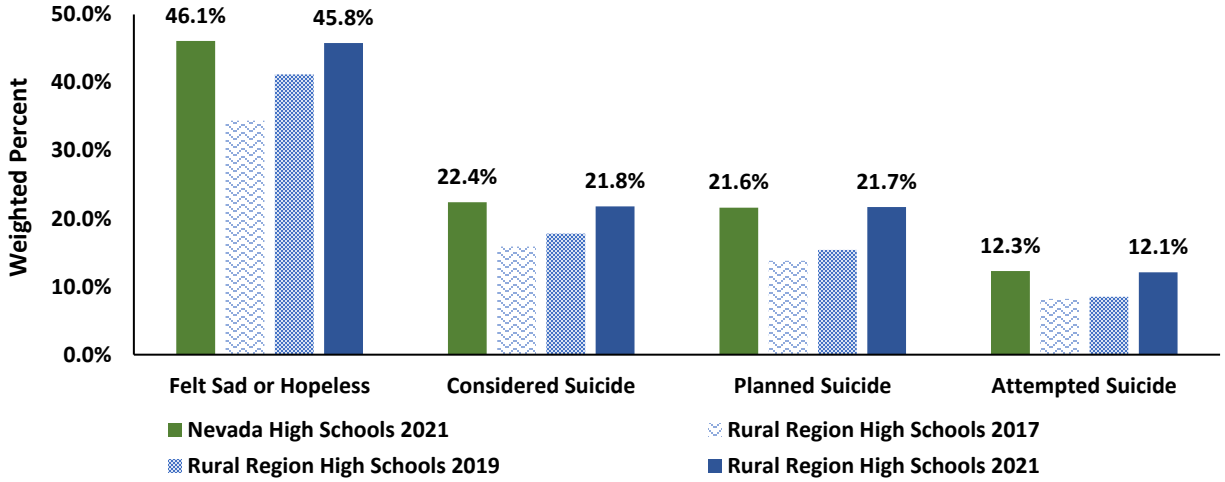
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2017-2018 and 2018-2019.
Chart scaled to 25.0% to display differences among groups.

Nevada percents continue to be higher than the United States for "serious mental illness in the past year," "any mental illness in the past year," and "had serious thoughts of suicide in the past year." Nevada had the same percent as the United States in 2018 for "major depressive episode in the past year" but was higher in 2019.

Youth Risk Behavior Survey (YRBS)

The YRBS monitors six categories of health-related behaviors that contribute to leading causes of death and disabilities among youth and adults. Nevada high school and middle school students are surveyed during the odd numbered years. In 2021, 597 high school and 522 middle school students participated in the YRBS in the Rural Region. The University of Nevada, Reno maintain the YRBS data and publishes data on each survey. For more information on the YRBS survey, please go to the following site: UNR YRBS

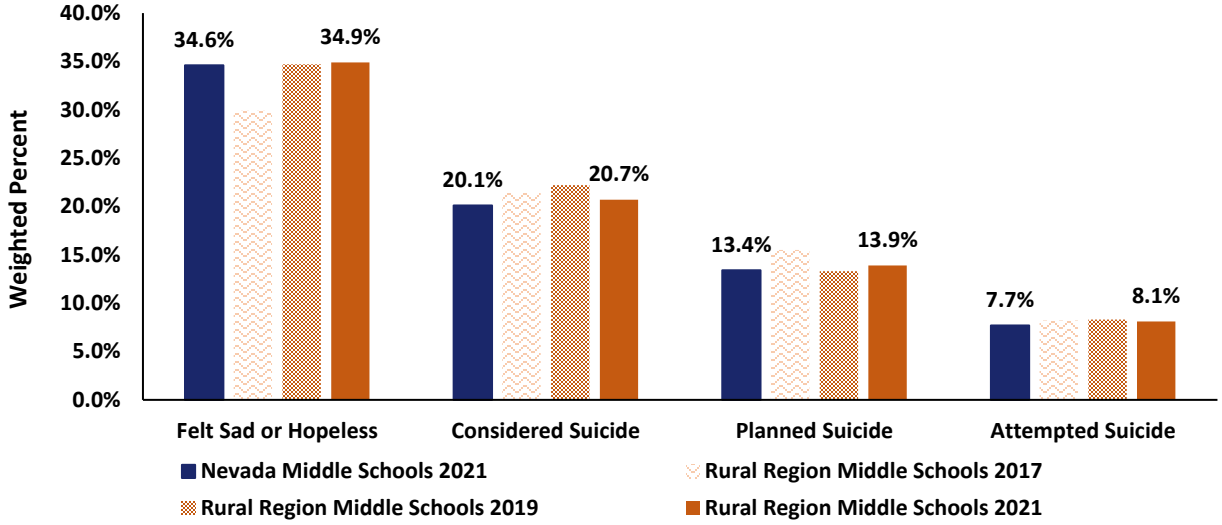
Figure 8a. Mental Health Behaviors, Rural Region High School Students 2017, 2019, and 2021, and Nevada High School Students, 2021.



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

From 2017 to 2021, there has been a steady increase in the percent of Rural Region high school students reporting that they felt sad or hopeless, considered suicide, planned suicide, or attempted suicide, with felt sad or hopeless having the highest percent (45.8%). All indicators measured in Figure 8a among Rural Region high school students in 2021 are lower than the Nevada high school 2021 percents, except for those who planned suicide, but not statistically lower.

Figure 8b. Mental Health Behaviors, Rural Region Middle School Students 2017, 2019, and 2021, and Nevada Middle School Students, 2021.



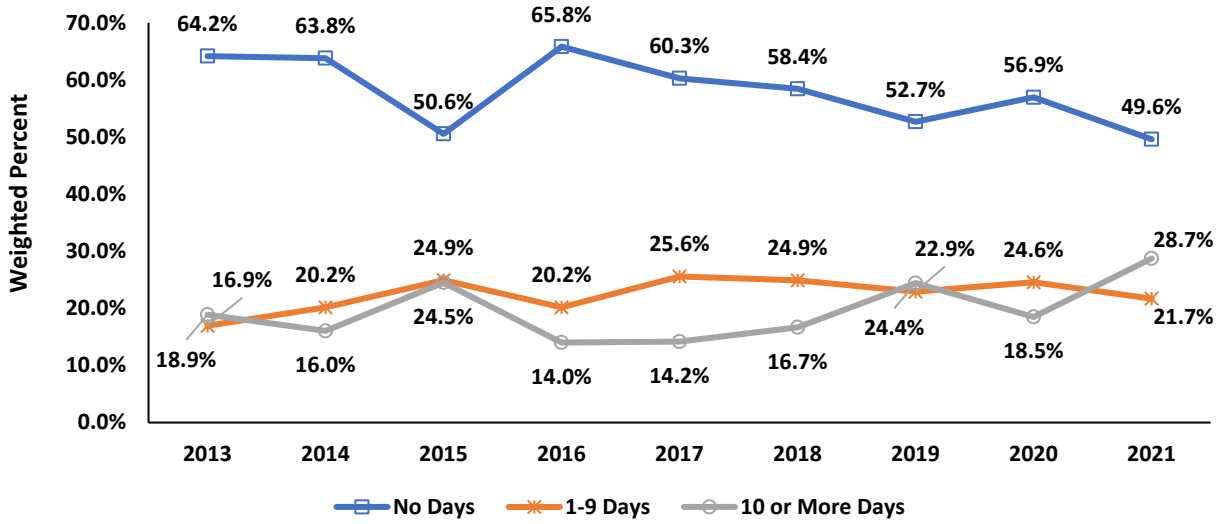
Source: Nevada Youth Risk Behavior Survey (YRBS).
Chart scaled to 40.0% to display differences among groups.

From 2017 to 2021, there has been an increase in the percent of Rural Region middle school students reporting that they felt sad or hopeless. The percent of those who reported that they considered suicide or attempted suicide was highest in 2019, and the percent of those who reported that they planned suicide was highest in 2017. All indicators measured in Figure 8b among Rural Region middle school students in 2021 are within a percent of Nevada high school 2021 percents.

Behavioral Risk Factor Surveillance System (BRFSS)

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

Figure 9. Percent of Adult BRFSS Respondents Who Experienced Poor Mental or Physical Health that Prevented Them from Doing Usual Activities by Days Affected in Past Month, Rural Region Residents, 2013-2021.

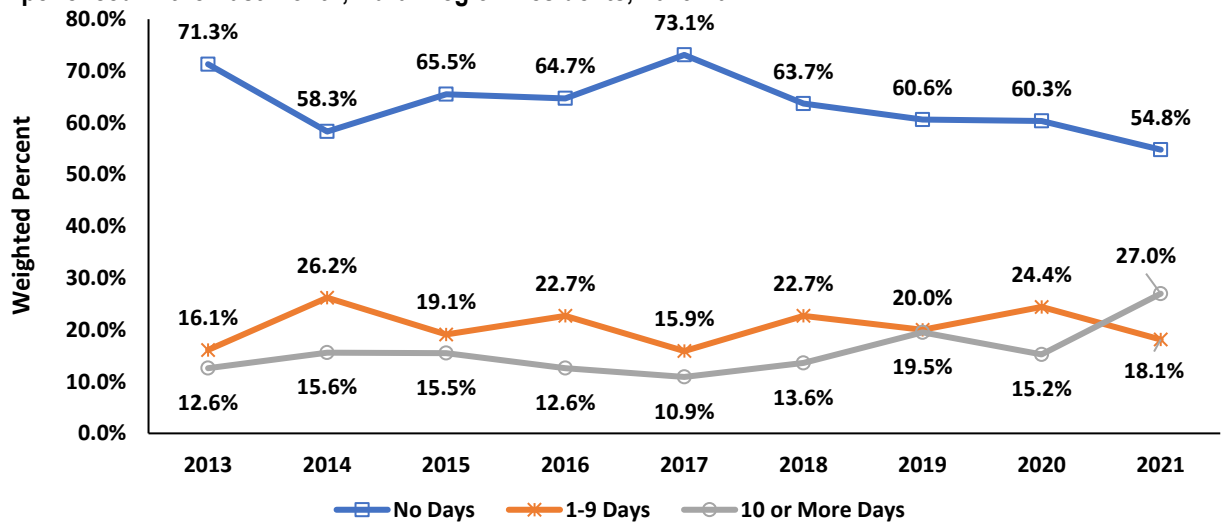


Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 70.0% to display differences among groups.
Specific question asked in survey: "During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?"

The percent of adult Rural Region BRFSS respondents who reported experiencing no days of poor mental health or physical health that prevented them from doing usual activities has steadily decreased from a high of 65.8% in 2016 to a low of 49.6% in 2021 (except for an increase in 2020).

In contrast, the percent of adult Rural Region BRFSS respondents who reported experiencing 10 or more days of poor mental health or physical health that prevented them from doing usual activities was at a high of 28.7% in 2021, up from a low of 14.0% in 2016.

Figure 10. Percent of Adult BRFSS Respondents Whose Mental Health was Not Good by Number of Days Experienced in the Past Month, Rural Region Residents, 2013-2021.

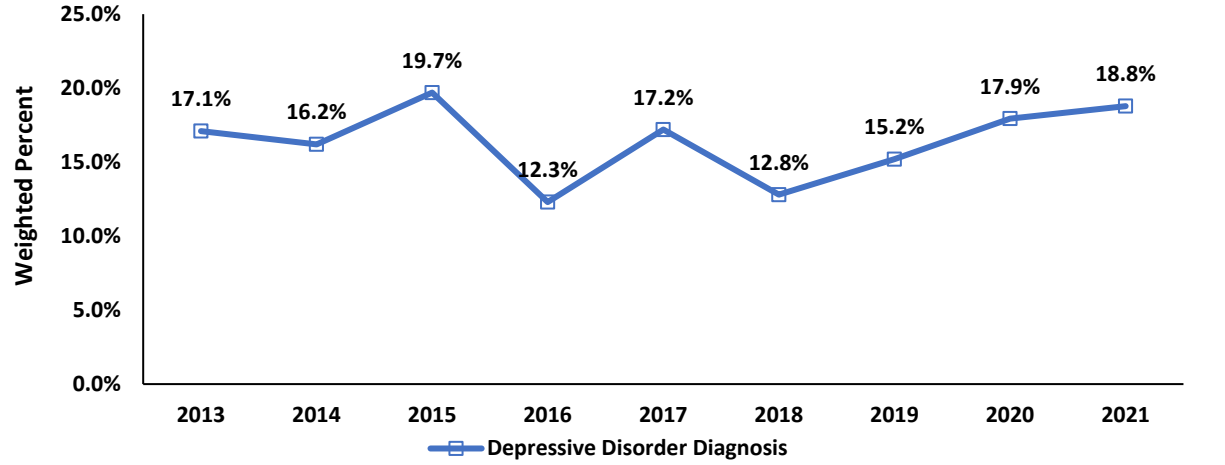


Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 80.0% to display differences among groups.
Specific question asked in survey: "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"

The percent of adult Rural Region BRFSS who reported who experienced no days in the past month in which their mental health was considered by them as "not good" steadily decreased from high of 73.1% in 2017 to a low of 54.8% in 2021. This percent has increased and decreased since 2013, with a high of 61.0% in 2014.

In contrast, the percent of adult Rural Region BRFSS respondents who reported experiencing 10 or more days of poor mental health or physical health that prevented them from doing usual activities was at a high of 27.0% in 2021, up from a low of 10.9% in 2017.

Figure 11. Percent of Adult BRFSS Respondents Who Have Ever Been Told They have a Depressive Disorder, Including Depression, Major/Minor Depression, or Dysthymia, Rural Region Residents, 2013-2021.



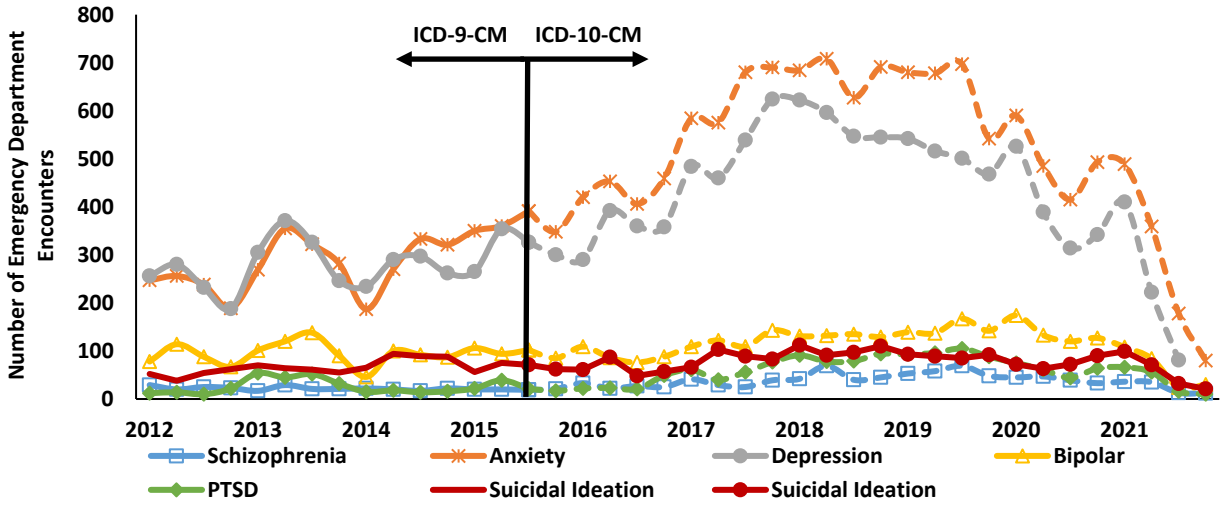
Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 25.0% to display differences among groups.
Specific question asked in survey: "(Ever told) you have a depressive disorder (including depression, major depression, dysthymia, or minor depression)?"

In the Rural Region, 18.8% of adult BRFSS respondents were told they have a depressive disorder in 2021. This percent has increased and decreased from year to year, with 2015 having the highest percent (19.7%).

Hospital Emergency Department Encounters

The hospital emergency department billing data includes data for emergency room patients for Nevada's non-federal hospitals. Since an individual can have more than one diagnosis during a single emergency department visit, the following numbers reflect the number of times a diagnosis in each of these categories was given, and therefore the following numbers are not mutually exclusive.

Figure 12. Mental Health-Related Emergency Department Encounters, by Quarter and Year, Rural Region Residents, 2012-2021.



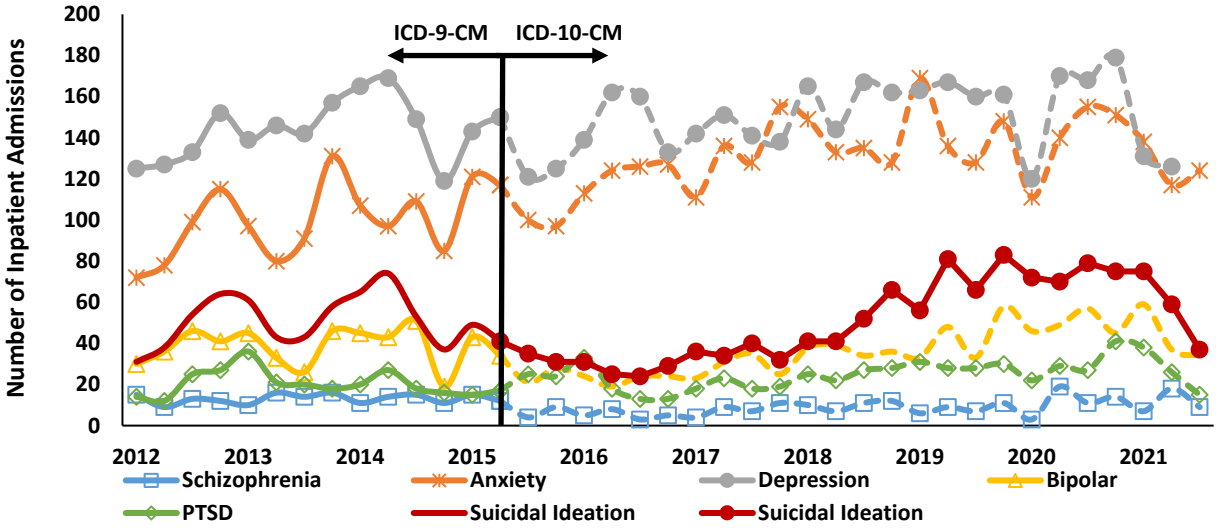
Source: Hospital Emergency Department Billing.
Categories are not mutually exclusive.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.
Note: Data for depression 2021 quarter four not available.

Anxiety has been the leading mental health-related diagnosis since 2014 in emergency department encounters among Rural Region residents, followed closely by depression. Both anxiety and depression-related diagnoses reached a high around 2018 before significantly decreasing by 2021. All the mental health-related diagnoses listed in Figure 12 above decreased from 2020 to 2021.

Hospital Inpatient Admissions

Hospital Inpatient Billing data includes data for patients discharged from Nevada's non-federal hospitals. Since an individual can have more than one diagnosis during a single inpatient admission, the following numbers reflect the number of times a diagnosis was given, and therefore the following numbers are not mutually exclusive.

Figure 13. Mental Health-Related Inpatient Admissions, by Quarter and Year, Rural Region Residents, 2012-2021.



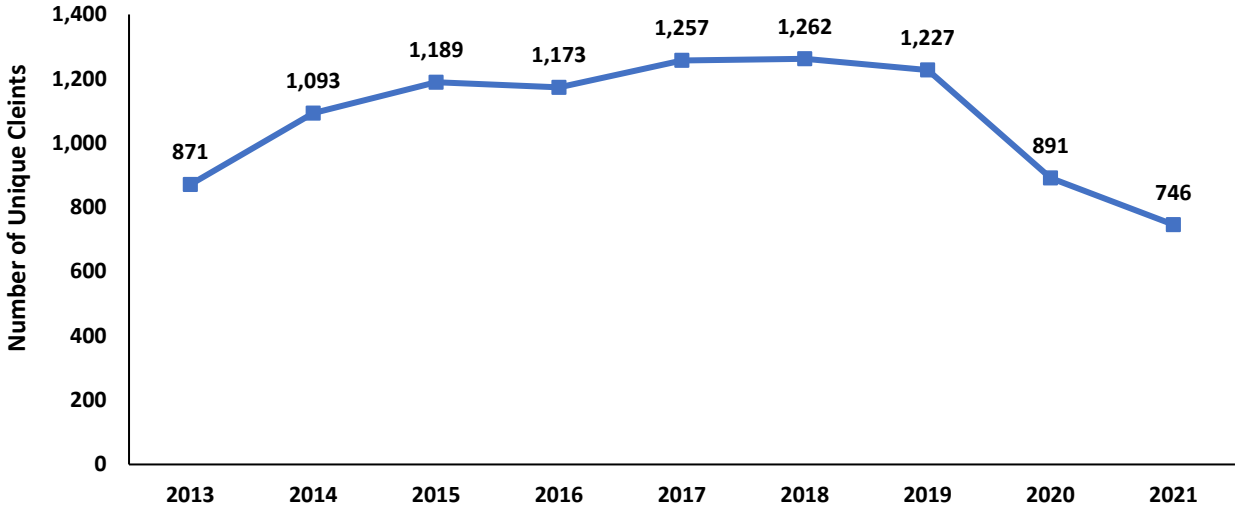
Source: Hospital Inpatient Billing.
Categories are not mutually exclusive.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.
Note: Data for depression 2021 quarter four not available.

Unlike emergency department encounters, depression was the leading cause of inpatient admissions until 2018 among Rural Region residents, followed by anxiety. From 2018 to 2021, anxiety-related admissions and depression-related admissions have switched several times as the leading cause. Following emergency department encounter trends, all the mental health-related diagnoses listed in Figure 13 above decreased from 2020 to 2021.

State-Funded Mental Health Services

State-funded mental health facilities are divided into Northern Nevada Adult Mental Health Services (NNAMHS), Southern Nevada Adult Mental Health Services (SNAMHS) and Rural Clinic and Community Health Services. Services that state-funded mental health facilities provide include inpatient acute psychiatric, mobile crisis, outpatient counseling, service coordination, and case management.

Figure 14. Unique Adult Clients Aged 18+* Served at State-Funded Mental Health Clinics, Rural Region Residents, 2013-2021.

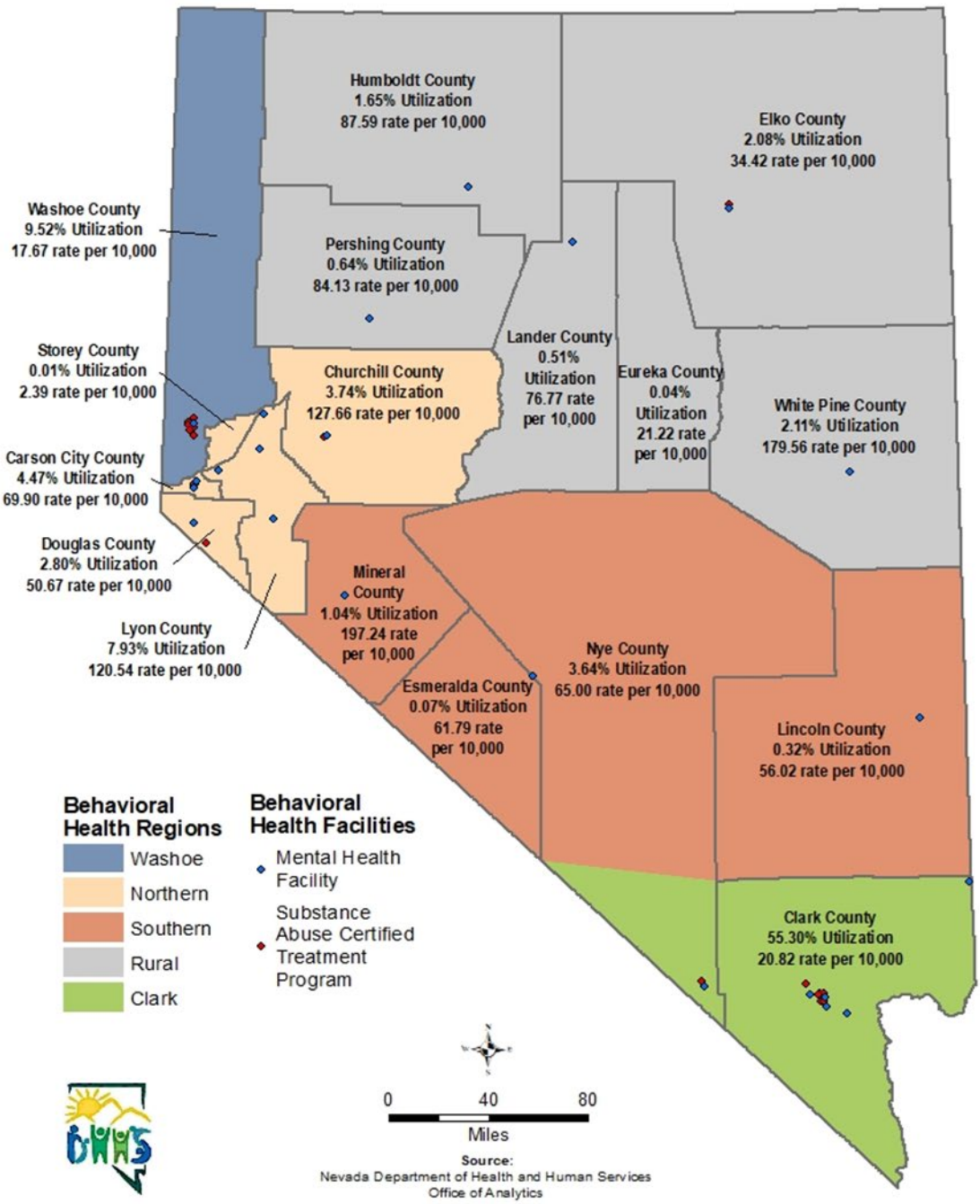


Source: State-Funded Mental Health: Avatar.
**A client is counted only once per year. Clients may be counted more than once across years.*

The number of unique clients in the Rural Region who utilized state-funded adult mental health facilities was at the lowest in 2021, with 746 persons. The highest number was in 2018, with 1,262 clients.

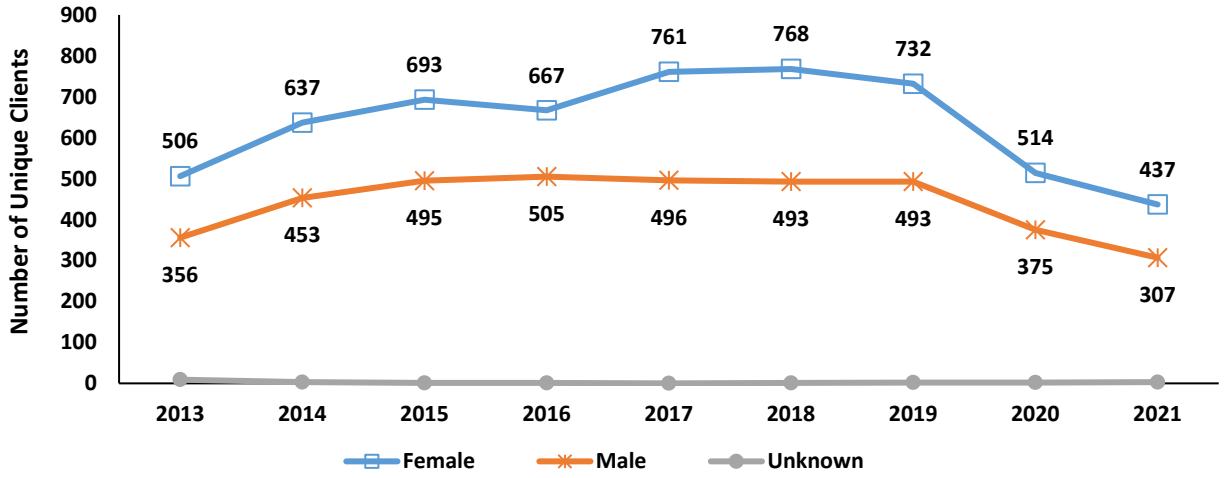
Figure 15 below shows the percent of Nevada state-funded adult mental health utilization each county represents, the rate of utilization (per 10,000 population), the behavioral health regions, and the locations of mental health and substance abuse treatment facilities.

Figure 15. State-Funded Mental Health Clinics Utilization by County, 2021.



Source: State-Funded Mental Health: Avatar.
**A client is counted only once per year. Clients may be counted more than once across years.*
***Percent (%)**: Number of clients who utilize mental health services in that county divided by total utilization.*
***Rate**: Number of clients who utilize mental health services in that county divided by county population per 100,000 people.*

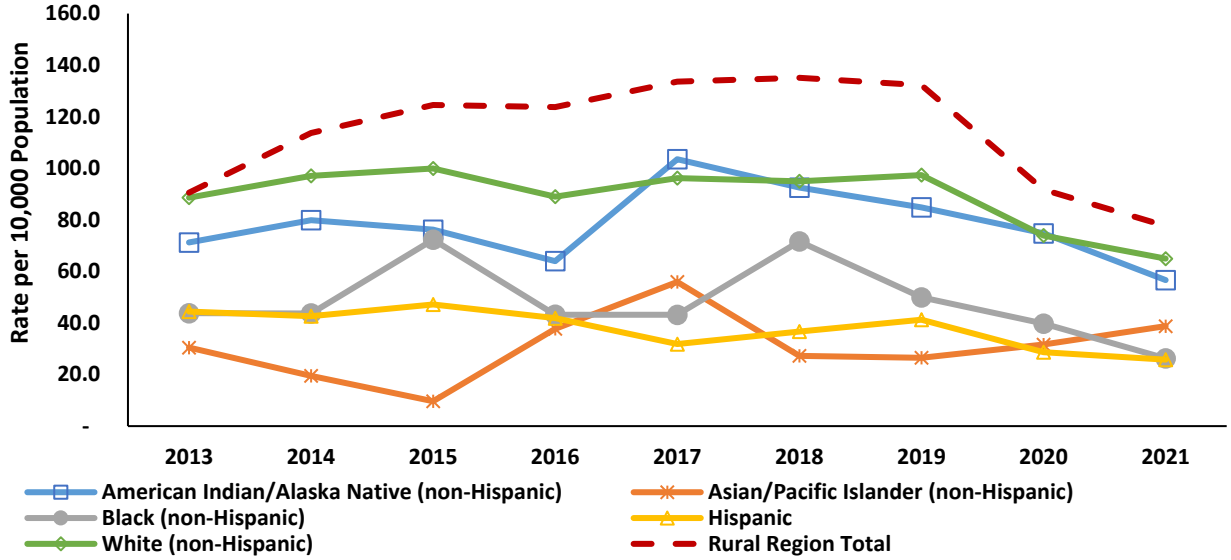
Figure 16. Adults Aged 18+* State-Funded Mental Health Clinics Utilization* by Gender, Rural Region Residents, 2013-2021.



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

From 2013 to 2021, female Rural Region residents consistently utilized the state-funded mental health clinics more than males. In 2021, 60.8 per 10,000 male population utilized the state-funded mental health clinics, compared to females at 95.9 per 10,000 female population.

Figure 17. State-Funded Mental Health Clinics Utilization* by Race/Ethnicity Crude Rates, Rural Region Residents, 2013-2021.



Source: State-Funded Mental Health: Avatar.
Race "Unknown" not included in analysis.
**A client is counted only once per year. Clients may be counted more than once across years.*

The White non-Hispanic Rural Region residents had the highest rates of clinic utilization in all years from 2013-2021 except for when the American Indian/Alaska Native population had the highest rates in 2017 and 2021.

Figure 18. Top Mental Health Clinic Services by Number of Patients Served*, Rural Region, 2013-2021.

Program	Year								
	2013	2014	2015	2016	2017	2018	2019	2020	2021
Ely Outpatient Counseling	120	165	174	250	292	276	159	195	91
Elko Outpatient Counseling	175	153	145	152	140	141	90	133	82
Elko Medication Clinic	112	102	133	163	155	141	124	193	157
Elko Outpatient Screening	10	90	176	171	200	223	83	52	0
Winnemucca Outpatient Counseling	88	91	78	79	106	105	63	92	60
Winnemucca Medication Clinic	53	57	71	90	117	125	96	172	134
Ely Medication Clinic	49	62	82	104	110	113	99	164	155

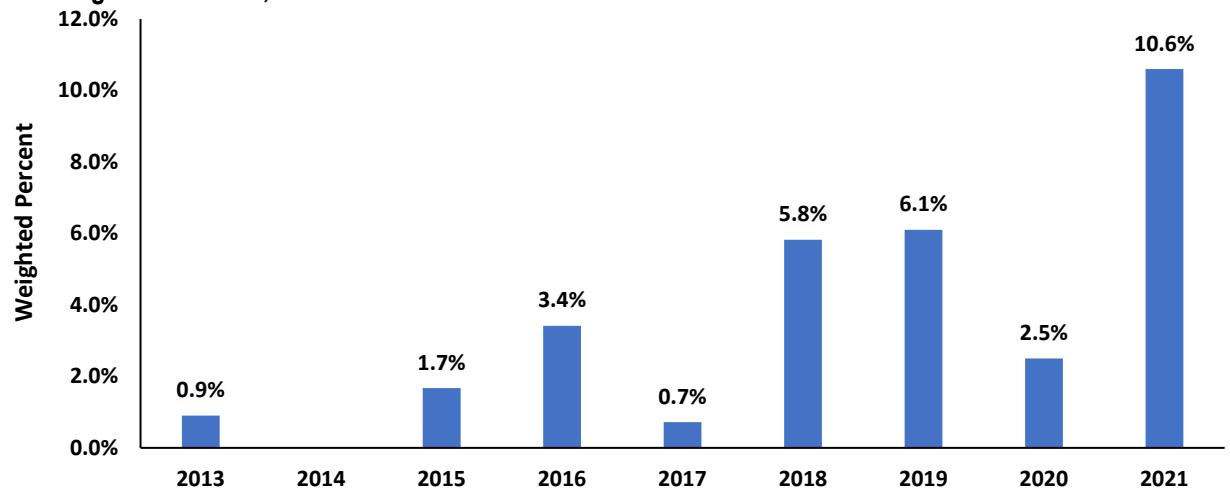
Source: State-Funded Mental Health: Avatar.
**A client is counted only once per year. Clients may be counted more than once across years.*

Patients were counted only once per program per year. Since a patient can receive services in more than one program, the counts above are not mutually exclusive. Counts for Ely Medication Clinic have been increasing, while counts for Ely Outpatient Counseling and Elko Outpatient Counseling have been declining since 2017.

Suicide

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

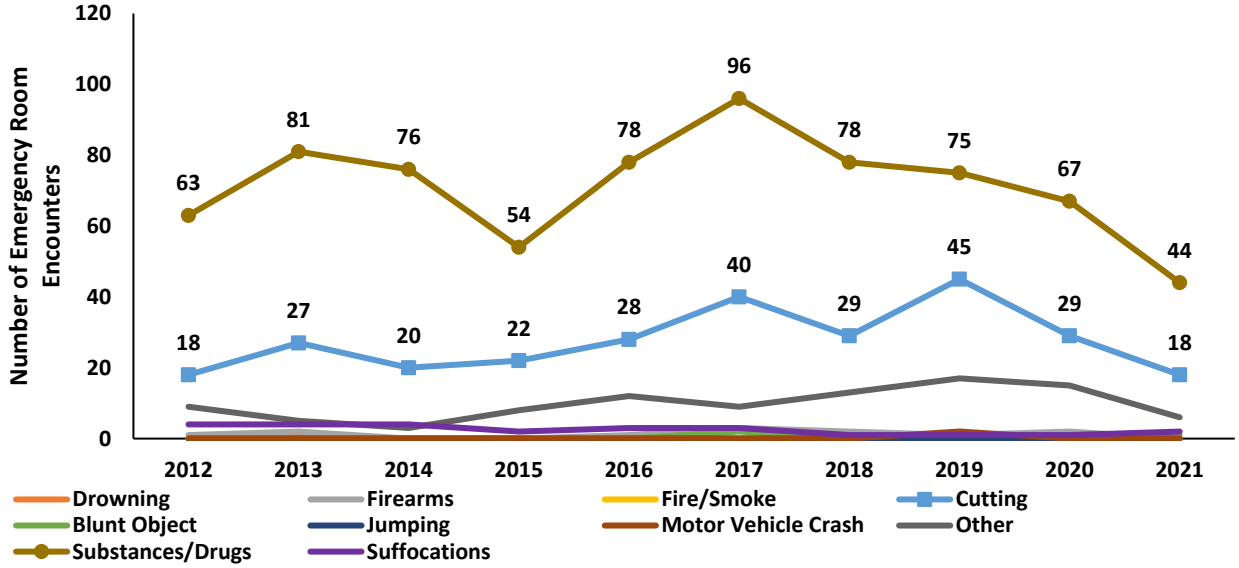
Figure 19. Percent of Adult BRFSS Respondents Who Have Seriously Considered Attempting Suicide, Rural Region Residents, 2013-2021.



Source: Behavioral Risk Factor Surveillance System (BRFSS).
Chart scaled to 12.0% to display differences among groups.
Indicator was not measured in 2014.
Specific question asked in survey: "During the past 12 months have you ever seriously considered attempting suicide?"

When asked "have you seriously considered attempting suicide during the past 12 months," 10.6% of adult Rural Region resident BRFSS respondents responded "yes" in 2021, which is the highest percent since 2013.

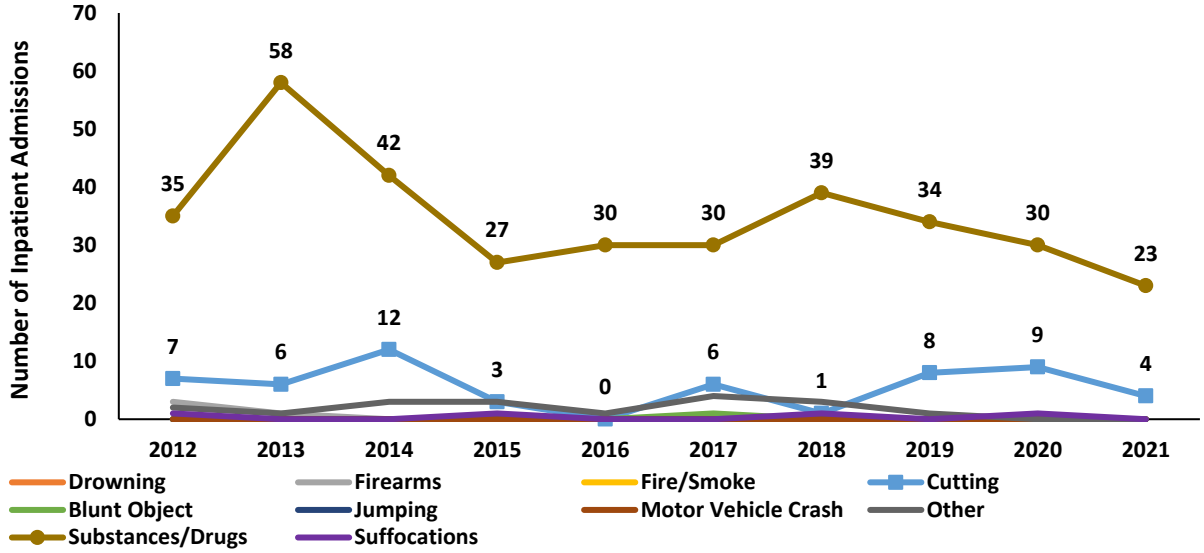
Figure 20. Suicide Attempt Emergency Department Encounters by Method, Rural Region Residents, 2012-2021.



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.

Emergency department encounters related to a suicide attempt, where the patient did not expire at the hospital, by substances/drugs remained the top method, followed by cutting. Counts for method of substances/drugs were highest in 2017, with 96 emergency room encounters, followed by a steady decline to 44 emergency room encounters in 2021.

Figure 21. Suicide Attempt Inpatient Admissions by Method, Rural Region Residents, 2012-2021.

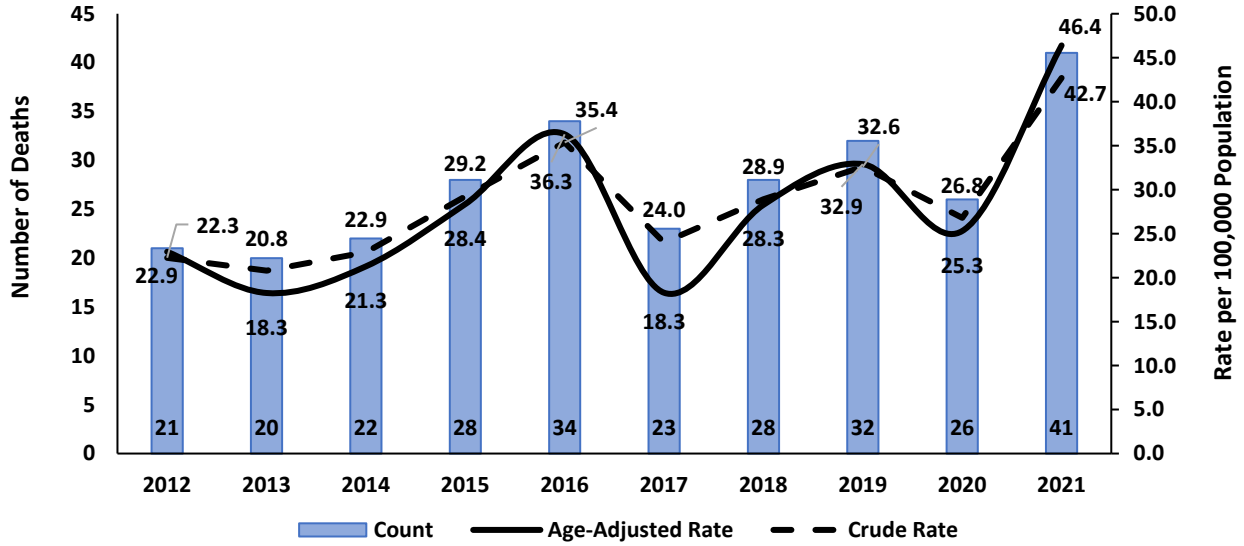


Source: Hospital Inpatient Billing.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.
A person can be included in more than category and therefore the counts above are not mutually exclusive.

Analogous to emergency department encounters among Rural Region residents, substances/drugs remained the top method of suicide attempt for inpatient admissions where the patient did not expire.

Counts for method of substances/drugs were highest in 2013, with 58 inpatient admissions, followed by a decline to 23 inpatient admissions in 2021.

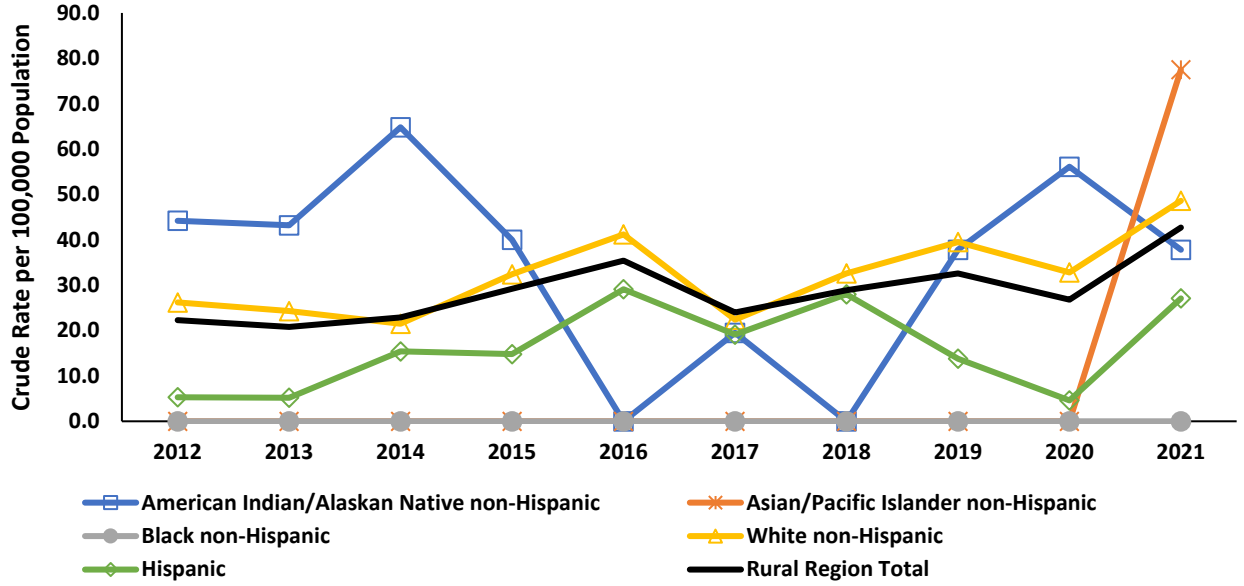
Figure 22. Number of Suicides and Rates, Rural Region Residents, 2012-2021.



Source: Nevada Electronic Death Registry System.

The age-adjusted suicide rate for 2021 among Rural Region residents was 46.4 per 100,000 population, which is a significant increase from 2020 at 25.3 per 100,000 population, and the highest rate since 2013 and 2017 (each with 18.3 per 100,000 population). The highest count was also in 2021, with 41 deaths among the Rural Region residents.

Figure 23. Crude Suicide Rates by Race/Ethnicity, Rural Region Residents, 2012-2021.



Source: Nevada Electronic Death Registry System.

Crude rates of suicide based on race/ethnicity are to be interpreted with caution due to low populations of minority groups such as American Indian/Alaskan Native non-Hispanic and Asian/Pacific Islander non-

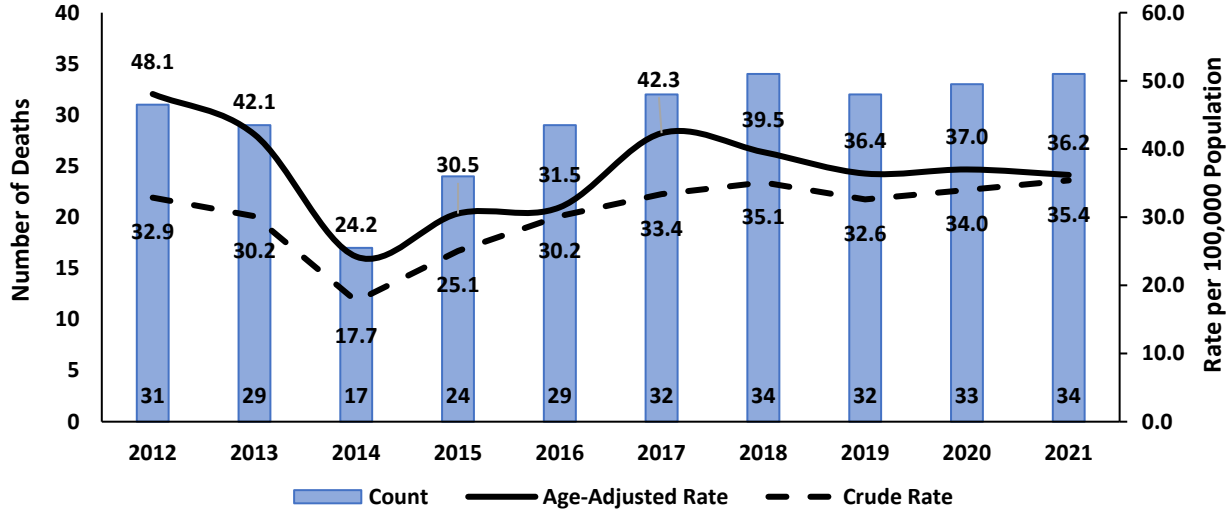
Hispanic. Of note however, rates among the Hispanic population have historically been lower than the Rural Region total rates, while the rates for the White non-Hispanic population have been frequently higher than the Rural Region total rates.

Mental Health-Related Deaths

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

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

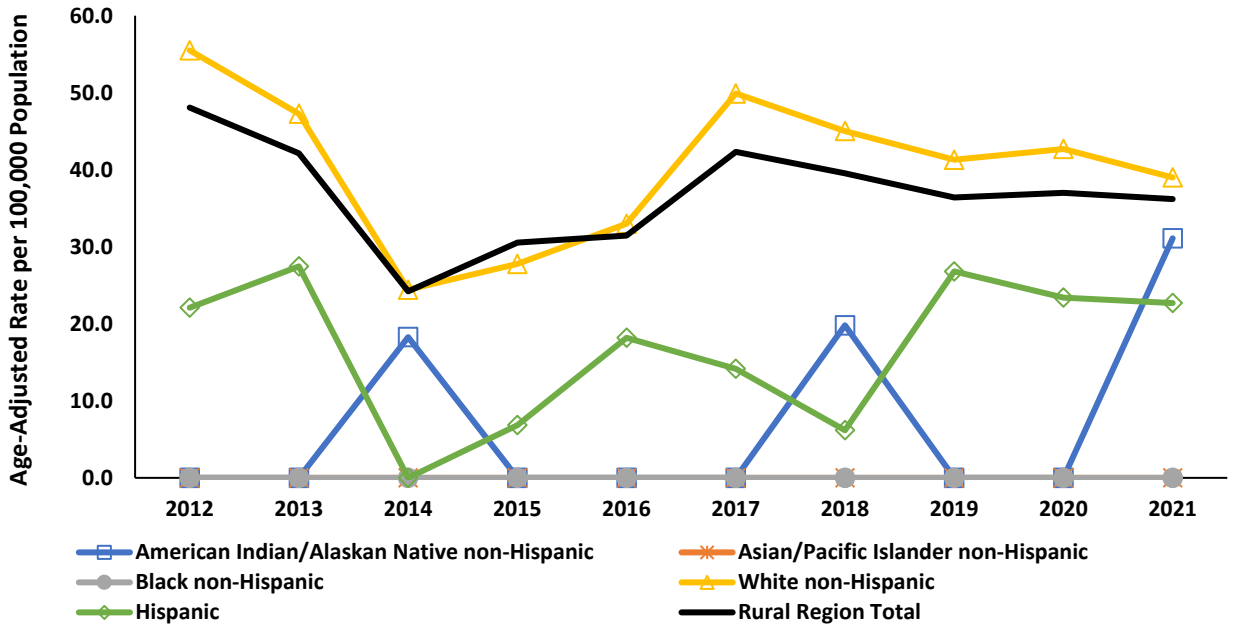
Figure 24. Mental Health-Related Deaths and Rates, Rural Region Residents, 2012-2021.



Source: Nevada Electronic Death Registry System.

The age-adjusted rate, crude rate, and counts of mental health-related deaths among Rural Region residents were at the lowest in 2014. The age-adjusted rate was the highest in 2012, at 48.1 per 100,000 population, and at 36.2 per 100,000 population in 2021.

Figure 25. Age-Adjusted Mental Health-Related Death Rates by Race/Ethnicity, Rural Region Residents, 2012-2021.



Source: Nevada Electronic Death Registry System.

Age-adjusted mental health-related deaths based on race/ethnicity are to be interpreted with caution due to low populations of minority groups such as American Indian/Alaskan Native non-Hispanic, Asian/Pacific Islander non-Hispanic, and Black non-Hispanic, which in total comprise 8.4% of the Rural Region's population. The White non-Hispanic rates closely mirror the Rural Region total rates, which comprises 68.6% of the population.

Substance Use

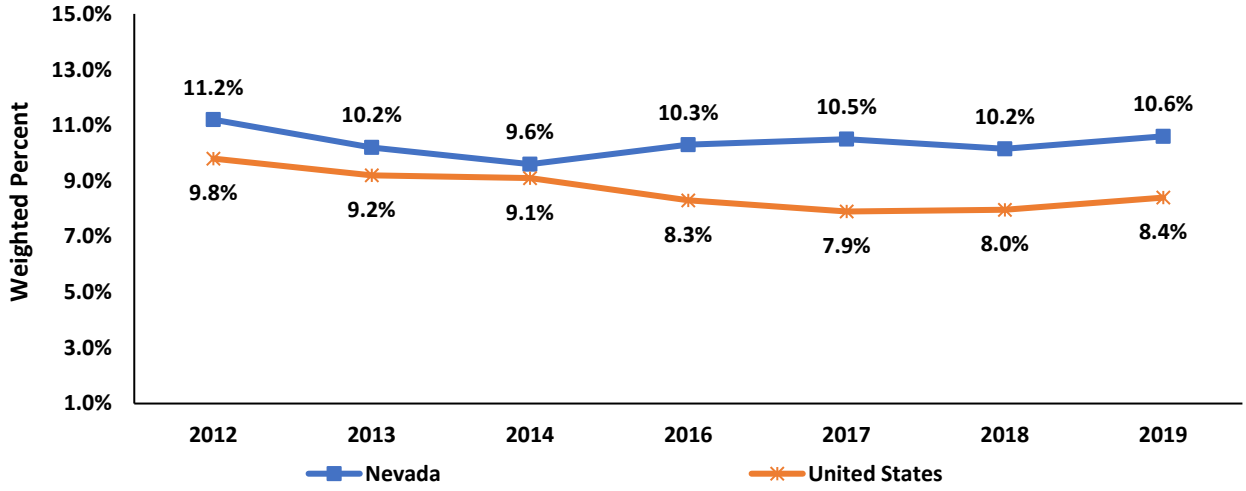
Substance use data are collected from hospital billing data, vital records data, and through national survey data including Substance Abuse and Mental Health Service Administration, BRFSS and YRBS.

National Survey on Drug Use and Health

The Substance Abuse and Mental Health Services Administration (SAMHSA) sponsors the National Survey on Drug Use and Health (NSDUH). The survey tracks trends of illicit drug, alcohol, and tobacco use, as well as mental health issues throughout the United States.

According to SAMHSA's website, state data tables and reports from the 2019-2020 NSDUH "are no longer available due to methodological concerns with combining the 2019 and 2020 data." Therefore, data in this report are from the NSDUH surveys are from the 2017-2018 and 2018-2019 reports. For more information, please visit SAMHSA 2019-2020 State Reports

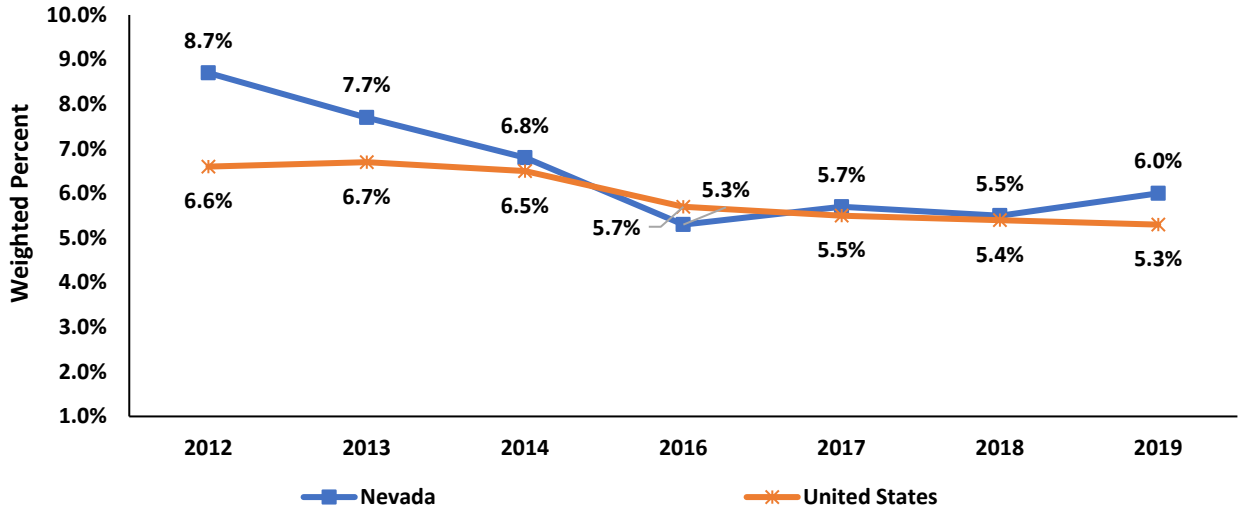
Figure 26. Illicit Drug Use Among Adolescents in the Past Month, Aged 12-17, Nevada and the United States, 2012-2019.



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

Although Nevada reported higher percents among adolescent illicit drug use than the United States in every year from 2012-2019, Nevada has remained within 3% of the United States each year, with 10.6% in 2019, compared to the United States at 8.4%. Nevada percent has remained steady, with a high of 11.2% in 2012 and a low of 9.6% in 2014.

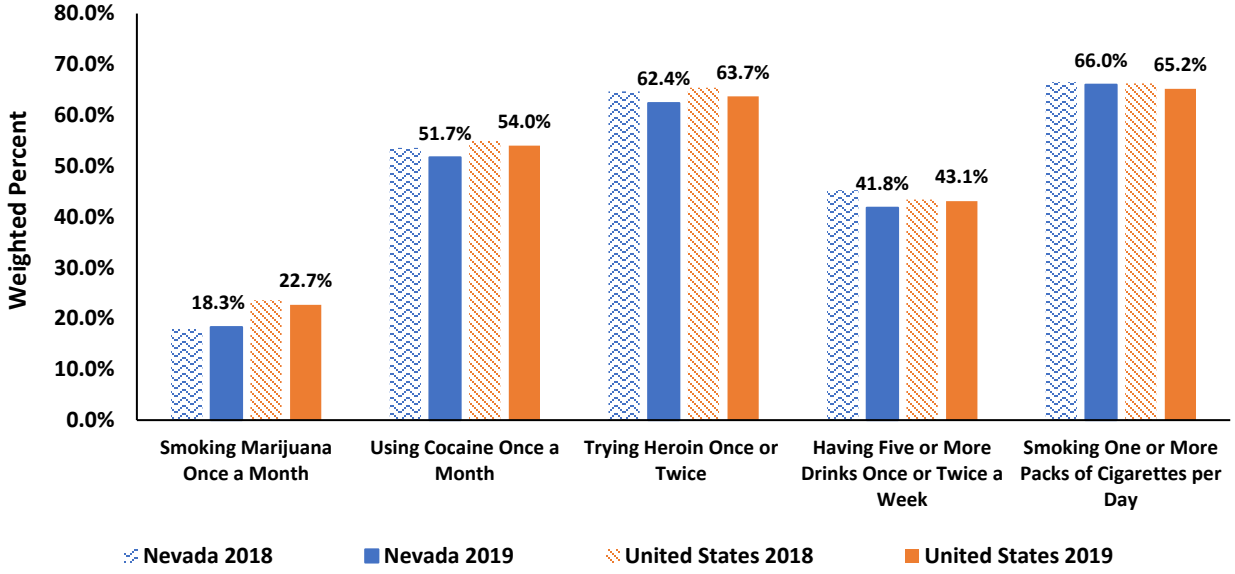
Figure 27. Alcohol Use Disorder in the Past Year, Aged 12 and Above, Nevada and the United States, 2012-2019.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health.
Chart scaled to 10.0% to display differences among groups.

Alcohol use disorder among Nevadans aged 12 and above has remained within 1% from the United States, with the exception in 2012 (8.7% and 6.6%, respectively).

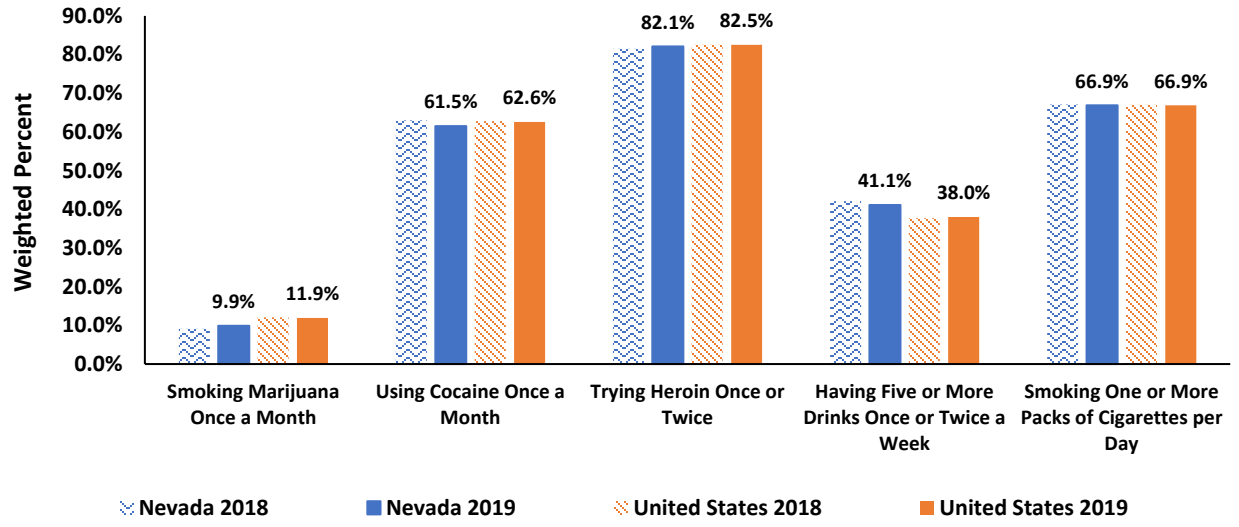
Figure 28. Perceptions of Great Risk from Alcohol or Substance Use, Adolescents Aged 12-17, Nevada and the United States 2018-2019.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2017-2018 and 2018-2019.
Chart scaled to 80.0% to display differences among groups.

For perceived risks, the higher the percent, the more the person perceives there is a risk from it. Nevada adolescents aged 12-17 perceived risk in 2019 is lower than the United States for most alcohol or substance use, including using cocaine once a month at 51.7% and the United States at 54.0%.

Figure 29. Perceptions of Great Risk from Alcohol or Substance Use, Young Adults Aged 18-25, Nevada and the United States 2018-2019.



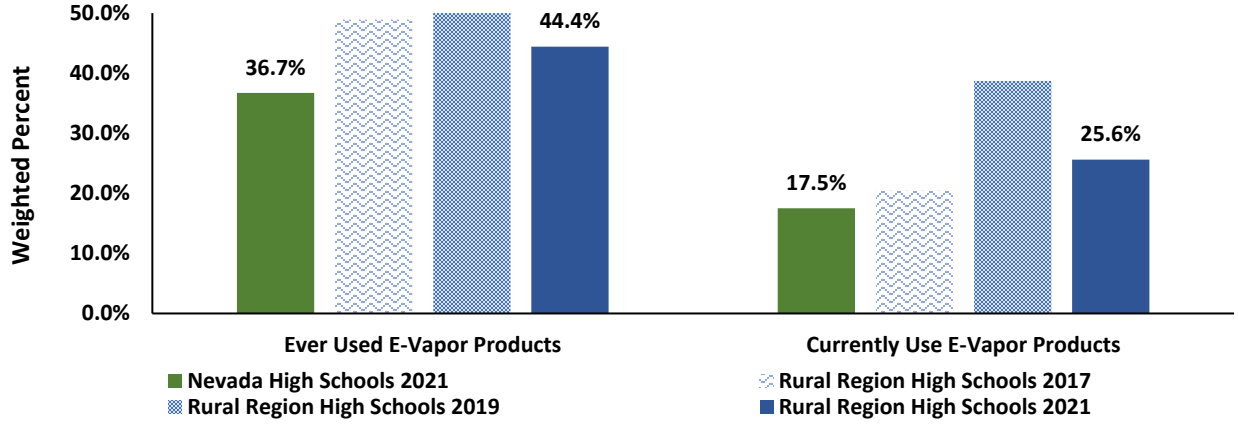
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2017-2018 and 2018-2019.
Chart scaled to 90.0% to display differences among groups.

Similar to Nevada adolescents aged 12-17, Nevadans' perceived risk among persons aged 18-25 is lower than the United States in 2019 for most alcohol or substance use except for having five or more drinks once or twice a week (41.1% and 38.0%, respectively), and both at 66.9% for smoking one or more packs of cigarettes per day.

Youth Risk Behavior Survey (YRBS)

The YRBS monitors six categories of health-related behaviors that contribute to leading causes of death and disabilities among youth and adults. Nevada high school and middle school students are surveyed during the odd numbered years. In 2021, 597 high school and 522 middle school students participated in the YRBS in the Rural Region. The University of Nevada, Reno maintain the YRBS data and publishes data on each survey. For more information on the YRBS survey, please go to the following site: UNR YRBS

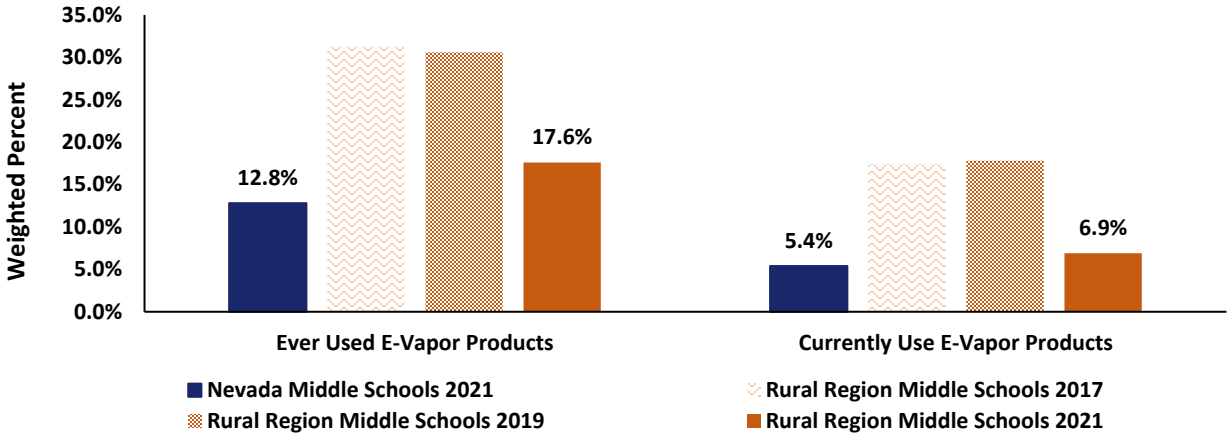
Figure 30a. Electronic Vapor (E-Vapor) Product Use, Rural Region High School Students, 2017, 2019, and 2021, and Nevada High School Students, 2021.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 70.0% to display differences among groups.
**Includes e-cigarettes, vapes, vape pens, e-cigars, e-hookahs, hookah pens, and mods such as 'JUUL', 'SMOK', 'Suorin', 'Vuse', and 'blu'.*

The percent of Rural Region high school students in 2021 who reported to currently use E-Vapor products was significantly higher than the percent of Nevada high school students in 2021, at 25.6% and 17.5%, respectively. The percent of Rural Region high school students in 2021 who reported to ever using E-Vapor products was higher than the percent of Nevada high school students in 2021, but not significantly. The percents for both indicators were highest in 2019 among Rural Region high school students.

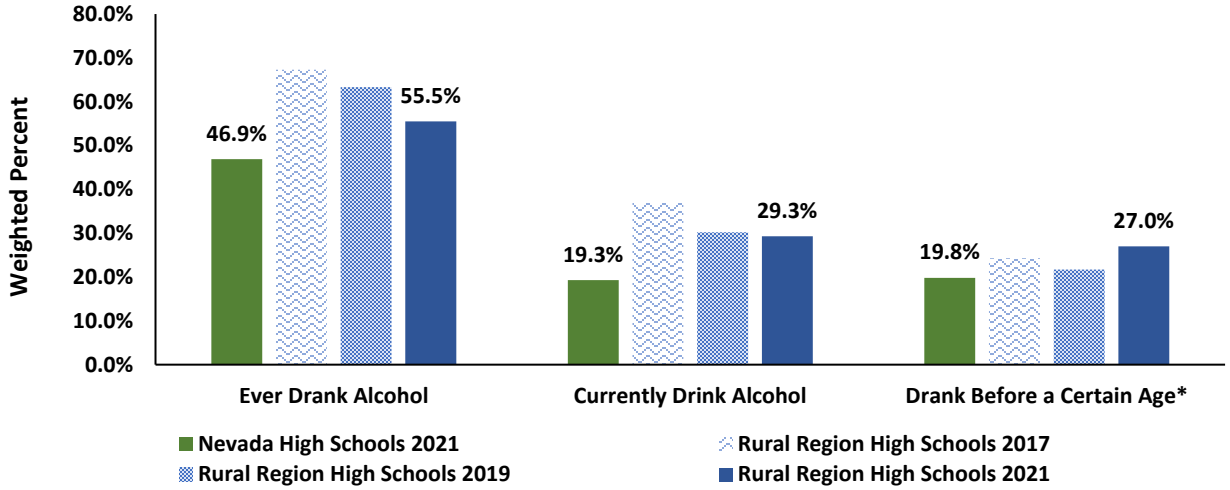
Figure 30b. Electronic Vapor (E-Vapor) Product Use, Rural Region Middle School Students, 2017, 2019, and 2021, and Nevada Middle School Students, 2021.



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

The percent of Rural Region middle school students who reported to ever using E-Vapor products or currently use E-Vapor products was lowest in 2021. was higher than the percent of Nevada high school students in 2021, but not significantly. The percent for both indicators among Rural Region middle school students in 2021 was higher than the percent of Nevada middle school students in 2021, but not significantly.

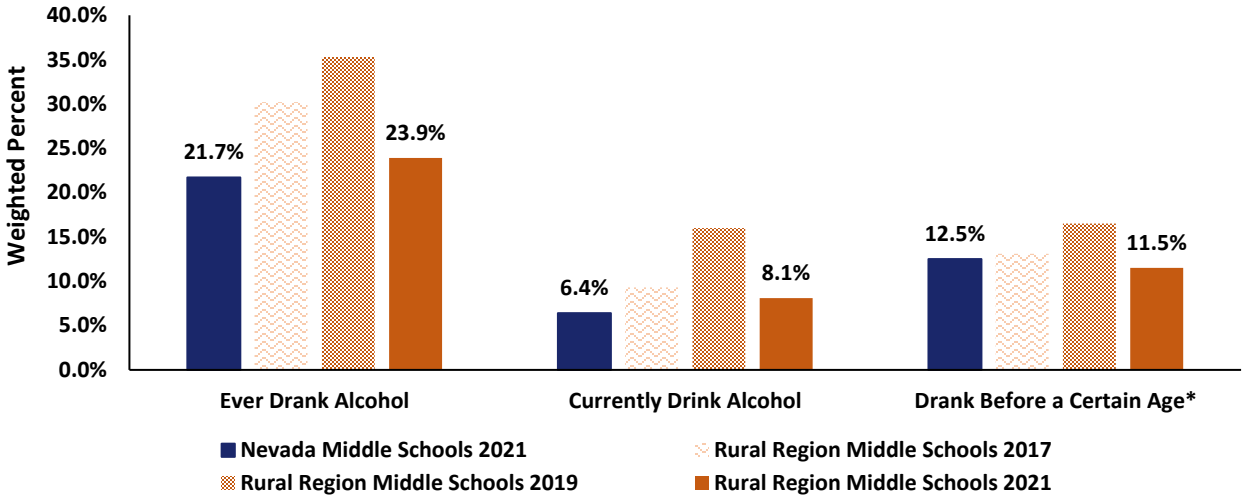
Figure 31a. Alcohol Use, Rural Region High School Students, 2017, 2019 and 2021, and Nevada High School Students, 2021.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 80.0% to display differences among groups.
**Among high school students, if they ever drank before age 13.*

The percent of high school students in the Rural Region who ever drank alcohol and currently drink alcohol has steadily declined from 2017 to 2021, while the percent who drank before a certain age was at the highest in 2021. The percent of Rural Region high school students in 2021 who currently drink alcohol or drank before a certain age are significantly higher than Nevada high school students in 2021.

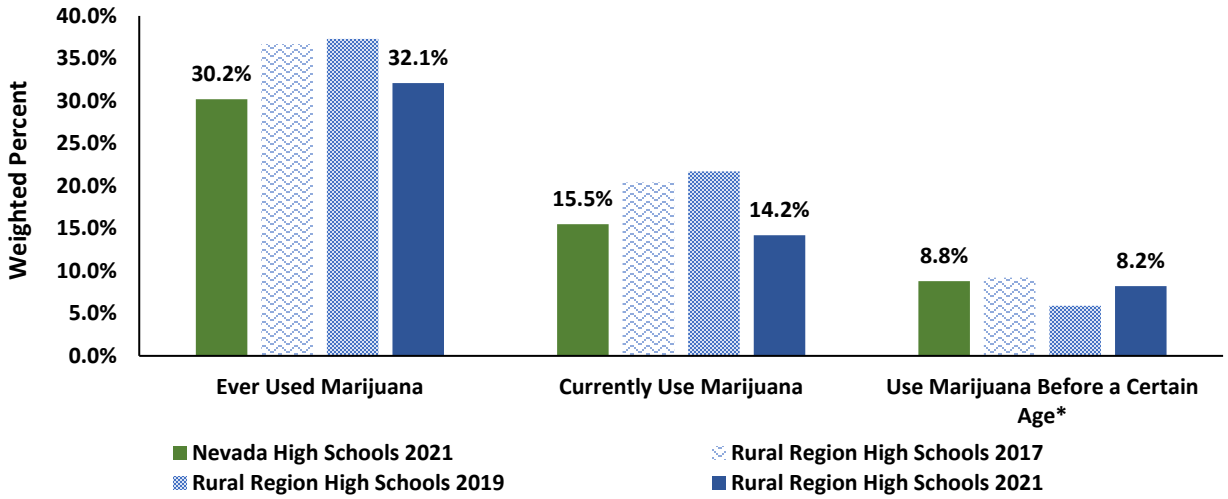
Figure 31b. Alcohol Use, Rural Region Middle School Students, 2017, 2019, and 2021, and Nevada Middle School Students, 2021.



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

The percent of Rural Region middle school students who ever drank alcohol, currently drink alcohol, and drank before a certain age were highest in 2019 and lowest in 2021.

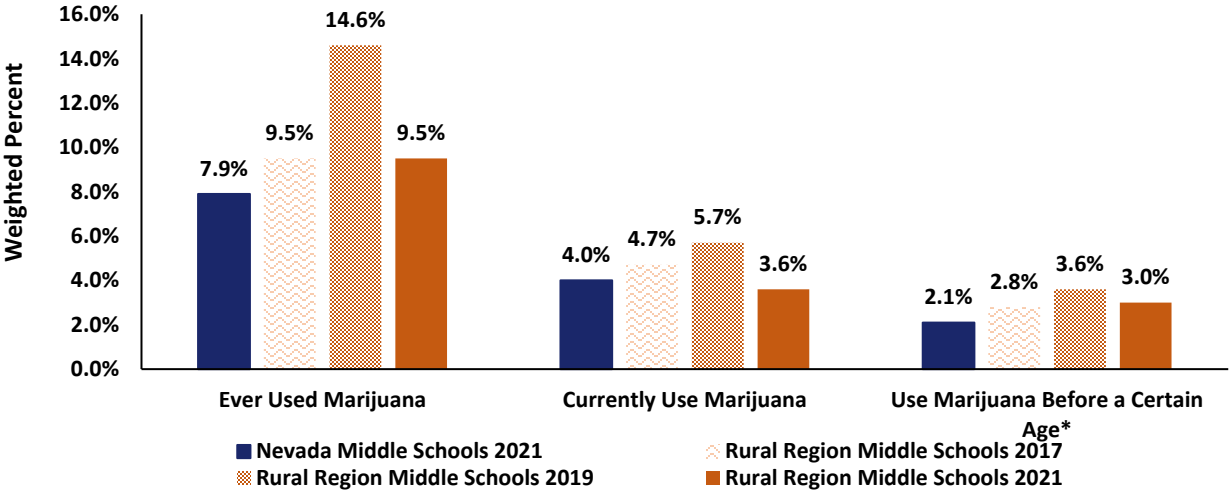
Figure 32a. Marijuana Use, Rural Region High School Students, 2017, 2019 and 2021, and Nevada High School Students, 2021.



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

The percent of high school students in the Rural Region who ever used marijuana and currently use marijuana was lowest in 2021 and highest in 2019, while the percent who used marijuana before a certain age (13 years old) was highest in 2017 and lowest in 2019. The percent of Rural Region high school students in 2021 who ever used marijuana was higher than the percent of Nevada high school students in 2021, but not significantly; the percent of Rural Region high school students in 2021 who currently use marijuana or used marijuana before a certain age was lower than the percent of Nevada high school students in 2021, but not significantly.

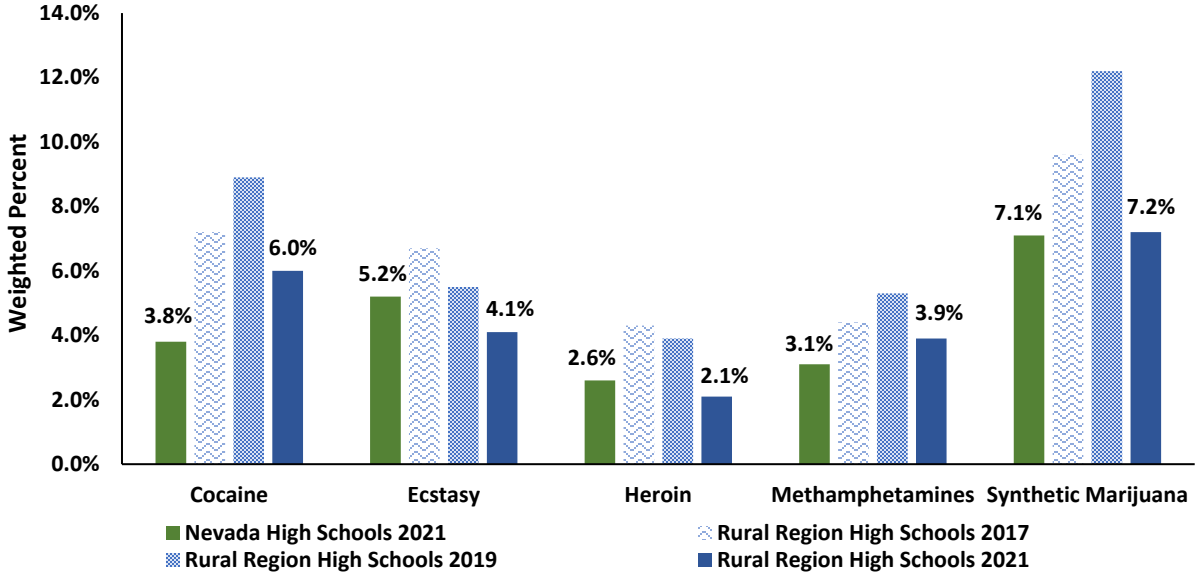
Figure 32b. Marijuana Use, Rural Region Middle School Students, 2017, 2019, and 2021, and Nevada Middle School Students, 2021.



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

The percent of middle school students in the Rural Region who ever used marijuana, currently use marijuana, or used marijuana before a certain age was highest in 2019. The percent of Rural Region high school students in 2021 who ever used marijuana or used marijuana before a certain age was higher than the percent of Nevada high school students in 2021, but not significantly; the percent of Rural Region high school students in 2021 who currently use marijuana was lower than the percent of Nevada high school students in 2021, but not significantly.

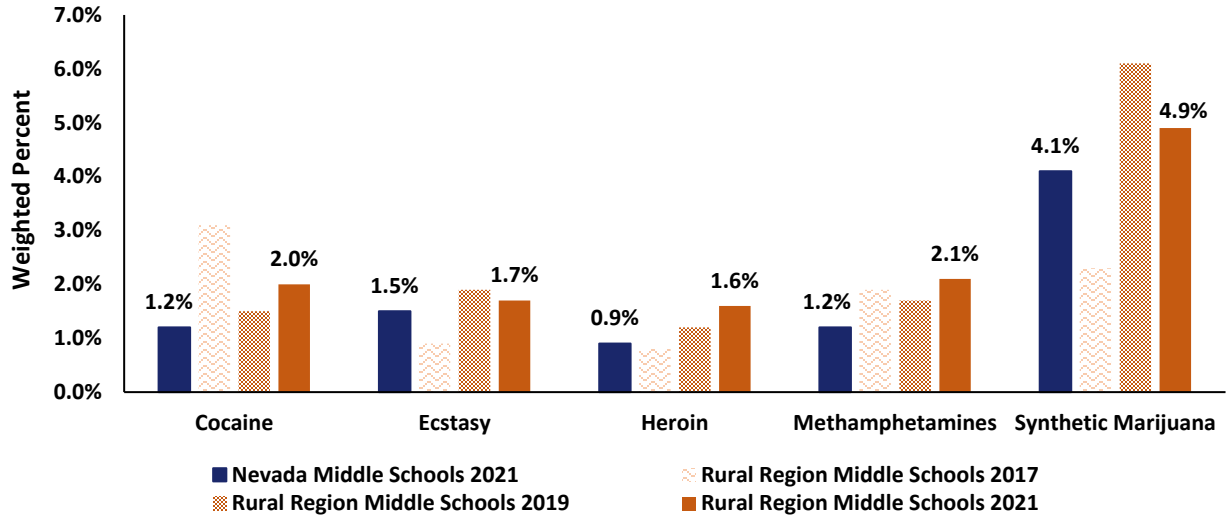
Figure 33a. Lifetime Drug Use, Rural Region High School Students, 2017, 2019, and 2021, and Nevada High School Students, 2021.



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

From 2019 to 2021, all categories of lifetime drug use listed in Figure 33a above decreased among the Rural Region high school students. Lifetime cocaine, methamphetamine, and synthetic marijuana use use among the Rural Region high school students in 2021 are higher than Nevada high school students in 2021, but not significantly; lifetime ecstasy and heroin use among the Rural Region high school students in 2021 are lower than Nevada high school students in 2021, but not significantly.

Figure 33b. Lifetime Drug Use, Rural Region Middle School Students, 2017, 2019, and 2021, and Nevada Middle School Students, 2021.



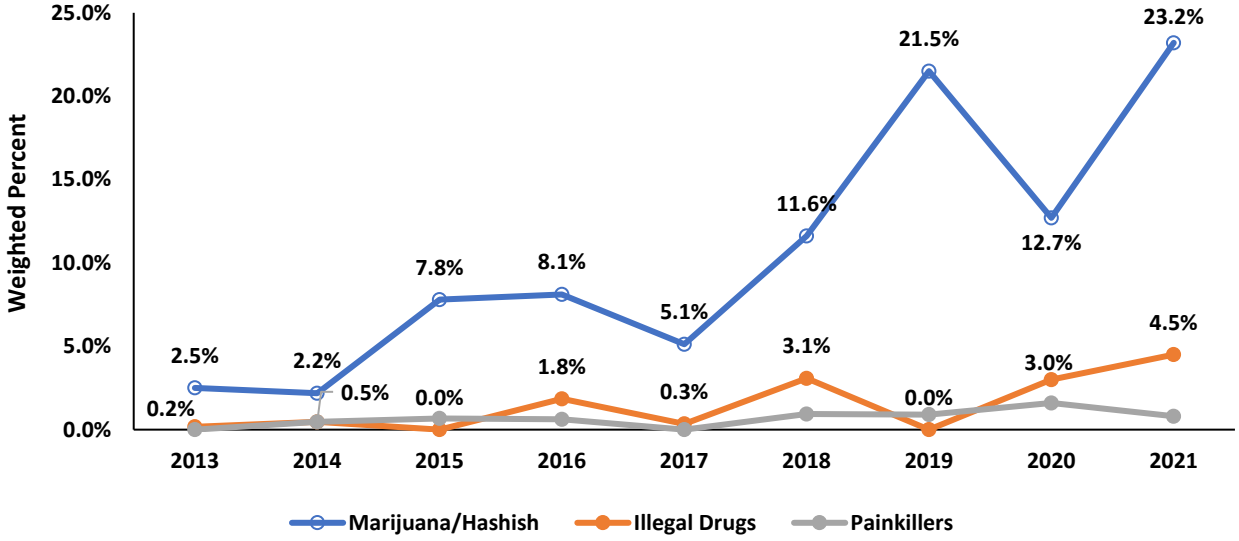
Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 7.0% to display differences among groups.

Lifetime drug use percents among Rural Region middle school students was highest in 2017 for cocaine use, highest in 2019 for ecstasy and synthetic marijuana use, and highest in 2021 for heroin and methamphetamine use. None of the illegal drug use percents in 2021 among Rural Region middle school students were statistically higher or lower than Nevada middle school students in 2021.

Behavioral Risk Factor Surveillance System

BRFSS collects information on adult health-related risk behaviors. According to the Centers for Disease Control and Prevention, BRFSS is a powerful tool for targeting and building health promotion activities. The survey has questions focusing on substance use including illegal drug use, e-cigarettes, and drunkenness.

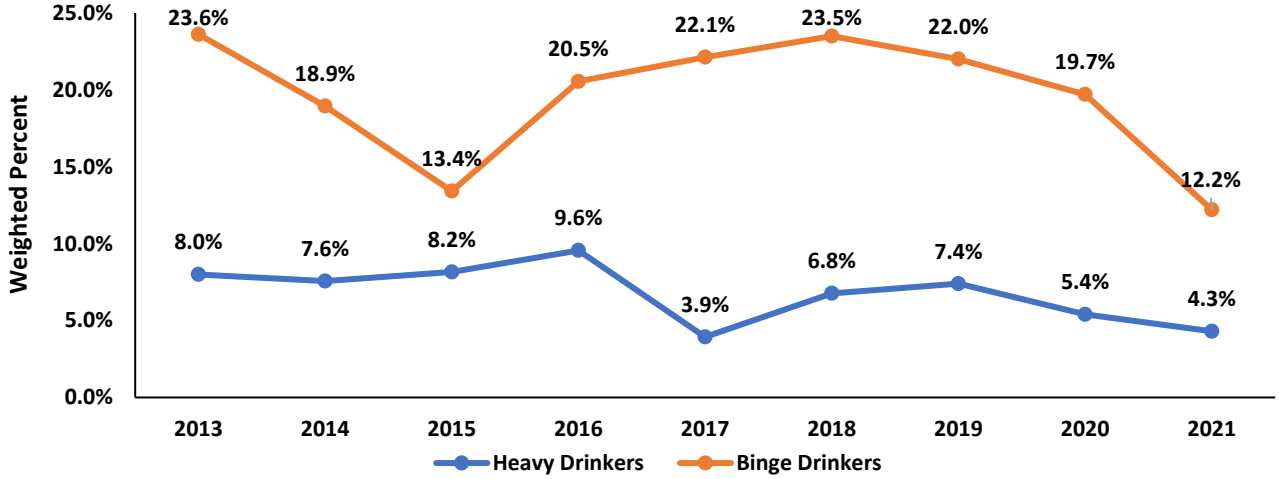
Figure 34. Adult BRFSS Respondents Who Used Marijuana/Hashish, Illegal Substances, or Painkillers to Get High in the Last 30 Days, Rural Region Residents, 2013-2021.



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

Marijuana use had an 828% increase from 2013 (2.5%) to 2021 (23.2%) among adult Rural Region BRFSS respondents. Marijuana use is expected to increase as marijuana was legalized in Nevada in 2017. Use of illegal drugs to get high was at the highest in 2021, at 4.5%, and was highest for painkillers in 2020, at 1.6% of those surveyed.

Figure 35. Percent of Adult BRFSS Respondents Who are Considered Binge Drinkers or Heavy Drinkers, Rural Region, 2013-2021.

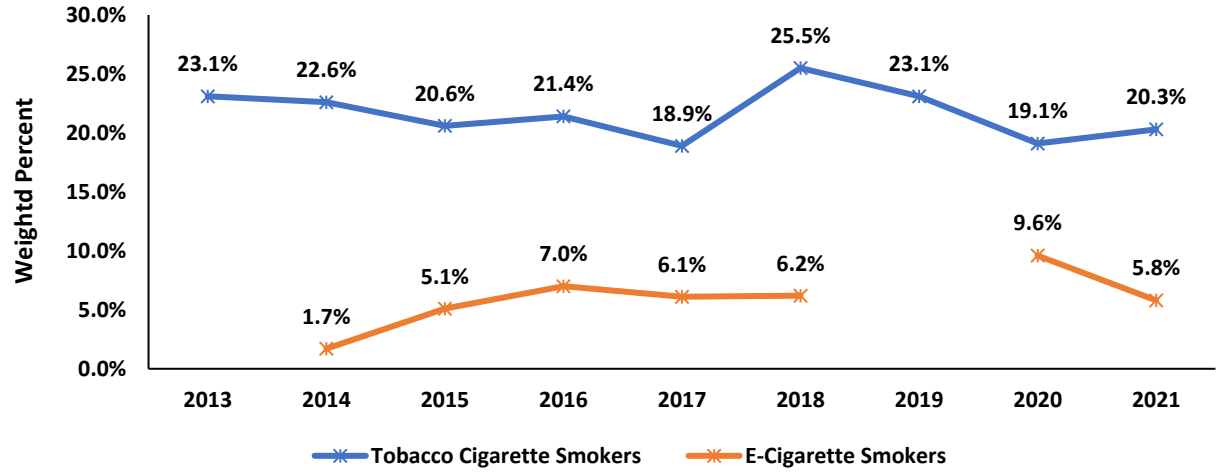


Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 25.0% to display differences among groups.
Heavy drinkers (adult men having more than 14 drinks per week and adult women having more than seven drinks per week).
Binge drinkers (adult men having five or more drinks on one occasion, adult women having four or more drinks on one occasion).

Binge drinking is defined in men as having five or more alcoholic beverages and woman having four or more alcoholic beverages on the same occasion. Heavy drinking is defined in men as consuming 15 or more alcoholic beverages per week, and women as consuming eight or more alcoholic beverages per week (CDC Binge and Heavy Drinking).

Binge drinking percents among adult Rural Region BRFSS respondents fluctuated from a high of 23.6% in 2013 to a low of 12.2% in 2021. Heavy drinking percents among adult Rural Region BRFSS respondents fluctuated from a high of 9.6% in 2016 to a low of 3.9% the following year, 2017.

Figure 36. Percent of Adult BRFSS Respondents Who are Current Tobacco Cigarette or E-Cigarette Smokers, Rural Region, 2013-2021.



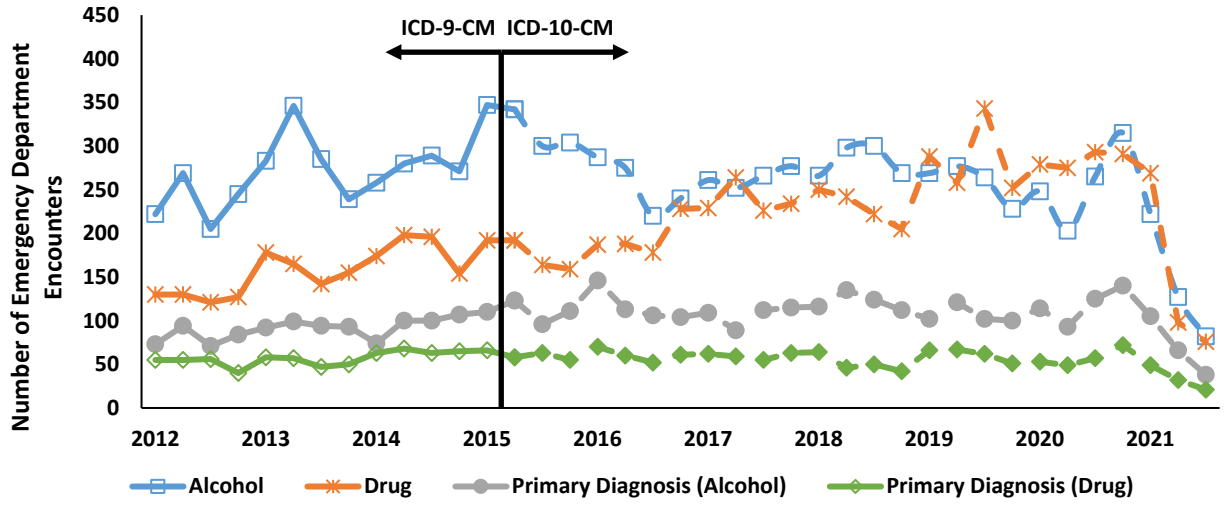
Source: Behavioral Risk Factor Surveillance System. Chart scaled to 30.0% to display differences among groups.
E-cigarette use was not collected until 2014, and not collected in 2019.
Current cigarette smokers are defined as individuals who have smoked at least 100 cigarettes in their lifetime and currently smoke. Current e-cigarette smokers are defined as individuals who currently have smoked on at least one day in the past 30 days or who currently report using e-cigarettes or other electronic "vaping" products every day or some days.

In 2021, 20.3% of adults in the Rural Region were current tobacco cigarette smokers, which has decreased from a high of 25.5% in 2018. E-cigarette use among adults in the Rural Region increases and decreases from year to year, ranging from a low of 1.7% (2014) to a high of 9.6% (2020).

Hospital Emergency Department Encounters

The hospital emergency department billing data provides health billing data for emergency departments patients for Nevada's non-federal hospitals. Since an individual can have more than one diagnosis during a single emergency department visit, the following numbers are not mutually exclusive.

Figure 37. Alcohol and Drug-Related Emergency Department Encounters by Quarter and Year, Rural Region Residents, 2012-2021.



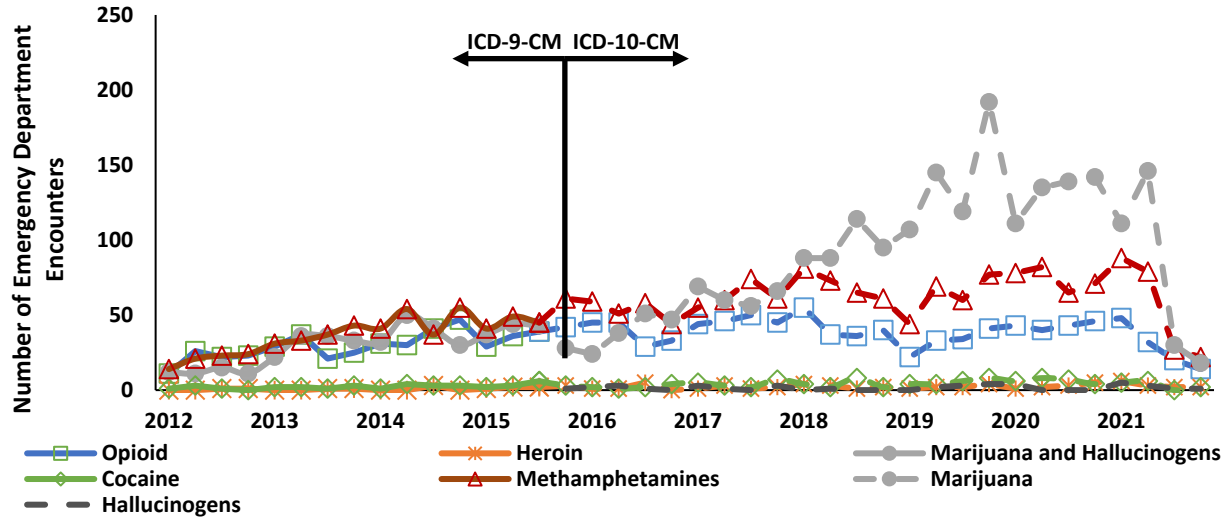
Source: Hospital Emergency Department Billing.
Categories are not mutually exclusive.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

The "primary diagnosis" is the condition established to be chiefly responsible for the emergency department visit. The "alcohol" and "drug" categories are for any visits where alcohol/drugs were listed in any of the diagnoses.

Alcohol-related emergency department encounters among Rural Region residents were more common than drug-related emergency department encounters from 2012-2019. Drug-related encounters increased from 2016-2019 but have fallen in 2021. In some quarters of 2020 and 2021, drug-related encounters were more common than alcohol-related encounters.

Emergency room encounters for drug and alcohol primary diagnoses have remained consistent from 2013-2021.

Figure 38. Drug-Related Emergency Department Encounters by Drug and Quarter and Year, Rural Region Residents, 2012-2021.



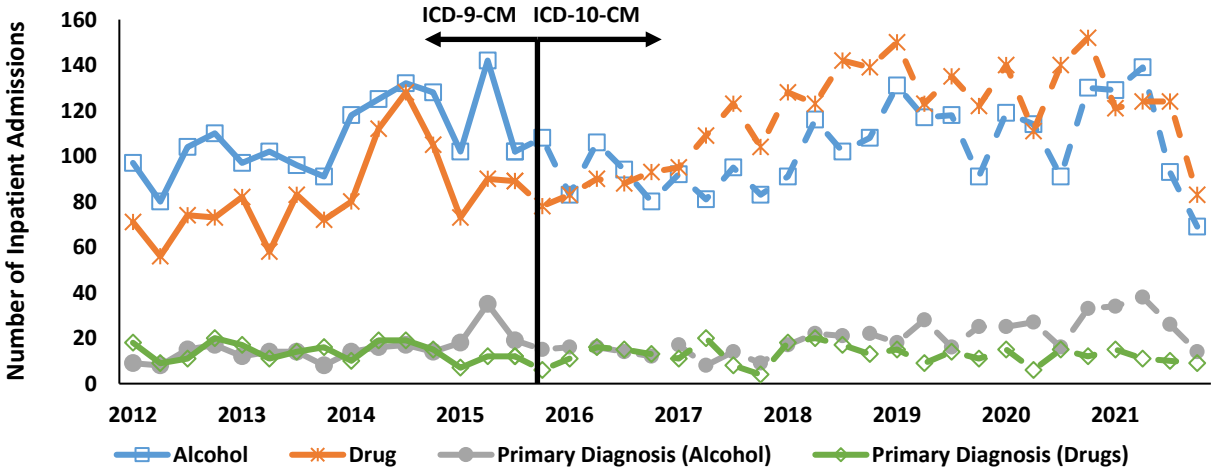
Source: Hospital Emergency Department Billing.
Categories are not mutually exclusive.
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Hallucinogens and marijuana were grouped together for ICD-9-CM, but in 2015 were separated into different groups in the ICD-10-CM codes. Emergency department encounters for marijuana increased from 2018 to 2020 before decreasing to counts similar to encounters for methamphetamines and opioids.

Hospital Inpatient Admissions

The hospital inpatient admission billing data provides health billing data for patients admitted to hospitals for longer than a 24-hour period. In 2021, more people were admitted into Nevada hospitals for drug-related issues than for alcohol-related issues.

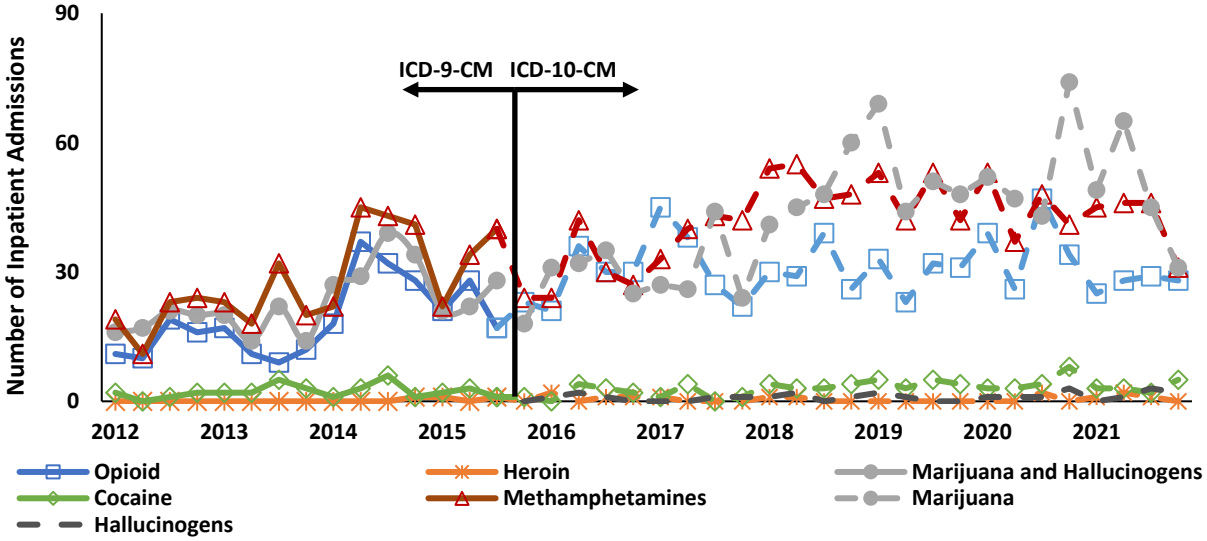
Figure 39. Alcohol and/or Drug-Related Inpatient Admissions by Quarter and Year, Rural Region Residents, 2012-2021.



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.

Alcohol-related inpatient admissions were more common than drug-related inpatient admissions until 2018 where drug-related admissions surpassed alcohol-related admissions and have remained higher through 2021 with the exception of quarter 1 in 2021.

Figure 40. Drug-Related Inpatient Admissions by Quarter and Year, Rural Region Residents, 2012-2021.



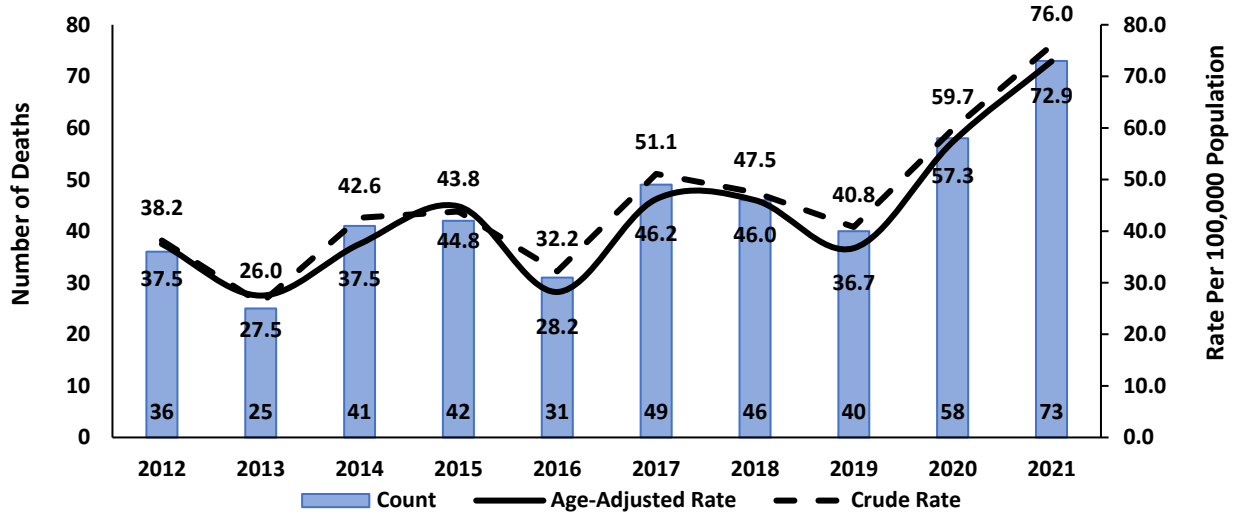
Source: Hospital Inpatient Billing.
Categories are not mutually exclusive.
ICD-9 codes were replaced by ICD-10 codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Hallucinogens and marijuana were grouped together for ICD-9-CM, but in 2015 were separated into different groups in the ICD-10-CM codes. Inpatient admissions for marijuana among Rural Region residents has increased over time, with spikes in 2019 and 2020.

Alcohol-Related and/or Drug-Related Deaths

Alcohol-related and/or drug-related deaths include deaths where alcohol/drugs are listed as the cause of death. In previous reports, contributing causes of death for alcohol/drugs were included; therefore, counts will be lower than in the previous report.

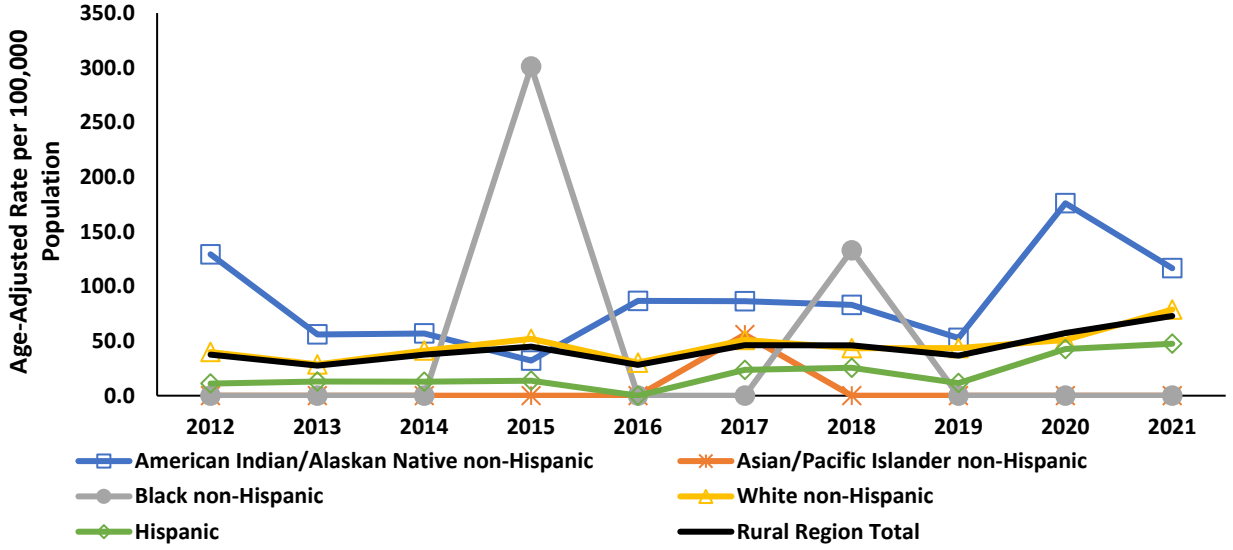
Figure 41. Alcohol-Related and/or Drug-Related Deaths and Rates, Rural Region Residents, 2012-2021.



Source: Electronic Death Registry System.

Alcohol-related/or drug-related age-adjusted rate increased in 2020 and 2021 from the previous years, with 59.7 and 76.0 alcohol-related and/or drug related deaths per 100,000 in the Rural Region, respectively. The years 2020 and 2021 represent the largest growth of alcohol-related and/or drug-related deaths and rates in the 10 year period shown in Figure 41 above.

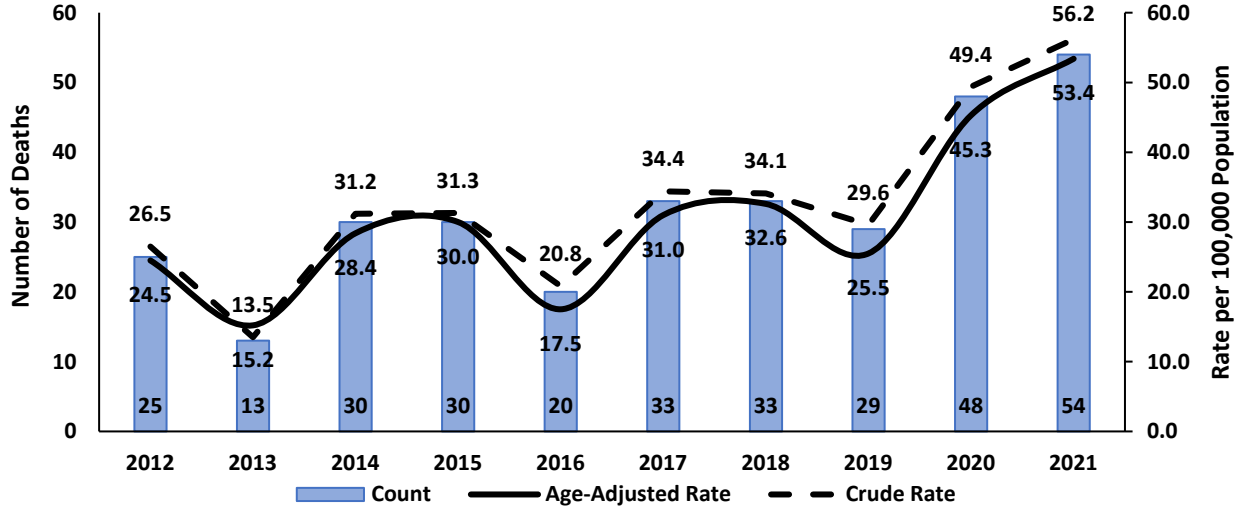
Figure 42. Age-Adjusted Rate for Alcohol-Related and/or Drug-Related Deaths by Race, Rural Region Residents, 2012-2021.



Source: Electronic Death Registry System.

Although it appears that the American Indian/Alaskan Native non-Hispanic population had higher rates of alcohol-related and/or drug-related deaths in all years from 2012 to 2021, these deaths are not statistically significant (95% confidence interval) due to the relatively small population size. Likewise, Black non-Hispanic rates had high variance due to low population counts.

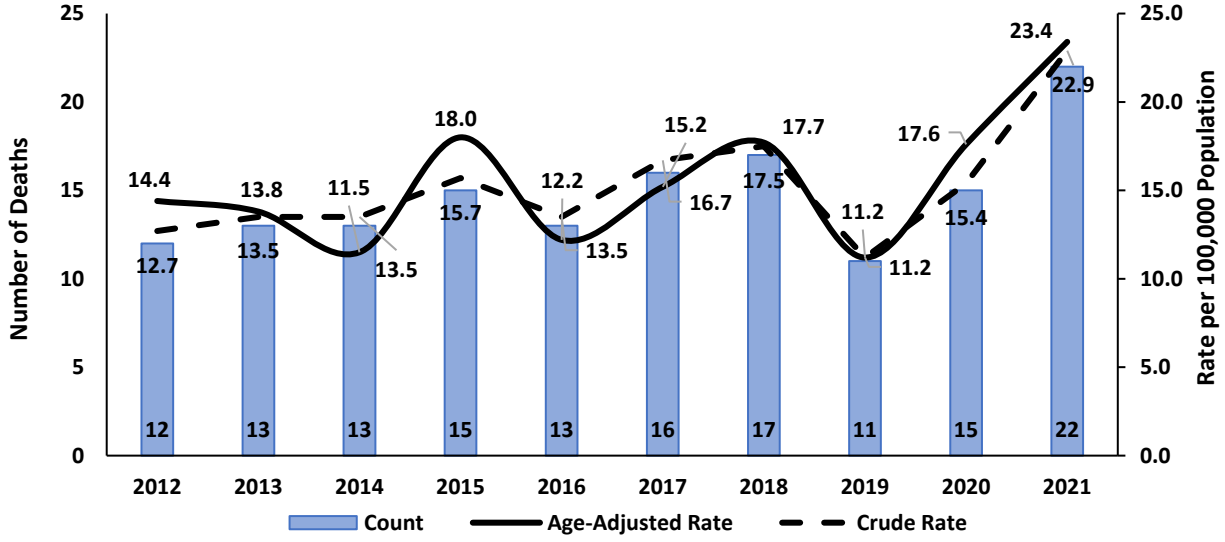
Figure 43. Alcohol-Related Deaths and Rates, Rural Region Residents, 2012-2021.



Source: Electronic Death Registry System.

Alcohol-related deaths among Rural Region residents have increased significantly in 2020 and 2021 and represent the largest growth in the 10-year period shown in Figure 43.

Figure 44. Drug-Related Deaths and Rates, Rural Region Residents, 2012-2021.



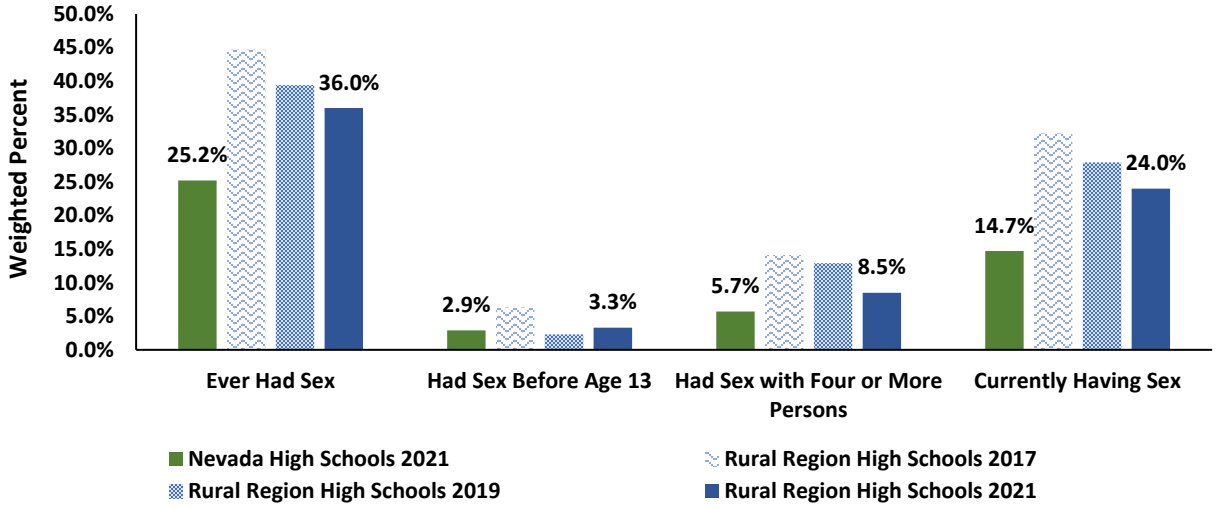
Source: Electronic Death Registry System.

In 2020 and 2021, drug-related deaths and rates increased sharply from the previous years. The age-adjusted rate rose to 45.3 and 53.4 per 100,000 population, respectively.

Youth (Adverse Effects from Youth)

Youth Risk Behavior Survey (YRBS)

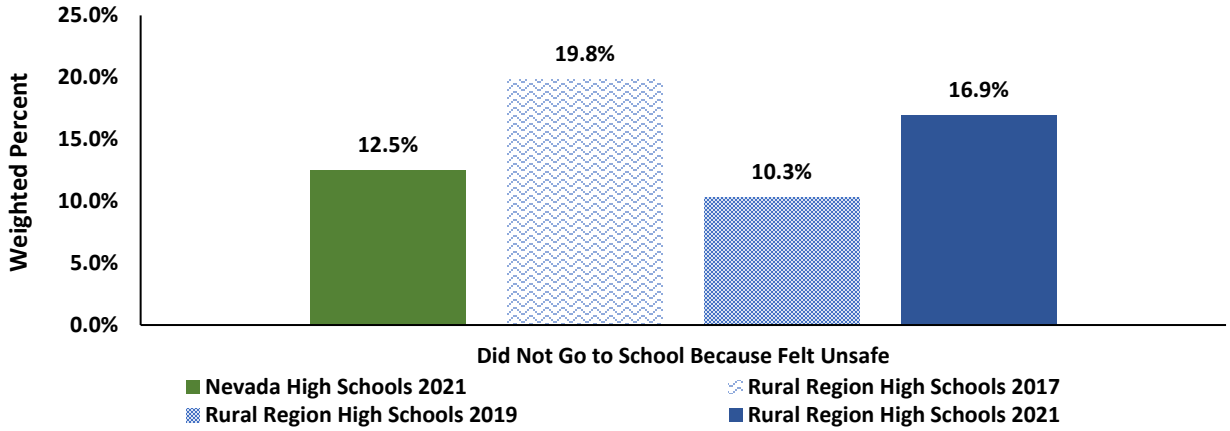
Figure 45. Sexual Behaviors Among Students, Rural Region High School Students, 2017, 2019, and 2021, and Nevada High School Students, 2021.



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

The percent of high school students in the Rural Region who ever had sex, had sex with four or more persons, and are currently having sex has steadily declined from 2017 to 2021, while the percent who had sex before age 13 was highest in 2017 but increased from 2019 to 2021. All percents of sexual behaviors listed above in Figure 45 among Rural Region high school students are higher than among Nevada high school students; the percent of Rural Region high school students in 2021 reporting ever having sex being significantly higher than the Nevada high school 2021 percents (36.0% and 25.2%, respectively).

Figure 46. Percent of Rural Region High School Students Who Didn't Go to School Because They Felt Unsafe, 2017, 2019, and 2021, and Nevada High School Students, 2021.



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

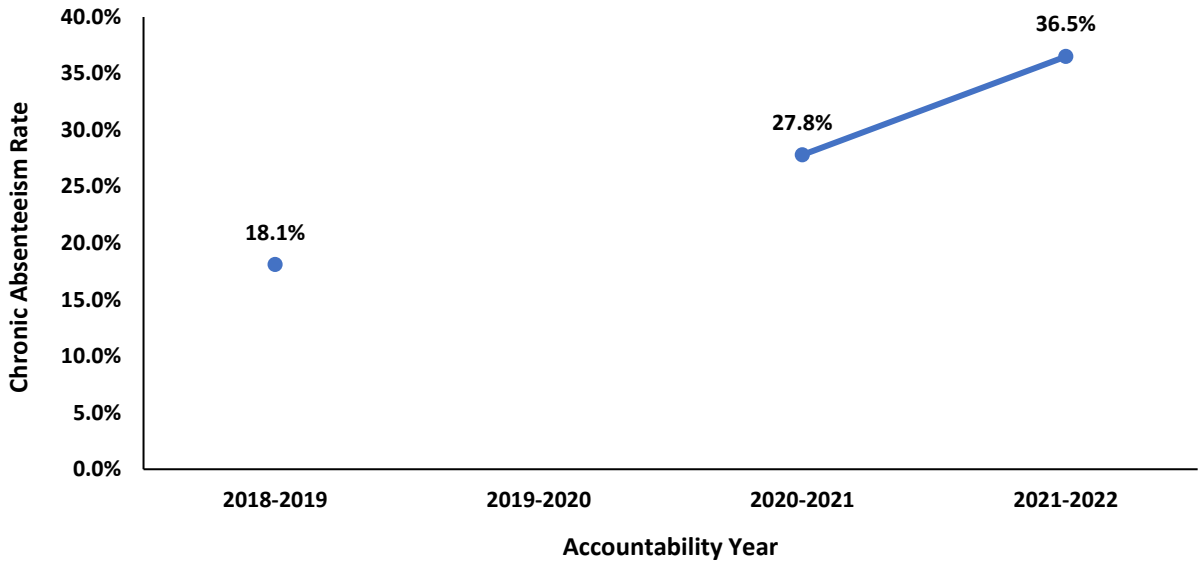
The percent of high school students in the Rural Region who did not go to school because they felt unsafe declined from 2017 to 2019, followed by an increase in 2021. The percent in 2021 was lower than among Nevada high school students in 2021, but not significantly.

Nevada Report Card

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

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

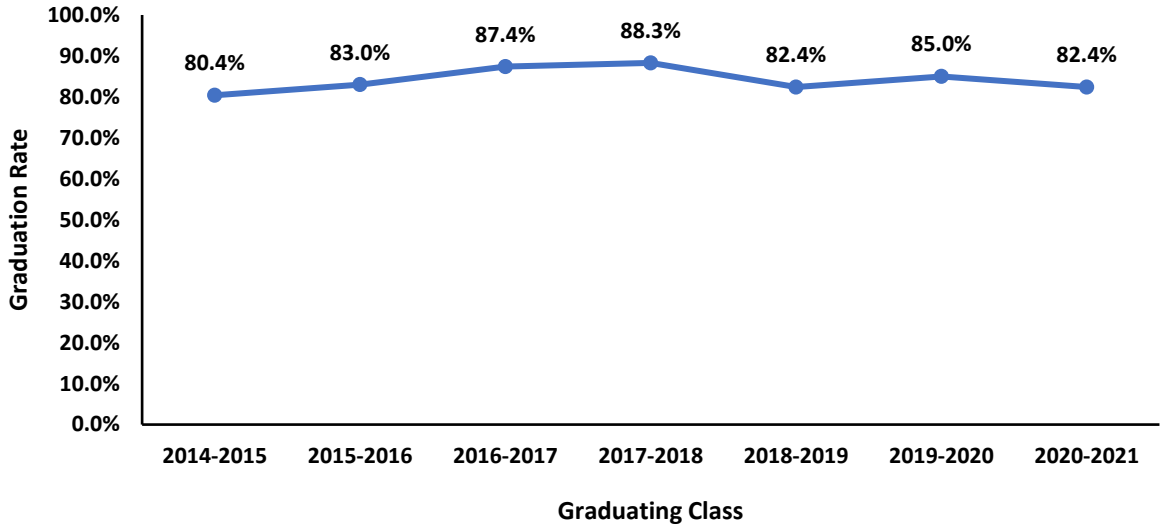
Figure 47. Chronic Absenteeism Rate, Rural Region, Nevada, 2019-2022.



Source: Nevada Department of Education, Report Card.
^Indicator was not measured during the 2019-2020 school year.
Chart scaled to 40.0% to display differences among groups.

The chronic absenteeism rate is the percentage of students who miss 10% or more of enrolled school days per year either with or without a valid excuse. The Rural Region's rate of chronic absenteeism has steadily increased since the 2018-2019 accountability year. The Rural Region reported the lowest rate of 18.1% during the 2018-2019 accountability year, and the highest rate during the 2021-2022 accountability year, at 36.5%. The chronic absenteeism rate was not collected for the 2019-2020 school year, due to the US Department of Education Covid-19 waiver.

Figure 48. High School Graduation Rate, Rural Region Residents, Class Cohorts 2014–2019.



Source: Nevada Department of Education, Report Card.

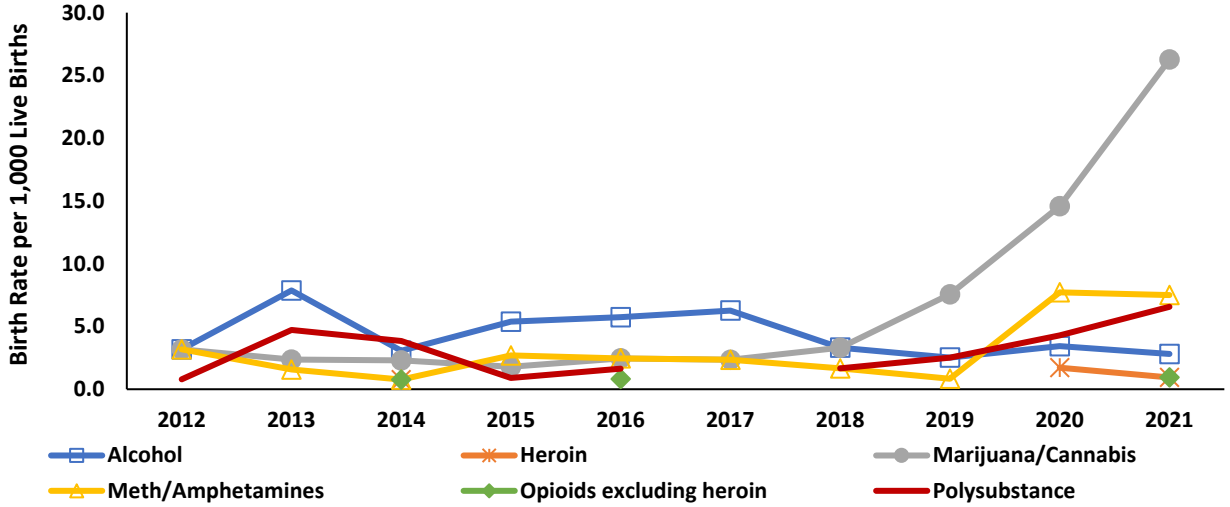
Graduation rate is defined as the rate at which 9th graders graduate by the end of the 12th grade (number of students who graduate in four years with a regular high school diploma divided by the number of students from the adjusted cohort for the graduation class). The highest graduation rate among Rural Region high schools since 2014 is 88.3% for the class of 2018. The graduation rate for the class of 2021 was 82.4%.

Maternal and Child Health

Substance Use Among Pregnant Nevadans (Births)

The data in this section are reflective of self-reported information provided by the mother on the birth record. On average, there were 1,207 live births per year to Rural Region residents between 2012 and 2021. In 2021, three birth certificates indicated alcohol use, 21 birth certificates indicated marijuana use, three indicated meth/amphetamine use, two indicated opiate use, and three indicated polysubstance (more than one substance) use during pregnancy.

Figure 49. Prenatal Substance Use Birth Rates (Self-Reported) for Select Substances, Rural Region Residents, 2012-2021.



Source: Nevada Electronic Birth Registry System.

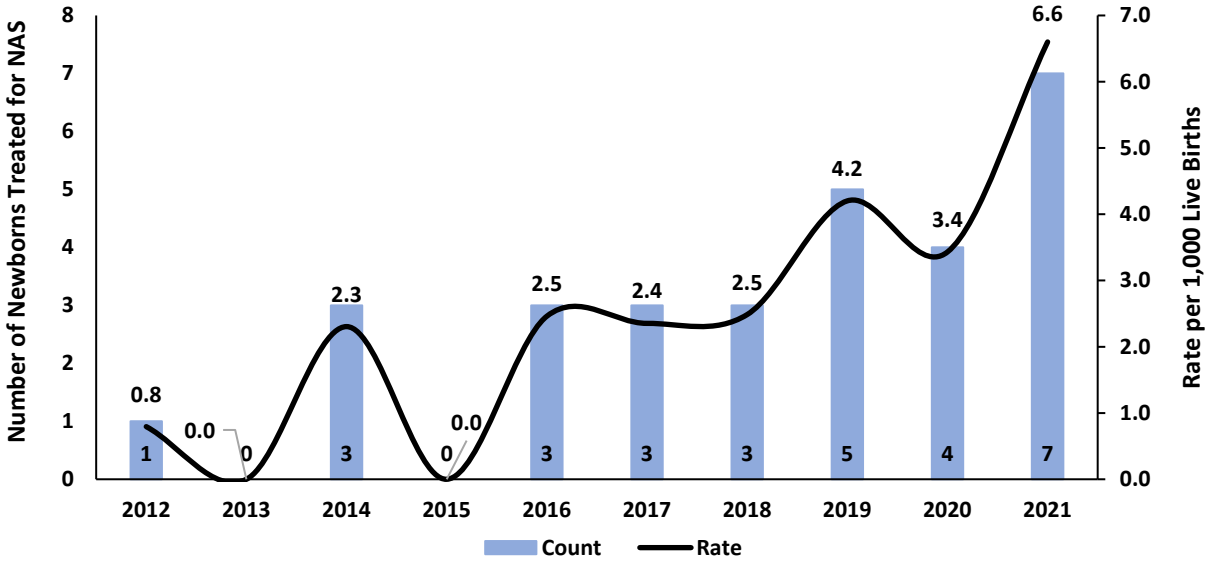
Of the self-reported substance use during pregnancy among Rural Region persons who gave birth between 2012 and 2021, the highest rate was with marijuana use in 2021, at 26.3 per 1,000 live births. Since 2019, the marijuana use rate has surpassed the alcohol use rate, which was at 2.8 per 1,000 births in 2021. In 2020, a rate of 7.7 per 1,000 live births was reported for meth/amphetamines, which is higher than 2012, at 3.2 per 1,000 live births. Polysubstance use (more than one substance) has increased from 0.9 per 1,000 live births in 2015 to 6.5 per 1,000 live births in 2021.

Because alcohol and substance use during pregnancy is self-reported by the mothers, rates are likely lower than actual rates due to underreporting, and expectant mothers may be reluctant to be forthcoming on the birth record for a variety of reasons.

Neonatal Abstinence Syndrome

Neonatal abstinence syndrome (NAS) is a group of conditions 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.

Figure 50. Neonatal Abstinence Syndrome, Rural Region Residents, 2012-2021.



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

The rate of inpatient admissions for NAS increased from 2020 to 2021, from 3.4 per 1,000 live births to 6.6 per 1,000 live births, which is the highest rate in the 10 year span listed in Figure 50 above.

Appendix

Hospital billing data (emergency department encounters and inpatient admissions) and mortality data both utilize International Classification of Diseases codes (ICD). Hospital billing uses ICD-CM which is a 7-digit code verses mortality where the ICD codes are 4-digit. In hospital billing data, the ICD codes are provided in the diagnosis fields, while mortality data the ICD codes are coded from the literal causes of death provided on the death certificate.

In October 2015, ICD-10-CM codes were implemented nationwide. Before October 2015, ICD-9-CM codes were used for medical billing. Therefore, 2015 data consists of two distinct coding schemes, ICD-9-CM and ICD-10-CM, respectively. Due to this change in coding schemes, hospital billing data from October 2015 forward may not be directly comparable to previous data.

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

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

All Diagnosis:

Anxiety: 300.0 (9); F41 (10)
Bi-Polar: 296.40-296.89 (9); F32.89, F31 (10)
Depression: 296.20-296.36, 311 (9); F32.0-F32.5, F33.0-F33.4, F32.9 (10)
Post-Traumatic Stress Disorder: 309.81 (9); F43.10, F43.12 (10)
Schizophrenia: 295 V11.0 (9); F20, Z65.8 (10)
Suicidal Ideation: V62.84 (9); R45.851 (10)
Suicide Attempts: E95.0-E95.9 (9); X71-X83, T36-T65, T71 (10)

Primary and All Diagnosis:

Alcohol: 291, 303, 980, 305.0, 357.5, 425.5, 535.3, 571.0, 571.1, 571.2,571.3, 790.3 (9); F10, K70, G62.1, I42.6, K29.2, R78.0, T51 (10).
Drug: 292, 304, 965, 967, 968, 969, 970, 305.2, 305.3, 305.4, 305.5, 305.6, 305.7, 305.8, 305.9 (9); F11- F16, T39, T40, T43, F18, F19 T41.0, T41.1, T41.2, T41.3, T41.4, T42.3, T43.4, T42.6, T42.7, T42.8 (10).

*Alcohol and drug use encounters are both Primary Diagnosis and All diagnosis were analyzed:

The following ICD-10 codes were used to define mortality causes:

Suicide-related deaths: X60-X84, Y87.0 (Initial cause of death is suicide).
Mental and behavioral-related deaths: F00-F09, and F20-F99 (Initial or contributing cause of death).
Alcohol-related deaths: K70, Y90, Y91, X45, X65, Y15, T51, G31.2, G62.1, I42.6, K29.2, K86.0, K85.0, R78.0, E24.4, O35.4, Q86.0, and Z72.1 (Initial cause of death).
Drug-related deaths: X40-X44, X60-X64, X85, Y10-Y14 (Initial cause of death).

Data Tables

Table 1. Population Distribution, Rural Region, 2012-2021.

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Rural	94,345	96,185	96,141	95,803	96,130	95,845	96,867	98,020	97,167	96,110
Sex										
Female	43,936	44,887	44,855	45,023	45,257	45,263	45,824	46,513	46,145	45,592
Male	50,409	51,298	51,286	50,780	50,873	50,582	51,043	51,507	51,022	50,518
Age										
<1	1,241	1,153	1,237	991	1,124	1,117	1,095	1,113	1,129	1,107
1-4	4,948	5,141	4,986	4,771	4,429	4,355	4,374	4,263	4,448	4,542
5-14	11,264	11,142	11,331	11,314	11,484	11,875	12,064	12,204	12,287	12,425
15-24	19,235	19,749	18,910	17,303	16,636	14,349	14,030	13,741	12,147	11,374
25-34	10,531	11,544	12,433	14,464	15,560	17,358	18,081	18,764	19,033	18,667
35-44	11,540	10,970	10,334	9,850	9,460	9,215	9,310	9,409	9,928	10,318
45-54	13,852	13,380	13,251	12,945	12,681	12,663	12,311	11,756	10,735	10,484
55-64	11,502	12,045	11,849	11,431	11,658	11,654	11,683	12,336	12,524	12,059
65-74	6,683	7,463	8,138	8,548	8,622	8,436	8,681	9,106	9,506	9,591
75-84	2,543	2,577	2,703	3,125	3,432	3,809	4,125	4,220	4,284	4,307
85+	1,007	1,019	968	1,060	1,044	1,012	1,113	1,109	1,148	1,237
Race/Ethnicity										
White non-Hispanic	68,624	70,069	69,648	67,899	67,887	67,110	67,479	68,292	67,084	65,885
Black non-Hispanic	1,375	1,370	1,373	1,423	1,449	1,481	1,497	1,502	1,509	1,523
Native American/Alaskan Native non-Hispanic	4,529	4,633	4,632	4,997	5,005	5,140	5,242	5,289	5,350	5,297
Asian/Pacific Islander non-Hispanic	959	985	1,026	1,153	1,151	1,182	1,224	1,218	1,265	1,290
Hispanic	18,857	19,128	19,461	20,332	20,638	20,933	21,425	21,718	21,960	22,116

Source: Nevada State Demographer, Vintage 2020.

Table 2: Prevalence Estimates of Health Risk Behaviors by Region, Nevada Adults, 2021.

Indicator	Clark	Northern	Rural	Southern	Washoe	Nevada
Ever seriously considered attempting suicide during the past 12 months	4.9% (3.2-6.6)	5.4% (2.7-8.1)	6.1% (1.6-10.6)	5.2% (0.0-11.9)	4.1% (2.6-5.5)	4.8% (3.6-6.0)
Heavy drinkers	6.2% (4.6-7.8)	7.9% (4.9-10.9)	7.4% (3.1-11.6)	2.2% (0.0-6.6)	6.8% (4.8-8.8)	6.4% (5.1-7.7)
Binge drinkers	16.4% (13.8-19.0)	15.9% (11.7-20.1)	22.0% (15.0-29.0)	11.3% (0.2-22.5)	18.3% (15.2-21.4)	15.0% (13.2-16.9)
General health poor or fair	21.4% (18.7-24.4)	18.7% (14.4-23.1)	16.1% (10.2-22.0)	22.4% (5.3-36.5)	19.6% (16.3-22.8)	20.9% (18.7-23.1)
Depressive disorder diagnosis	18.0% (15.5-20.7)	21.9% (18.0-25.8)	15.2% (9.5-20.9)	16.9% (1.2-32.9)	16.8% (13.8-19.9)	17.7% (15.7-19.7)
Ten or more days of poor mental health	17.4% (15.0-20.3)	22.4% (17.4-27.2)	19.5% (12.9-26.0)	17.3% (1.3-25.5)	17.3% (14.4-20.2)	17.6% (15.5-19.6)
Ten or more days of poor mental or physical health kept from usual activities	23.3% (19.7-27.6)	20.5% (14.8-26.2)	24.4% (14.0-34.9)	29.1% (12.8-45.3)	20.3% (16.1-24.5)	22.9% (19.8-25.9)
Used marijuana/hashish in the last 30 days	16.4% (13.8-19.3)	20.3% (15.6-25.1)	21.5% (14.0-29.0)	11.0% (1.9-11.5)	18.7% (15.4-21.9)	17.4% (15.3-19.4)
Used other illegal drugs in the last 30 days	1.7% (0.8-2.6)	1.6% (0.1-3.1)	0.0% --	2.3% (0.0-4.5)	3.1% (1.6-4.6)	1.9% (1.2-2.6)
Used prescription drugs/pain killer to get high in last 30 days	0.6% (0.5-1.1)	1.0% (0.0-2.2)	0.9% (0.0-2.2)	0.0% (0.0-2.9)	0.9% (0.4-1.5)	1.0% (0.2-1.1)
Current tobacco cigarette smokers	14.9% (12.7-17.5)	17.4% (13.0-21.8)	23.1% (15.7-30.4)	17.0% (3.9-26.5)	15.7% (12.7-18.8)	15.7% (13.8-17.5)
Difficulty doing errands alone because of physical, mental, or emotional condition	8.7% (6.8-10.9)	10.6% (6.9-14.3)	7.2% (3.3-11.1)	10.8% (0.0-25.2)	7.5% (5.5-9.5)	8.6% (7.1-10.2)
Serious difficulty concentrating, remembering, or making decisions because of physical, mental, or emotional condition	13.0% (10.8-15.4)	13.9% (9.8-18.0)	14.4% (8.2-20.7)	9.4% (1.5-16.9)	11.1% (8.5-13.7)	12.8% (11.0-14.6)

Source: Behavioral Risk Factor Surveillance System (BRFSS).

Table 3a. Age-Adjusted Rates per 100,000 of Mental Health-Related Emergency Department Encounters by Region, Nevada Residents, 2021.

Region	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicidal Ideation
Clark	497.7 (488.7-506.6)	1,523.8 (1,508.2-1,539.4)	700.1 (689.6-710.6)	687.2 (676.7-697.8)	114.0 (109.7-118.3)	608.3 (598.3-618.3)
Northern	107.4 (92.2-122.5)	1,161.5 (1,113.9-1,209.1)	439.7 (411.1-468.3)	370.1 (342.6-397.7)	90.4 (76.9-104.0)	339.7 (312.4-367.0)
Rural	97.3 (77.9-116.8)	1,196.3 (1,125.8-1,266.8)	768.8 (713.1-824.6)	249.4 (218.3-280.6)	171.6 (143.9-199.2)	246.3 (214.0-278.7)
Southern	279.6 (234.1-325.1)	1,114.7 (1,030.8-1,198.5)	437.3 (384.7-489.8)	347.7 (298.2-397.1)	116.5 (87.7-145.2)	538.7 (474.9-602.5)
Washoe	224.0 (210.6-237.5)	1,318.4 (1,286.0-1,350.7)	701.1 (677.8-724.4)	345.9 (329.3-362.5)	88.2 (79.8-96.6)	406.4 (388.1-424.6)
Nevada	420.5 (413.4-427.7)	1,457.5 (1,444.3-1,470.6)	681.9 (673.0-690.8)	602.0 (593.5-610.5)	110.6 (107-114.3)	553.3 (545.0-561.5)

Source: Hospital Emergency Department Billing.
Rates are per 100,000 age-specific population, provided by the state demographer, Vintage 2020.
Categories are not mutually exclusive.

Table 3b. Crude Rates per 100,000 of Mental Health-Related Emergency Department Encounters by Region, Nevada Residents, 2021.

Region	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicidal Ideation
Clark	496.1 (487.1-505.0)	1,541.1 (1,525.3-1,556.9)	716.0 (705.2-726.8)	686.0 (675.5-696.5)	113.9 (109.6-118.2)	601.1 (591.3-611.0)
Northern	98.4 (84.5-112.3)	1,165.3 (1,117.5-1,213.1)	462.1 (432.0-492.1)	353.9 (327.6-380.3)	86.7 (73.7-99.7)	302.9 (278.6-327.3)
Rural	99.9 (79.9-119.9)	1,150.8 (1,082.9-1,218.6)	759.5 (704.4-814.6)	256.0 (224.0-287.9)	154.0 (129.2-178.8)	232.0 (201.6-262.5)
Southern	237.6 (199.0-276.3)	1,112.8 (1,029.1-1,196.5)	435.9 (383.5-488.3)	311.4 (267.1-355.7)	103.2 (77.8-128.7)	449.0 (395.9-502.2)
Washoe	221.5 (208.2-234.8)	1,326.2 (1,293.6-1,358.7)	720.3 (696.4-744.3)	345.7 (329.1-362.3)	88.1 (79.8-96.5)	395.7 (378.0-413.5)
Nevada	414.7 (407.6-421.7)	1,470.3 (1,457.0-1,483.5)	698.6 (689.5-707.8)	596.0 (587.6-604.5)	109.7 (106.0-113.3)	540.1 (532.1-548.2)

Source: Hospital Emergency Department Billing.
Rates are per 100,000 population, provided by the state demographer, Vintage 2020.
Categories are not mutually exclusive.

Table 4a. Age-Adjusted Rates per 100,000 of Mental Health-Related Inpatient Admissions by Region, Nevada Residents, 2021.

Region	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicidal Ideation
Clark	242.1 (236.0-248.3)	1,220.3 (1,206.6-1,234.0)	888.2 (876.5-900.0)	475.6 (467.0-484.2)	214.4 (208.5-220.2)	470.3 (461.6-479.0)
Northern	74.1 (61.9-86.3)	1,077.0 (1,032.8-1,121.1)	912.2 (871.0-953.4)	397.9 (369.6-426.3)	324.6 (298.0-351.3)	656.9 (618.8-695.1)
Rural	51.6 (37.0-66.2)	535.4 (489.8-581.0)	512.7 (467.6-557.8)	188.9 (160.9-216.8)	139.7 (114.7-164.7)	273.6 (239.4-307.8)
Southern	103.2 (76.8-129.5)	1,153.8 (1,079.8-1,227.9)	900.2 (832.8-967.7)	395.0 (344.4-445.6)	269.8 (228.1-311.5)	369.4 (318.1-420.8)
Washoe	201.4 (188.9-213.9)	892.1 (866.1-918.2)	900.8 (874.7-926.9)	303.4 (288.1-318.7)	232.3 (218.5-246.0)	628.9 (606.3-651.5)
Nevada	218.0 (212.9-223.0)	1,133.5 (1,122.2-1,144.8)	873.4 (863.5-883.3)	434.4 (427.3-441.5)	221.5 (216.4-226.7)	496.5 (488.8-504.2)

Source: Hospital Inpatient Billing.
Rates are per 100,000 age-specific population, provided by the state demographer, Vintage 2020.
Categories are not mutually exclusive.

Table 4b. Crude Rates per 100,000 of Mental Health-Related Inpatient Admissions by Region, Nevada Residents, 2021.

Region	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicidal Ideation
Clark	249.0 (242.7-255.4)	1,279.5 (1,265.1-1,293.9)	926.6 (914.4-938.9)	491.6 (482.7-500.5)	217.2 (211.2-223.1)	471.9 (463.2-480.7)
Northern	72.4 (60.5-84.3)	1,165.3 (1,117.5-1,213.1)	960.3 (916.9-1,003.7)	387.1 (359.5-414.6)	290.7 (266.8-314.6)	580.9 (547.1-614.6)
Rural	49.9 (35.8-64.1)	551.5 (504.5-598.4)	516.1 (470.7-561.5)	182.1 (155.1-209.1)	124.9 (102.5-147.2)	256.0 (224.0-287.9)
Southern	96.7 (72.0-121.4)	1,529.0 (1,430.9-1,627.1)	1,121.0 (1,037.0-1,205.0)	383.5 (334.4-432.6)	263.9 (223.1-304.6)	326.1 (280.8-371.4)
Washoe	206.6 (193.7-219.4)	936.2 (908.9-963.5)	950.5 (923.0-978.1)	314.6 (298.8-330.5)	227.5 (214.1-241.0)	615.4 (593.2-637.5)
Nevada	223.5 (218.3-228.7)	1,207.3 (1,195.3-1,219.3)	926.9 (916.3-937.4)	448.4 (441.1-455.7)	222.2 (217.0-227.3)	492.4 (484.7-500.1)

Source: Hospital Inpatient Billing.
Rates are per 100,000 population, provided by the state demographer, Vintage 2020.
Categories are not mutually exclusive.

Table 5. Mental Health-Related Deaths Age-Adjusted Rates and Region, Nevada Residents, 2021.

Region	White non-Hispanic	Black non-Hispanic	Native American/ Alaskan Native non-Hispanic	Asian/Pacific Islander non-Hispanic	Hispanic	Total
Clark	44.3 (40.9-47.8)	53.2 (43.0-63.4)	60.9 (12.2-109.7)	30.3 (23.2-37.4)	31.3 (24.7-37.8)	42.0 (39.3-44.8)
Northern	79.5 (69.1-89.9)	0.0 (0.0-0.0)	26.7 (0.0-63.8)	47.7 (0.0-113.8)	39.7 (7.9-71.5)	74.8 (65.2-84.3)
Rural	39.0 (24.8-53.2)	0.0 (0.0-0.0)	31.1 (0.0-74.2)	0.0 (0.0-0.0)	22.7 (0.0-48.3)	36.2 (24.0-48.4)
Southern	32.6 (21.9-43.2)	73.7 (0.0-218.3)	38.6 (0.0-114.2)	0.0 (0.0-0.0)	74.0 (1.5-146.5)	34.0 (23.7-44.3)
Washoe	78.3 (69.6-87.0)	106.5 (27.6-185.4)	154.5 (30.9-278.1)	67.6 (35.4-99.7)	45.9 (25.8-66.0)	75.4 (67.7-83.2)
Nevada	53.9 (50.9-56.9)	54.5 (44.4-64.6)	54.0 (28.3-79.7)	34.2 (27.1-41.3)	33.9 (27.8-39.9)	49.8 (47.4-52.3)

Source: Electronic Death Registry System.
Rates are per 100,000 age-specific population, provided by the state demographer, Vintage 2020.

Table 6. Suicide Attempts and Suicides by Leading Method and Region, Nevada Residents, 2021.

Region	Suicide Attempts				Suicides		
	Emergency Department Encounters		Inpatient Admissions		Substance	Hanging/ Suffocation	Firearms/ Explosives
	Substance	Cutting	Substance	Cutting			
Clark	55.4 (52.4-58.4)	32.7 (30.4-35.0)	51.2 (48.3-54.1)	17.8 (16.1-19.5)	2.6 (2.0-3.3)	3.5 (2.7-4.2)	10.7 (9.4-12.0)
Northern	88.2 (75.1-101.4)	13.3 (8.2-18.4)	63.7 (52.6-74.9)	8.2 (4.2-12.2)	2.5 (0.3-4.8)	7.1 (3.4-10.9)	24.5 (17.6-31.4)
Rural	45.8 (32.3-59.3)	18.7 (10.1-27.4)	25.0 (15.0-35.0)	4.2 (0.1-8.2)	5.2 (0.6-9.8)	5.2 (0.6-9.8)	28.1 (17.5-38.7)
Southern	67.2 (46.6-87.8)	36.1 (21.0-51.1)	42.6 (26.2-59.0)	9.8 (2.0-17.7)	1.6 (0.0-4.9)	4.9 (0.0-10.5)	27.9 (14.6-41.1)
Washoe	57.5 (50.7-64.2)	4.4 (2.5-6.2)	48.1 (41.9-54.3)	9.5 (6.8-12.3)	3.9 (2.2-5.7)	4.1 (2.3-6.0)	13.3 (10.0-16.5)
Nevada	57.8 (55.2-60.4)	27.1 (25.3-28.9)	50.7 (48.3-53.2)	15.4 (14.1-16.8)	2.9 (2.3-3.4)	3.9 (3.2-4.6)	12.8 (11.6-14.0)

Source: Hospital Emergency Department Billing, Inpatient Billing, and the Electronic Death Registry System.
Rates are per 100,000 population, provided by the state demographer, Vintage 2020.

Table 7. Suicide Crude Rates by Age, Race/Ethnicity and Region, Nevada Residents, 2021.

	Clark	Northern	Rural	Southern	Washoe	Nevada
Age Group						
Less then 15	0.9 (0.0-1.7)	0.0 (0.0-0.0)	0.0 (0.0-0.0)	11.7 (0.0-34.7)	2.2 (0.0-5.3)	1.1 (0.3-2.0)
15-24	19.2 (14.5-24.0)	18.1 (0.4-35.7)	105.5 (45.8-165.2)	0.0 (0.0-0.0)	20.4 (9.7-31.1)	21.3 (17.0-25.7)
25-34	20.0 (15.2-24.7)	35.0 (12.1-57.8)	26.8 (3.3-50.3)	39.0 (0.0-83.2)	25.5 (13.4-37.7)	22.2 (17.9-26.5)
35-44	20.5 (15.6-25.4)	76.0 (37.5-114.5)	87.2 (30.2-144.2)	17.1 (0.0-50.7)	23.8 (11.7-35.8)	25.1 (20.3-29.8)
45-54	27.2 (21.4-33.0)	43.7 (17.9-69.5)	38.2 (0.8-75.5)	29.3 (0.0-69.9)	28.7 (14.6-42.7)	28.7 (23.5-33.9)
55-64	22.7 (17.1-28.3)	30.5 (9.4-51.7)	41.5 (5.1-77.8)	65.6 (13.1-118.1)	23.4 (11.2-35.7)	25.0 (20.0-30.0)
65-74	17.9 (12.0-23.7)	45.4 (19.7-71.0)	31.3 (0.0-66.7)	22.0 (0.0-52.4)	28.5 (13.6-43.4)	22.7 (17.2-28.1)
75-84	33.1 (21.8-44.4)	85.3 (37.0-133.5)	69.6 (0.0-148.5)	70.4 (1.4-139.5)	48.3 (19.8-76.9)	43.0 (32.4-53.7)
85+	50.4 (24.9-75.9)	79.6 (1.6-157.5)	0.0 (0.0-0.0)	161.2 (0.0-343.5)	119.5 (36.7-202.4)	67.3 (43.2-91.4)
Race/Ethnicity						
White non-Hispanic	27.0 (23.8-30.2)	44.9 (34.1-55.6)	48.6 (31.7-65.4)	42.7 (24.0-61.5)	32.5 (26.0-38.9)	31.1 (28.3-33.8)
Black non-Hispanic	17.3 (12.3-22.2)	88.6 (0.0-211.3)	0.0 (0.0-0.0)	0.0 (0.0-0.0)	0.0 (0.0-0.0)	16.9 (12.2-21.6)
Native American/Alaskan Native non-Hispanic	6.4 (0.0-19.1)	16.9 (0.0-50.1)	37.8 (0.0-90.1)	51.6 (0.0-152.7)	26.8 (0.0-64)	19.4 (5.0-33.7)
Asian/Pacific Islander non-Hispanic	11.0 (7.1-14.8)	0.0 (0.0-0.0)	77.5 (0.0-229.5)	0.0 (0.0-0.0)	5.7 (0.0-13.6)	10.4 (6.9-14.0)
Hispanic	10.2 (8.0-12.4)	11.9 (0.2-23.5)	27.1 (5.4-48.8)	10.9 (0.0-32.2)	7.0 (2.4-11.6)	10.2 (8.2-12.2)
Total	18.2 (16.5-20.0)	38.2 (29.6-46.9)	42.7 (29.6-55.7)	36.1 (21.0-51.1)	23.0 (18.7-27.3)	21.2 (19.7-22.8)

Source: Electronic Death Registry System.
Rates are per 100,000 population, provided by the state demographer, Vintage 2020.

Table 8a. Drug-Related Emergency Department Encounters Age-Adjusted Rates by Drug Type and Region, Nevada Residents, 2021.

Region	Opioids	Heroin	Cocaine	Methamphetamine	Marijuana	Hallucinogens
Clark	174.9 (169.7-180.2)	11.1 (9.8-12.5)	63.3 (60.1-66.5)	476.9 (468.1-485.8)	334.1 (326.8-341.5)	20.6 (18.8-22.5)
Northern	130.1 (114.3-146.0)	12.4 (7.1-17.8)	19.5 (12.6-26.4)	276.9 (252.1-301.7)	332.8 (306.0-359.5)	6.5 (2.7-10.3)
Rural	115.6 (94.4-136.8)	13.7 (6.3-21.2)	16.0 (7.3-24.7)	231.0 (200.2-261.8)	325.5 (288.9-362.0)	12.3 (4.7-19.9)
Southern	264.0 (224.5-303.6)	10.2 (2.0-18.3)	42.9 (25.0-60.8)	479.8 (421.8-537.8)	366.4 (314.4-418.4)	18.9 (5.8-31.9)
Washoe	166.1 (154.6-177.6)	17.2 (13.4-21)	28.3 (23.6-33.0)	442.3 (423.1-461.5)	216.7 (203.4-229.9)	5.3 (3.2-7.3)
Nevada	171.3 (166.8-175.8)	12.2 (11.0-13.4)	53.7 (51.2-56.2)	454.8 (447.3-462.2)	317.3 (311.2-323.5)	17.2 (15.8-18.7)

Source: Hospital Emergency Department Billing.
Rates are per 100,000 age-specific population, provided by the state demographer, Vintage 2020.
Categories are not mutually exclusive.

Table 8b. Drug-Related Emergency Department Encounters Crude Rates by Drug Type Region, Nevada Residents, 2021.

Region	Opioids	Heroin	Cocaine	Methamphetamine	Marijuana	Hallucinogens
Clark	178.3 (172.9-183.6)	11.1 (9.8-12.4)	64.7 (61.5-68.0)	466.9 (458.2-475.5)	333.4 (326.1-340.8)	20.3 (18.5-22.1)
Northern	131.6 (115.5-147.6)	10.7 (6.1-15.3)	15.8 (10.2-21.4)	244.3 (222.4-266.2)	303.4 (279.1-327.8)	5.6 (2.3-8.9)
Rural	118.6 (96.8-140.4)	13.5 (6.2-20.9)	13.5 (6.2-20.9)	224.7 (194.8-254.7)	317.3 (281.7-353.0)	10.4 (4.0-16.9)
Southern	280.2 (238.2-322.2)	9.8 (2.0-17.7)	36.1 (21.0-51.1)	431.0 (378.9-483.1)	313.0 (268.6-357.4)	13.1 (4.0-22.2)
Washoe	166.5 (155.0-178.1)	16.6 (13.0-20.2)	28.6 (23.8-33.4)	424.8 (406.4-443.2)	213.6 (200.6-226.7)	5.2 (3.2-7.2)
Nevada	174.1 (169.5-178.6)	12.0 (10.8-13.2)	54.4 (51.8-56.9)	440.5 (433.2-447.8)	313.7 (307.5-319.8)	16.7 (15.3-18.1)

Source: Hospital Emergency Department Billing.
Rates are per 100,000 population, provided by the state demographer, Vintage 2020.
Categories are not mutually exclusive.

Table 9a. Drug-Related Inpatient Admissions Age-Adjusted Rates by Drug Type and Region, Nevada Residents, 2021.

Region	Opioids	Heroin	Cocaine	Methamphetamine	Marijuana	Hallucinogens
Clark	241.7 (235.6-247.8)	3.1 (2.4-3.8)	68.4 (65.2-71.6)	413.5 (405.4-421.7)	508.9 (499.9-517.8)	12.2 (10.8-13.6)
Northern	275.0 (252.7-297.4)	2.1 (0.0-4.2)	22.2 (15.3-29.1)	358.5 (330.4-386.6)	386.2 (357.9-414.4)	6.6 (2.7-10.6)
Rural	110.1 (89.5-130.7)	3.5 (0.1-6.9)	15.4 (7.0-23.7)	178.6 (151.6-205.6)	213.8 (183.4-244.2)	7.3 (1.5-13.2)
Southern	157.2 (128.2-186.2)	3.7 (0.0-8.9)	24.5 (13.5-35.5)	294.4 (250.9-337.9)	373.7 22.7	4.4 (0.0-10.4)
Washoe	297.8 (282.6-312.9)	2.7 (1.3-4.2)	27.4 (22.7-32.1)	378.7 (361.4-396.1)	277.8 (263.1-292.5)	3.8 (2.1-5.5)
Nevada	245.7 (240.5-251.0)	3.0 (2.4-3.6)	56.9 (54.4-59.4)	397.1 (390.2-404.0)	455.9 (448.6-463.2)	10.4 (9.3-11.5)

Source: Hospital Inpatient Billing.
Rates are per 100,000 age-specific population, provided by the state demographer, Vintage 2020.
Categories are not mutually exclusive.

Table 9b. Drug-Related Inpatient Admissions Crude Rates by Drug Type and Region, Nevada Residents, 2021.

Region	Opioids	Heroin	Cocaine	Methamphetamine	Marijuana	Hallucinogens
Clark	255.4 (249.0-261.8)	3.2 (2.4-3.9)	73.4 (70.0-76.8)	416.1 (407.9-424.3)	522.7 (513.5-531.9)	12.2 (10.8-13.6)
Northern	297.3 (273.2-321.5)	2.0 (0.0-4.0)	20.4 (14.1-26.7)	319.3 (294.2-344.3)	366.2 (339.4-393.0)	5.6 (2.3-8.9)
Rural	114.5 (93.1-135.8)	4.2 (0.1-8.2)	13.5 (6.2-20.9)	174.8 (148.4-201.2)	197.7 (169.6-225.8)	6.2 (1.2-11.2)
Southern	185.2 (151.0-219.3)	3.3 (0.0-7.8)	31.1 (17.1-45.1)	288.4 (245.8-331.0)	386.8 (337.4-436.1)	3.3 (0.0-7.8)
Washoe	307.6 (291.9-323.2)	2.7 (1.2-4.2)	27.6 (22.9-32.3)	379.8 (362.4-397.2)	283.3 (268.3-298.3)	3.9 (2.2-5.7)
Nevada	260.7 (255.1-266.2)	3.0 (2.4-3.7)	60.9 (58.2-63.6)	396.5 (389.7-403.4)	466.1 (458.7-473.6)	10.3 (9.2-11.4)

Source: Hospital Inpatient Billing.
Rates are per 100,000 population, provided by the state demographer, Vintage 2020.
Categories are not mutually exclusive.

Table 10. Drug- and Alcohol-Related Age-Adjusted Death Rates by Race/Ethnicity and Region, Nevada Residents, 2021.

Region	White non-Hispanic	Black non-Hispanic	Native American/ Alaskan Native non-Hispanic	Asian/Pacific Islander non-Hispanic	Hispanic	Total
Clark	71.3 (66.6-76.1)	74.7 (64.4-84.9)	114.9 (63.2-166.5)	11.5 (7.6-15.3)	35.4 (31.0-39.8)	54.6 (51.8-57.5)
Northern	91.7 (78.4-104.9)	102.6 (0.0-244.7)	115.7 (23.1-208.3)	23.0 (0.0-68.0)	61.3 (32.2-90.4)	86.5 (74.8-98.2)
Rural	78.8 (58.4-99.3)	0.0 (0.0-0.0)	116.6 (23.3-209.9)	0.0 (0.0-0.0)	47.5 (18.1-77.0)	72.9 (56.2-89.7)
Southern	89.9 (65.9-113.9)	77.1 (0.0-228.2)	43.8 (0.0-129.8)	0.0 (0.0-0.0)	65.4 (8.1-122.7)	83.3 (62.4-104.2)
Washoe	101.8 (91.3-112.2)	170.3 (97.4-243.1)	150.7 (61.6-239.7)	17.7 (4.6-30.8)	43.5 (31.1-55.9)	85.0 (77.2-92.9)
Nevada	80.3 (76.3-84.3)	79.0 (68.7-89.2)	117.7 (82.5-152.9)	12.1 (8.4-15.8)	38.0 (33.9-42.1)	62.8 (60.2-65.5)

Source: Electronic Death Registry System.
Rates are per 100,000 age-specific population, provided by the state demographer, Vintage 2020.