Substance Abuse Prevention and Treatment Agency 2019 Epidemiologic Profile

Rural Nevada Behavioral Health Region: Elko, Eureka, Humboldt, Lander, Pershing, and White Pine Counties

November 2019

Office of Analytics on behalf of

Nevada Department of Health and Human Services

DIVISION OF PUBLIC AND BEHAVIORAL HEALTH

Steve Sisolak
Governor
State of Nevada

Richard Whitley, MS
Director
Department of Health and Human Services

Lisa Sherych
Administrator
Division of Public and Behavioral Health

Ihsan Azzam Ph.D., M.D.
Chief Medical Officer
Division of Public and Behavioral Health

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Acknowledgements

Prepared by and Additional Information:
Office of Analytics
Nevada Department of Health and Human Services
State of Nevada
4126 Technology Way, Suite 201
Carson City, Nevada 89706
Email: data@dhhs.nv.gov
Website: Office of Analytics

Thank you to following for providing leadership, data and technical support for this report:

Lily Gu, MS
Biostatistician II

Jen Thompson
Health Program Specialist II

Amy Lucas, MS
Health Resource Analyst II

Andrea R. Rivers
Health Program Manager II

Sandra Atkinson
Health Resource Analyst II

Taylor Lensch, PhD(c), MPH
YRBS Coordinator, UNR

Craig Osborne
Biostatistician II

Jillian Mackie
Biostatistician II

Sneha Ravikumar, MSc., M. Phil
Health Program Specialist

Kyra Morgan, MS
Chief Biostatistician

Multidisciplinary Prevention Advisory Committee

Statewide Epidemiologic Workgroup

University of Nevada, Reno School of Community Health Sciences, Nevada Youth Risk Behavior Survey

Data Sources/Limitations

Age-Adjusted Rates
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. 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). 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.

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 350,000 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 individual 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.

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

Hospital Billing Data (Emergency Department Encounter and Inpatient Admissions)
The hospital billing data provides health billing data for emergency department encounters and inpatient admissions for Nevada's non-federal hospitals. NRS 449.485 mandates all hospitals in Nevada 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 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. ICD-10-CM diagnoses codes replaced ICD-9-CM diagnoses codes in the last quarter of 2015. Therefore, data prior to last quarter in 2015 may not be directly comparable to data thereafter. In addition, the data includes billed hospital charges, procedure codes, discharge status, and external cause of injury codes. The billing information is for billed charges and not the actual payment received by the hospital.

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 website has three categories: "school and district information," "assessment and accountability" and "fiscal and technology."

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.

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 of Nevada. These data are representative of 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. For more information on the survey: SAMHSA.

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.

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 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 level. The YRBS is a biennial, anonymous, and voluntary survey of students in 9th through 12th grade in traditional, public high schools that monitors 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, other 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.

Executive Summary

Purpose

This report is intended to provide an overview of behavioral health in the rural region of Nevada. This includes the counties of Elko, Eureka, Humboldt, Lander, Pershing, and White Pine. The analysis can be used to identify issues of concern and areas that may need to be addressed.

Key Findings

Mental Health

- Females were significantly more likely to report having been diagnosed with a depressive disorder than males.
- In 2018, Rural Nevada females utilized the state-funded mental health clinics at 1,692.3 per 100,000 female population, compared to Rural Nevada males at 967.6 per 100,000 male population.
- Emergency department encounters related to anxiety increased significantly from 2010 to 2018 both in counts and rates.
- Emergency department encounters related to depression also increased significantly from 2010 to 2018 from 420 (465.6 per 100,000 Rural Nevada residents) to 2,310 (2,408.3 per 100,000 Rural Nevada residents).
- From 2010 to 2018, inpatient admissions related to depression increased significantly from 379 (420.1 per 100,000 Rural Nevada residents) to 614 (640.1 per 100,000 Rural Nevada residents).
- For both emergency department encounters and inpatient admissions, the most common method for attempted suicides was a substance or drug overdose attempt.
- In 2018, the age-adjusted mental health-related death rate for the Hispanic population (6.3 deaths per 100,000 population) was significantly lower than the Nevada overall rate (39.4 deaths per 100,000 population).

Substance Use

- There was a significant decrease in current use of e-vapor products in Rural Nevada high school students from 2015 (32.9%) to 2017 (20.4%). Among middle school students in Rural Nevada, there was also a significant decrease in current use of e-vapor products from 17.4% (2015) to 7.7% (2017).
- The use of synthetic marijuana in middle school students significantly declined from 2015 (6.8%) to 2017 (2.3%) based on 95% confidence intervals.
- Reported marijuana use significantly increased from 2014 (2.2%) to 2018 (11.6%).
- In 2018, Rural Nevada males (34.1%) were significantly more likely to report binge drinking compared to females (10.6%).
- Rural Nevada adults (25.5%) were significantly more likely to report being current tobacco smokers compared to all Nevada adults statewide (15.7%).

- The age-adjusted rate for alcohol and/or drug-related deaths in Rural Nevada has increased from 35.0 deaths per 100,000 population in 2016 to 51.5 deaths per 100,000 population in 2018.

Demographic Snapshot

Figure 1. Selected Demographics for Rural Nevada.

Population, 2018 estimate*	95,919
Population, 2010 estimate*	90,213
Population, percentage change*	6.3%
Male persons, 2018 estimate*	50,536 (52.7%)
Female Persons, 2018 estimate*	45,383 (47.3%)
Median household income (2017), 2013-2017**	$67,532
Per capita income in the past 12 months (2017), 2013-2017**	$28,688
Persons in poverty, percent (2017) **	12.2%
With a disability, under the age 65 years, percent, 2013-2017**	9.7%
Land area (square miles), 2017**	51,389

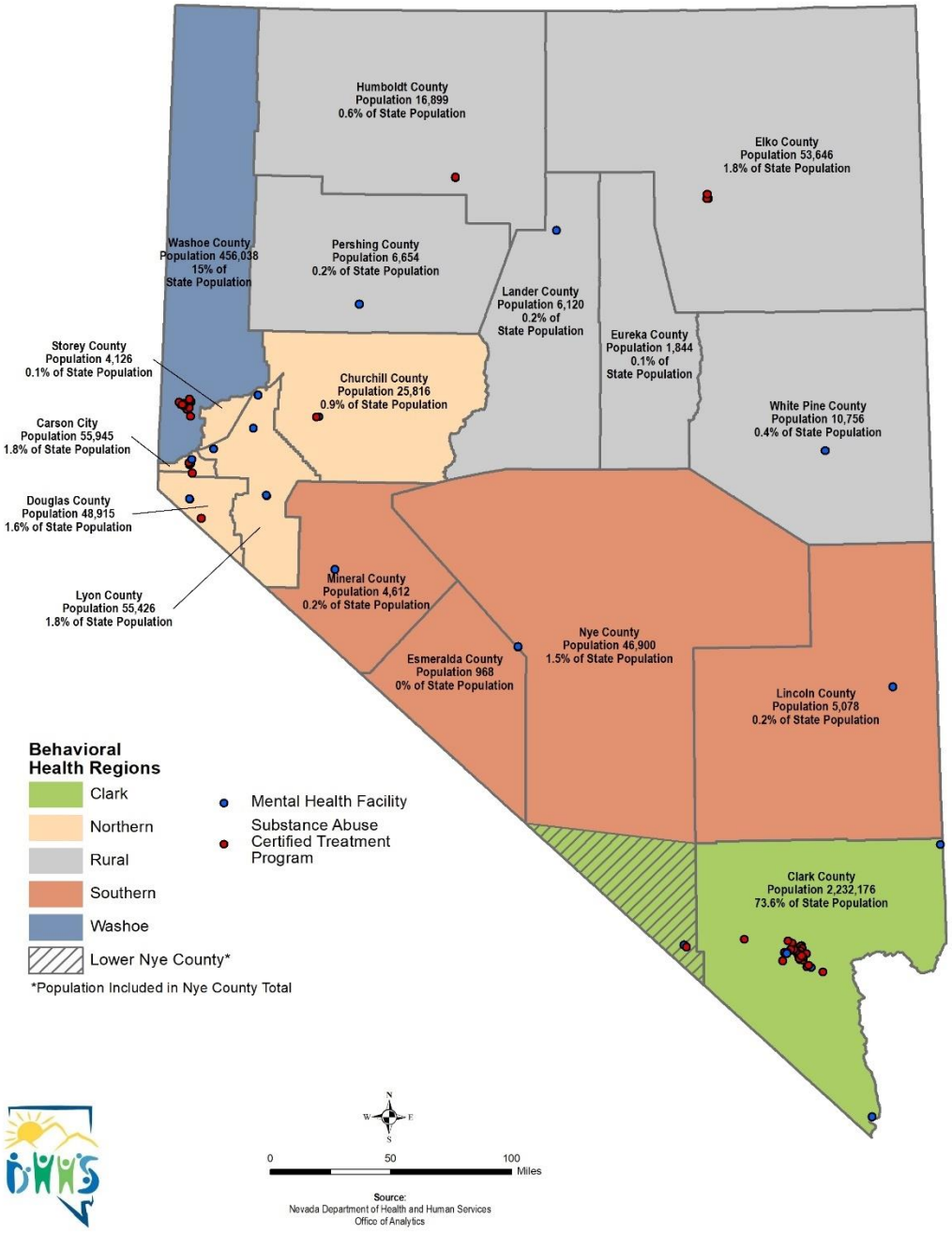
*Source: *Nevada State Demographer, Vintage 2018 and **US Census Bureau.*

In 2018, the estimated population for Rural Nevada was 95,919, a 6.3% increase from the 2010 estimated population. The population is made up of approximately 47.3% females and 52.7% males. The median household income is $67,532. The land area in Rural Nevada is approximately 51,389 square miles.

Elko County (53,646 estimated residents) holds 1.8% of Nevada's population and is the largest county in the Rural Nevada region. Eureka County is the least populated county in the Rural Nevada region, with an estimated population of 1,844 (0.1% of Nevada's population).

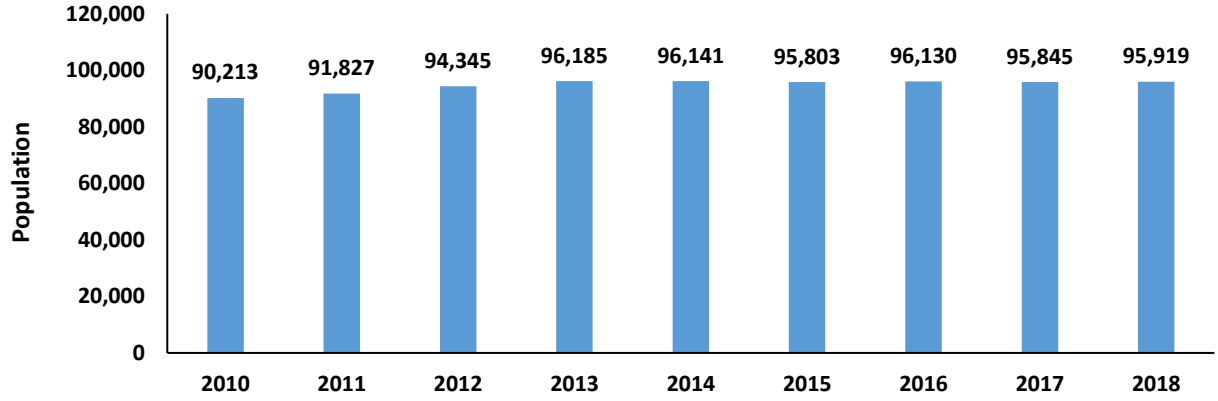
During the 2017 session, regional behavioral health boards were formed to address behavioral health in Nevada. The regions were redrawn during the 2019 session and Nye County was split into regions. Mineral County was moved from the Northern region to the Southern region.

Figure 2. Nevada Population Distribution by County and Behavioral Health Region, 2018.



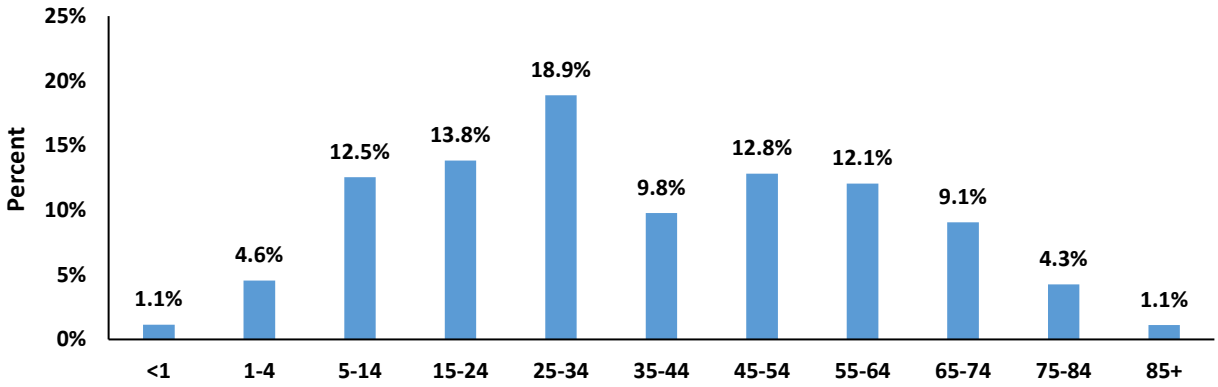
Source: Nevada State Demographer, Vintage 2018;
***Clark Region**: Clark County and southern Nye County*
***Northern Nevada Region:** Carson City, Churchill, Douglas, Lyon, and Storey Counties.*
***Rural Nevada Region:** Elko, Eureka, Humboldt, Lander, Pershing, and White Pine Counties.*
***Southern Nevada Region:** Esmeralda, Lincoln, and northern Nye Counties.*
***Washoe Region**: Washoe County.*
**Nye County: North Nye County is included in Southern Region and southern Nye County is in part of Clark County Region. For data purposes, Nye county data is included in Southern Nevada Region Report and not in the Clark County Region report.*

Figure 3. Rural Nevada Population, 2010-2018.



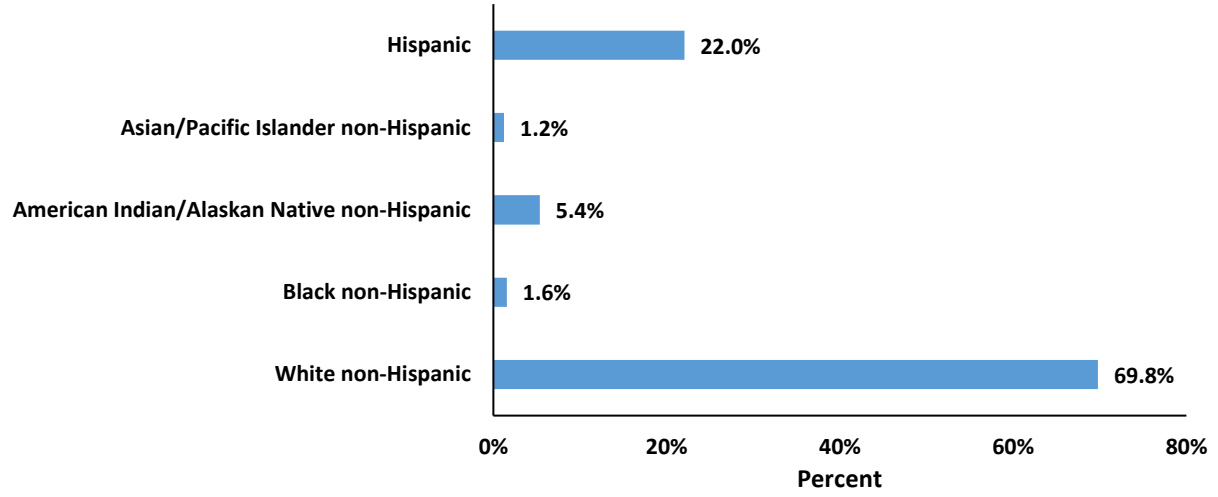
Source: Nevada State Demographer, Vintage 2018.

Figure 4. Rural Nevada Population by Age Group, 2018.



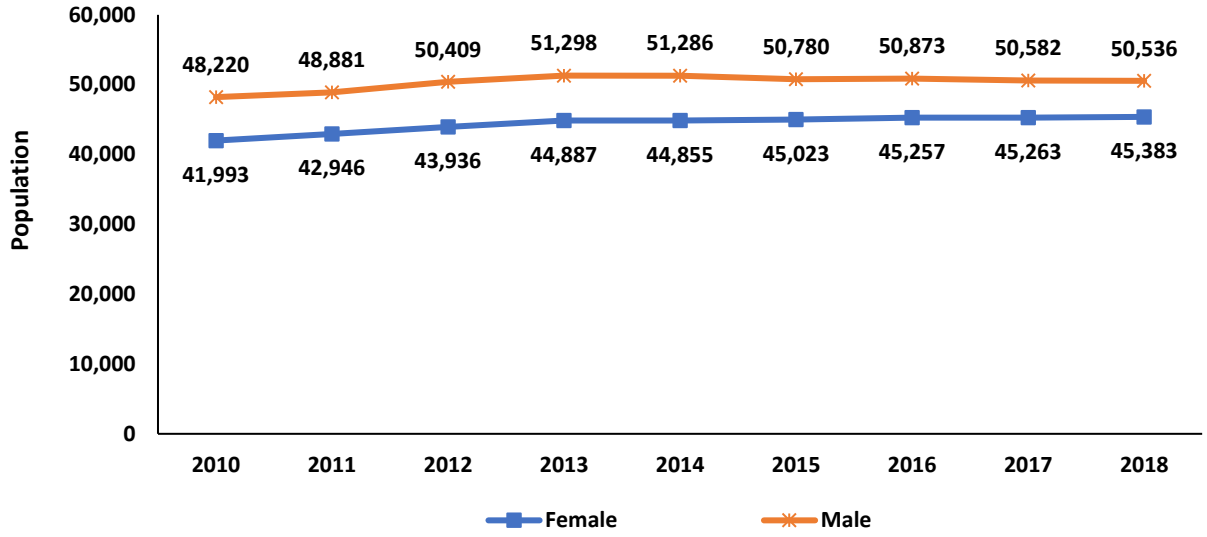
Source: Nevada State Demographer, Vintage 2018.
Chart scaled to 25% to display differences among groups.

Figure 5. Rural Nevada Population by Race/Ethnicity, 2018.



Source: Nevada State Demographer, Vintage 2018.
Chart scaled to 80% to display differences among groups.

Figure 6. Rural Nevada Population Distribution by Sex, 2010-2018.



Source: Nevada State Demographer, Vintage 2018.

In 2018, the estimated population for Rural Nevada was 95,919, a 6.3% increase from the 2010 estimated population. The population is made up of approximately 47.3% females and 52.7% males.

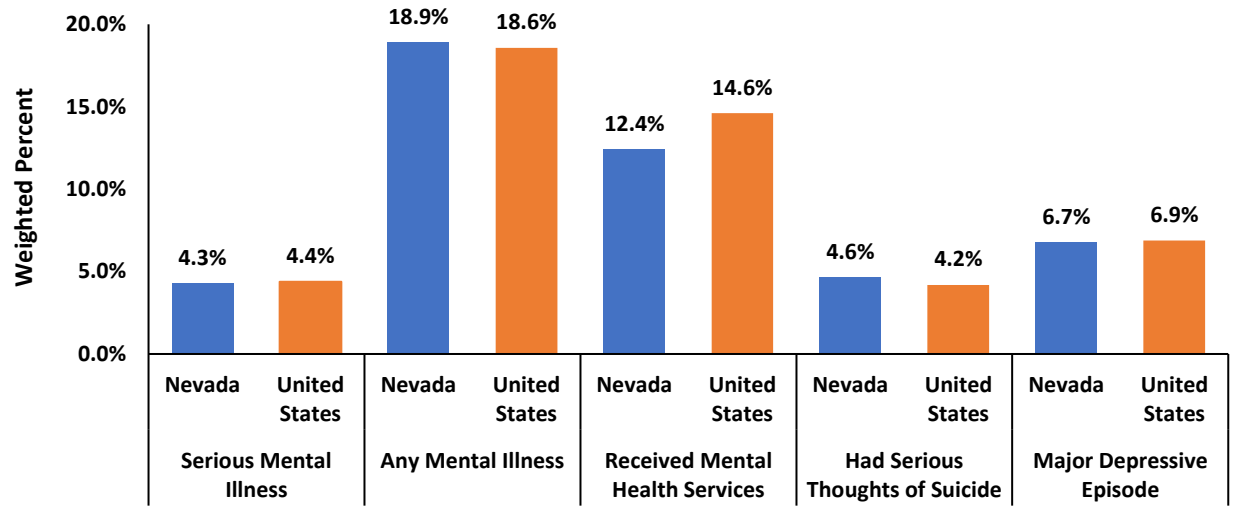
Mental Health

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.

Figure 7. Prevalence of Mental Health Measures, Nevada and United States, 2016-2017.



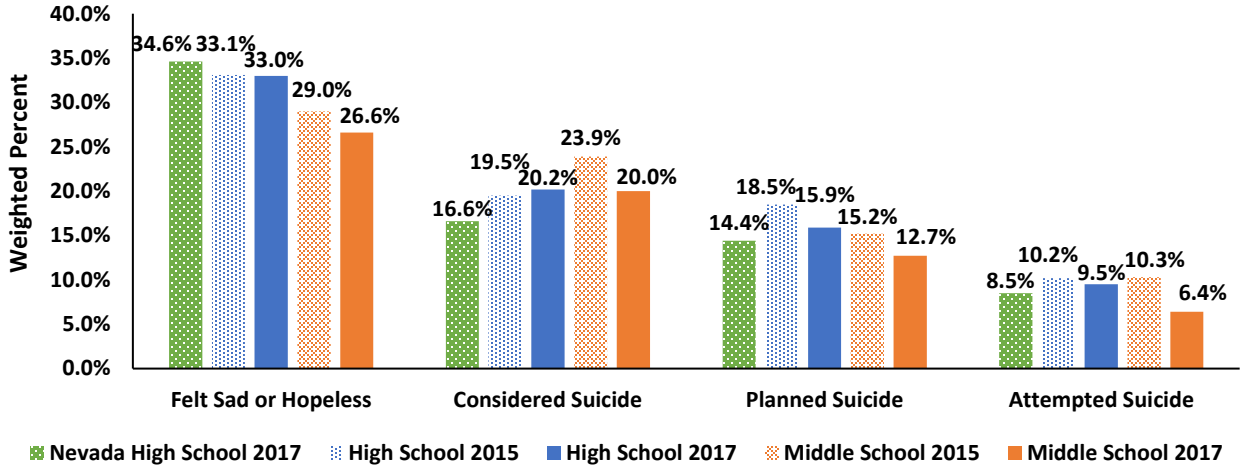
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2016-2017.
Chart scaled to 20% to display differences among groups.

Nevada has remained within a percent of the nation for most mental health issues. Nevada was slightly higher than the national measure with "any mental illness" and "having had serious thoughts of suicide," in Nevada 18.9% and 4.6% respectively and nationally, 18.6% and 4.2%.

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 years. In 2017, 710 high school and 584 middle school students in Rural Nevada participated in the YRBS. The University of Nevada, Reno maintains the YRBS data and publishes data on each survey. For more information on the YRBS survey, please go to the following site: UNR YRBS.

Figure 8. Mental Health Behaviors, Rural Nevada Middle and High School Students, 2015 and 2017, and Nevada Statewide High School Students, 2017.



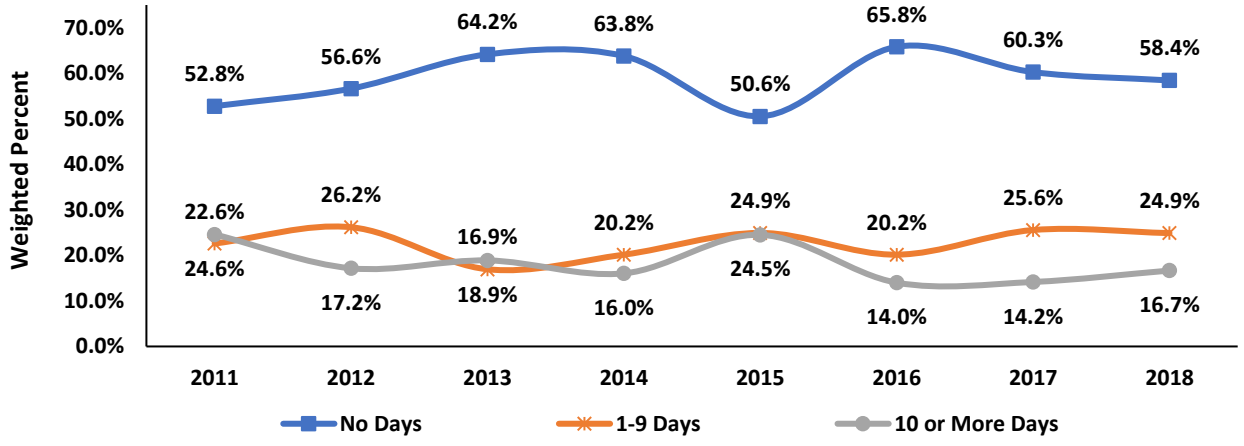
Source: Nevada Youth Risk Behavior Survey (YRBS).
Chart scaled to 40% to display differences among groups.

In 2017, approximately 33.0% of Rural Nevada high school students and 26.6% of middle school students felt sad or hopeless during the past 12 months. In 2017, about 20.2% of high school students and 20.0% of middle school students have considered suicide, while 15.9% and 12.7%, respectively, have planned to commit suicide in the past 12 months. In 2017, about 9.5% of high school students and 6.4% of middle school students have attempted suicide in the past 12 months.

Behavioral Risk Factor Surveillance System (BRFSS)

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.

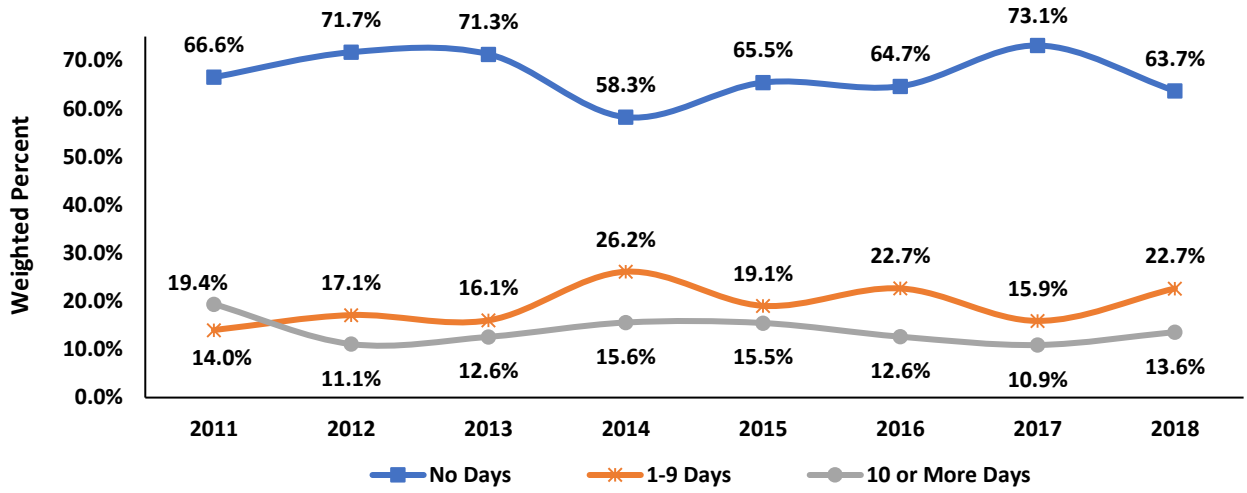
Figure 9. Percentage of Rural Nevada Adults Who Experienced Poor Mental or Physical Health that Prevented Them from Doing Usual Activities, 2011-2018.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 70% to display differences among groups.
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?"

From 2011 to 2018, trends in poor mental or physical health among Rural Nevada adults were relatively constant. In 2018, 58.4% of Rural Nevada adults reported experiencing zero days of poor mental or physical health that prevented them from doing usual activities, while 24.9% reported experiencing one to nine such days and 16.7% reported experiencing 10 or more such days. These trends did not differ from those across Nevada statewide.

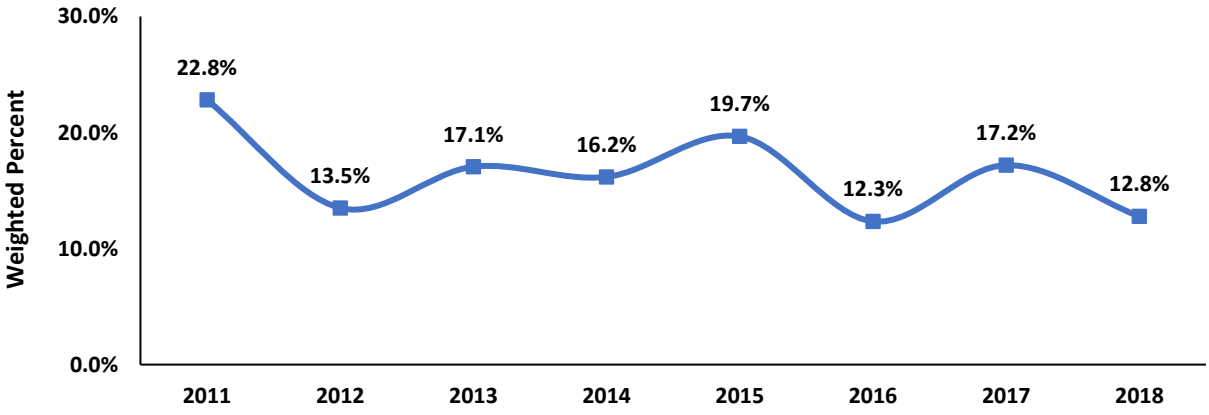
Figure 10. Percentages of Adults in Which Their Mental Health Was Not Good by Number of Days Experienced, Rural Nevada Residents, 2011-2018.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 70% to display differences among groups.
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?"

From 2011 to 2018, the trends in mental health among Rural Nevada adults remained consistent. In 2018, 63.7% of Rural Nevada adults reported experiencing zero days of unfavorable mental health, while 22.7% reported one to nine such days and 13.6% reported 10 or more such days. These trends did not differ by demographics in Rural Nevada and were comparable to the trends across Nevada statewide.

Figure 11. Percentages of Adults Who Have Ever Been Told They Have a Depressive Disorder, Including Depression, Major/Minor Depression, or Dysthymia, Rural Nevada Residents, 2011-2018.



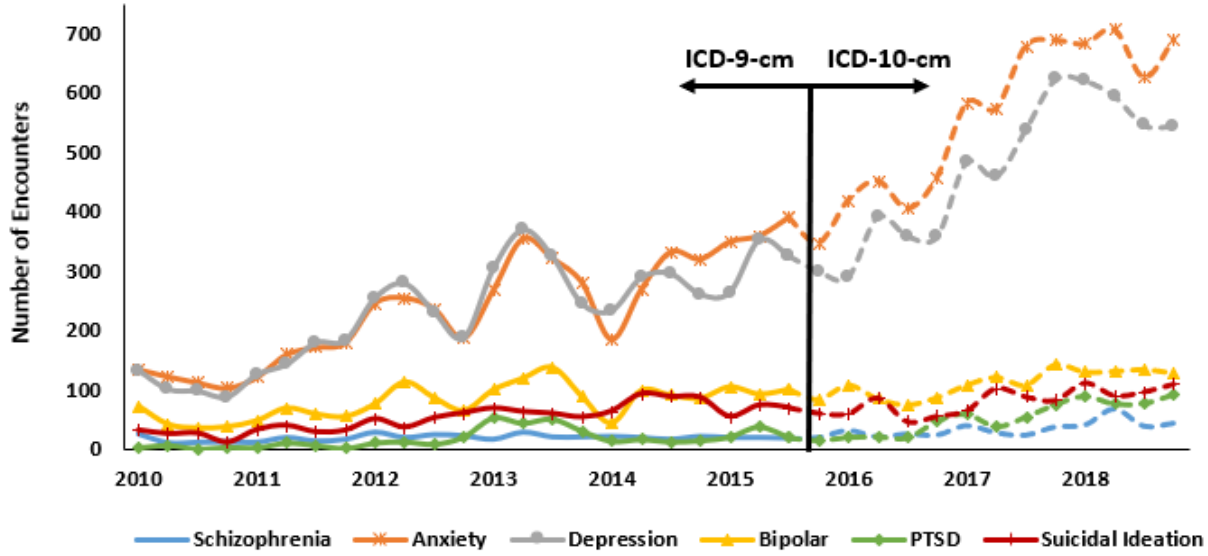
Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 30% to display differences among groups.
Question asked in survey: "(Ever told) you have a depressive disorder (including depression, major depression, dysthymia, or minor depression)?"

From 2011 to 2018, trends in depressive disorder diagnoses among Rural Nevada adults have remained consistent and comparable to trends in Nevada statewide. In 2018, 12.8% of Rural Nevada adults reported ever having been diagnosed with a depression disorder. In 2018, Rural Nevada females (20.0%) were significantly more likely to report having been diagnosed with a depressive disorder than males (6.4%).

Hospital Emergency Department Encounters

The hospital emergency department billing data includes data for emergency room patients for Nevada's non-federal hospitals. There were 4,601 visits related to mental health disorders among Rural Nevada residents in 2018. 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 in Rural Nevada, by Quarter and Year, 2010-2018.



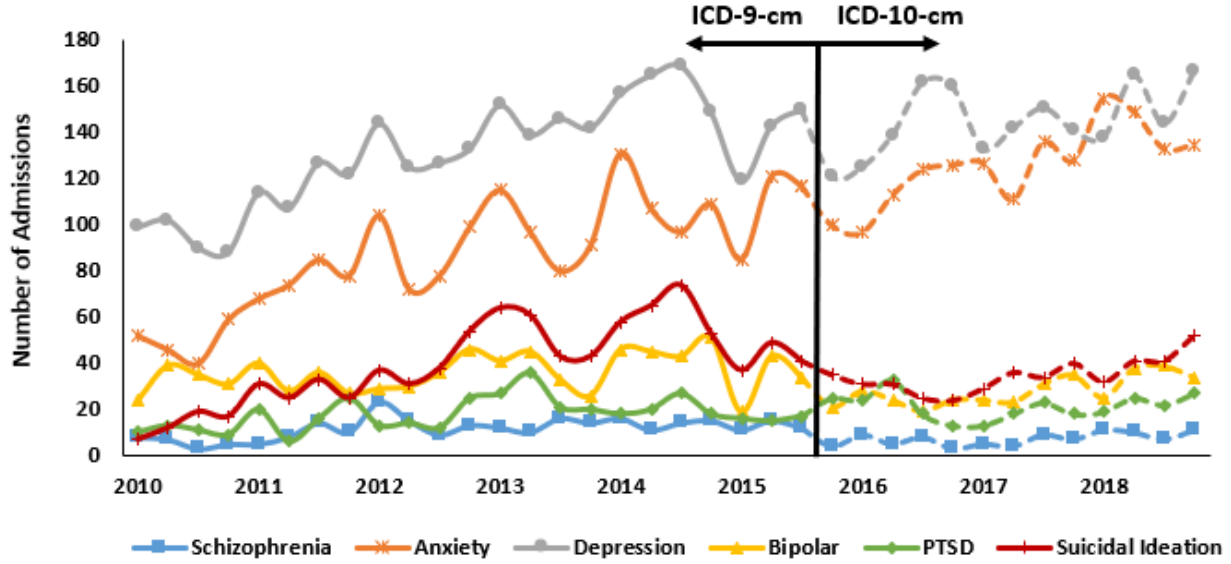
Source: Hospital Emergency Department Billing.
Categories are not mutually exclusive.
ICD-9 codes were replaced by ICD-10 codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Anxiety has been the leading mental health-related diagnosis encountered at emergency departments in Rural Nevada since 2016. Emergency department encounters related to anxiety increased significantly from 2010 to 2018 both in counts and rates. When adjusted for population growth, 2010 had 479 (531.0 per 100,000 Rural Nevada residents) anxiety-related emergency department encounters and 2018 had 2,710 (2,825.3 per 100,000 Rural Nevada residents) encounters. Emergency department encounters related to depression also increased significantly from 2010 to 2018 from 420 (465.6 per 100,000 Rural Nevada residents) to 2,310 (2,408.3 per 100,000 Rural Nevada residents).

Hospital Inpatient Admissions

Hospital Inpatient Billing data includes data for patients discharged from Nevada's non-federal hospitals. There were 1,093 inpatient admissions related to mental health disorders among Rural Nevada residents in 2018. 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 in Rural Nevada, by Quarter and Year, 2010-2018.



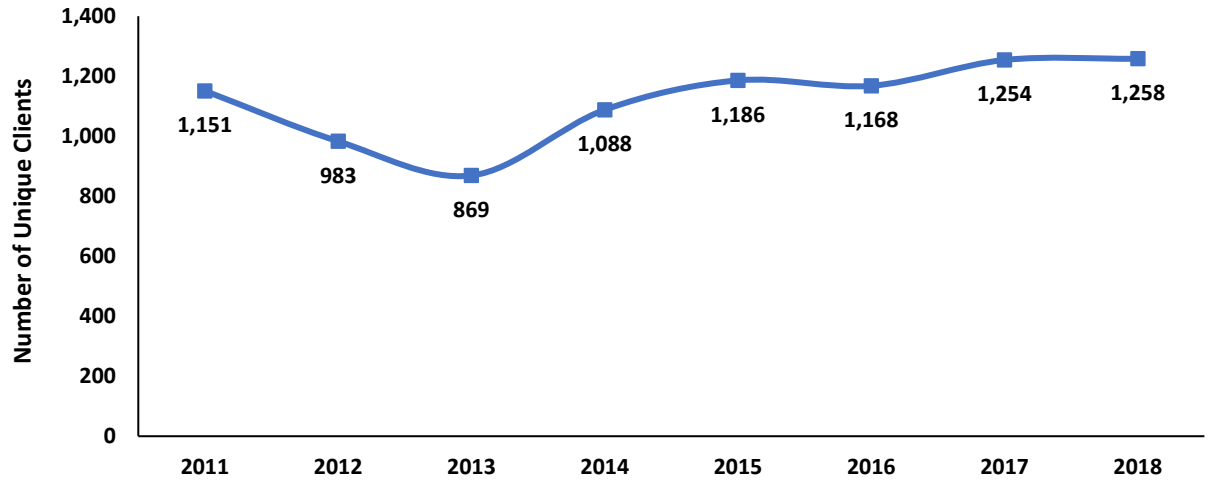
Source: Hospital Inpatient Billing.
Categories are not mutually exclusive.
ICD-9 codes were replaced by ICD-10 codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Unlike emergency department encounters, depression is the leading diagnosis for mental health-related inpatient admissions in Rural Nevada. From 2010 to 2018, inpatient admissions related to depression increased significantly from 379 (420.1 per 100,000 Rural Nevada residents) to 614 (640.1 per 100,000 Rural Nevada residents). Anxiety has also increased significantly from 2010 to 2018 both in counts and rates, which are adjusted for population growth. In 2010, Rural Nevada saw 197 (218.4 per 100,000 Rural Nevada residents) anxiety-related inpatient admissions, and in 2018, Rural Nevada saw 572 (596.3 per 100,000 Rural Nevada residents) anxiety-related inpatient admissions.

State-Funded Mental Health Services (Avatar)

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. Different services that mental health facilities provide include inpatient acute psychiatric, mobile crisis, outpatient counseling, service coordination, and case management.

Figure 14. Unique Clients* Served at State-Funded Mental Health Clinics, Rural Nevada Residents, 2011-2018.



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

The Affordable Care Act (ACA) went into effect in 2014. Therefore, many Nevada residents are now able to access non-state-funded facliites through the expansion of Medicaid. This likely contributes to the decline of the number of unique clients served* by state-funded mental health facilities in Nevada overall. However, this trend is not seen in Rural Nevada, where the number of unique clients served has increased from 2013 (869) to 2018 (1,258).

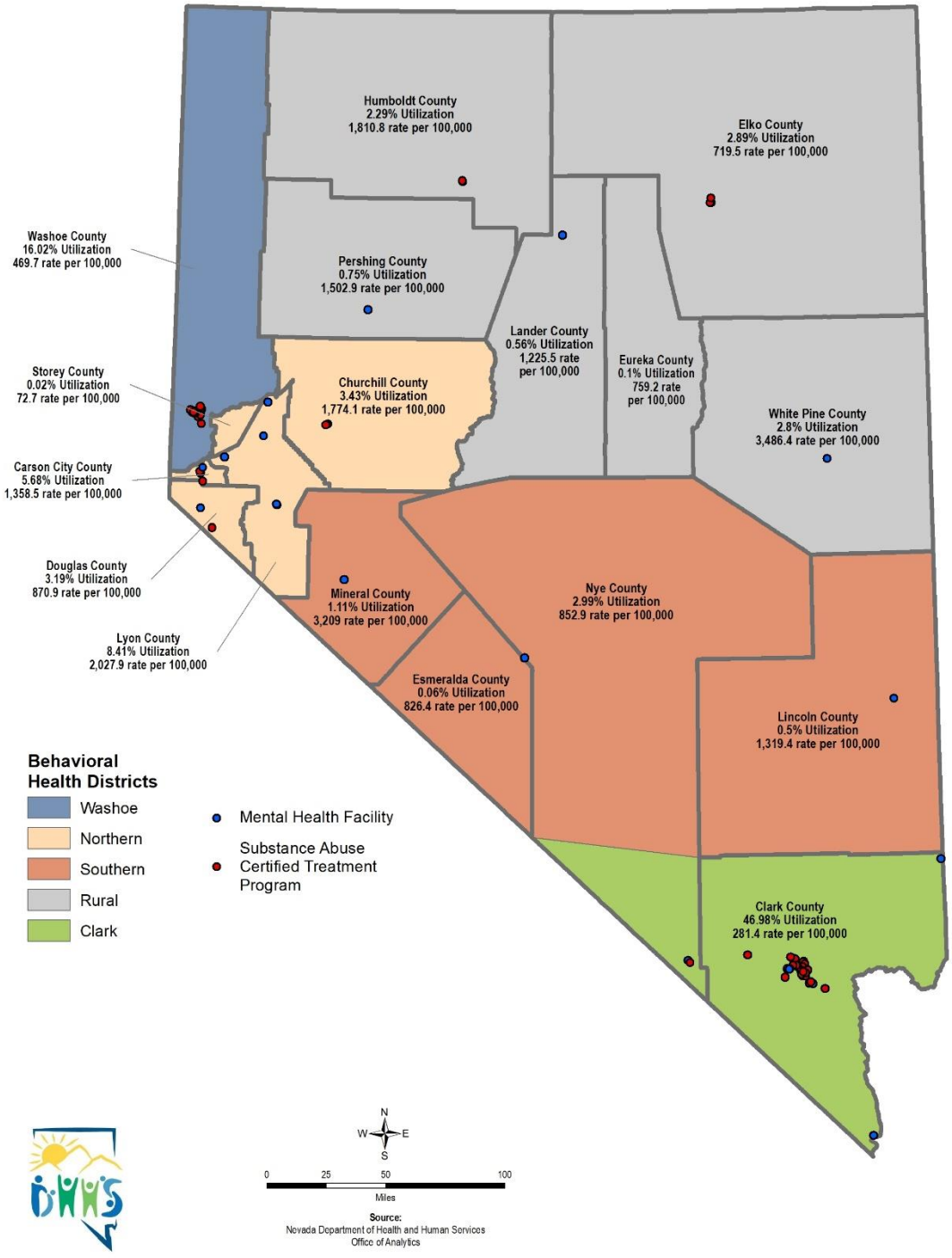
Figure 15. Top Mental Health Clinic Services by Number of Patients Served*, Rural Nevada, 2011-2018.

Program	2011	2012	2013	2014	2015	2016	2017	2018
Elko Medication Clinic	164	133	156	142	82	103	108	112
Elko Outpatient Counseling	153	145	141	142	235	153	222	175
Elko Outpatient Screening	171	176	201	224	43	91	21	10
Ely Medication Clinic	104	82	110	113	63	62	50	49
Ely Outpatient Counseling	250	174	292	277	145	165	121	120
Ely Outpatient Counseling Wait List	142	108	139	107	1	43	3	31
Winnemucca Medication Clinic	90	71	117	125	119	57	90	53
Winnemucca Outpatient Counseling	79	78	106	105	200	91	171	88

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

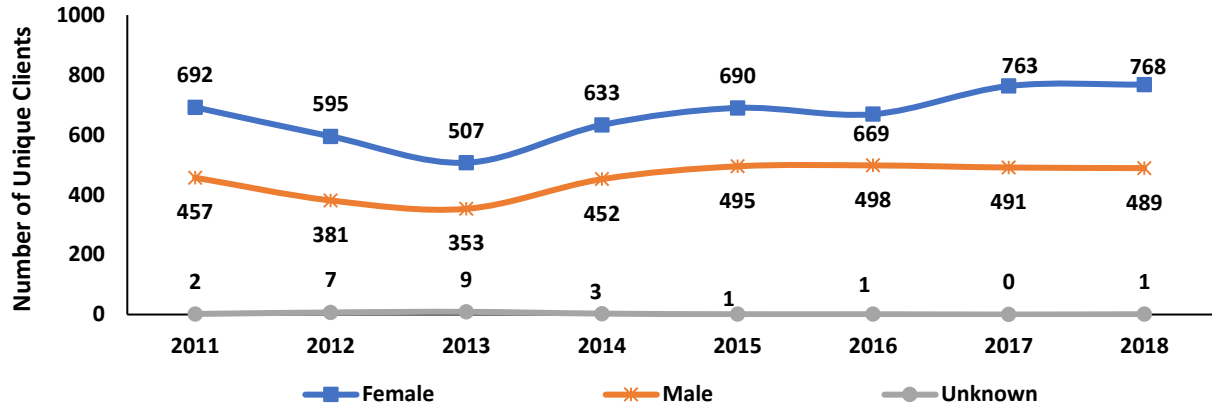
Patients were counted only once per program per year. Since a patient can receive services in more than one program, the counts above are not mutually exclusive.

Figure 16. State-Funded Mental Health Clinics Utilization by County, 2018



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

Figure 17. State-Funded Mental Health Clinics Utilization* by Gender, Rural Nevada Residents, 2011-2018.

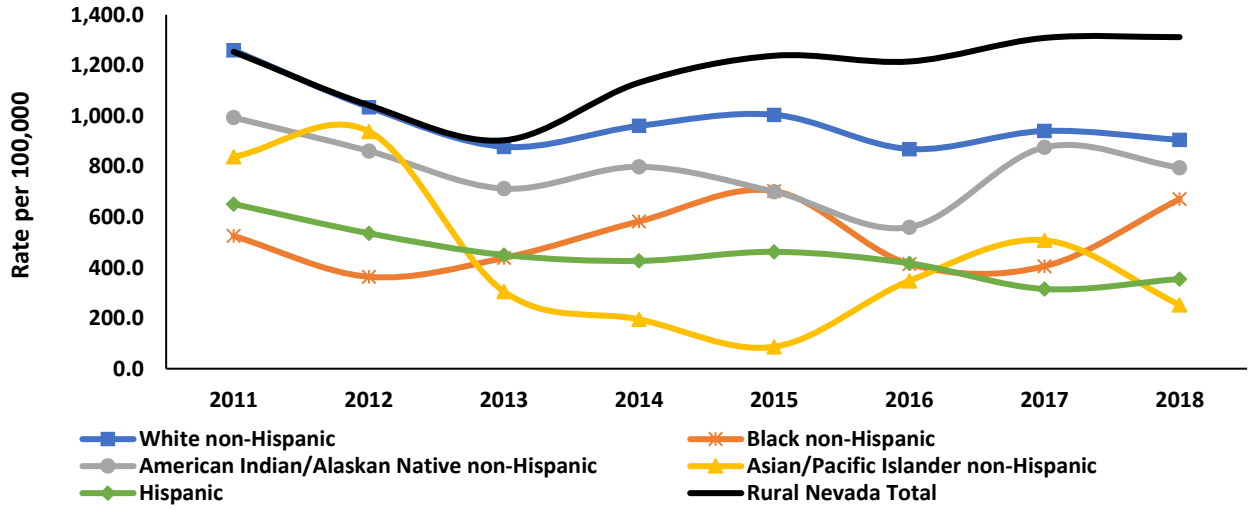


Source: Avatar.
**A client is counted only once per year. Clients may be counted more than once across years.*

From 2011 to 2018, females in Rural Nevada have significantly utilized the state-funded mental health clinics more than males (95% confidence interval). In 2018, Rural Nevada females utilized the state-funded mental health clinics at 1,692.3 per 100,000 female population, compared to Rural Nevada males at 967.6 per 100,000 male population.

Of patients who utilized state-funded mental health services in 2018, the most common age group was 25 to 34-year-olds, on average accounting for 20.1% of the patients. Those with less than 12th grade (no diploma education) accounted for 16.8% of the patients, followed by high school graduates at 12.1%.

Figure 18. State-Funded Mental Health Clinics Utilization* by Race/Ethnicity, Rural Nevada Residents, 2011-2018.



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

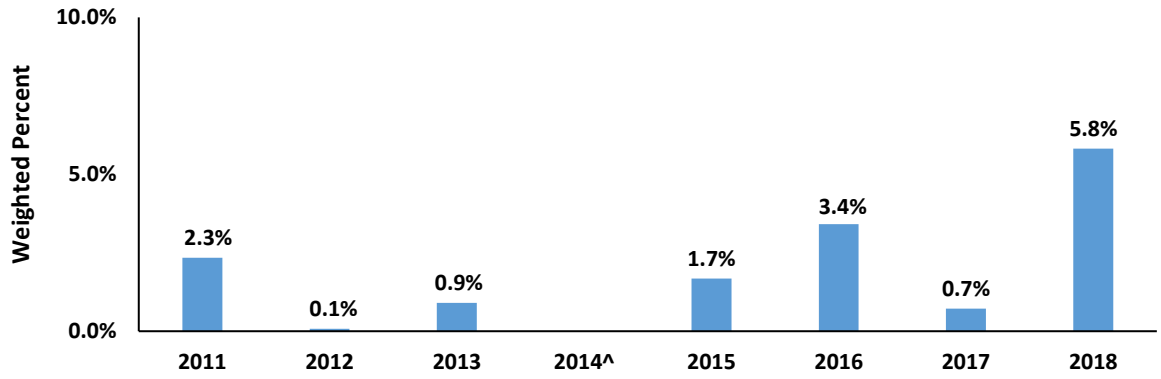
The state-funded mental health clinics utilization rate in Rural Nevada showed little change from 2011 to 2018. The White non-Hispanic population had the highest rate over the seven-year period, which was at

905.3 per 100,000 population in 2018. The Asian/Pacific Islander population had the lowest rate with 251.9 per 100,000 population.

Suicide

While suicidal ideation is not a mental illness, one of the most common causes of suicide is mental illness. Risk factors for suicide include depression, bipolar disorder and personality disorders. Of those who attempt or die from suicide, many have a diagnosed mental illness.

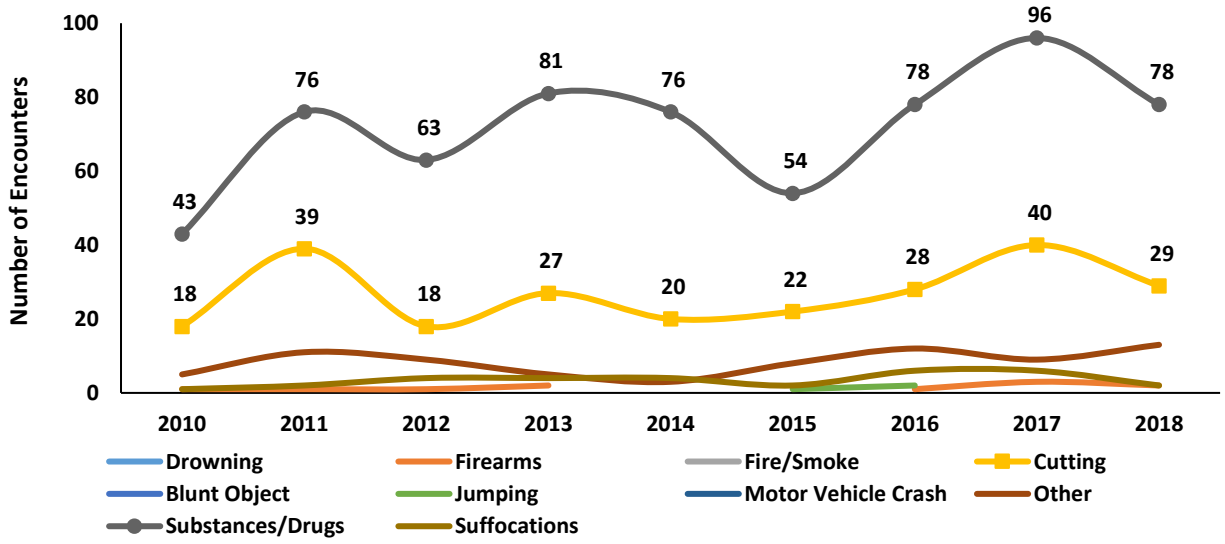
Figure 19. Percentage of Rural Nevada Adults Who Have Seriously Considered Attempting Suicide in the Past 12 Months, 2011-2018.



Source: Behavioral Risk Factor Surveillance System (BRFSS).
Charts scaled to 10% to display differences among groups.
^Indicator was not measured in 2014.

In 2018, 5.8% of rural Nevadans reported having seriously considered attempting suicide in the past 12 months, which is not significantly different from the prevalence across Nevada statewide.

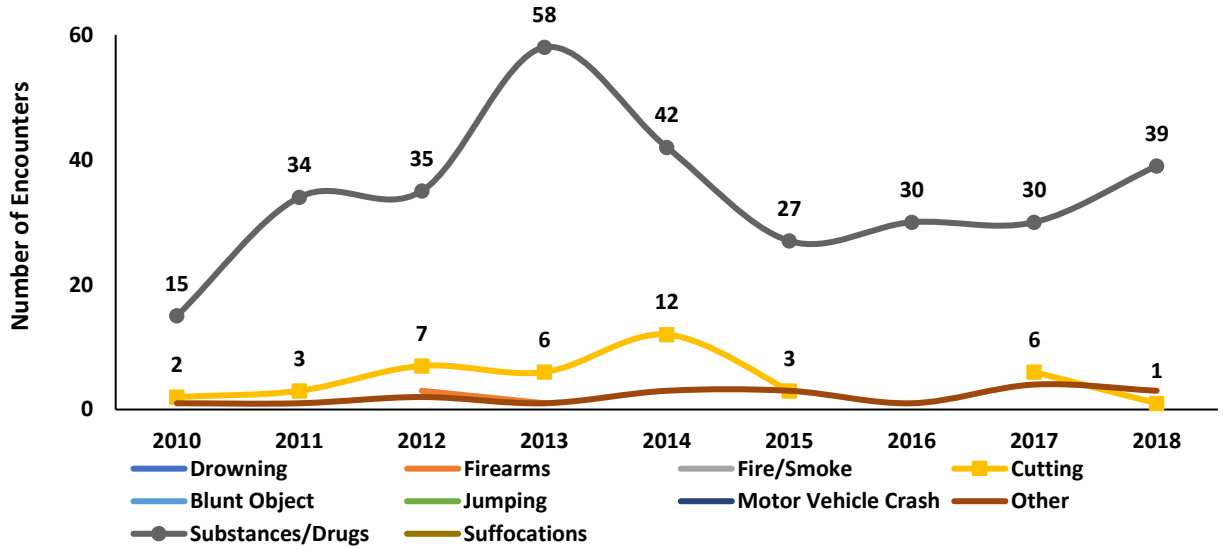
Figure 20. Suicide Attempt Emergency Department Encounters by Method, Rural Nevada Residents, 2010-2018.



Source: Hospital Emergency Department Billing.
ICD-10 codes replaced ICD-9 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.

Attempted suicides, where the patient did not expire at the hospital, have remained steady from 2010 to 2018 for the entire state. However, the number of suicide attempt emergency department encounters have nearly doubled in Rural Nevada during the same period. The most common method for attempted suicides is a substance or drug overdose attempt.

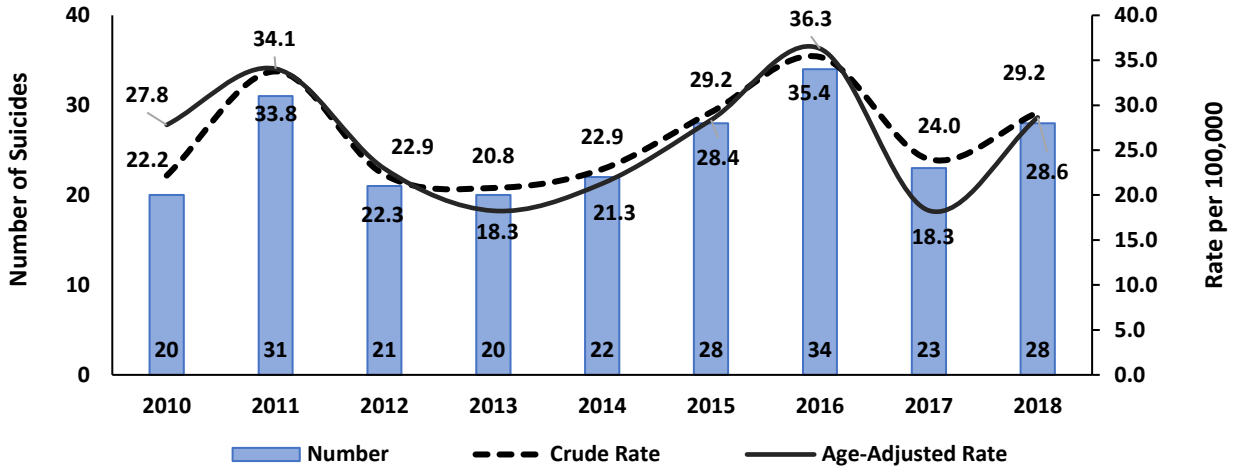
Figure 21. Suicide Attempt Inpatient Admissions by Method, Rural Nevada Residents, 2011-2018.



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

Inpatient admissions for attempted suicides, where the patient was admitted and did not expire at the hospital, have increased from 2010 to 2018. The most common method was substances or drugs.

Figure 22. Number of Suicides and Age-Adjusted Rates, Rural Nevada Residents, 2010-2018.

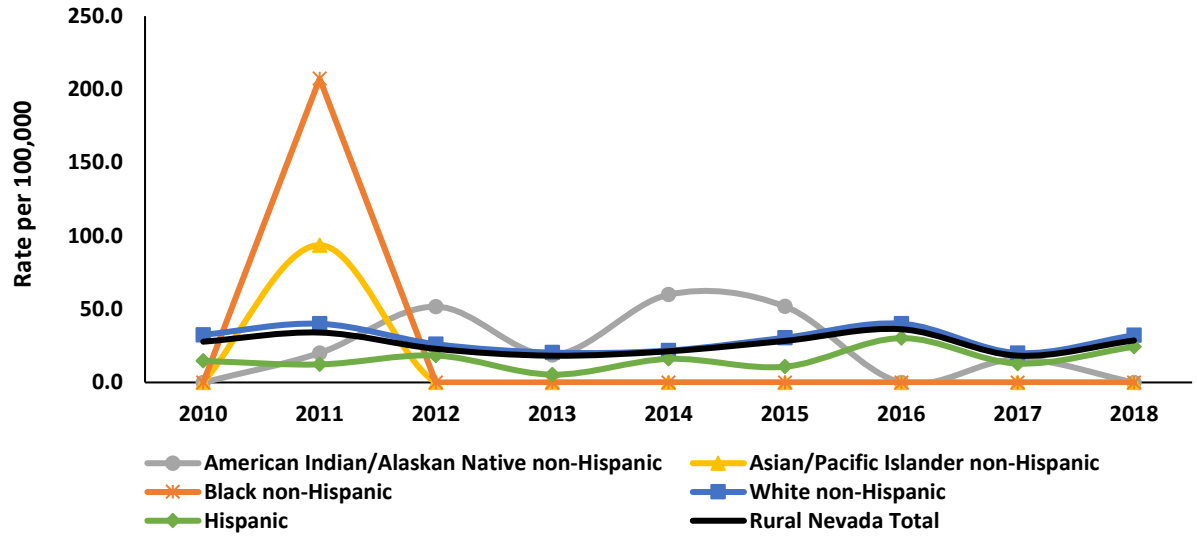


Source: Nevada Electronic Death Registry System.

The age-adjusted suicide rate in 2018 in Rural Nevada is 28.6 per 100,000 population, which is higher than the overall Nevada rate at 21.0 per 100,000 population. Between 2010 and 2018, Rural Nevada experienced the highest age-adjusted suicide rate in 2016, at 35.4 per 100,000 population, and the lowest

rate at 18.3 per 100,000 population in 2013 and 2017. From 2010 to 2018, there have been 227 suicides in Rural Nevada; on average, 25 suicides occur each year.

Figure 23. Age-Adjusted Suicides Rates by Race/Ethnicity, Rural Nevada Residents, 2010-2018.



Source: Nevada Electronic Death Registry System.

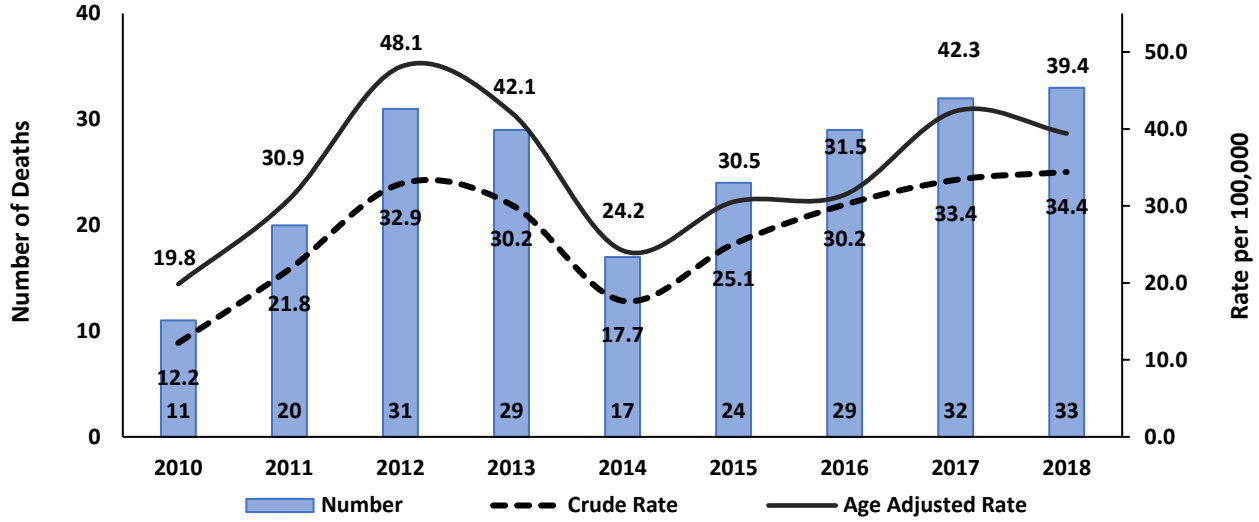
The age-adjusted suicide rates for White non-Hispanics were comparable to the overall rate for Rural Nevada for each year from 2010 to 2018, with 32.2 per 100,000 population in 2018. The age-adjusted suicide rate for American Indian/Alaskan Native was above the Rural Nevada rate (2012 through 2015) but was not significantly higher based on 95% confidence intervals. Rates among Hispanics were lower than Rural Nevada rates for all years. Rates among Black non-Hispanics were lower than Rural Nevada rates from 2012 to 2018.

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 Age-Adjusted Rates, Rural Nevada Residents, 2010-2018.

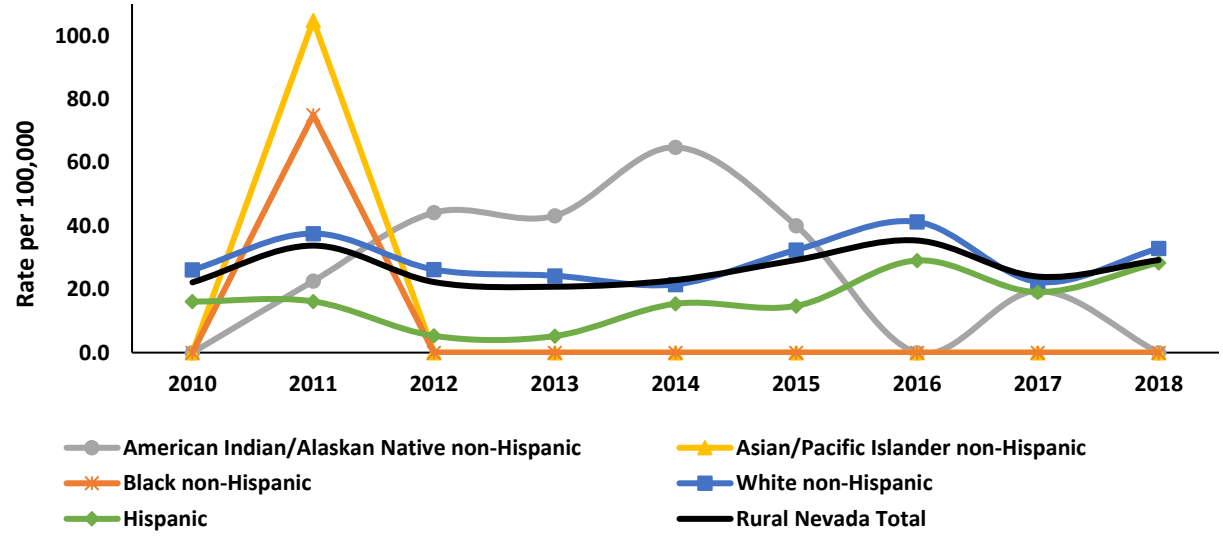


Source: Nevada Electronic Death Registry System.

In 2018, the age-adjusted mental health-related death rate in Rural Nevada, at 39.4 deaths per 100,000 population, was lower than the overall Nevada rate (48.7 deaths per 100,000 population).

Most of the mental health-related deaths in Rural Nevada were from those aged 75 and older; 26 of the 33 deaths related to mental health in Rural Nevada in 2018 were from those of this age group. Mental health-related deaths were highest among individuals who had high school diplomas.

Figure 25. Age-Adjusted Mental Health-Related Death Rates by Race/Ethnicity, Rural Nevada Residents, 2010-2018.



Source: Nevada Electronic Death Registry System.

In 2018, the age-adjusted mental health-related death rate for the Hispanic population (6.3 deaths per 100,000 population) was significantly lower than the Nevada overall rate (39.4 deaths per 100,000 population) in Rural Nevada.

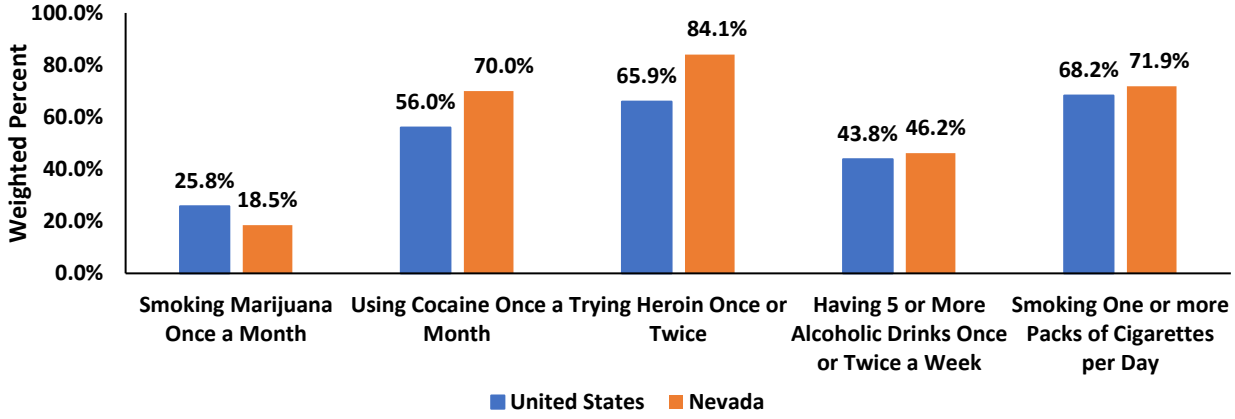
Substance Use

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.

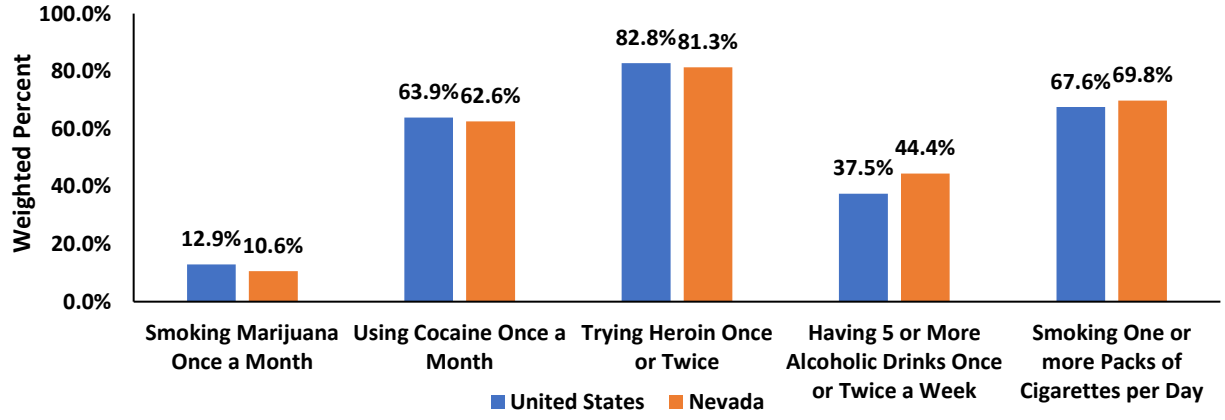
Figure 26. Perceptions of Great Risk from Alcohol or Substance, Ages 12-17, Nevada and the United States, 2017.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2011-2017.

Among Nevadan teens (age 12-17), perceived risk for using cocaine, trying heroin, drinking more than 5 drinks, and smoking is greater than that of the United States, while young adults (age18-25) perceived risk is lower than the United States for using cocaine and trying heroin.

Figure 27. Perceptions of Great Risk from Alcohol or Substance, Ages 18-25, Nevada and the United States, 2016-2017.

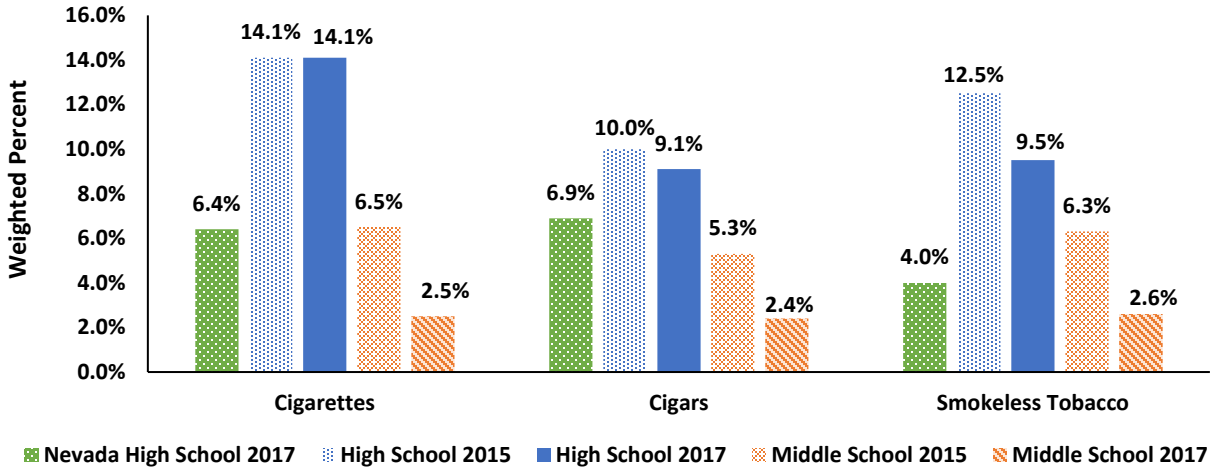


Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010-2016.

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 years. In 2017, 710 high school and 584 middle school students in Rural Nevada participated in the YRBS. The University of Nevada, Reno maintains the YRBS data and publishes data on each survey. For more information on the YRBS survey, please go to the following site: UNR YRBS.

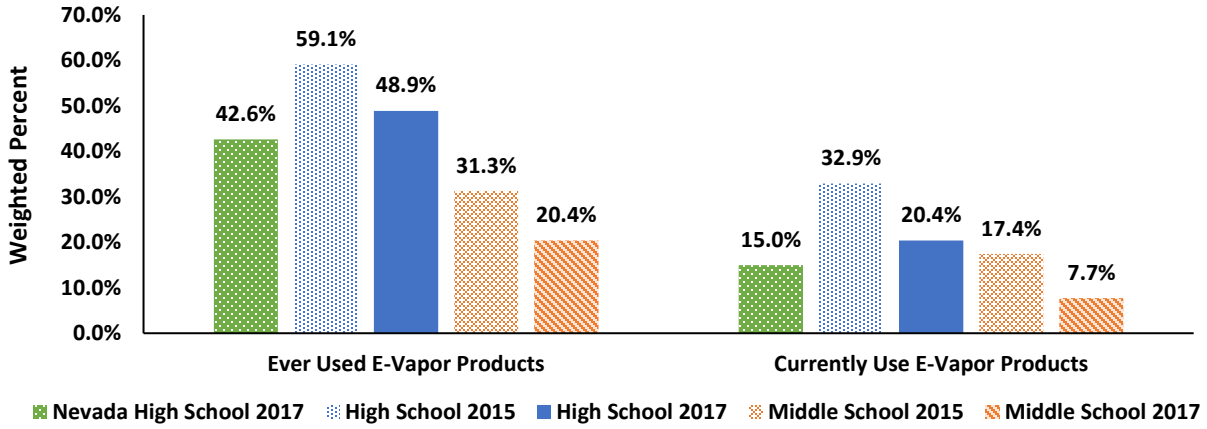
Figure 28. Current Tobacco Use, Rural Nevada Middle and High School Students, 2015 and 2017, and Nevada Statewide High School Students, 2017.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 16% to display differences among groups.

There was no significant change in tobacco cigarette use (14.1%) from 2015 to 2017 in Rural Nevada high schoolers. However, there was a decline in cigarette use from 6.5% to 2.5% in Rural Nevada middle schoolers from 2015 to 2017. Cigar and smokeless tobacco usage also declined from 2015 to 2017 among Rural Nevada middle schoolers.

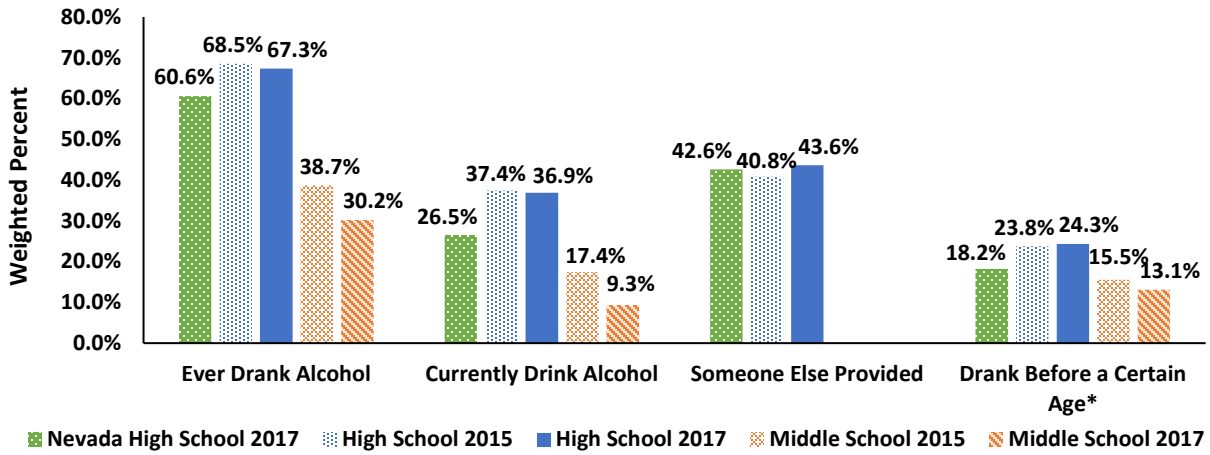
Figure 29. Electronic Vapor Product Use, Rural Nevada Middle and High School Students, 2015 and 2017, and Nevada Statewide High School Students, 2017.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 70% to display differences among groups.

There was a significant decrease in current use of e-vapor products in Rural Nevada high school students from 2015 (32.9%) to 2017 (20.4%). Among middle school students in Rural Nevada, there was also a significant decrease in current use of e-vapor products from 17.4% (2015) to 7.7% (2017). Trends in e-vapor product use among Rural Nevada students were not significantly different to patterns across Nevada statewide.

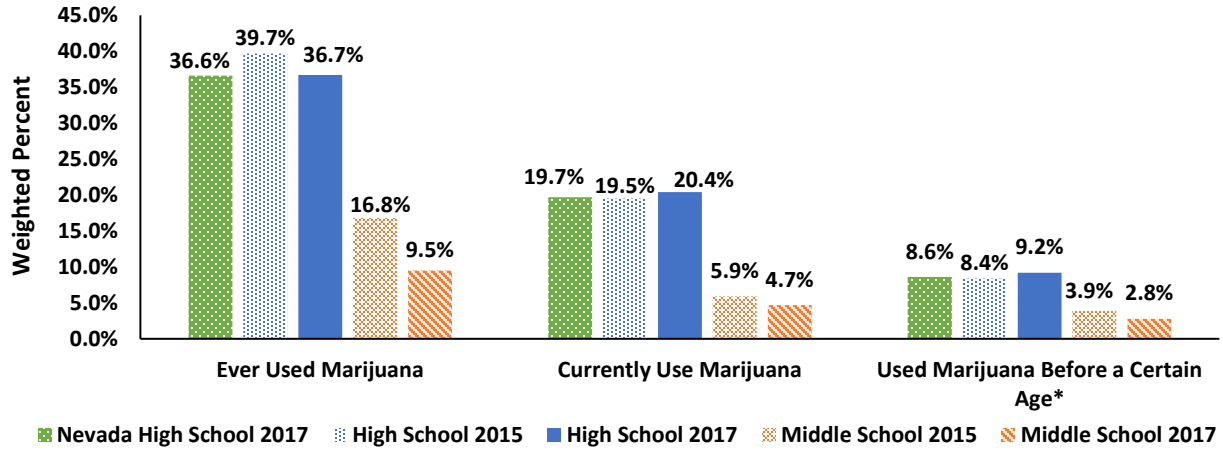
Figure 30. Alcohol Use, Rural Nevada Middle and High School Students, 2015 and 2017, and Nevada Statewide High School Students, 2017.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 80% to display differences among groups.
**In high school students, if they ever drank before age 13, and in middle school students if they ever drank before age 11.*

Approximately 67.3% of high school students and 30.2% of middle school students in Rural Nevada have ever had a drink of alcohol, which is not significantly different compared to Nevada statewide. Approximately 36.9% of Rural Nevada high school students currently drink alcohol, and 43.6% have had alcohol provided to them by someone else. Of Rural Nevada high school students, 24.3% had drank alcohol before the age of 13 years, and 13.1% of middle school students had drank alcohol before the age of 11 years.

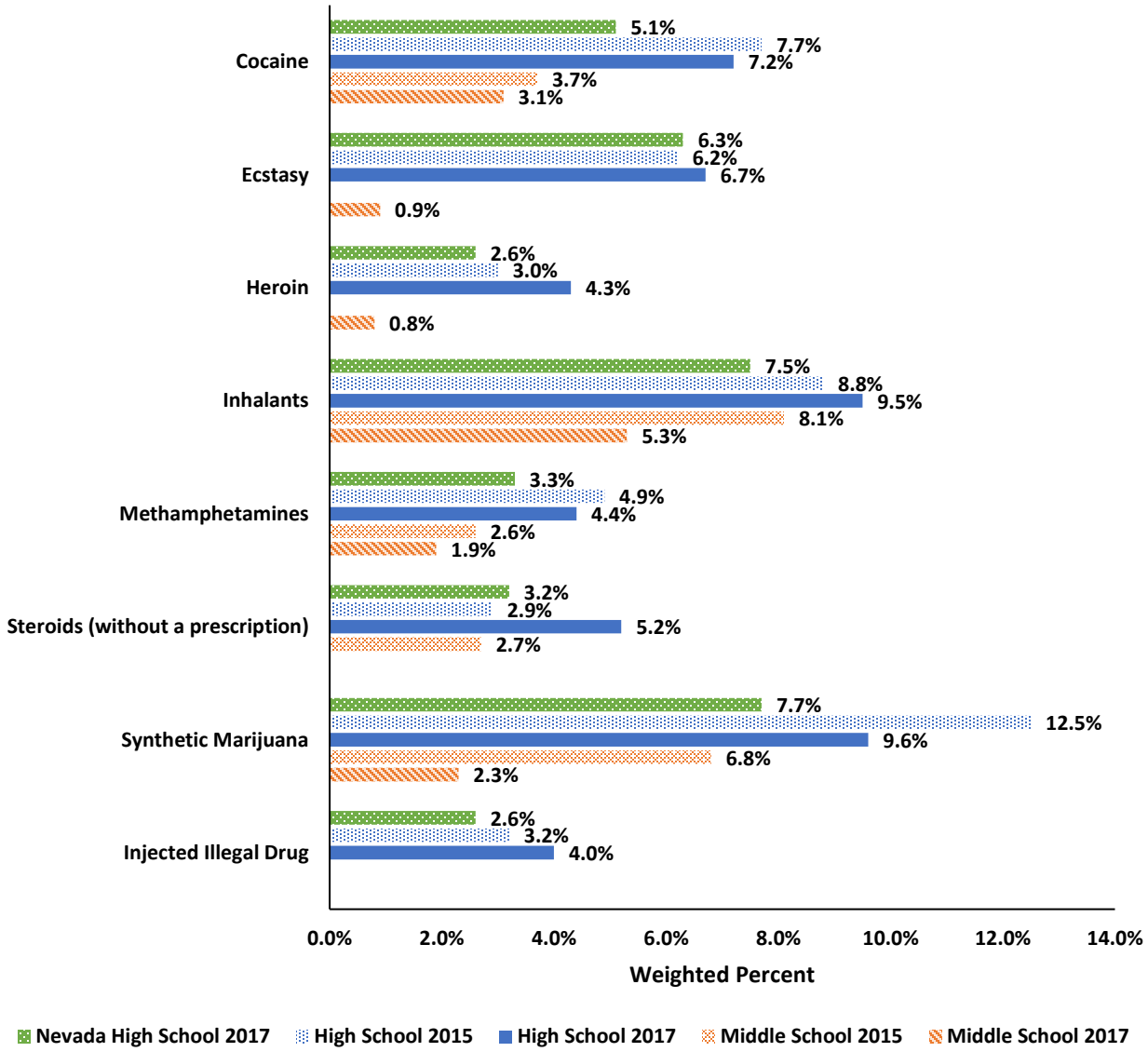
Figure 31. Marijuana Use, Rural Nevada Middle and High School Students, 2015 and 2017, and Nevada Statewide High School Students, 2017.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 45% to display differences among groups.
**In high school students, if they ever used marijuana before age 13, and in middle school students if they ever used marijuana before age 11.*

There was no significant change in marijuana use from 2015 to 2017 in Rural Nevada. Approximately 36.7% of high school students reported trying marijuana in 2017, which is comparable to Nevada statewide (36.6%). In 2017, 9.2% of Rural Nevada high schoolers had used marijuana before age 13, while 2.8% of middle school students had used marijuana before age 11.

Figure 32. Lifetime Drug Use, Rural Nevada Middle and High School Students, 2015 and 2017, and Nevada Statewide High School Students, 2017.



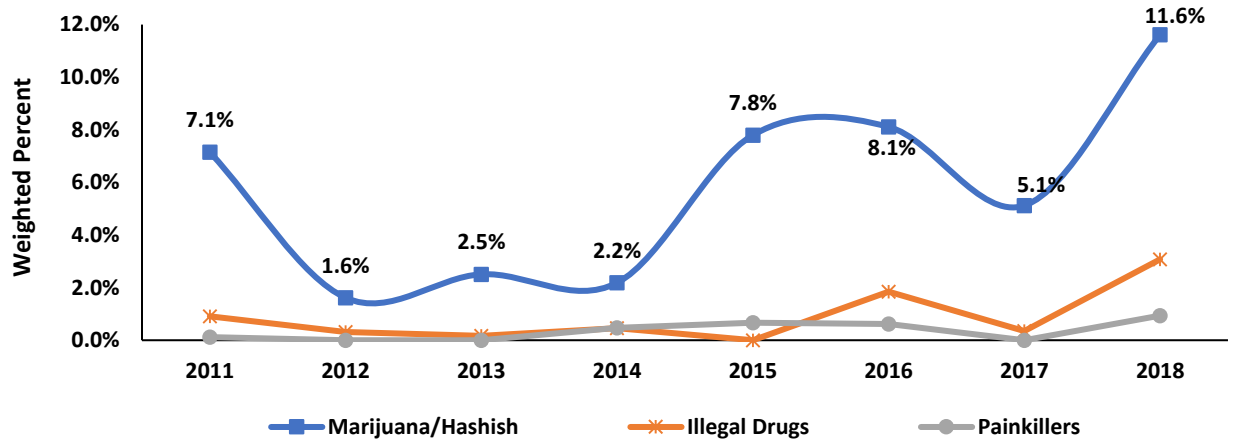
Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 14% to display differences among groups.

Drug use among high school students in 2017 is higher in Rural Nevada then Nevada overall. Drug use among middle school students in Rural Nevada is higher than Nevada overall for methamphetamines but was lower in all other reported categories. From 2015 to 2017, use of inhalants decreased in Rural Nevada middle schoolers, from 8.1% to 5.3%. The use of synthetic marijuana in middle school students significantly declined from 2015 (6.8%) to 2017 (2.3%) based on 95% confidence intervals.

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.

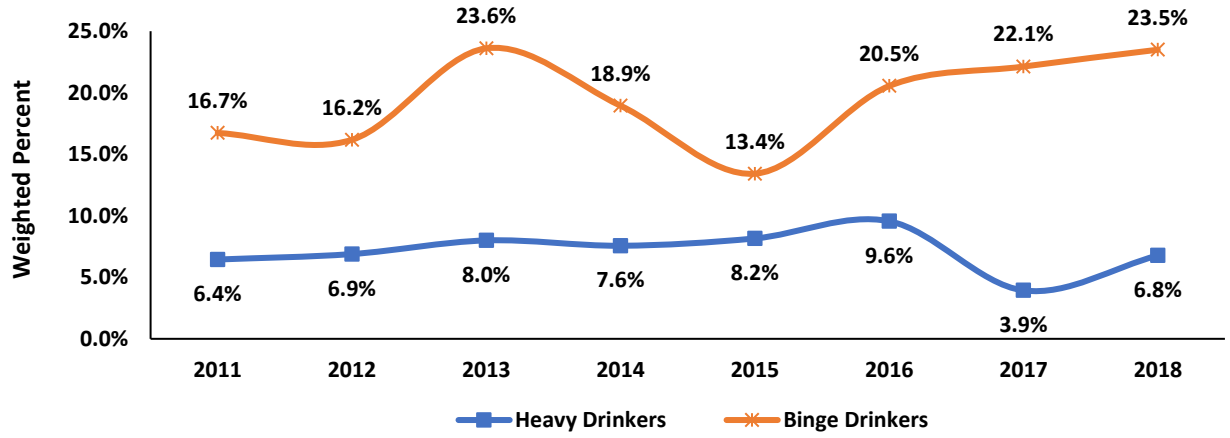
Figure 33. Percentage of Rural Nevada Adults Who Used Illegal Substances, Marijuana/Hashish, or Painkillers to Get High in the Last 30 Days, 2011-2018.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 12% to display differences among groups.
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 significantly increased from 2014 (2.2%) to 2018 (11.6%) in Rural Nevada. Self-reporting of marijuana use is expected to increase as marijuana was legalized in Nevada in 2017. In 2018, 3.1% of rural Nevada adults reported using illegal drugs in the past 30 days, while 0.9% reported using painkillers. These trends did not differ significantly from those across Nevada statewide.

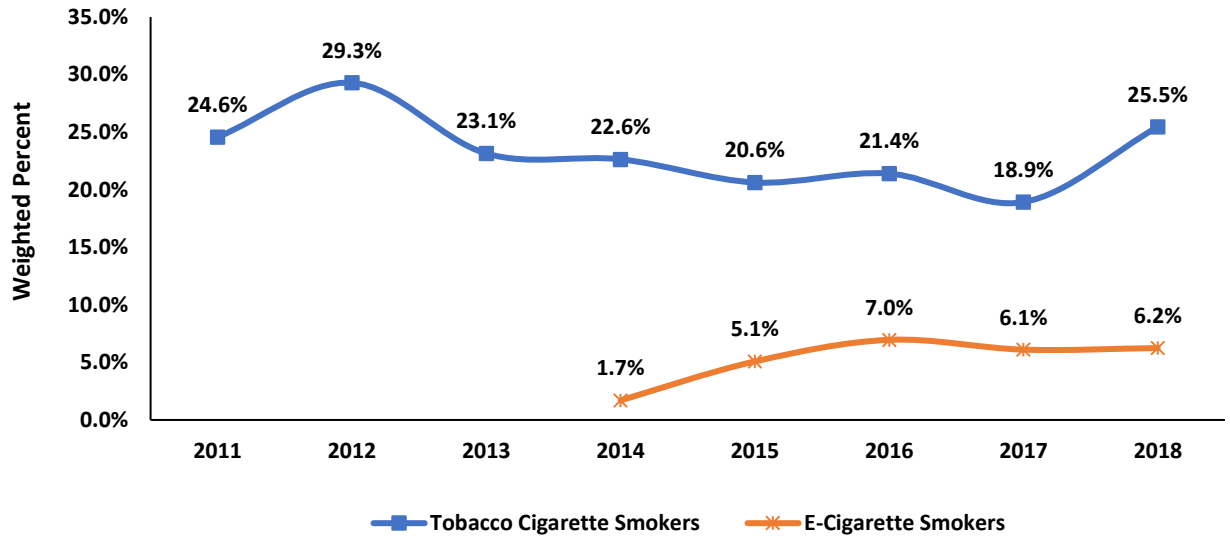
Figure 34. Percentage of Rural Nevada Adults Who are Considered Binge Drinkers or Heavy Drinkers, 2011-2018.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 25% 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 in women as having four or more alcoholic beverages on an occasion. Heavy drinking is defined in men as consuming more than two alcoholic beverages, and in women as consuming more than one alcoholic beverage per day. In 2018, Rural Nevada males (34.1%) were significantly more likely to report binge drinking compared to females (10.6%). In 2018, Rural Nevada adults (23.5%) were significantly more likely to report binge drinking compared to all Nevada adults statewide (15.0%).

Figure 35. Percentage of Rural Nevada Adults Who are Current Tobacco Cigarette or E-Cigarette Smokers, 2011-2018.



Source: Behavioral Risk Factor Surveillance System.
Chart scaled to 35% to display differences among groups.
E-cigarette use was not collected until 2014.
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.

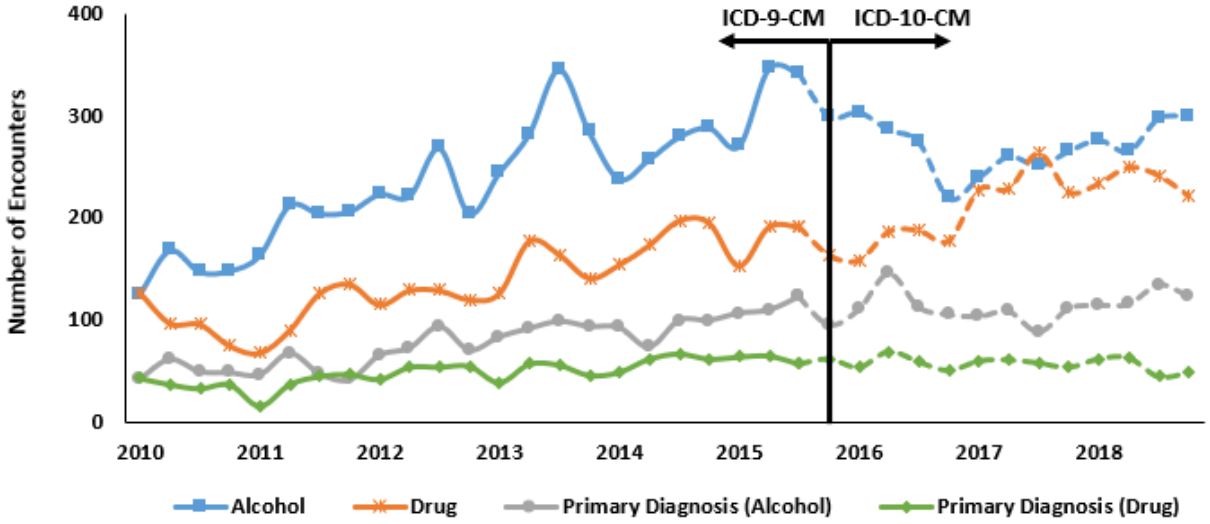
From 2011 to 2018, trends in tobacco cigarette or e-cigarette usage among Rural Nevada adults did not significantly change. In 2018, 25.5% of Rural Nevada adults reported currently smoking tobacco cigarettes, while 6.2% reported currently smoking e-cigarettes. In 2018, Rural Nevada adults (25.5%) were significantly more likely to report being current tobacco smokers compared to all Nevada adults statewide (15.7%). In 2018, Rural Nevada college graduates (9.9%) were significantly less likely to report being current tobacco smokers compared to high school graduates (34.4%).

Intravenous drug use (IDU) also increases the risk of contracting HIV/AIDS and Hepatitis C. In Nevada, IDU among HIV/AIDS individuals is collected, whereas Hepatitis C related IDU is not collected. For 2018, there were no new cases of HIV/AIDS that were transmitted through IDU in Rural Nevada. In 2018, there were 12 individuals in Rural Nevada who were living with HIIV/AIDS that was contracted though IDU.

Hospital Emergency Department Encounters

The hospital emergency department billing data provides health billing data for emergency department 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 36. Alcohol and/or Drug-Related Emergency Department Encounters in Rural Nevada by Quarter and Year, 2010-2018.

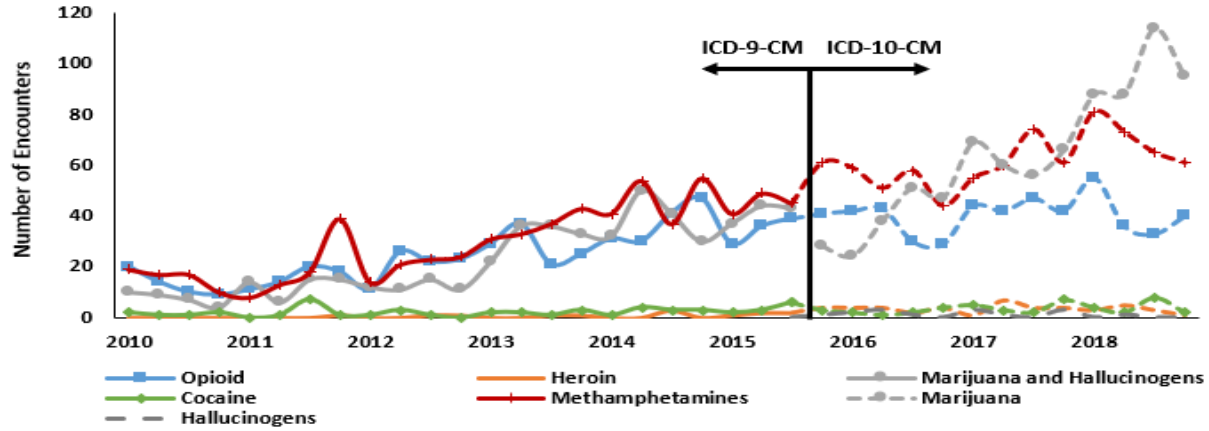


Source: Hospital Emergency Department Billing.
Categories are not mutually exclusive.
ICD-9 codes were replaced by ICD-10 codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

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 or drugs were listed in any of the diagnoses.

Overall, from 2010 to 2018, alcohol-related visits to the emergency department were more common than drug-related visits in Rural Nevada. In 2018, there were a total of 1,962 alcohol and/or drug-related emergency department encounters in Rural Nevada. Out of this number, 490 were alcohol-related (primary diagnosis) and 223 were drug-related (primary diagnosis).

Figure 37. Drug-Related Emergency Department Encounters in Rural Nevada by Drug and Quarter and Year, 2010-2018.



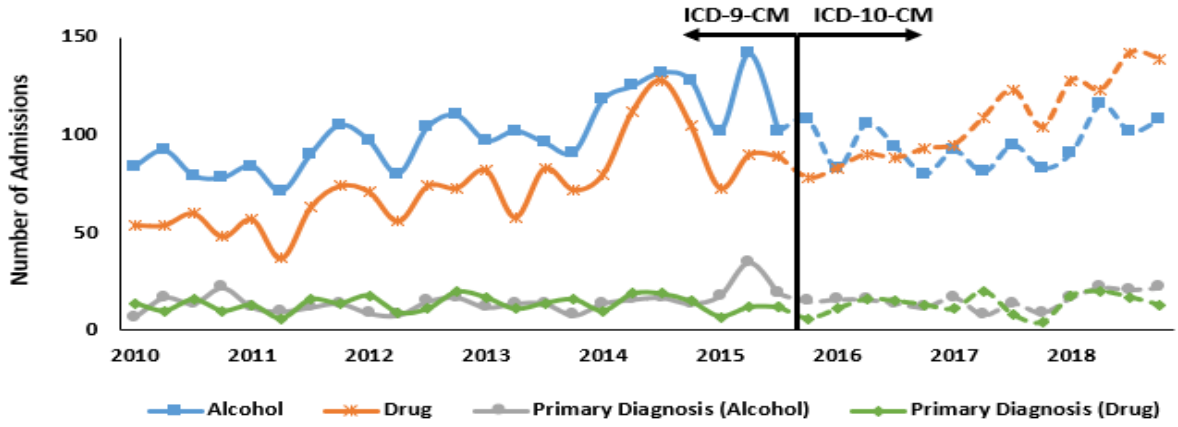
Source: Hospital Emergency Department Billing.
Categories are not mutually exclusive. ICD-9 codes were replaced by ICD-10 codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Hallucinogens and marijuana were grouped together for ICD-9-CM, but in 2015, they were separated into their own groups in the ICD-10-CM codes. In Rural Nevada, emergency department encounters for marijuana and methamphetamines increased from 2017 to 2018, while the number of encounters decreased for opioids, heroin, cocaine, and hallucinogens.

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 2018, more people were admitted into Rural Nevada hospitals for drug-related issues than alcohol related issues. Of the 838 alcohol and/or drug-related admissions, 417 were alcohol-related and 532 were drug-related.

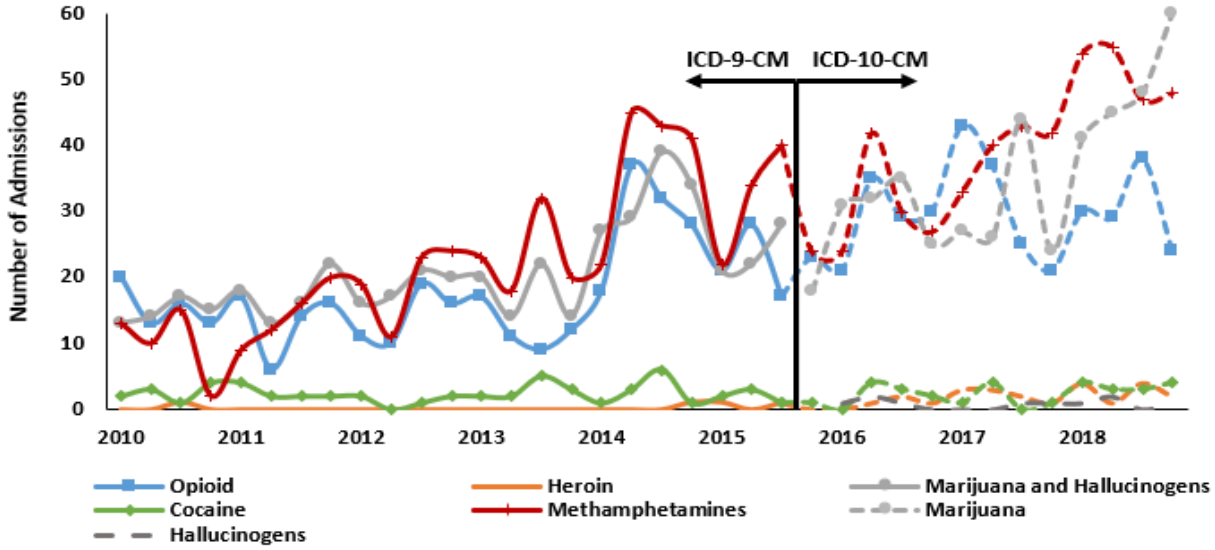
Figure 38. Alcohol and/or Drug-Related Inpatient Admissions in Rural Nevada by Quarter and Year, 2010-2018.



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.

Alcohol-related admissions were more common than drug-related admissions from 2010 to 2016, after which drug-related admissions surpassed alcohol-related admissions.

Figure 39. Drug-Related Inpatient Admissions in Rural Nevada by Quarter and Year, 2010-2018.



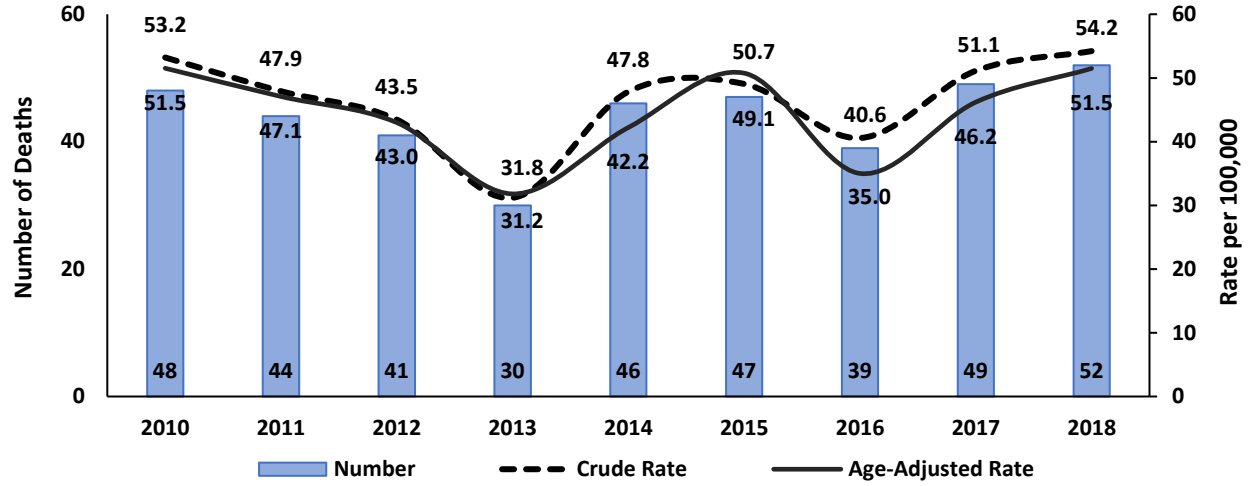
Source: Hospital Inpatient Billing.
Categories are not mutually exclusive.
ICD-9 codes were replaced by ICD-10 codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Hallucinogens and marijuana were grouped together for ICD-9-CM, but in 2015, they were separated into their own groups in the ICD-10-CM codes. From 2010 to 2018, inpatient admissions in Rural Nevada for marijuana and/or hallucinogens, methamphetamines, and opioids have increased, while admissions for heroin and cocaine have remained constant. The most common drug-related inpatient admissions in 2018 were from methamphetamines (204) followed by marijuana (194).

Alcohol and/or Drug-Related Deaths

Alcohol and/or drug-related deaths include deaths where alcohol and/or 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. In 2018, 52 deaths were related to alcohol and/or drugs in Rural Nevada.

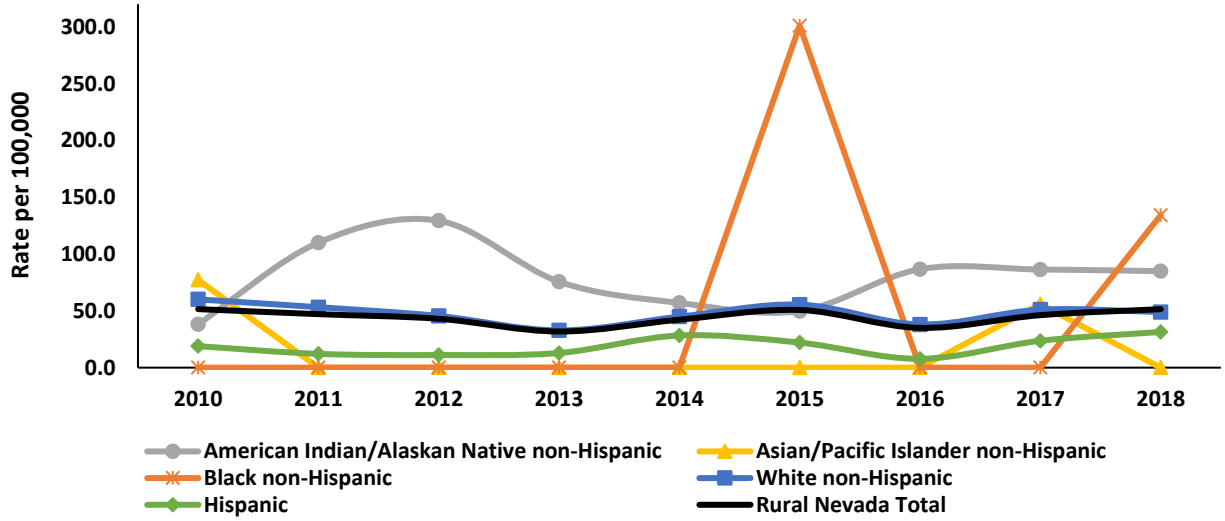
Figure 40. Alcohol and/or Drug-Related Deaths and Age-Adjusted Rates, Rural Nevada Residents, 2010-2018.



Source: Electronic Death Registry System.

The age-adjusted rate for alcohol and/or drug-related deaths in Rural Nevada has increased from 35.0 deaths per 100,000 population in 2016 to 51.5 deaths per 100,000 population in 2018. The age-adjusted rate for alcohol and/or drug-related deaths in Rural Nevada in 2018 is not significantly different from the overall rate in Nevada statewide (50.3 deaths per 100,000 population). From 2010 to 2018, the age group with the most alcohol and/or drug-related deaths was 55 to 64 years.

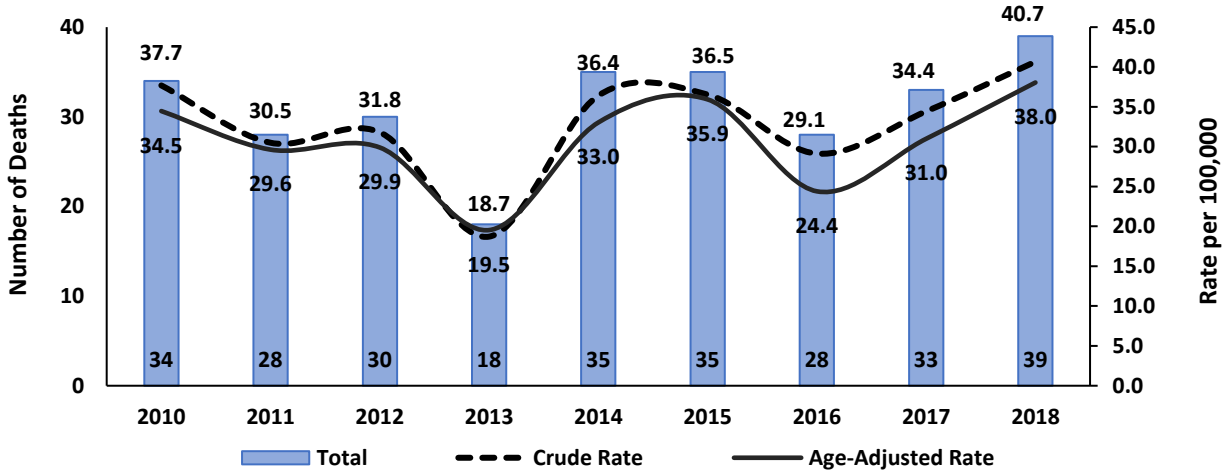
Figure 41. Alcohol and/or Drug-Related Deaths by Race, Rural Nevada Residents, 2010-2018.



Source: Electronic Death Registry System.

The Black non-Hispanic population had the highest rate in alcohol and/or drug-related deaths in 2018 (134.3 deaths per 100,000 population), but the rate is not statistically significant (95% confidence interval) due to the relatively small population size. Overall, from 2010 to 2018, the alcohol and/or drug-related death rate remained constant among races.

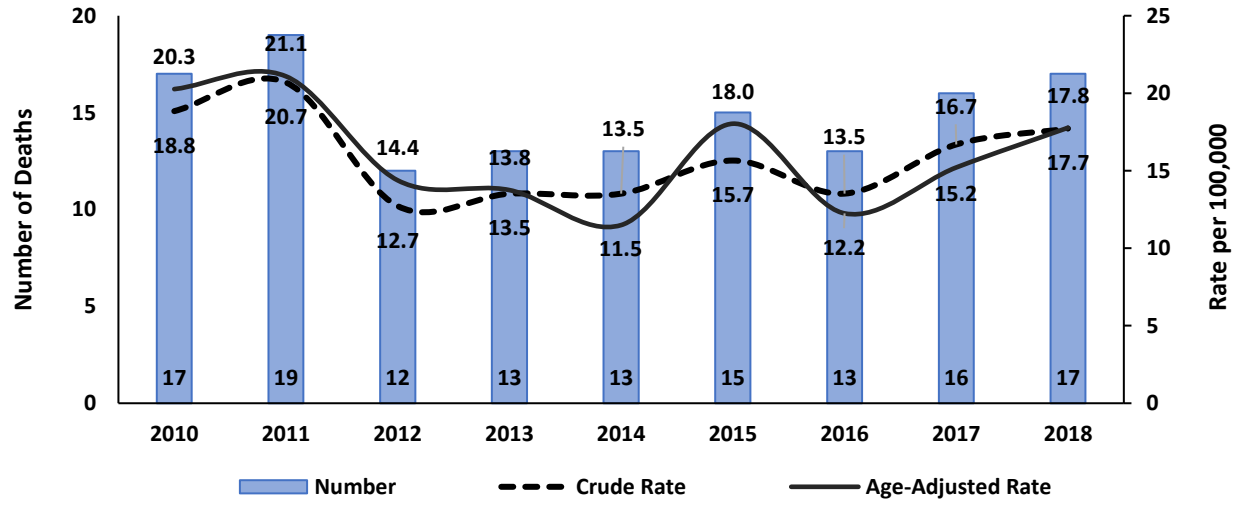
Figure 42. Alcohol-Related Deaths and Age-Adjusted Rates, Rural Nevada Residents, 2010-2018.



Source: Electronic Death Registry System.

Alcohol-related deaths in Rural Nevada have not significantly changed between 2010 to 2018, but there was an increase in deaths from 2016 to 2018. The age-adjusted rate of 38.0 deaths per 100,000 population in Rural Nevada in 2018 was not significantly higher than the Nevada statewide rate of 32.1 deaths per 100,000 population.

Figure 43. Drug-Related Deaths and Age-Adjusted Rates, Rural Nevada Residents, 2010-2018.



Source: Electronic Death Registry System.

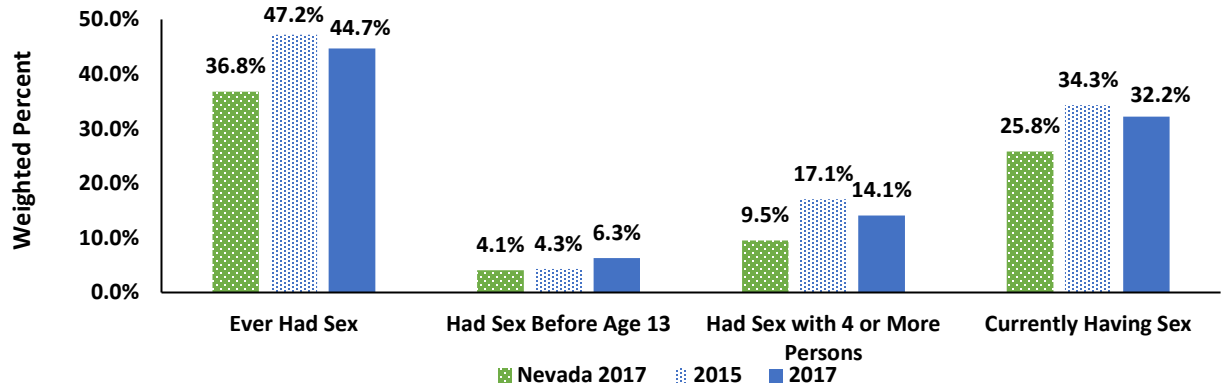
Drug-related deaths in Rural Nevada have not significantly changed between 2010 to 2018, but there was an increase in deaths from 2016 to 2018. The age-adjusted rate of 17.8 deaths per 100,000 population in Rural Nevada in 2018 was not significantly lower than the Nevada statewide rate of 21.4 deaths per 100,000 population.

Youth

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 years. In 2017, 710 high school and 584 middle school students in Rural Nevada participated in the YRBS.

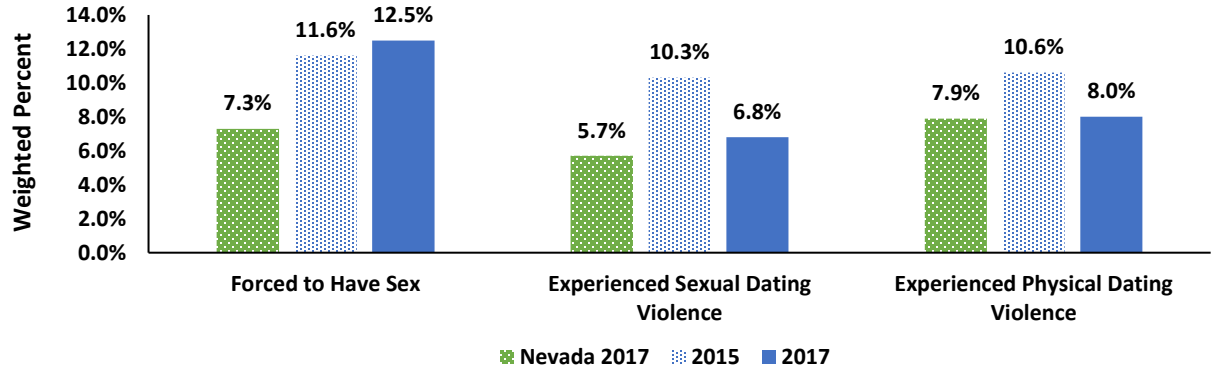
Figure 44. Sexual Behaviors Among Students, Rural Nevada High School Students, 2015 and 2017, and Nevada Statewide High School Students, 2017.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 50% to display differences among groups.

From 2015 to 2017, sexual behaviors among Rural Nevada high schoolers did not significantly change. Nearly half of all Rural Nevada high schoolers reported ever having had sexual intercourse and approximately one-third reported that they were currently sexually active. In 2017, percentages of sexual behaviors were higher in Rural Nevada high schoolers compared to all Nevada high schoolers statewide, although this difference was not significant (95% confidence interval).

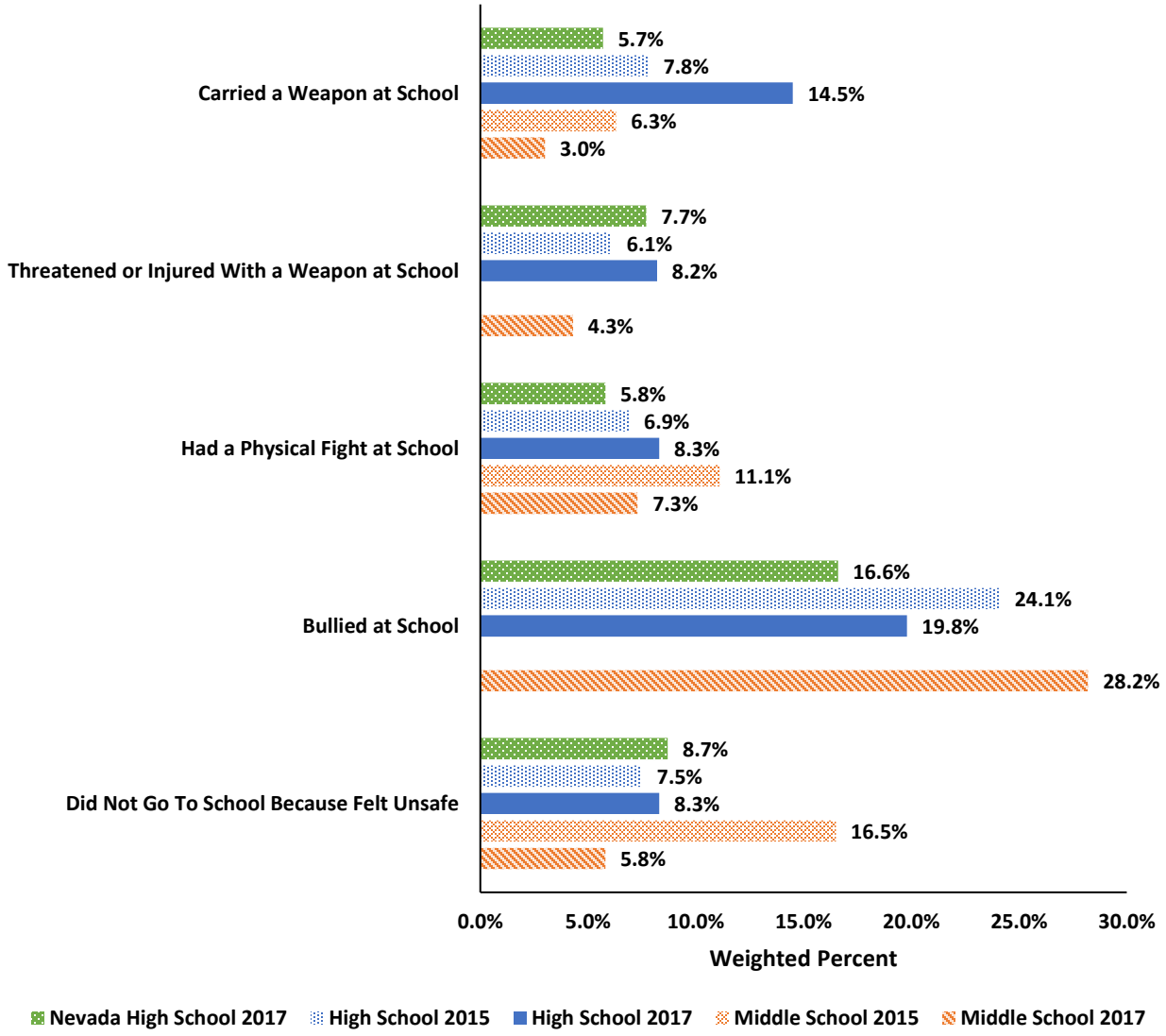
Figure 45. Sexual Violence Among Students, Rural Nevada High School Students, 2015 and 2017, and Nevada Statewide High School Students, 2017.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 14% to display differences among groups.

From 2015 to 2017, the percentages of Rural Nevada high schoolers experiencing sexual or dating violence decreased, although this difference was not statistically significant. In 2017, compared to Nevada high schoolers statewide (7.3%), Rural Nevada high schoolers were significantly more likely to have ever been physically forced to have sexual intercourse (12.5%).

Figure 46. Violence Among Students, Rural Nevada Middle School and High School Students, 2015 and 2017, and Nevada Statewide High School Students, 2017.



Source: Nevada Youth Risk Behavior Survey.
Chart scaled to 30% to display differences among groups.

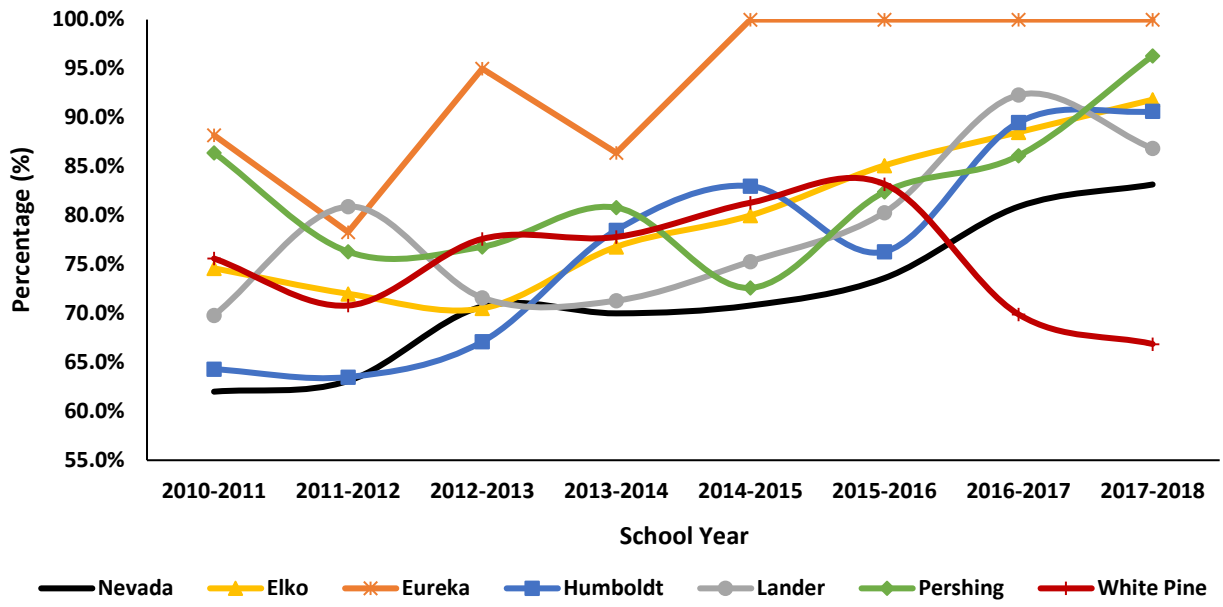
In 2017, Rural Nevada high schoolers (14.5%) were significantly more likely to have carried a weapon on school property in the past 30 days compared to Nevada high schoolers statewide (5.7%); this trend was also seen in 2015. From 2015 to 2017, there was a significant decline in the percentage of Rural Nevada middle schoolers who did not go to school because of feeling unsafe, from 16.5% to 5.8%. In 2017, Rural Nevada middle schoolers (28.2%) were significantly more likely to have been bullied on school property in the past 12 months compared to Nevada middle schoolers statewide (22.7%).

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, students are more likely to experience difficulties in school, such as higher rates of suspensions, expulsions, dropouts, and truancy, as well as poorer grades. Nationally, 50% of students aged 14 and 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. High School Graduation Percentage, Rural Nevada, Class Cohorts 2010–2018.



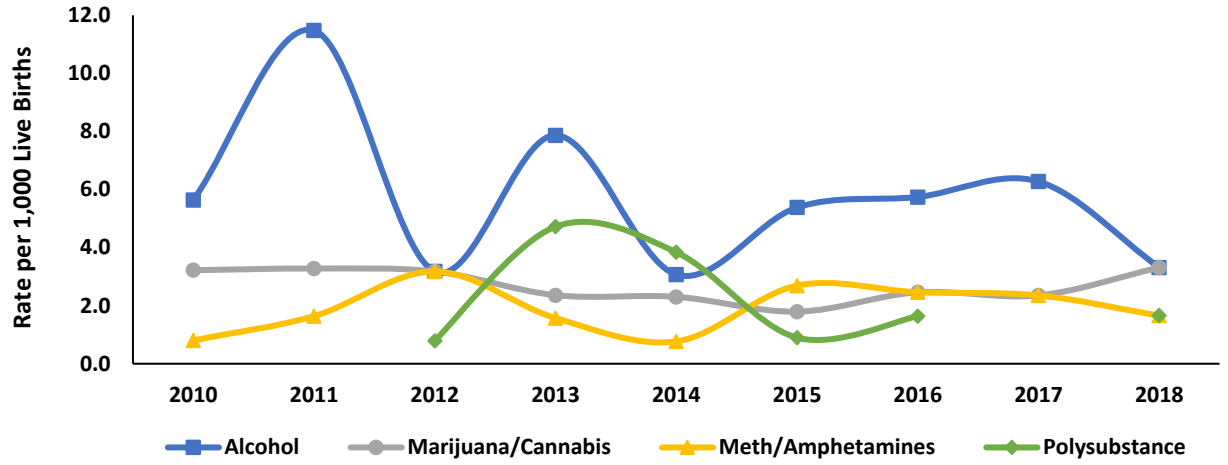
Source: Nevada Department of Education, Report Card.

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). In Rural Nevada, from 2010 to 2018, high school graduation rates have increased, except among White Pine County high schools. For the class of 2018, Rural Nevada high schools posted graduation rates above the overall Nevada statewide rate of 83.2%, except for White Pine County high schools, which saw the lowest graduation rate in Rural Nevada, at 66.9%. Since the 2014-2015 school year, Eureka County has had a 100% high school graduation rate.

Maternal and Child Health

The data in this section is reflective of self-reported information provided by the mother on the birth record. On average, there were 1,234.4 live births per year to Rural Nevada residents between 2010 and 2018. In 2018, four birth certificates indicated alcohol use, four indicated marijuana use, two indicated meth/amphetamine use, and two indicated polysubstance use during the mother's pregnancy.

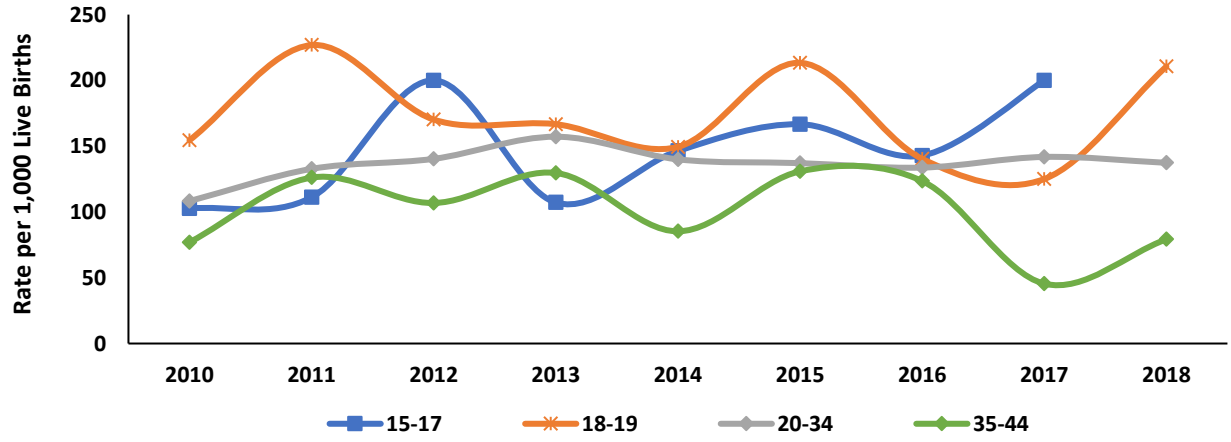
Figure 48. Self-Reported Prenatal Substance Abuse Birth Rates for Select Substances, Rural Nevada, 2010-2018.



Source: Nevada Electronic Birth Registry System.

From 2010 to 2018, prenatal substance abuse in Rural Nevada has remained relatively constant. In 2018, there were approximately 3.3 cases of alcohol or marijuana/cannabis prenatal usage per 1,000 live births and 1.7 cases of methamphetamine or polysubstance prenatal usage per 1,000 live births. 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.

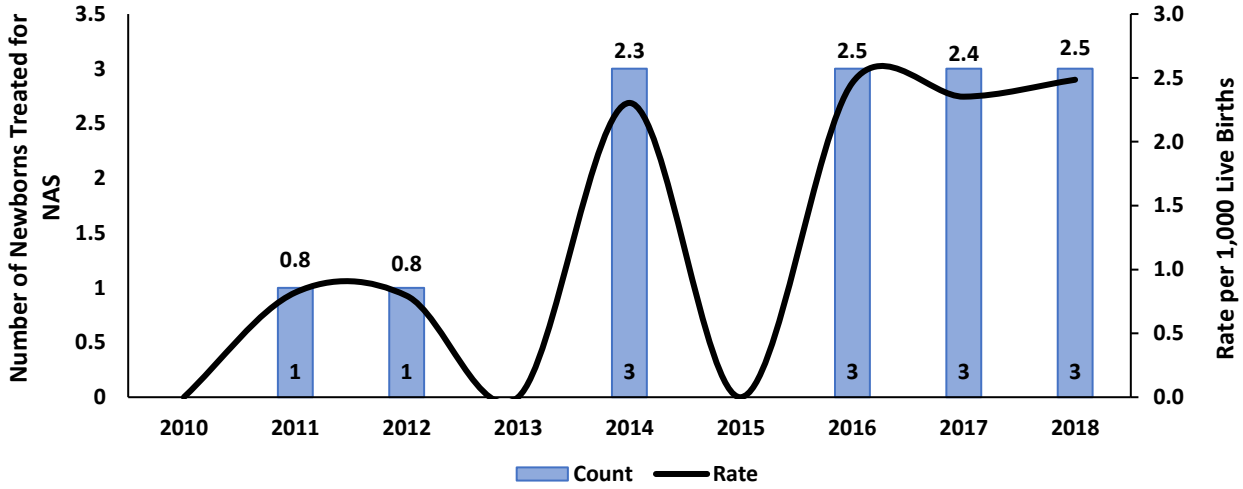
Figure 49. Self-Reported Prenatal Tobacco Use Birth Rates, Rural Nevada, 2010-2018.



Source: Nevada Electronic Birth Registry System.

In 2018, Rural Nevada women who were aged 18 to 19 years had the highest crude rate of tobacco usage during pregnancy (210.5 cases per 1,000 live births), while those aged 35 to 44 years had the lowest crude rate (79.2 cases per 1,000 live births), although this is not significantly different (95% confidence interval). Tobacco prenatal usage rates within each age group have remained constant from 2010 to 2018.

Figure 50. Neonatal Abstinence Syndrome, Rural Nevada, 2010-2018.



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

Neonatal abstinence syndrome (NAS) refers to a cluster of problems that occur in a newborn who has been exposed to addictive illegal or prescription drugs while in the mother's womb. Withdrawal or abstinence symptoms develop shortly after birth. Inpatient admissions for NAS has increased in Rural Nevada since 2010, from zero newborns admitted to three newborns admitted in 2018.

Appendix

Hospital billing data (emergency department 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 death where the ICD codes are 4-digit. In hospital billing data, the ICD codes are provided in the diagnosis fields, while death 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.

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 T410, 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, K73, K74, 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-S64, X85, Y10-Y14 (Initial cause of death).
*The 218 EPI Profile utilized contributing cause of death for drug and alcohol related deaths, this methodology is changed to only the initial cause of death in this report, numbers will have decreased due to this change.

Data Tables

Table 1. Population Distribution, Rural Nevada Residents, 2010-2018.

	2010	2011	2012	2013	2014	2015	2016	2017	2018
Rural	90,213	91,827	94,345	96,185	96,141	95,803	96,130	95,845	95,919
Sex									
Female	41,993	42,946	43,936	44,887	44,855	45,023	45,257	45,263	45,383
Male	48,220	48,881	50,409	51,298	51,286	50,780	50,873	50,582	50,536
Age									
<1	1,409	1,207	1,241	1,153	1,237	991	1,124	1,117	1,097
1-4	5,158	5,239	4,948	5,141	4,986	4,771	4,429	4,355	4,365
5-14	12,158	11,597	11,264	11,142	11,331	11,314	11,484	11,875	12,030
15-24	16,955	18,094	19,235	19,749	18,910	17,303	16,636	14,349	13,260
25-34	7,920	9,128	10,531	11,544	12,433	14,464	15,560	17,358	18,119
35-44	12,358	11,898	11,540	10,970	10,334	9,850	9,460	9,215	9,363
45-54	14,212	13,986	13,852	13,380	13,251	12,945	12,681	12,663	12,284
55-64	10,920	11,153	11,502	12,045	11,849	11,431	11,658	11,654	11,565
65-74	6,042	6,084	6,683	7,463	8,138	8,548	8,622	8,436	8,686
75-84	2,195	2,479	2,543	2,577	2,703	3,125	3,432	3,809	4,086
85+	885	961	1,007	1,019	968	1,060	1,044	1,012	1,065
Race/Ethnicity									
White non-Hispanic	65,181	66,532	68,624	70,069	69,648	67,899	67,887	67,110	66,940
Black non-Hispanic	1,133	1,334	1,375	1,370	1,373	1,423	1,449	1,481	1,491
Native American/Alaskan Native non-Hispanic	4,347	4,430	4,529	4,633	4,632	4,997	5,005	5,140	5,156
Asian/Pacific Islander non-Hispanic	904	954	959	985	1,026	1,153	1,151	1,182	1,191
Hispanic	18,648	18,577	18,857	19,128	19,461	20,332	20,638	20,933	21,141

Source: Nevada State Demographer, Vintage 2018.

Table 2: Prevalence Estimates of Health Risk Behaviors by Region, Nevada Adults, 2018.

Indicator	Clark	Northern	Rural	Southern	Washoe	Nevada
Ever seriously considered attempting suicide during the past 12 months	2.9% (1.6-4.2)	5.0% (2.9-7.0)	5.8% (1.6-10.0)	2.2% (0.0-4.4)	4.4% (2.8-6.0)	3.4% (2.4-4.4)
Heavy Drinkers	5.5% (4.0-7.0)	5.9% (3.5-8.4)	6.8% (3.1-10.4)	9.7% (4.1-15.2)	7.4% (5.6-9.1)	5.9% (4.8-7.1)
Binge Drinkers	13.9% (11.5-16.3)	14.0% (10.3-17.7)	23.5% (17.1-29.8)	10.6% (4.9-16.3)	19.4% (16.4-22.4)	15.0% (13.2-16.9)
General Health Poor or Fair	20.6% (18.0-23.2)	23.8% (19.1-28.5)	20.7% (15.1-26.4)	25.2% (16.7-33.8)	18.4% (15.5-21.4)	20.6% (18.5-22.6)
Depressive Disorder Diagnosis	15.3% (13.0-17.6)	19.2% (15.0-23.4)	12.8% (7.9-17.7)	17.5% (9.8-25.1)	16.7% (13.7-19.6)	15.7% (14.0-17.5)
Ten or more days of poor mental health	15.2% (12.7-17.6)	22.3% (17.4-27.2)	13.6% (8.8-18.5)	13.8% (7.7-19.8)	19.1% (16.0-22.2)	16.1% (14.3-18.0)
Ten or more days of poor mental or physical health kept from usual activities	22.8% (18.8-26.7)	24.7% (18.5-30.8)	16.7% (10.0-23.4)	28.9% (18.4-39.3)	19.4% (15.5-23.3)	22.2% (19.3-25.1)
Used marijuana/hashish in the last 30 days	13.9% (11.2-16.7)	14.4% (10.6-18.1)	11.6% (6.1-17.1)	13.1% (7.2-19.0)	16.8% (13.9-19.8)	14.3% (12.3-16.4)
Used other illegal drugs in the last 30 days	1.1% (0.4-1.7)	2.8% (0.1-5.6)	3.1% (0.0-6.6)	0.7% (0.0-2.0)	1.7% (0.8-2.6)	1.3% (0.8-1.9)
Used prescription drugs/pain killer to get high in last 30 days	1.0% (0.3-1.8)	1.4% (0.0-3.8)	0.9% (0.0-2.8)	0.7% (0.0-2.0)	0.7% (0.1-1.3)	1.0% (0.4-1.6)
Current tobacco cigarette smokers	15.0% (12.6-17.4)	17.4% (13.0-21.8)	25.5% (19.2-31.7)	23.5% (15.3-31.7)	15.2% (12.5-18.0)	15.7% (13.9-17.5)
Currently e-cigarette smokers	5.8% (4.0-7.5)	7.2% (4.3-10.1)	6.2% (2.4-10.1)	6.2% (1.4-11.1)	7.0% (4.9-9.0)	6.1% (4.8-7.4)
Difficulty doing errands alone because of physical, mental, or emotional condition	7.0% (5.4-8.7)	9.4% (5.9-12.8)	7.4% (3.9-10.9)	6.4% (2.8-10.0)	8.2% (5.9-10.4)	7.4% (6.1-8.6)
Serious difficulty concentrating, remembering, or making decisions because of physical, mental, or emotional condition	13.0% (10.6-15.4)	14.9% (10.9-18.9)	13.5% (8.5-18.5)	10.8% (5.6-16.1)	13.1% (10.3-15.9)	13.1% (11.2-14.9)

Source: Behavioral Risk Factor Surveillance System (BRFSS).

For more information about BRFSS indictors: Office of Analytics Reports.

Table 3a. Age-Adjusted Rates per 100,000 of Mental Health-Related Emergency Department Encounters by Region, Nevada Residents, 2018.

Region	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicidal Ideation
Clark	9.2 (8.0-10.5)	137.3 (132.5-142.2)	70.1 (66.7-73.6)	33.5 (31.2-35.9)	10.8 (9.4-12.1)	17.3 (15.6-19.0)
Northern	116.0 (100.5-131.5)	1,632.3 (1,574.9-1,689.6)	817.7 (777.7-857.7)	426.8 (396.5-457.1)	140.2 (122.6-157.9)	230.2 (207.1-253.3)
Rural	33.7 (21.8-45.5)	392.7 (353.6-431.7)	183.7 (156.8-210.6)	84.4 (65.5-103.4)	18.5 (9.7-27.3)	96.4 (76.6-116.2)
Southern	226.5 (184.6-268.5)	1,675.4 (1,569.8-1,781.0)	913.0 (834.6-991.3)	493.4 (431.2-555.5)	153.0 (119.8-186.1)	617.9 (548.6-687.3)
Washoe	104.1 (95.1-113.2)	1,035.3 (1,006.7-1,063.9)	1,122.8 (1,092.9-1,152.7)	356.4 (339.5-373.3)	239.1 (225.0-253.3)	537.4 (516.0-558.9)
Nevada	361.5 (354.7-368.3)	1,912.7 (1,897.2-1,928.2)	1,172.1 (1,160.0-1,184.1)	654.1 (645.0-663.2)	194.1 (189.1-199.0)	566.7 (558.2-575.3)

Source: Hospital Emergency Department Billing.
Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2018.
Categories are not mutually exclusive.

Table 3b. Crude Rates per 100,000 of Mental Health-Related Emergency Department Encounter by Region, Nevada Residents, 2018.

Region	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicidal Ideation
Clark	9.6 (8.3-10.9)	139.5 (134.6-144.5)	72.0 (68.5-75.6)	34.2 (31.8-36.6)	10.9 (9.5-12.3)	17.1 (15.4-18.8)
Northern	113.0 (97.9-128.1)	1,637.5 (1,580.0-1,695.0)	845.3 (804.0-886.6)	401.1 (372.6-429.6)	127.7 (111.7-143.8)	200.3 (180.2-220.4)
Rural	32.3 (20.9-43.7)	404.5 (364.3-444.8)	186.6 (159.3-214.0)	79.2 (61.4-97.0)	17.7 (9.3-26.1)	94.9 (75.4-114.4)
Southern	194.6 (158.5-230.6)	1,680.0 (1,574.2-1,785.9)	906.9 (829.1-984.7)	420.4 (367.5-473.4)	142.5 (111.6-173.3)	529.9 (470.4-589.4)
Washoe	110.7 (101.1-120.4)	1,104.7 (1,074.2-1,135.2)	1,187.8 (1,156.2-1,219.5)	373.7 (355.9-391.4)	241.0 (226.7-255.2)	529.1 (508.0-550.2)
Nevada	360.5 (353.8-367.3)	1,929.5 (1,913.9-1,945.2)	1,195.8 (1,183.5-1,208.1)	652.0 (642.9-661.1)	192.1 (187.2-197.0)	556.4 (548.0-564.8)

Source: Hospital Emergency Department Billing.
Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2018.
Categories are not mutually exclusive.

Table 4a. Age-Adjusted Rates per 100,000 of Mental Health-Related Inpatient Admissions by Region, Nevada Residents, 2018.

Region	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicidal Ideation
Clark	6.8 (5.8-7.9)	128.2 (123.6-132.8)	118.1 (113.7-122.6)	35.5 (33.1-37.9)	24.6 (22.6-26.6)	42.1 (39.4-44.8)
Northern	81.7 (69.1-94.3)	1,365.7 (1,316.7-1,414.7)	1,255.5 (1,208.4-1,302.6)	422.1 (393.2-451.0)	310.1 (284.4-335.8)	538.7 (504.3-573.0)
Rural	27.7 (16.4-39.0)	226.9 (197.5-256.3)	212.7 (184.2-241.2)	73.8 (56.8-90.7)	34.5 (22.3-46.6)	76.6 (59.2-93.9)
Southern	162.0 (128.0-196.0)	1,182.1 (1,102.3-1,261.8)	1,095.9 (1,017.6-1,174.2)	507.3 (448.9-565.7)	219.3 (181.3-257.2)	472.4 (413.6-531.2)
Washoe	104.1 (95.1-113.2)	1,035.3 (1,006.7-1,063.9)	1,122.8 (1,092.9-1,152.7)	356.4 (339.5-373.3)	239.1 (225.0-253.3)	537.4 (516.0-558.9)
Nevada	38.8 (23.3-54.4)	582.9 (524.9-640.9)	561.3 (504.7-617.9)	137.2 (108.4-166.1)	126.2 (97.1-155.4)	131.1 (103.6-158.7)

Source: Hospital Inpatient Billing.
Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2018.
Categories are not mutually exclusive.

Table 4b. Crude Rates per 100,000 of Mental Health-Related Inpatient Admissions by Region, Nevada Residents, 2018.

Region	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicidal Ideation
Clark	7.3 (6.1-8.4)	133.7 (128.9-138.5)	122.1 (117.5-126.7)	36.8 (34.3-39.3)	25.1 (23.0-27.2)	42.4 (39.7-45.1)
Northern	85.2 (72.0-98.3)	1,568.6 (1,512.4-1,624.9)	1,433.0 (1,379.2-1,486.8)	431.6 (402.1-461.1)	294.4 (270.0-318.8)	497.3 (465.6-529.0)
Rural	24.0 (14.2-33.8)	238.7 (207.8-269.7)	223.1 (193.2-253.0)	76.1 (58.6-93.6)	32.3 (20.9-43.7)	78.2 (60.5-95.9)
Southern	151.2 (119.4-182.9)	1,466.3 (1,367.4-1,565.3)	1,308.2 (1,214.8-1,401.7)	503.8 (445.9-561.8)	222.4 (183.9-260.9)	430.9 (377.2-484.5)
Washoe	110.7 (101.1-120.4)	1,104.7 (1,074.2-1,135.2)	1,187.8 (1,156.2-1,219.5)	373.7 (355.9-391.4)	241.0 (226.7-255.2)	529.1 (508.0-550.2)
Nevada	36.2 (21.7-50.7)	585.7 (527.4-644.0)	570.6 (513.1-628.1)	131.3 (103.7-158.9)	108.7 (83.6-133.8)	131.3 (103.7-158.9)

Source: Hospital Inpatient Billing.
Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2018.
Categories are not mutually exclusive.

Table 5. Suicides (Crude) Rates by Age, Race/Ethnicity and Region, Nevada Residents, 2018.

	Clark	Northern	Rural	Southern	Washoe	Nevada
Age Group						
Less then 15	1.8 (0.5-03.0)	0.0 -	0.0 -	36.5 (0.0-77.8)	0.0 -	1.8 (0.8-2.9)
15-24	17.5 (12.7-22.3)	37.7 (4.7-70.8)	13.6 (0.0-29.1)	0.0 -	11.3 (2.9-19.8)	16.7 (12.7-20.7)
25-34	24.3 (18.8-29.8)	16.6 (0.0-35.3)	29.4 (7.6-51.2)	44.7 (0.0-95.4)	12.4 (3.8-20.9)	23.2 (18.7-27.8)
35-44	24.2 (18.8-29.6)	32.0 (0.0-68.3)	50.2 (19.1-81.3)	0.0 -	22.4 (10.2-34.6)	25.8 (20.9-30.7)
45-54	27.6 (21.6-33.5)	48.8 (9.8-87.9)	27.6 (7.2-48.1)	46.6 (0.0-99.3)	32.5 (17.5-47.5)	30.5 (25.0-35.9)
55-64	28.4 (21.9-34.9)	34.6 (0.7-68.5)	37.2 (14.1-60.3)	56.2 (6.9-105.4)	24.0 (11.4-36.6)	30.0 (24.4-35.7)
65-74	22.4 (15.6-29.3)	57.6 (7.1-108.0)	29.0 (7.5-50.5)	84.4 (21.9-147.0)	33.7 (16.6-50.8)	30.2 (23.6-36.7)
75-84	36.2 (23.6-48.7)	24.5 (0.0-72.4)	47.5 (9.5-85.6)	18.1 (0.0-53.4)	25.5 (3.1-47.8)	34.5 (24.4-44.6)
85+	30.2 (9.3-51.1)	93.9 (0.0-278.1)	64.8 (0.0-138.1)	130.5 (0.0-311.4)	64.3 (1.3-127.3)	45.1 (24.2-65.9)
Race/Ethnicity						
White non-Hispanic	31.7 (28.2-35.2)	32.9 (19.1-46.6)	32.6 (23.4-41.8)	49.0 (28.5-69.5)	25.8 (20.0-31.7)	32.3 (29.4-35.1)
Black non-Hispanic	14.0 (9.4-18.7)	0.0 -	0.0 -	0.0 -	0.0 -	13.2 (8.8-17.5)
Native American/Alaskan Native non-Hispanic	6.7 (0.0-19.7)	0.0 -	52.3 (0.0-111.5)	0.0 -	0.0 -	14.2 (1.8-26.7)
Asian/Pacific Islander non-Hispanic	13.1 (8.6-17.5)	0.0 -	0.0 -	0.0 -	12.6 (0.3-25.0)	13.4 (9.2-17.6)
Hispanic	8.6 (6.5-10.8)	28.4 (5.7-51.1)	6.6 (0.0-15.6)	24.9 (0.0-59.3)	4.4 (0.5-08.2)	8.6 (6.7-10.6)
Total	20.1 (18.3-22.0)	29.2 (18.4-40.0)	27.9 (20.4-35.4)	41.7 (25.0-58.4)	18.4 (14.5-22.4)	21.7 (20.0-23.3)

Source: Electronic Death Registry System.

Rates are per 100,000 population, provided by the state demographer, vintage 2018.

Table 6. Suicide Attempts and Suicides by Leading Method and Region, Nevada Residents, 2018.

Region	Suicide Attempts				Suicides		
	Emergency Department Encounters		Inpatient Admissions		Substance	Hanging/ Suffocation	Firearms/ Explosives
	Substance	Cutting	Substance	Cutting			
Clark	63.7 (60.4-67.0)	28.3 (26.1-30.5)	53.3 (50.3-56.3)	7.2 (6.1-08.3)	3.0 (2.3-03.8)	5.0 (4.1-05.9)	10.5 (9.2-11.9)
Northern	53.1 (42.7-63.4)	20.0 (13.6-26.3)	72.0 (60.0-84.1)	22.6 (15.8-29.4)	4.2 (1.3-07.1)	5.3 (2.0-08.5)	16.8 (11.0-22.7)
Rural	81.3 (63.3-99.4)	30.2 (19.2-41.2)	40.7 (27.9-53.4)	1.0 (0.0-03.1)	3.1 (0.0-06.7)	2.1 (0.0-05.0)	22.9 (13.4-32.5)
Southern	93.8 (68.8-118.8)	55.6 (36.3-74.9)	48.6 (30.6-66.7)	12.2 (3.2-21.2)	6.9 (0.1-13.8)	5.2 (0.0-11.1)	29.5 (15.5-43.6)
Washoe	64.5 (57.1-71.8)	11.4 (8.3-14.5)	66.7 (59.2-74.2)	11.0 (7.9-14.0)	3.7 (2.0-05.5)	2.4 (1.0-03.8)	10.5 (7.5-13.5)
Nevada	64.3 (61.4-67.1)	25.8 (24.0-27.6)	56.0 (53.3-58.7)	8.6 (7.6-09.7)	3.4 (2.7-04.1)	4.7 (3.9-05.4)	12.1 (10.9-13.3)

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 2018.

Table 7. Mental Health-Related Deaths Age-Adjusted Rates by Region, Nevada Residents, 2018.

Region	White non-Hispanic	Black non-Hispanic	Native American/ Alaskan Native	Asian/Pacific Islander	Hispanic	Total
Clark	48.7 (45.0-52.5)	52.1 (41.0-63.2)	9.3 (0.0-27.5)	33.6 (25.2-42.0)	29.8 (22.3-37.4)	45.1 (42.1-48.1)
Northern	64.6 (55.0-74.2)	75.0 (0.0-222.0)	45.7 (0.0-97.4)	62.2 (0.0-148.4)	45.6 (9.1-82.1)	62.6 (53.7-71.6)
Rural	45.0 (29.2-60.9)	0.0 -	20.8 (0.0-61.6)	0.0 -	6.3 (0.0-18.5)	39.4 (26.0-52.9)
Southern	31.1 (19.9-42.2)	0.0 -	67.9 (0.0-201.0)	0.0 -	0.0 -	30.0 (19.4-40.5)
Washoe	62.0 (53.9-70.0)	116.1 (23.2-208.9)	73.7 (0.0-175.9)	48.5 (19.9-77.2)	28.0 (10.7-45.4)	60.3 (52.9-67.6)
Nevada	52.4 (49.3-55.4)	55.2 (44.0-66.3)	28.5 (8.8-48.3)	35.1 (27.1-43.1)	29.6 (23.0-36.1)	48.7 (46.1-51.3)

Source: Electronic Death Registry System.
Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2018.

Table 8a. Drug-Related Emergency Department Encounters Age-Adjusted Rates by Drug Type and Region, Nevada Residents, 2018.

Region	Opioids	Heroin	Cocaine	Methampetamines	Marijuana	Hallucinogens
Clark	204.4 (198.6-210.3)	9.7 (8.4-10.9)	91.1 (87.1-95.0)	474.4 (465.3-483.5)	424.6 (416.0-433.2)	19.9 (18.0-21.7)
North	193.9 (174.3-213.4)	8.3 (4.6-12.0)	26.4 (18.5-34.2)	274.6 (249.4-299.7)	327.1 (300.0-354.2)	4.9 (1.5-8.3)
Rural	167.1 (141.5-192.6)	11.9 (5.2-18.6)	16.0 (8.2-23.9)	298.6 (263.6-333.6)	379.9 (342.0-417.9)	1.0 (0.0-3.1)
Southern	213.5 (174.3-252.7)	9.7 (3.0-16.4)	20.5 (7.8-33.3)	406.2 (350.9-461.5)	610.5 (541.9-679.0)	9.3 (0.2-18.4)
Washoe	233.2 (219.4-247.0)	12.2 (9.0-15.3)	57.5 (50.5-64.5)	512.2 (491.0-533.4)	290.3 (274.5-306.1)	5.6 (3.4-7.7)
Nevada	300.1 (294.1-306.1)	12.3 (11.1-13.5)	73.7 (70.7-76.6)	393.9 (386.8-401.0)	443.0 (435.6-450.4)	6.7 (5.8-7.7)

Source: Hospital Emergency Department Billing.
Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2018.
Categories are not mutually exclusive.

Table 8b. Drug-Related Emergency Department Encounters Crude Rates by Drug Type and Region, Nevada Residents, 2018.

Region	Opioids	Heroin	Cocaine	Methampetamines	Marijuana	Hallucinogens
Clark	208.7 (202.7-214.7)	9.7 (8.4-11.0)	93.0 (89.0-97.0)	467.4 (458.5-476.4)	421.8 (413.3-430.4)	19.6 (17.7-21.4)
North	198.2 (178.2-218.2)	10.0 (5.5-14.5)	22.6 (15.8-29.4)	240.2 (218.2-262.3)	294.9 (270.5-319.3)	4.2 (1.3-7.1)
Rural	171.0 (144.8-197.1)	12.5 (5.4-19.6)	16.7 (8.5-24.9)	291.9 (257.7-326.1)	401.4 (361.3-441.5)	1.0 (0.0-3.1)
Southern	198.1 (161.7-234.4)	13.9 (4.3-23.5)	17.4 (6.6-28.1)	359.6 (310.6-408.6)	529.9 (470.4-589.4)	6.9 (0.1-13.8)
Washoe	240.1 (225.9-254.3)	12.5 (9.3-15.7)	57.0 (50.1-63.9)	492.1 (471.7-512.4)	285.3 (269.8-300.8)	5.5 (3.3-7.6)
Nevada	316.3 (310.0-322.7)	13.4 (12.1-14.7)	77.5 (74.4-80.6)	390.7 (383.7-397.8)	451.3 (443.7-458.9)	6.6 (5.7-7.5)

Source: Hospital Emergency Department Billing.
Rates are per 100,000 population, provided by the state demographer, vintage 2018.
Categories are not mutually exclusive.

Table 9a. Drug-Related Inpatient Admissions Age-Adjusted Rates by Drug Type and Region, Nevada Residents, 2018.

Region	Opioids	Heroin	Cocaine	Methampetamines	Marijuana	Hallucinogens
Clark	289.9 (283.0-296.8)	10.3 (9.0-11.6)	88.0 (84.2-91.8)	391.6 (383.4-399.8)	457.9 (449.1-466.7)	6.9 (5.8-8.0)
North	390.9 (363.9-417.8)	17.4 (11.8-23.0)	38.6 (29.5-47.8)	433.7 (402.3-465.2)	508.4 (475.6-541.3)	8.8 (4.2-13.4)
Rural	120.3 (98.9-141.7)	8.9 (3.7-14.2)	17.1 (8.1-26.0)	207.1 (178.7-235.5)	201.1 (172.8-229.4)	4.8 (0.1-9.5)
Southern	142.5 (114.6-170.4)	6.9 (.9-13.0)	23.3 (11.1-35.4)	272.2 (227.4-316.9)	425.5 (373.4-477.5)	2.0 (0.0-6.0)
Washoe	364.6 (347.8-381.5)	20.9 (16.9-24.8)	37.6 (31.9-43.2)	436.5 (417.1-455.8)	395.4 (377.3-413.4)	6.0 (3.7-8.4)
Nevada	300.1 (294.1-306.1)	12.3 (11.1-13.5)	73.7 (70.7-76.6)	393.9 (386.8-401.0)	443.0 (435.6-450.4)	6.7 (5.8-7.7)

Source: Hospital Inpatient Billing.
Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2018.
Categories are not mutually exclusive.

Table 9b. Drug-Related Inpatient Admissions Crude Rates by Drug Type and Region, Nevada Residents, 2018.

Region	Opioids	Heroin	Cocaine	Methampetamines	Marijuana	Hallucinogens
Clark	301.9 (294.7-309.1)	11.0 (9.6-12.4)	93.1 (89.1-97.1)	392.5 (384.3-400.8)	467.4 (458.4-476.4)	6.9 (5.8-8.0)
North	425.8 (396.5-455.1)	19.5 (13.2-25.7)	36.3 (27.7-44.8)	384.8 (356.9-412.7)	484.2 (452.9-515.4)	7.4 (3.5-11.2)
Rural	126.1 (103.7-148.6)	11.5 (4.7-18.2)	14.6 (6.9-22.2)	212.7 (183.5-241.9)	202.3 (173.8-230.7)	4.2 (0.1-8.3)
Southern	173.7 (139.7-207.8)	8.7 (1.1-16.3)	24.3 (11.6-37.1)	246.7 (206.1-287.3)	446.5 (391.9-501.1)	1.7 (0.0-5.1)
Washoe	392.9 (374.8-411.1)	23.2 (18.8-27.7)	37.5 (31.9-43.1)	429.6 (410.5-448.6)	403.9 (385.5-422.4)	5.7 (3.5-7.9)
Nevada	316.3 (310.0-322.7)	13.4 (12.1-14.7)	77.5 (74.4-80.6)	390.7 (383.7-397.8)	451.3 (443.7-458.9)	6.6 (5.7-7.5)

Source: Hospital Inpatient Billing.
Rates are per 100,000 population, provided by the state demographer, vintage 2018.
Categories are not mutually exclusive.

Table 10. Drug- and Alcohol-Related Age-Adjusted Death Rates by Race/Ethnicity and Region, Nevada Residents, 2018.

Region	White non-Hispanic	Black non-Hispanic	Native American/ Alaskan Native	Asian/ Pacific Islander	Hispanic	Total
Clark	59.6 (55.3-63.9)	47.4 (38.7-56.1)	55.1 (19.1-91.0)	18.8 (13.5-24.1)	28.0 (23.6-32.4)	45.1 (42.4-47.8)
Northern	60.7 (50.0-71.4)	75.0 (0.0-222.0)	10.5 (0.0-31.0)	0.0 -	43.8 (15.2-72.5)	55.0 (45.8-64.3)
Rural	49.0 (33.6-64.3)	134.3 (0.0-397.5)	84.9 (0.0-181.0)	0.0 -	31.4 (8.1-54.7)	51.5 (37.5-65.5)
Southern	83.9 (61.7-106.0)	81.2 (0.0-193.6)	67.9 (0.0-201.0)	0.0 -	43.7 (0.0-93.1)	79.4 (59.7-99.2)
Washoe	69.2 (69.2-69.2)	78.3 (78.3-78.3)	150.9 (150.9-150.9)	14.7 (14.7-14.7)	32.6 (32.6-32.6)	58.4 (58.4-58.4)
Nevada	63.7 (60.2-67.2)	50.4 (41.7-59.1)	69.3 (42.7-95.9)	18.2 (13.4-23.1)	30.2 (26.0-34.3)	50.3 (47.9-52.7)

Source: Electronic Death Registry System.

Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2018.