Youth Suicide:
Behaviors and Circumstances
Nevada, 2020

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Office of Analytics

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Accessibility Disclosure

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Data Sources/Terminology

The following data sources were used to research factors that may influence an individual's decision to choose suicide. This report includes data from 2017 to 2020 but is limited by available data; national and NVRS data are through 2019.

Age-Adjusted Rates
A rate measures the frequency of a specific event over a given period, divided by the total number of people within the population over the same period. 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 2000 (Census table P25-1130). Rates are age-adjusted to eliminate any potential confounding effects or biases that may result from health factors associated with specific ages.

Center for Health Information and Analysis (CHIA)
Hospitalization data in this report are collected by CHIA, a research center housed at the University of Nevada, Las Vegas. CHIA collects billing records from all hospital inpatient, outpatient, and ambulatory surgical centers. More information can be found at http://www.chiaunlv.com/index.php.

Crude Rates
The crude rate is the frequency with which an event or circumstance occurs per unit of population.

Nation Violent Death Reporting System
According to CDC, the National Violent Death Reporting System (NVDRS) links information about the "who, when, where, and how" from data on violent deaths and provides insights about "why" the deaths occurred. Each state submits data, and the NVDRS program provides finalized files each year. NVDRS includes all types of violent deaths, including homicides and suicides in all settings for all age groups. The data are de-identified and unable to be matched back to the death record.

Nevada State Demographer
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.

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

Web-based Injury Statistics Query and Reporting System (WISQARS)
The Center for the Disease Control and Prevention (CDC) WISQARS is an interactive online database that provides fatal and nonfatal injury, violent death, and cost of injury data (WISCARS).

Youth Risk Behavior Survey (YRBS)
The purpose of the YRBS is to provide Nevada data to assess trends in priority health-risk behaviors among high school students, measure progress toward achieving national health objectives for Healthy

People 2020 and other program and policy indicators and evaluate the impact of broad school and community interventions at the national, state, and local levels. The YRBS is a biennial, anonymous, and voluntary survey of 9th through 12th grade students in traditional, public high schools and Nevada charter schools and public middle schools that monitor the prevalence of health risk behaviors among youth. The survey asks students to 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, sexually transmitted diseases, and unintended pregnancy; (3) Tobacco use; (4) Alcohol and other drug use; (5) Unhealthy dietary behaviors; and (6) Physical inactivity. For more information on YRBS: UNR YRBS.

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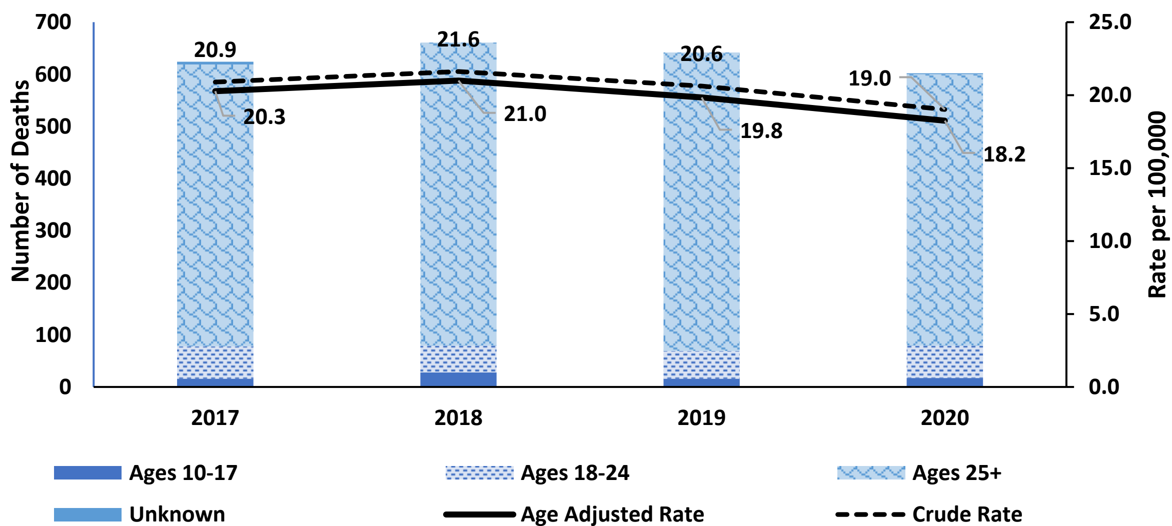
Introduction

Suicide is defined as an act of intentional self-harm resulting in death and is a pressing public health concern in Nevada. High rates of suicide can result in public complacency, diminishing discussion and community action. The consequence can be a lack of preparedness for preventing these deaths and the secondary harm they cause.

Nevada ranks 7th highest in the nation for suicide (WISQARS 2019). In Nevada, the age-adjusted rate for deaths from suicide in 2019 was 19.8 per 100,000 population, which is higher than the national rate at 14.5 per 100,000. On average, roughly 632 Nevadans die by suicide each year, and approximately 12% of the suicides from 2017-2020 were among young adults (ages 18-24) and youth (ages 10-17).

Figure 1. Suicide Counts and Rates (per 100,000 population), 2017-2020.



Source: Nevada Electronic Death Registry and Nevada State Demographer (2020).

This report is intended to explore suicides among youths and young adults in Nevada from 2017-to 2020. Youths are defined as individuals ages 10 to 17 years old, and young adults are defined as individuals ages 18 to 24 years old. In 2020, there were 346,375 youths and 295,778 young adults living in Nevada.

The data and information in this report highlight the need to address and prevent this public health problem. This document is intended to briefly examine youth suicide, not a complete discussion or action plan.

Suicides (Overview)

Suicide is the leading cause of death for people aged 10 to 17 and is significantly higher than deaths from assault, non-transport accidents, and malignant neoplasms (cancer). Death by suicide comprises 25% of the youth deaths from 2017 to 2020. Similarly, in young adults, deaths by suicide (n=218) are the 2nd leading cause of death, with non-transport accidents as the leading cause (n=228). In young adults, deaths by suicide are significantly higher than assault (homicides), transport accidents, and malignant neoplasms (cancer).

Figure 2. Leading Causes of Death by Age Group, 2017-2020 Combined.

Youth Deaths Ages 10-17				
Rank	**Leading Cause of Death**	**N.**	**%**	**Crude Rate (CI)**
1	Intentional self-harm (suicide)	77	25.2%	5.7 (4.4-6.9)
2	Transport accidents	58	19.0%	4.3 (3.2-5.4)
3	Assault (homicide)	38	12.4%	2.8 (1.9-3.7)
4	Non-transport accidents	28	9.2%	2.1 (1.3-2.8)
5	Malignant neoplasms	24	7.8%	1.8 (1.1-2.5)
6	All other diseases (residual)	81	26.5%	6.0 (4.7-7.2)
	Total	**306**	**100.0%**	**22.5 (12.9-32.1)**
Young Adult Deaths Ages 18-24				
Rank	**Leading Cause of Death**	**N.**	**%**	**Crude Rate (CI)**
1	Non-transport accidents	228	22.7%	19.9 (17.3-22.5)
2	Intentional self-harm (suicide)	218	21.7%	19.0 (16.5-21.6)
3	Transport accidents	164	16.3%	14.3 (12.1-16.5)
4	Assault (homicide)	145	14.4%	12.7 (10.6-14.7)
5	Malignant neoplasms	47	4.7%	4.1 (2.9-5.3)
6	All other diseases (residual)	202	20.1%	17.6 (15.2-20.1)
	Total	**1,004**	**100.0%**	**87.6 (66.2-109.0)**

Source: Nevada Electronic Death Registry and Nevada State Demographer (2020).

Deaths by suicide in youth and young adults have remained steady the past four years, with an average of 76 deaths a year. Males comprise roughly 80% of the deaths related to suicide, and white non-Hispanics comprise 50% of the deaths. In nearly 54% of deaths, firearms were the leading method of suicide, with hanging or suffocation the second most common method (31%). There have been 77 deaths from suicide between 2017-2020, averaging 19 deaths a year in youth. In young adults, there have been 228 deaths from suicide between 2017-2020, averaging 57 deaths a year.

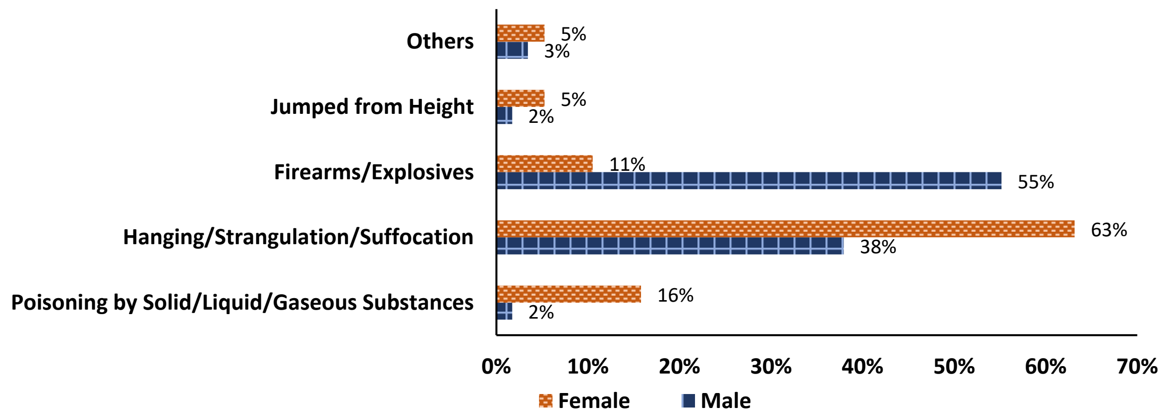
Figure 3. Suicide Demographics by Age Group, 2017-2020 Combined.

Demographics	10-17		18-24		Total	
	N	%	N	%	N	%
Total	77	100.0%	228	100.0%	305	100.0%
2017	16	20.8%	62	27.2%	78	25.6%
2018	28	36.4%	51	22.4%	79	25.9%
2019	16	20.8%	53	23.2%	69	22.6%
2020	17	22.1%	62	27.2%	79	25.9%
Sex						
Male	58	75.3%	185	81.1%	243	79.7%
Female	19	24.7%	43	18.9%	62	20.3%
Race/Ethnicity						
White non-Hispanic	36	46.8%	117	51.3%	153	50.2%
Black non-Hispanic	8	10.4%	22	9.6%	30	9.8%
Native American/Alaskan Native non-Hispanic	0	0.0%	3	1.3%	3	1.0%
Asian/Pacific Islander non-Hispanic	8	10.4%	23	10.1%	31	10.2%
Hispanic	22	28.6%	61	26.8%	83	27.2%
Other/Unknown	3	3.9%	2	0.9%	5	1.6%
Method of Suicide						
Poisonings	4	5.2%	16	7.0%	20	6.6%
Hanging/Suffocation	34	44.2%	61	26.8%	95	31.1%
Firearms	34	44.2%	130	57.0%	164	53.8%
Cutting/Stabbing	0	0.0%	4	1.8%	4	1.3%
Jumping	2	2.6%	7	3.1%	9	3.0%
Others	3	3.9%	10	4.4%	13	4.3%

Source: Nevada Electronic Death Registry and Nevada State Demographer (2020).

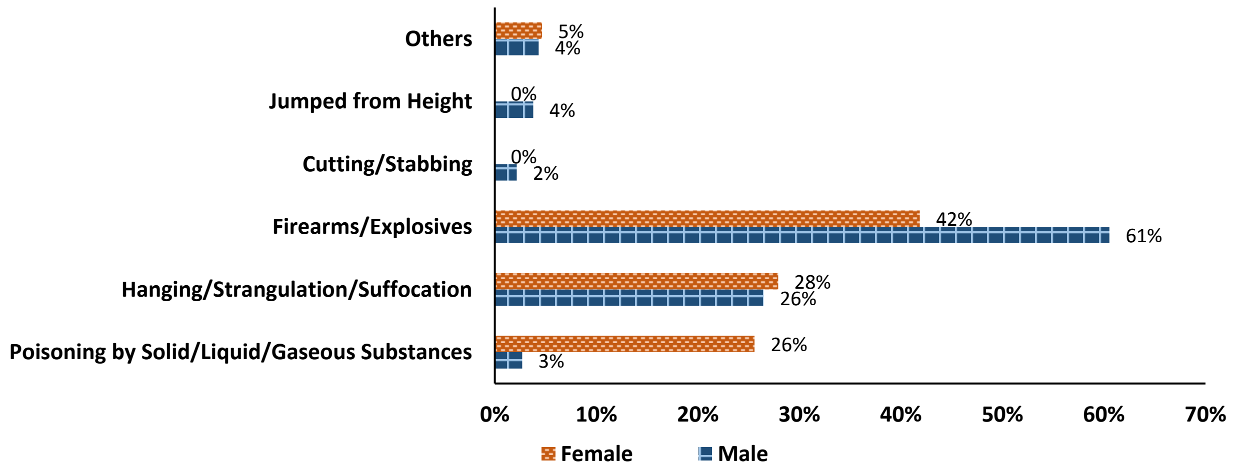
Regarding geographical location, of the youth and young adult suicides from 2017 to 2020, 69% were Clark County residents, 16% were Washoe County residents, and 6% were Elko residents. The remaining counties combined accounted for 9% of the suicides. The crude rate for suicide deaths in Elko County is significantly higher than all other counties, with 40.6 per 100,000 county and age specific population.

Figure 4a. Method of Suicide by Sex and Age Group (10-17), 2017-2020 Combined.



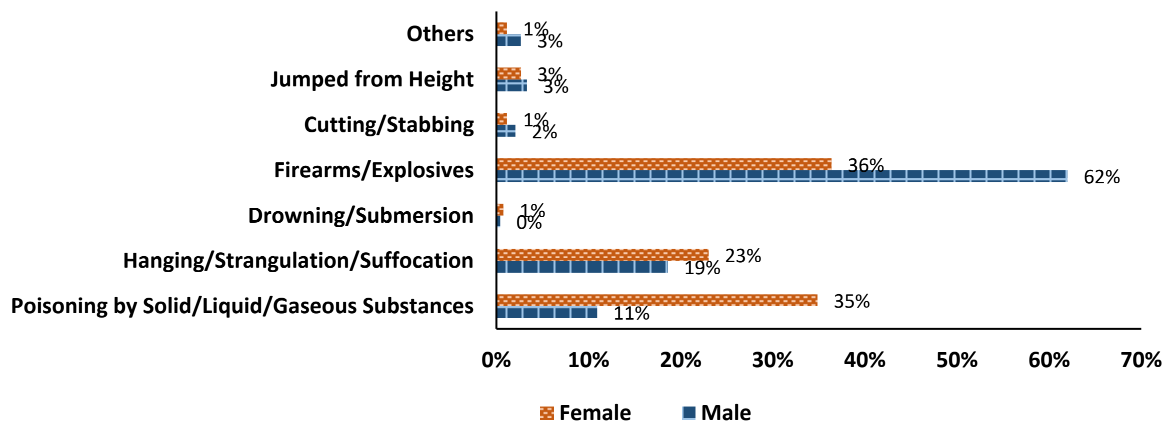
Source: Nevada Electronic Death Registry.

Figure 4b. Method of Suicide by Sex and Age Group (18-24), 2017-2020 Combined.



Source: Nevada Electronic Death Registry.

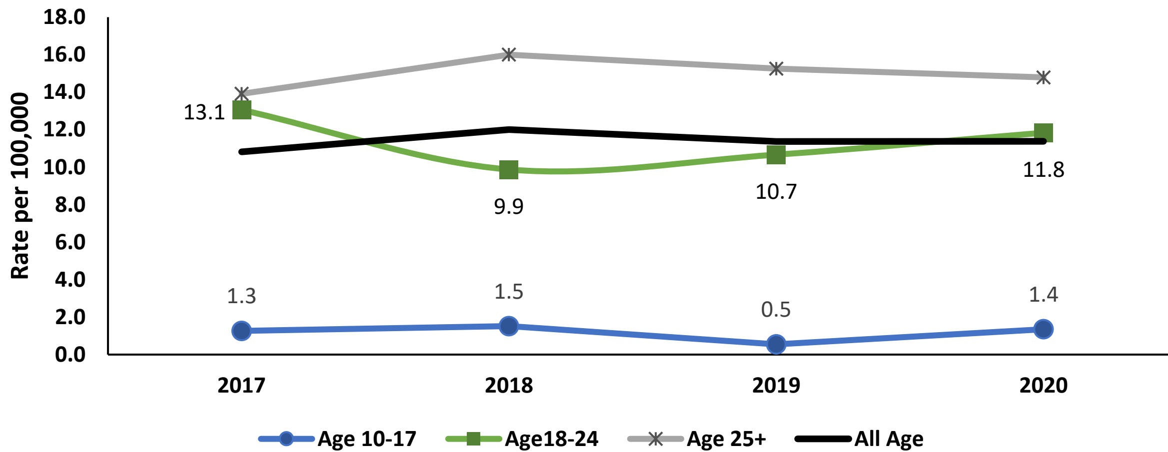
Figure 4c. Method of Suicide by Sex and Age Group (25+), 2017-2020 Combined.



Source: Nevada Electronic Death Registry.

Firearms/explosives are the leading method of suicide for each age group for sex, except females ages 10-17, where hanging/strangulation/suffocation is the leading method (Figure 4a). For young adults and those over 24, firearms are the leading method for deaths from suicides in both sexes. The rate of firearm-related suicides has remained steady from 2017 to 2020.

Figure 5. Firearms as the Method of Suicide (Rate) by Age Group (25+) and Year, 2017-2020.



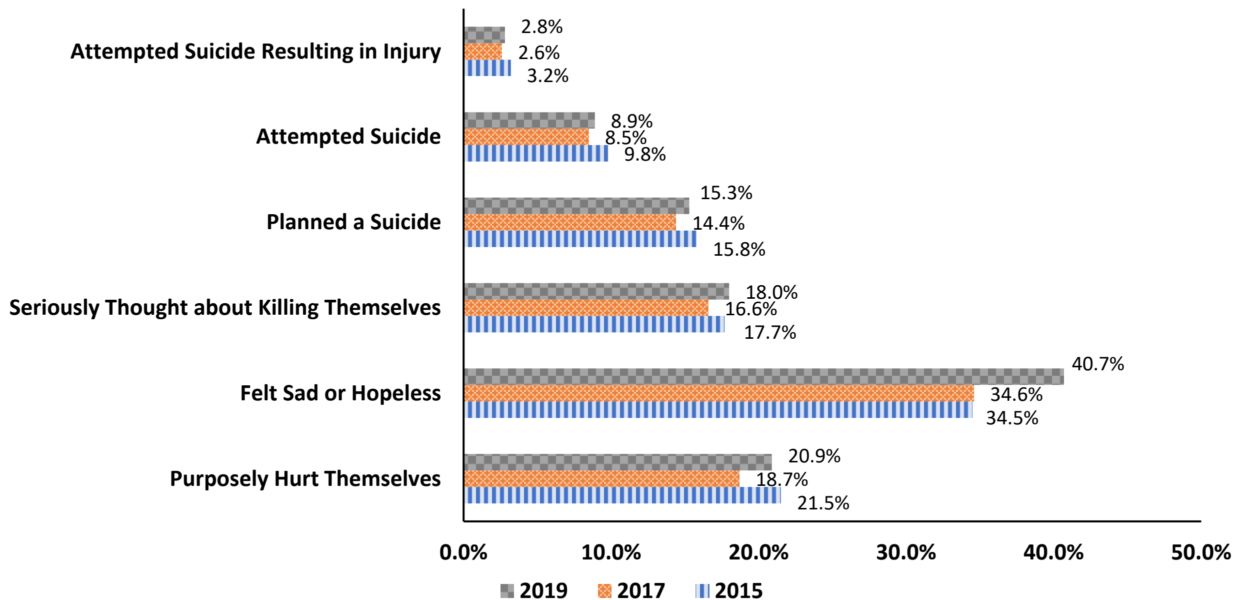
Source: Nevada Electronic Death Registry.

Youth Behaviors

The Youth Risks Behavioral Survey (YRBS) is distributed to middle school and high school students throughout Nevada during odd years. There are six questions related to suicide. The last survey was completed in 2019. The University of Nevada, Reno collects and maintains the YRBS data and publishes each survey. For more information on YRBS, please go to the following site: Nevada YRBS.

According to the University of Nevada, Reno, "the YRBS includes five state-added questions assessing lifetime prevalence of adverse childhood events (ACES), including physical abuse by an adult, verbal abuse by an adult, forced sex, domestic household violence, household mental illness, and house substance abuse. The ACE questions were summed to create a total ACE score (range 0-6). ACE scores were only calculated for youth who answered at least one ACE question (n=4,939). The weighted chi-square test assessed differences in risk behaviors by ACE score (0 ACE, 1 ACE, 2 ACE, or 3+ ACE). The Cochran-Armitage test for trend was used to assess the relationship between ACEs and risk behaviors."

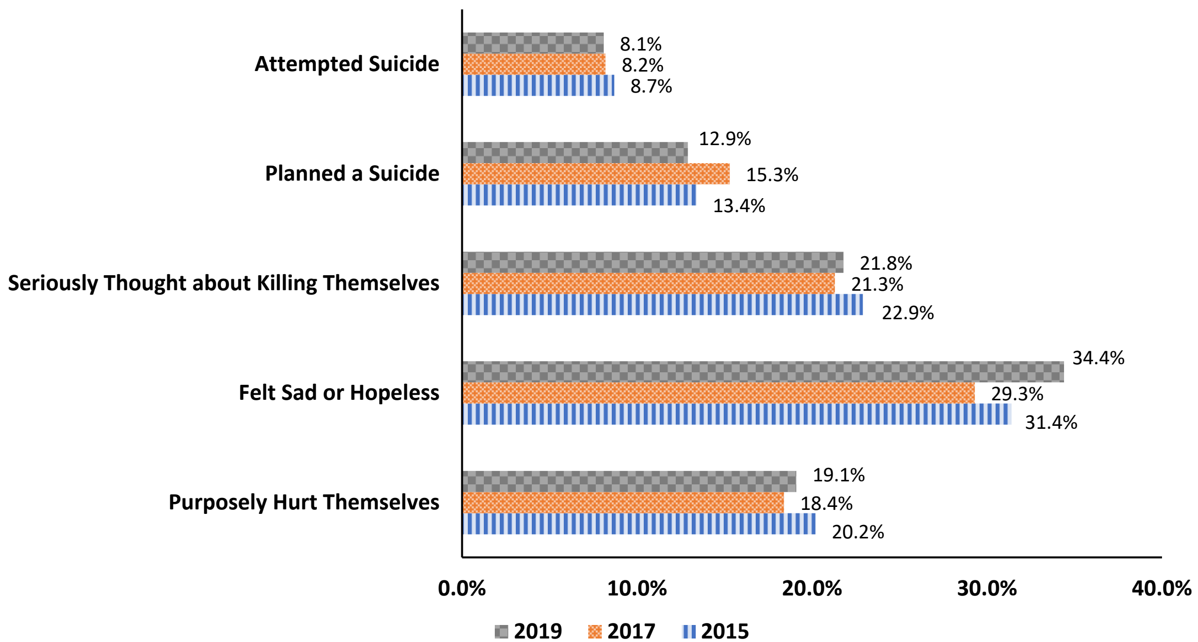
Figure 6. Suicide-Related Questions for High School Students by Year, 2015, 2017, and 2019.



Source: Nevada Youth Risk Behavior Survey (YRBS).

Questions:
During the past 12 months, did you do something to purposely hurt yourself without wanting to die, such as cutting or burning yourself?
During the past 12 months, have you ever felt so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?
During the past 12 months, did you ever seriously think about killing yourself?
During the past 12 months, did you make a plan about how you would kill yourself?
During the past 12 months, did you try to kill yourself?
In the past 12 months, did a suicide attempt result in an injury, poisoning, or overdose that had to be treated by a doctor or nurse? (High School).

Figure 7. Suicide-Related Questions for Middle School Students by Year, 2015, 2017, and 2019.



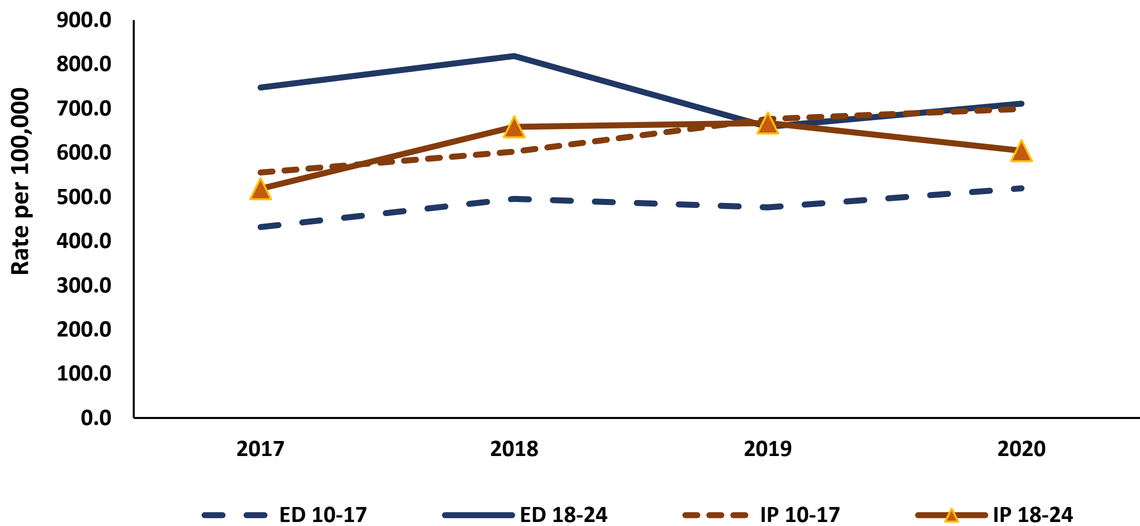
Source: Nevada Youth Risk Behavior Survey (YRBS).

The percentage of high school students feeling sad or depressed is significantly lower in 2017 than in both 2019 and 2015. There are higher female response rates to purposely hurting themselves, feeling sad or depressed, and seriously thinking about killing themselves than males. For all questions related to suicide, there were higher correlations with those who were bullied or electronically bullied, had three or more for ACEs and had low connectedness with family and school. In 2019, there is no significance between ages and race/ethnicity with suicide-related questions in YRBS.

Question response rates remained steady from year to year among middle school students from 2015 to 2019. Females in middle school had a high percentage of responses to questions regarding hurting themselves, feeling sad or hopeless, seriously thinking about killing themselves and planning to kill themselves. Those with three or more ACEs score were significantly more likely to have tried to kill themselves, but those with two or more ACEs score where more likely to think about killing themselves but not go through with it. In 2019, there is no significance between ages and race/ethnicity with suicide-related questions in YRBS in middle school students.

While understanding that YRBS offers insight to the youth in Nevada, the hospital billing data capture events in Nevada, including visits related to suicide ideation and attempted suicides that did not result in death. Suicide ideation describes the thoughts, wishes, and preoccupations with death and suicide, and a suicide attempt is the act of harming oneself to end one's life but does not result in death. There were 1,164 emergency department encounters (ED) and 630 inpatient admissions (IP) where there was a billing code for both suicide ideation and a suicide attempt. These counts will be included in both groupings, and therefore counts are not mutually exclusive.

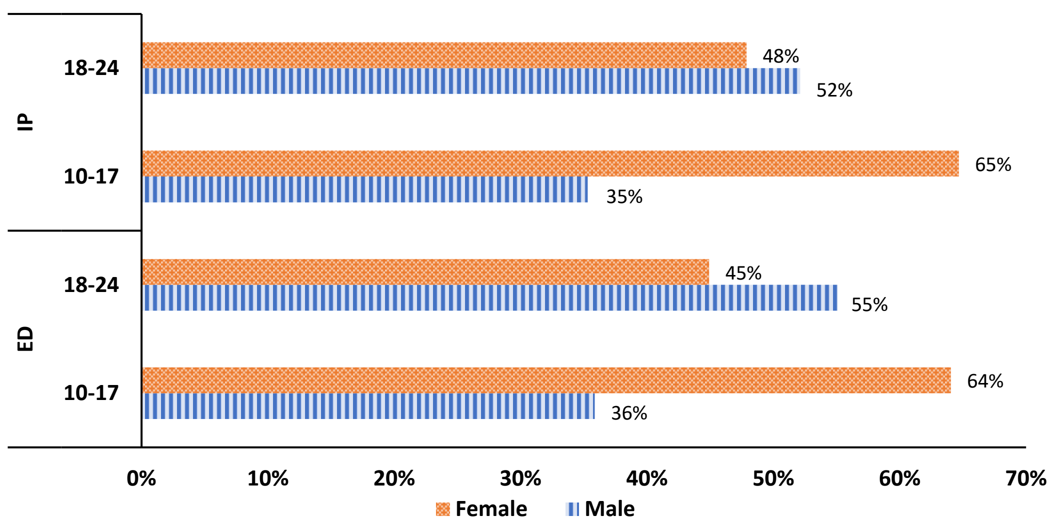
Figure 8. Hospital Encounters with Suicide Ideation, 2017-2020.



Source: Center for Health Information and Analysis (Billing Data).

From 2017-2020, there were 14,949 emergency room visits with a suicide ideation code included in the visit (age 10-24). Among the age group of 10 to 17, there has been a steady increase in suicide ideation from 2017-to 2020, with the highest crude rate of 519.4 per 100,000 (n=1,799) in 2020. There has been a steady decrease from 2017-2020 among the 18-24 age group, with the peak suicide ideation rate in 2018 at 818.6 per 100,000. For inpatient admissions (IP) from 2017-2020, the 10-14 age group suicide ideation rate has increased each year slightly from 555.2 per 100,000 in 2017 to 699.0 per 100,000 in 2020. The 18-24 age group rate increased from 2017-2019 and then declined slightly from 667.2 per 100,000 in 2019 to 604.5 per 100,000 in 2020.

Figure 9. Suicide Ideation Hospital Encounters by Gender, 2017-2020.



Source: Center for Health Information and Analysis (Billing Data).

For the 10-17 age group, 64% of the ED visits for suicide ideation were female, whereas, in the 18-24 age group, there are more male visits than female visits (55% and 45%, respectively). Inpatient admissions

follow a similar pattern to ED visits, where females comprised 65% of the 10-14 age group. There is a proportional ratio of males to females admitted for the 18-24 age group (52% and 48%, respectively).

Figure 10. Suicide Attempts Emergency Department Encounters and Inpatient Admissions by Age Group, 2017-2020.

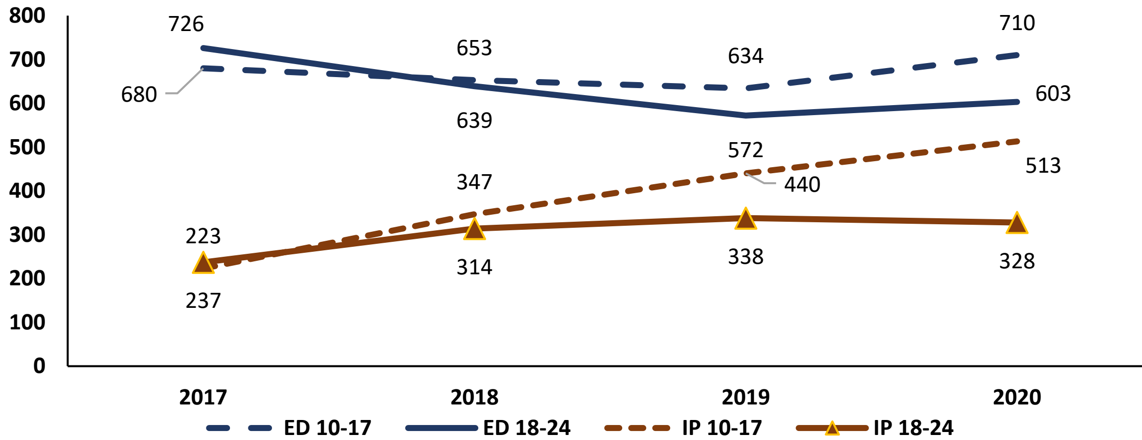


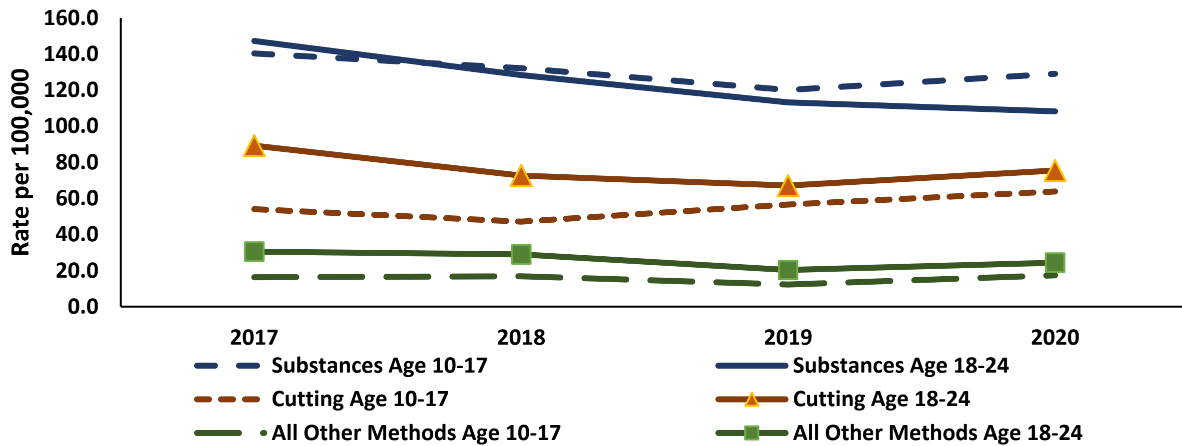
Figure 11. Suicide Attempts Demographics by Age Group, 2017-2020 Combined.

Demographics	Emergency Department Encounters					
	10-17		18-24		Total	
	N	%	N	%	N	%
Total	2,677	100.0%	2,540	100.0%	5,217	100.0%
2017	680	25.4%	726	28.6%	1,406	27.0%
2018	653	24.4%	639	25.2%	1,292	24.8%
2019	634	23.7%	572	22.5%	1,206	23.1%
2020	710	26.5%	603	23.7%	1,313	25.2%
Gender						
Female	2,048	76.5%	1,570	61.8%	3,618	69.4%
Male	628	23.5%	970	38.2%	1,598	30.6%
Unknown	1	0.0%	0	0.0%	2	0.0%
Race/Ethnicity						
White non-Hispanic	1,371	51.2%	1,256	49.4%	2,627	50.4%
Black non-Hispanic	346	12.9%	402	15.8%	748	14.3%
Native American/Alaskan Native non-Hispanic	31	1.2%	34	1.3%	65	1.2%
Asian/Pacific Islander non-Hispanic	107	4.0%	95	3.7%	202	3.9%
Hispanic	480	17.9%	453	17.8%	933	17.9%
Other/Unknown	342	12.8%	300	11.8%	642	12.3%

Source: Center for Health Information and Analysis (Billing Data).

Females make up roughly 70% of emergency department suicide attempts for both age groups, whereas deaths from suicides are more predominately male. Use of substances or overdoses are the most common method of attempted suicide for both age groups and sexes across all years.

Figure 12. Suicide Attempts Emergency Department Encounters by Method, 2017-2020.



Source: Center for Health Information and Analysis (Billing Data).

Figure 13. Suicide Attempts Demographics by Age Group, 2017-2020 Combined.

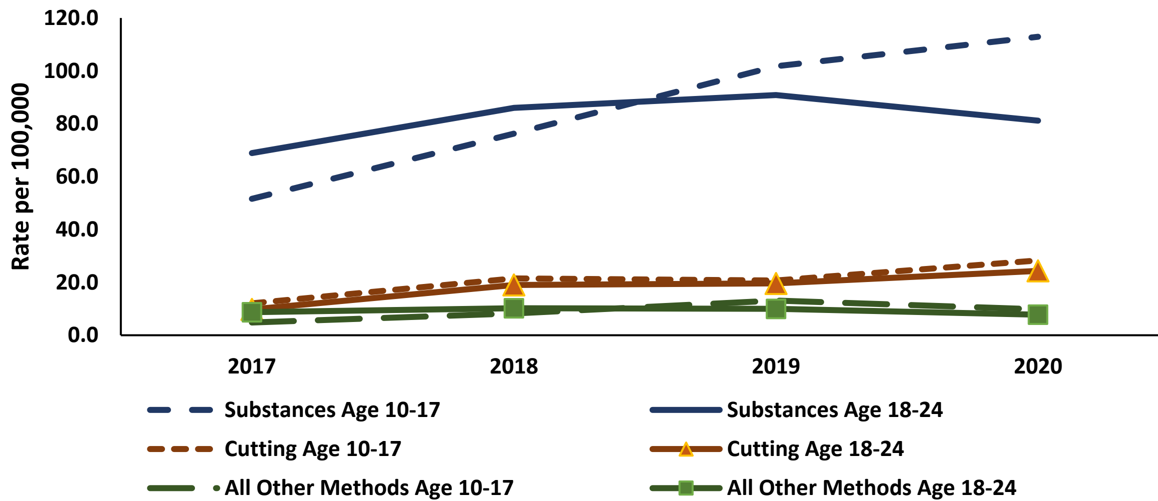
Demographics	Inpatient Admissions 10-17 N	%	18-24 N	%	Total N	%
Total	1,523	100.0%	1,217	100.0%	2,740	100.0%
2017	223	14.6%	237	19.5%	460	16.8%
2018	347	22.8%	314	25.8%	661	24.1%
2019	440	28.9%	338	27.8%	778	28.4%
2020	513	33.7%	328	27.0%	841	30.7%
Gender						
Female	1,181	77.5%	736	60.5%	1,917	70.0%
Male	342	22.5%	479	39.4%	821	30.0%
Unknown	0	0.0%	2	0.2%	2	0.1%
Race/Ethnicity						
White non-Hispanic	678	44.5%	558	45.9%	1,236	45.1%
Black non-Hispanic	114	7.5%	120	9.9%	234	8.5%
Native American/Alaskan Native non-Hispanic	27	1.8%	9	0.7%	36	1.3%
Asian/Pacific Islander non-Hispanic	39	2.6%	40	3.3%	79	2.9%
Hispanic	201	13.2%	157	12.9%	358	13.1%
Other/Unknown	464	30.5%	333	27.4%	797	29.1%

Source: Center for Health Information and Analysis (Billing Data).

Females make up 70% of inpatient admission for suicide attempts for both age groups, whereas deaths from suicides are more predominately male. Use of substances or overdoses are the most common

method of attempted suicide for both age groups across all years but have risen significantly from 2017 to 2020 for the 10-17 age group.

Figure 14. Suicide Attempts Inpatient Admissions by Method, 2017-2020.



Source: Center for Health Information and Analysis (Billing Data).

Both suicide ideation and suicide attempt from the emergency departments and inpatient admissions data matched all the deaths from 2017-2020 of youth and young adults (ages 10-24). There were 1,310 total deaths (all causes), and 108 (8.2%) people presented in the hospital with suicide ideation or a suicide attempt before their death. Of those 108 people, 52 (18.3%) died by suicide. The 108 people accounted for 265 hospital encounters for suicide ideation and suicide attempts.

There were 23 non-transport accidents; 22 were from a drug overdose.

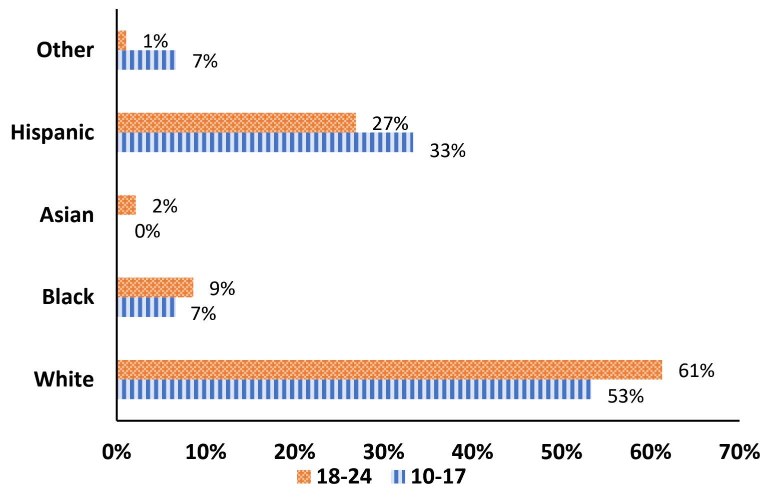
On average, death occurred 301 days after the last hospital encounter, and most persons had two visits before their death. The maximum number of visits was 51, though it should be stated that this death was not due to suicide but was a homicide.

Figure 15. Hospital Encounters Where Death Occurred, Cause of Death, 2017-2020 combined.

Leading Cause of Death	Ages 10-17	Ages 18-24
Intentional self-harm (suicide)	46.7%	50.5%
Non-Transport accidents	13.3%	22.5%
Assault (homicide)	13.3%	6.5%
Transport accidents	13.3%	4.3%
Malignant neoplasms	6.7%	2.2%
All other diseases (residual)	6.7%	14.0%
Total	100.0%	100.0%

Source: Center for Health Information and Analysis (Billing Data) and Nevada Electronic Death Registry.

Figure 16. Hospital Encounters Where Death Occurred, Race/Ethnicity, 2017-2020.



Source: Center for Health Information and Analysis (Billing Data) and Nevada Electronic Death Registry.

Figure 17. Hospital Encounter where Death Occurred After by Payer Source, 2017-2020 combined.

Primary Payer Source	Suicide Attempts		Suicide Ideation	
	ED	IP	ED	IP
CHAMPUS OR CHAMPVA	0.0%	0.0%	14.7%	14.7%
Commercial Insurer	4.7%	5.4%	4.9%	4.9%
County Indigent Referral	0.0%	0.0%	0.0%	0.0%
HMO	14.0%	24.3%	6.9%	6.9%
Miscellaneous	0.0%	0.0%	1.0%	1.0%
Negotiated Discounts (PPO)	16.3%	29.7%	10.8%	10.8%
Nevada Medicaid	14.0%	10.8%	13.7%	13.7%
Nevada Medicaid HMO	46.5%	24.3%	44.1%	44.1%
Other Medicaid	0.0%	2.7%	3.9%	3.9%
Self-Pay	4.7%	2.7%	0.0%	0.0%
Total	100.0%	100.0%	100.0%	100.0%

Source: Center for Health Information and Analysis (Billing Data).

For emergency department visits related to suicide attempts and for both emergency department visits and inpatient admission related to suicide ideation, Nevada Medicaid HMO is listed as the payer source for nearly 45% of the 265 encounters.

Deaths by suicide from 2017-2020 for persons 18 years and younger were matched with Nevada's Division of Child and Family Services (DCFS) statewide child welfare information system, UNITY, to see if there were any events where child welfare agencies were involved with the child or family at any point before the deaths by suicide. Child or family involvement with Child Protective Services (CPS) and Foster Care Services were explored. The matches are displayed in Figure 18.

There were 115 children with death by suicide matched to UNITY data. There were 42 children involved with child welfare agencies via Child Protective Services for at least one incident of alleged child abuse or neglect associated with their families. 10 children were substantiated victims of child abuse or neglect

for at least one allegation on one report; there were three children with confirmed repeat substantiated maltreatment during their lives. Eight children with CPS involvement had at least one foster care episode resulting from that child welfare involvement. Additionally, two of the deaths by suicide occurred while the children were in foster care.

Figure 18. Child Welfare Involvement before Death from Suicide.

Reporting Measure	N	%
Child Protective Services (CPS)		
Participants on at least one screened-in report[1]	42	36.5%
Alleged victims on at least one screened-in report[2]	37	32.2%
Substantiated victims who had at least one substantiated allegation of abuse or neglect[3]	10	8.7%
Repeat victims with substantiated repeat maltreatment[4]	3	2.6%
Foster Care		
Number of children who had at least one foster care episode resulting from CPS involvement[5]	8	7.0%
Number of children who died while still in foster care[6]	2	1.7%

Source: DCFS UNITY database.

[1]Screened-in reports: a subset of total CPS reports received by child welfare agencies that agency personnel will respond to and attempt to make face-to-face contact with the children and families to assess child safety and family functioning. Screened-in reports may have a final report disposition of Investigation, Institutional Investigation, Agency Assessment, or Differential Response.

[2]This count indicates children who are alleged victims and associated with at least one allegation of abuse or neglect inflicted upon them by at least one alleged perpetrator; children can be associated with multiple allegations/perpetrators per report or maybe alleged victims on multiple screened-in reports. The count indicates alleged victims associated with allegations regardless of the finding (such as substantiation or un-substantiation).

[3]Children who are confirmed, or substantiated, victims of abuse or neglect inflicted upon them by at least one confirmed perpetrator; children can be associated with multiple substantiated allegations and perpetrators per report or maybe substantiated victims on multiple reports.

[4]Children who are confirmed to be substantiated victims of abuse or neglect inflicted upon them by at least one confirmed perpetrator on multiple screened-in reports. This is the count of children in the suicide population who had more than one separate incident of confirmed abuse or neglect.

[5]Children who were removed from their caregiver(s) and placed in foster care at least once but possibly more than once due to CPS involvement.

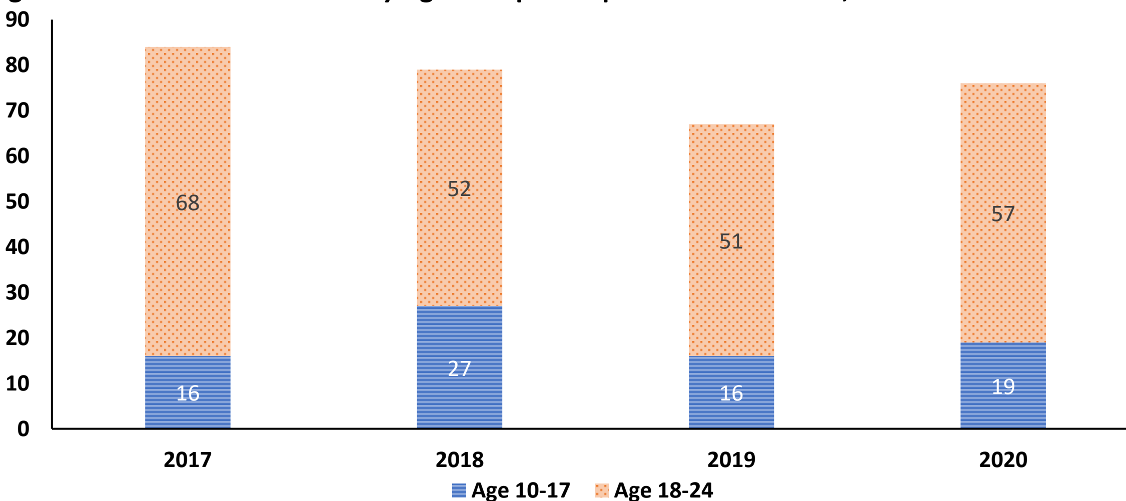
[6]Children whose foster care episode end reason was 'Death of Child."

Circumstances Among Deaths by Suicide

In 2017, the Office of Public Health Investigations and Epidemiology (OPHIE) received a grant to support the National Violent Death Reporting System (NVDRS). Information relating to violent deaths, including all homicides and suicides that occur in Nevada, is collected from the vital records data (death certificates), the medical examiners, and law enforcement. Due to the type of data entered, there is a reporting delay which is why this report only contains data from 2017-to 2020. The data from 2020 is preliminary and subject to changes. These data provide a complete picture of the deaths, including relationship problems, mental health, treatment, toxicology results, life stressors, and demographics such as sexual orientation and gender identity.

There were 306 violent deaths from suicide in the NVDRS data from 2017-2020 for persons aged 10 to 24, whereas the state death certificates have 305 deaths. It is important to note that the NVDRS data and the state vital records data are not the same. A death could be ruled an accident or listed as undetermined in one system and ruled a suicide or assault in the other. Accidents are not reported in the NVDRS. This means the numbers are not mutually exclusive. The NVDRS data is de-identified, and therefore it is unknown if the 305 deaths in the state vital records data are the same cases in the NVDRS data.

Figure 19. Deaths from Suicide by Age Group as Reported from NVDRS, 2017-2020.



Source: National Violent Death Reporting System (Nevada Data).

On average, there are 20 deaths by suicide among ages 10-17 and 57 deaths among ages 18-24 each year. The year with the highest combined deaths was 2017, with 84 deaths, and 2019 had the lowest count with 67 deaths. Over the four years, there were four deaths from suicide where the person was transgender. Within the four years, there were 12 cases where the individual was listed as gay/lesbian or bisexual. Seven individuals had documented time in a psychiatric hospital (2.6% in the 10-17 age group and 2.2% in the 18-24 age group).

Figure 20. Deaths from Suicide by Reporting Measure as Reported from NVDRS, 2017-2020.

Reporting Measure	10-17	18-24
Victim was perceived by self or others to be depressed at the time of the injury	23	84
Victim had been identified as currently having a mental health problem	23	73
History of ever being treated for a mental health or substance abuse problem	23	57
Victim had a history of attempting suicide before the fatal incident	13	64
Victim disclosed to another person their thoughts and/or plans to commit suicide within the last month (2017-2019)	17	56
Victim had a non-alcohol-related substance abuse problem	11	52
Alcohol Use	2	42
Victim had alcohol dependence or alcohol problem	2	37
Victim had relationship problems with a family member (other than an intimate partner) that appear to have contributed to the death	19	19
Problems at or related to school appear to have contributed to the death	22	6
Victim had a history of abuse (physical, mental or emotional) or neglect (physical or emotional) as a child	5	12
Substance abuse in child victim's household	1	0

Source: National Violent Death Reporting System (Nevada Data).

Figure 20 displays different reporting metrics, including where alcohol was found in toxicology. This comprises two persons in the 10-17 age group (2.6%) and 42 in the 18-24 age group (18.4%). Both youth and young adults have the highest counts of perceived depression and are identified as having a mental health problem. Of the youth, 29.5% and 36.8% had perceived to be depressed at the time of the injury. Similarly, 29.5% of the youth had a perceived mental health problem and 32.0% of the young adults. For the youth, there was a higher count of problems related to school than the young adults (n=22 and n=6 respectively).

While it was not collected in 2020, 17 youth and 56 young adults had expressed thought of their plans to commit suicide within the last month, (24.4% and 24.6% respectively). While it is important to note that roughly 24% of the NVDRS reported suicides, the deceased did disclose their plans to commit suicide, and there is no data for those where a person did disclose their plans and did complete death by suicide.

Conclusion

In Nevada, suicides in youth and young adults are a growing concern. Deaths by suicide are the leading cause of death in Nevada for ages 10-17 and is completely preventable. Males are more likely to complete death by suicide than females, possibly indicating a need to target outreach to males. Females tend to attempt suicide more than completed suicides. Youths who have experienced negative life experiences can be more prone to suicidal thoughts and even suicide attempts. Increasing prevention measures and awareness may help lower suicide rates in Nevada.

For more information on suicide prevention, the Office of Suicide Prevention has materials available for parents and youth.

Resources

Suicide Prevention Lifeline:

1-800-273-TALK (8255)
www.suicidepreventionlifeline.org

Children's Mobile Crisis Response Team:

(702) 486-7865 (Southern and Rural NV)
(775) 688-1670 (Northern NV)

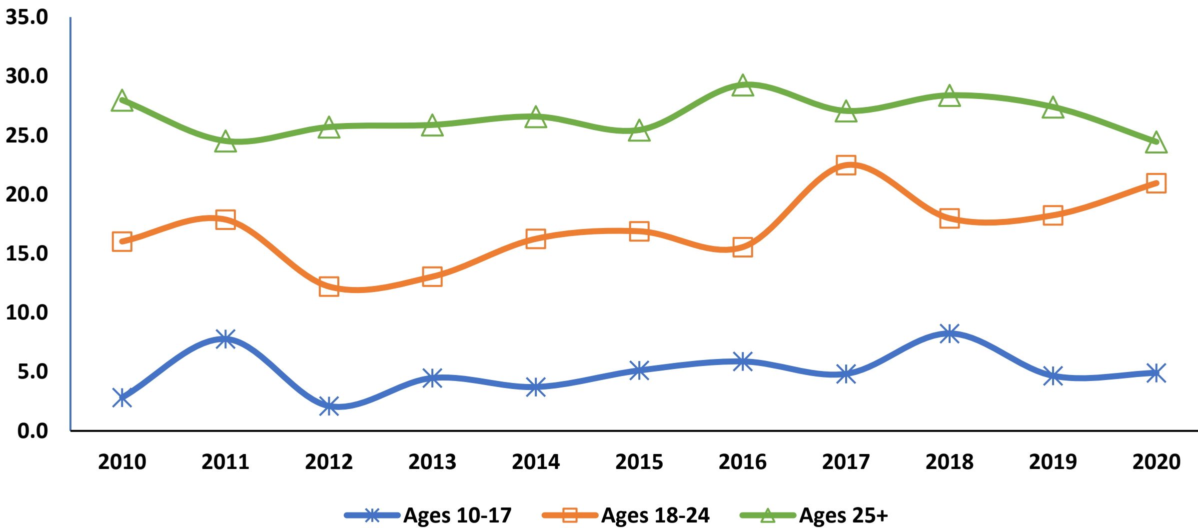
Addition Data Resources

DHHS Nevada Suicide Data Dashboard

Veteran Suicide Report - November 2021 (nv.gov)

Appendix

Figure 21. Deaths by Suicide Crude Rates by Age Group, 2010-2020.



Source: Nevada Electronic Death Registry and Nevada State Demographer (2020).

Figure 22a. Deaths by Suicide Crude Rates (per 100,000) by Age Group and Region, 2010-2020.

Region	10-17	18-24	25+	Total
2010				
Clark	3.4 (0.9-6.0)	13.8 (8.4-19.2)	26.5 (23.7-29.3)	43.7 (33.0-54.5)
Northern	5.3 (0.0-15.6)	23.6 (0.5-46.7)	26.0 (17.2-34.9)	54.9 (12.6-97.3)
Rural	-	16.4 (0.0-39.1)	33.0 (17.8-48.3)	49.4 (11.4-87.4)
Southern	-	48.2 (0.0-115.0)	48.0 (26.4-69.6)	96.2 (7.8-184.5)
Washoe	-	19.2 (5.9-32.4)	31.3 (24.7-38.0)	50.5 (30.6-70.4)
Total	8.7 (0.0-21.6)	121.2 (0.0-252.5)	164.9 (109.7-220.0)	294.7 (95.4-494.1)
2011				
Clark	7.3 (3.6-11.1)	13.8 (8.4-19.2)	22.1 (19.5-24.6)	43.2 (31.5-54.9)
Northern	5.3 (0.0-15.6)	6.0 (0.0-17.8)	34.3 (24.2-44.5)	45.6 (13.4-77.8)
Rural	17.5 (0.0-41.8)	45.2 (9.0-81.3)	41.3 (24.4-58.2)	104.0 (26.7-181.3)
Southern	-	-	47.8 (26.3-69.3)	47.8 (26.3-69.3)
Washoe	9.3 (0.2-18.4)	33.7 (16.0-51.3)	24.4 (18.6-30.2)	67.4 (34.8-99.9)
Total	39.4 (0.0-86.8)	98.6 (27.7-169.6)	169.9 (113.0-226.8)	308.0 (132.7-483.2)

Source: Nevada Electronic Death Registry and Nevada State Demographer (2020).

Figure 22b. Deaths by Suicide Crude Rates (per 100,000) by Age Group and Region, 2010-2020.

Region	10-17	18-24	25+	Total
2012				
Clark	1.9 (0.0-3.8)	12.0 (7.0-17.0)	25.1 (22.4-27.9)	39.1 (29.4-48.7)
Northern	-	11.8 (0.0-28.1)	24.2 (15.7-32.7)	36.0 (11.2-60.8)
Rural	-	20.8 (0.0-44.3)	31.2 (16.8-45.6)	52.0 (14.1-90.0)
Southern	-	-	45.9 (24.7-67.1)	45.9 (24.7-67.1)
Washoe	4.6 (0.0-10.9)	11.9 (1.5-22.4)	25.1 (19.2-30.9)	41.5 (18.9-64.1)
Total	6.5 (0.0-14.7)	56.4 (1.2-111.7)	151.5 (98.8-204.2)	214.5 (98.3-330.6)
2013				
Clark	2.8 (0.6-5.1)	10.0 (5.5-14.6)	23.7 (21.1-26.3)	36.6 (27.2-46.0)
Northern	-	5.9 (0.0-17.5)	40.5 (29.5-51.6)	46.5 (23.8-69.1)
Rural	19.3 (0.0-46.2)	6.6 (0.0-19.5)	27.1 (13.8-40.4)	53.1 (0.0-106.1)
Southern	19.6 (0.0-57.9)	99.6 (12.3-186.8)	30.3 (13.1-47.4)	149.4 (6.7-292.1)
Washoe	8.9 (0.2-17.7)	21.4 (7.4-35.4)	28.5 (22.3-34.7)	58.9 (30.0-87.8)
Total	50.7 (0.0-126.9)	143.5 (13.2-273.8)	150.2 (100.0-200.4)	344.4 (87.7-601.1)
2014				
Clark	3.2 (0.8-5.6)	15.0 (9.6-20.5)	23.5 (21.0-26.1)	41.8 (31.4-52.2)
Northern	-	24.8 (0.5-49.1)	45.0 (33.4-56.6)	69.8 (33.9-105.7)
Rural	10.5 (0.0-31.2)	20.4 (0.0-43.5)	28.5 (14.9-42.0)	59.4 (2.1-116.7)
Southern	19.8 (0.0-58.7)	39.6 (0.0-94.4)	52.1 (29.8-74.3)	111.5 (0.0-227.4)
Washoe	4.4 (0.0-10.4)	14.3 (2.9-25.7)	28.8 (22.7-35.0)	47.5 (23.8-71.1)
Total	38.0 (0.0-106.0)	114.0 (0.0-233.1)	177.9 (121.8-234.1)	330.0 (86.8-573.2)
2015				
Clark	3.9 (1.3-6.4)	17.9 (11.9-23.8)	23.3 (20.7-25.8)	45.0 (34.0-55.9)
Northern	10.9 (0.0-26.1)	19.0 (0.0-40.5)	25.4 (16.7-34.0)	55.3 (10.0-100.6)
Rural	11.1 (0.0-32.7)	22.6 (0.0-48.2)	39.1 (23.4-54.7)	72.7 (9.8-135.6)
Southern	-	19.7 (0.0-58.3)	38.8 (19.8-57.8)	58.5 (0.9-116.1)
Washoe	8.6 (0.2-17.0)	9.5 (0.2-18.7)	31.1 (24.8-37.5)	49.2 (25.1-73.2)
Total	34.4 (0.0-82.1)	88.6 (0.0-189.5)	157.6 (105.5-209.8)	280.7 (79.9-481.5)
2016				
Clark	4.9 (2.1-7.7)	15.5 (10.0-20.9)	25.7 (23.1-28.3)	46.1 (35.3-57.0)
Northern	-	6.6 (0.0-19.6)	38.5 (27.9-49.0)	45.1 (21.5-68.6)
Rural	23.2 (0.0-55.3)	54.0 (14.0-94.0)	40.0 (24.3-55.7)	117.2 (29.4-205.0)
Southern	40.0 (0.0-95.4)	19.6 (0.0-57.9)	34.0 (16.2-51.8)	93.6 (0.0-205.1)
Washoe	6.2 (0.0-13.3)	6.9 (0.0-14.8)	39.3 (32.2-46.4)	52.5 (30.5-74.5)
Total	74.3 (0.0-171.7)	102.6 (0.0-207.2)	177.5 (123.7-231.3)	354.5 (98.7-610.3)

Source: Nevada Electronic Death Registry and Nevada State Demographer (2020).

Figure 20c. Deaths by Suicide Crude Rates (per 100,000) by Age Group and Region, 2010-2020.

Region	10-17	18-24	25+	Total
2017				
Clark	4.4 (1.8-7.0)	20.8 (14.5-27.1)	25.7 (23.1-28.3)	50.9 (39.4-62.4)
Northern	5.3 (0.0-15.6)	27.1 (0.5-53.7)	39.4 (28.8-50.0)	71.8 (24.3-119.3)
Rural	-	9.2 (0.0-27.1)	29.6 (16.3-42.9)	38.8 (7.5-70.0)
Southern	19.6 (0.0-58.1)	20.1 (0.0-59.6)	35.6 (17.6-53.7)	75.4 (0.0-171.4)
Washoe	6.1 (0.0-13.0)	30.0 (13.7-46.3)	25.7 (20.0-31.4)	61.8 (32.9-90.7)
Total	35.4 (0.0-93.7)	107.2 (0.6-213.8)	156.1 (105.8-206.3)	298.7 (83.5-513.9)
2018				
Clark	7.8 (4.4-11.2)	19.2 (13.2-25.1)	26.8 (24.1-29.4)	53.7 (41.7-65.7)
Northern	5.3 (0.0-15.8)	13.5 (0.0-32.2)	36.4 (26.3-46.5)	55.2 (16.0-94.5)
Rural	22.4 (0.0-53.5)	27.6 (0.0-58.9)	35.2 (20.8-49.6)	85.3 (8.5-162.0)
Southern	57.4 (0.0-122.4)	-	45.8 (25.7-65.9)	103.2 (18.2-188.3)
Washoe	4.0 (0.0-9.5)	13.5 (2.7-24.2)	25.9 (20.2-31.6)	43.3 (21.4-65.3)
Total	96.9 (0.0-212.4)	73.8 (7.1-140.5)	170.1 (117.2-222.9)	340.8 (105.8-575.8)
2019				
Clark	3.9 (1.5-6.2)	14.9 (9.8-20.1)	24.6 (22.1-27.1)	43.4 (33.3-53.4)
Northern	5.4 (0.0-15.9)	27.6 (0.6-54.7)	38.8 (28.5-49.2)	71.8 (23.8-119.8)
Rural	-	64.6 (16.7-112.4)	37.5 (22.8-52.2)	102.0 (39.5-164.6)
Southern	-	-	45.0 (25.3-64.7)	45.0 (25.3-64.7)
Washoe	9.9 (1.2-18.5)	21.5 (8.2-34.9)	31.1 (24.9-37.2)	62.5 (34.3-90.6)
Total	19.1 (0.0-40.7)	128.7 (35.2-222.1)	176.9 (123.5-230.4)	324.7 (156.3-493.1)
2020				
Clark	5.3 (2.5-8.1)	18.2 (12.6-23.9)	21.5 (19.2-23.8)	45.1 (34.3-55.8)
Northern	-	34.3 (4.2-64.4)	41.2 (30.6-51.7)	75.5 (34.8-116.1)
Rural	10.5 (0.0-31.2)	75.3 (19.5-131.1)	26.8 (14.4-39.2)	112.7 (23.8-201.5)
Southern	18.6 (0.0-55.2)	-	48.5 (28.2-68.7)	67.1 (10.3-123.9)
Washoe	2.0 (0.0-5.9)	20.9 (8.0-33.9)	26.6 (20.9-32.2)	49.5 (27.0-72.0)
Total	36.5 (0.0-100.4)	148.7 (44.3-253.2)	164.5 (113.3-215.7)	349.8 (130.2-569.3)

Source: Nevada Electronic Death Registry and Nevada State Demographer (2020).