

# *Substance Abuse Prevention and Treatment Agency 2019 Epidemiologic Profile*

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*Nevada  
October 2019*

*Office of Analytics on behalf of*



**Nevada Department of  
Health and Human Services**

**DIVISION OF PUBLIC AND  
BEHAVIORAL HEALTH**



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# Acknowledgements

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# Data Sources/Limitations

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## **Age-Adjusted Rates**

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

## **Enhanced HIV/AIDS Reporting System**

The Enhanced HIV/AIDS Report System (eHARS) is a Centers for Disease Control and Prevention (CDC) developed application used by Nevada Division of Public and Behavioral Health for data management, reporting, and analysis.

## **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.

## **Monitoring the Future Survey**

Since 1975 Monitoring the Future Survey has measured alcohol and drug use, and related attitudes among adolescent students nationwide. Survey participants report their drug use behaviors across three-time periods: lifetime, past year, and past month. Students from both public and private schools participate in

the survey. The survey is funded by the National Institute on Drug Abuse (NIDA), a component of the National Institutes of Health (NIH), and conducted by the University of Michigan.

### **Medicaid**

The Division of Health Care Financing and Policy (DHCFP) data warehouse is comprised of claims data submitted by over 28,000 Medicaid providers from within Nevada and across the country. While DHCFP staff conscientiously make every effort to validate these data through continuous provider education and the use of highly experienced audit staff, the Division relies heavily on providers to submit accurate and complete information on Medicaid patients. It should therefore be understood by the users of DHCFP reports on disease morbidity and patient health that the data source for these reports are based solely on patient claims data and may not be a complete and comprehensive health record.

### **Nevada 211**

Nevada 211 is a phone number that helps Nevadans connect with services they need including mental health-related services, substance abuse and prevention, suicide crisis intervention, and pregnancy-related concerns and help.

### **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”.

### **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](#).

### **Treatment Episode Data Sets**

Treatment Episode Data Sets (TEDS) are a compilation of demographic, substance use, mental health, clinical, legal, and socioeconomic characteristics of persons who are receiving publicly funded substance use and/or mental health services. State administrative data systems, claims, and encounter data are the primary data sources. The state role in submitting TEDS to the Substance Abuse and Mental Health Services Administration (SAMHSA) is critical, since TEDS is the only national data source for client-level information on persons who use substance use treatment services. TEDS also provides a mechanism for states to report treatment admissions and discharges of persons receiving mental health services. This

reporting framework supports SAMHSA's initiative to build a national behavioral health data set accessible (with appropriate confidentiality protection) by the public; local, state, and federal policymakers; researchers; and many others for comparisons and trends on the characteristics of persons receiving substance use and/or mental health treatment services. TEDS provides outcomes data in support of SAMHSA's program, performance measurement, and management goals.

### **United States Census Bureau**

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

### **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 9<sup>th</sup> through 12<sup>th</sup> 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

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

Key Findings:

- **Mental Health**

- Female students have significantly higher percent of feeling sad/hopeless, and suicide thoughts including considering, planning and attempting suicide.
- Female adults have significantly higher response rate for reporting days of poor physical or mental health, and those age 18-24 had significantly higher poor mental health than other age groups. The Health Community Coalition (HCC) had significantly higher days of poor mental health.
- Females have reported a significantly higher percent of being told they have a depressive disorder.
- For emergency department encounters anxiety is the leading mental health-related diagnosis. Females have significantly higher visits for anxiety, depression, bipolar disorder and PTSD, whereas males are significantly higher encounters for schizophrenia and suicide ideation. The Churchill Community Coalition (CCC), and Partners Allied for Community Excellence (PACE) had significantly higher visits for anxiety and depression.
- For inpatient admissions unlike emergency department encounters, depression is the leading diagnosis for mental health-related inpatient admissions. The PACT/CARE coalitions (Clark County) have significantly higher admissions for schizophrenia, bipolar disorder, and suicide ideation, whereas CCC and HCC have significantly higher admissions from anxiety and PTSD.
- Unique clients served at State-funded mental health clinics has declined significantly since 2011. The Affordable Care Act (ACA) went into effect in 2014. Therefore, many Nevada residents are now able to access non-state-funded facilities through the expansion of Medicaid. This likely contributes to the decline of the clients represented in the above chart.
- The Nye Community Coalition has a significantly higher crude rate for suicide in 2018.
- The Partnership Carson City (PCC) and Join Together Northern Nevada (JTNN) coalitions have significantly higher rates for mental health related deaths.
- The LGBT community have significantly higher percent of depressive disorder diagnosis's and days of poor mental health.

- **Substance Abuse**

- Nevada is comparable to the nation with marijuana use among youth (YRBS).
- Drugs use among teens is higher in Nevada than the nation.
- Marijuana use has more than doubled from 2011 to 2018. Adults age 25-34 were significantly higher than Nevada.
- Binge drinking is significantly higher among those aged 18-54 and in the JTNN coalition.
- Emergency department and Inpatient visits for both drugs and alcohol continue to increase both counts and rates which consider population growth.
- Emergency department and inpatient visits have increase to marijuana use and is the leading drug-related visits.

## Nevada SAPTA EPI Profile

- The PACT/CARE coalition (Clark County) had significantly lower rate due to drug and alcohol deaths.
- Since marijuana has been legalized in 2017, reported marijuana use during pregnancy has more than doubled and has surpassed all other substances.
- Teen pregnancy has significantly lower rate of tobacco use during pregnancy than all other age groups.
- The LGBT community have significantly higher percent of current marijuana use.

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# Demographic Snapshot

Figure 1. Selected Demographics for Nevada.

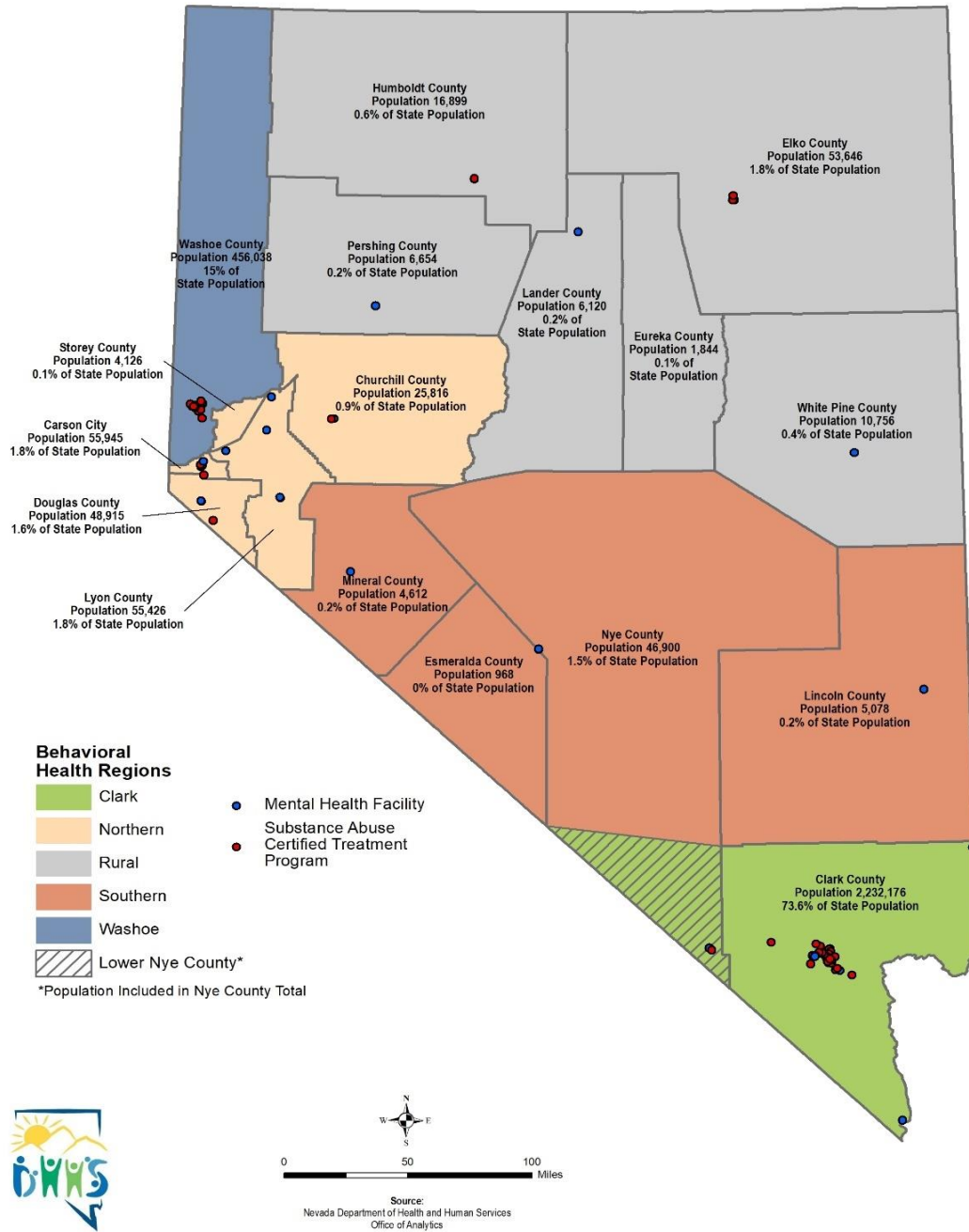
	<b>Nevada</b>
Population, 2018 estimate*	3,031,919
Population, 2010 estimate*	2,705,845
Population, percentage change*	12.1%
Male persons, 2018 estimate*	1,519,219 (50.1%)
Female Persons, 2018 estimate*	1,512,700 (49.9%)
Median household income (2017), 2013-2017**	\$55,434
Per capita income in the past 12 months (2017), 2013-2017**	\$28,450
Persons in poverty, percent (2017) **	14.2%
With a disability, under the age 65 years, percent, 2013-2017**	9.1%
Land area (square miles), 2017**	109,806

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



In 2018, the estimated population for Nevada was 3,031,919, a 12.1% increase from the 2010 estimated population. The population is made up of approximately equal percentages of females and males. The median household income is \$55,434. Nevada’s land area is approximately 109,806 square miles.

Figure 2. Nevada Population Distribution by County, 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, Pershing, and White Pine Counties.

**Southern Nevada Region:** Esmeralda, Lincoln, and northern Nye Counties.

**Washoe Region:** Washoe County.

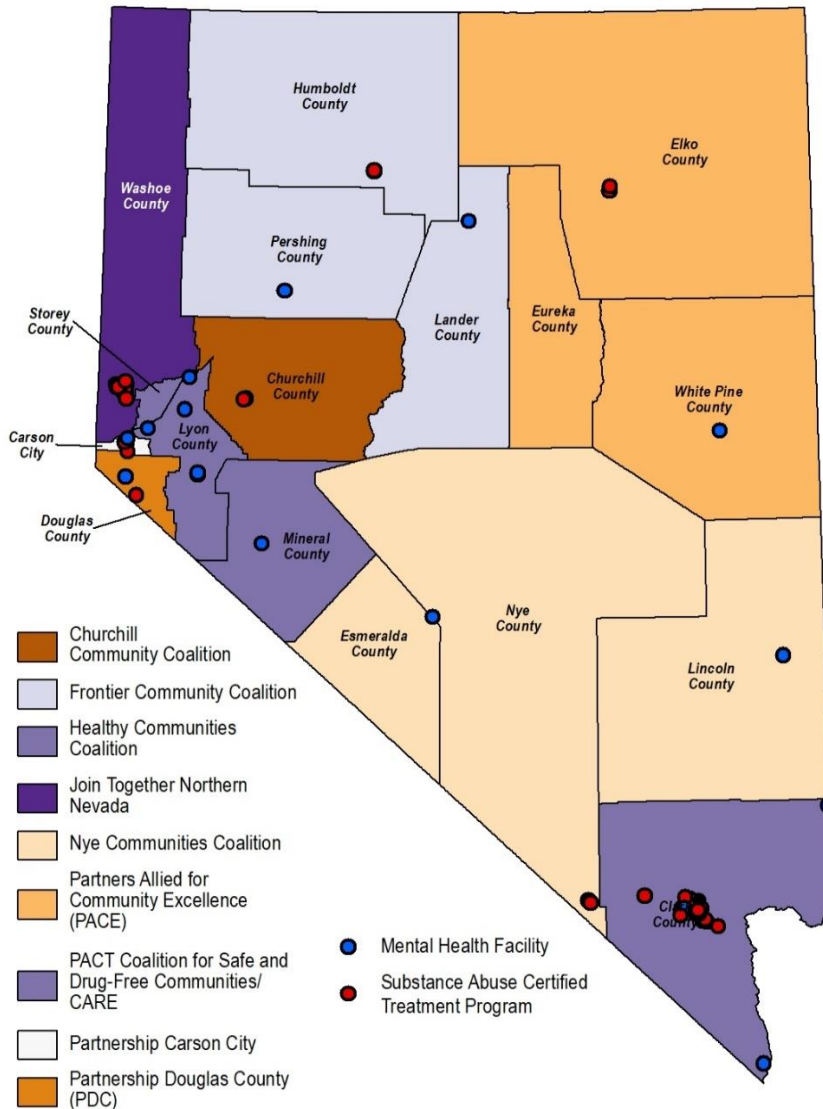
\*Nye County: North Nye County is included in Southern Region and southern Nye County is in part of Clark County Region. For data purposes, Nye county data is included in Southern Nevada Region Report and not in the Clark County Region report.

## Nevada SAPTA EPI Profile

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

With 73.6% of Nevada’s population living in Clark County, it is the most populous area in the state, with 2,232,176 persons. Esmeralda County is the least populous county, with 0.4% of Nevada’s population, an estimated 968 persons.

**Figure 3. SAPTA Prevention Coalitions, 2018.**

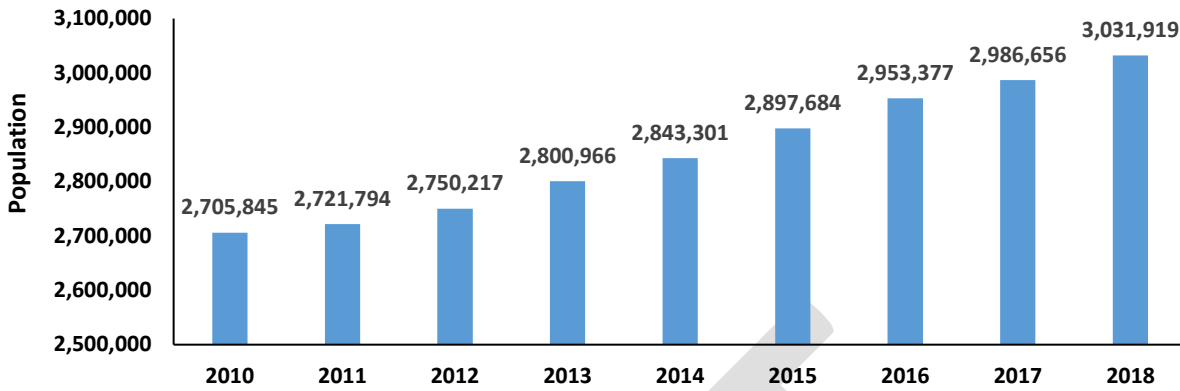


SAPTA currently supports 10 (2 in Clark County) community coalitions that pass-through the funding for direct services to providers for prevention. The programs are funded to provide one or more prevention strategies that are promoted by the Center for Substance Abuse Prevention (CSAP). Those strategies are:

- Information dissemination
- Prevention education
- Alternative activities
- Problem identification and referral
- Community-based processes
- Environmental strategies

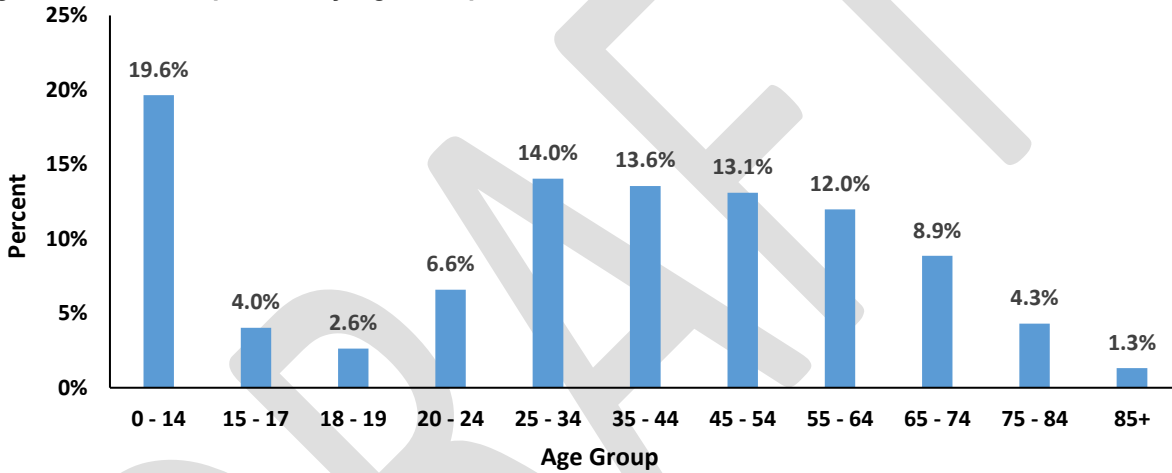
Source: Nevada State Demographer, Vintage 2018.

Figure 4. Nevada Population, 2010-2018.



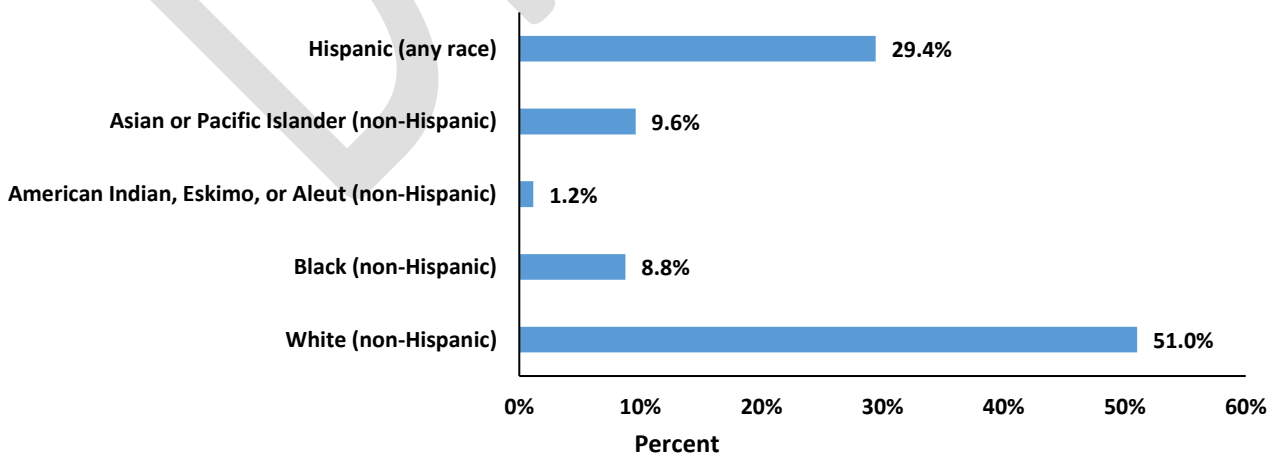
Source: Nevada State Demographer, Vintage 2018.

Figure 5. Nevada Population by Age Group, 2018.



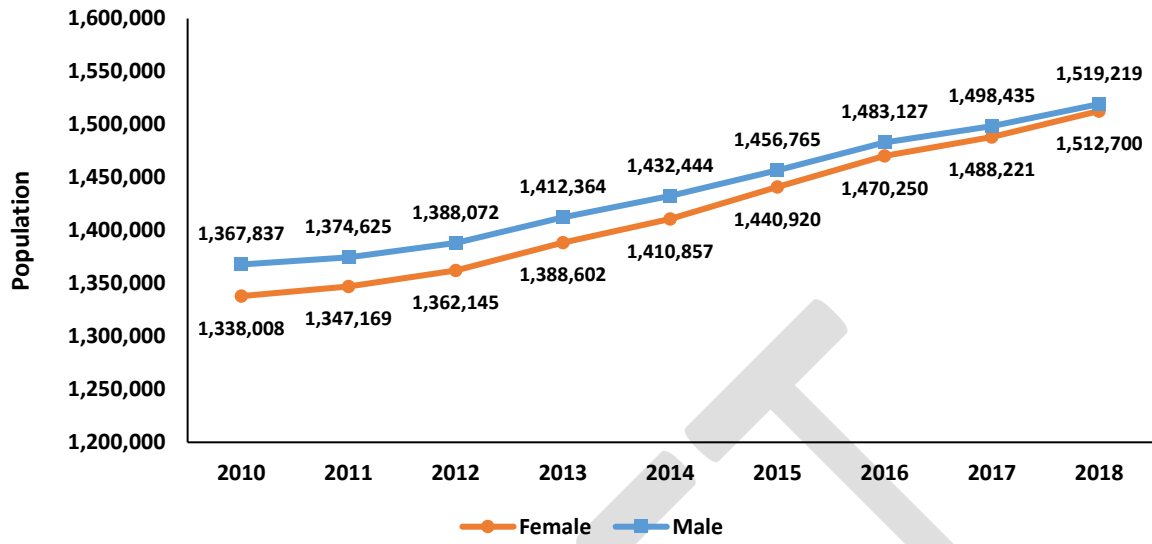
Source: Nevada State Demographer, Vintage 2018.  
Chart scaled to 25% to display differences among groups.

Figure 6. Nevada Population by Race/Ethnicity, 2018.



Source: Nevada State Demographer, Vintage 2018.  
Chart scaled to 60% to display differences among groups.

Figure 7. Nevada Population Distribution by Sex, 2010-2018.



Source: Nevada State Demographer, Vintage 2018.  
Chart scaled to display differences among years.

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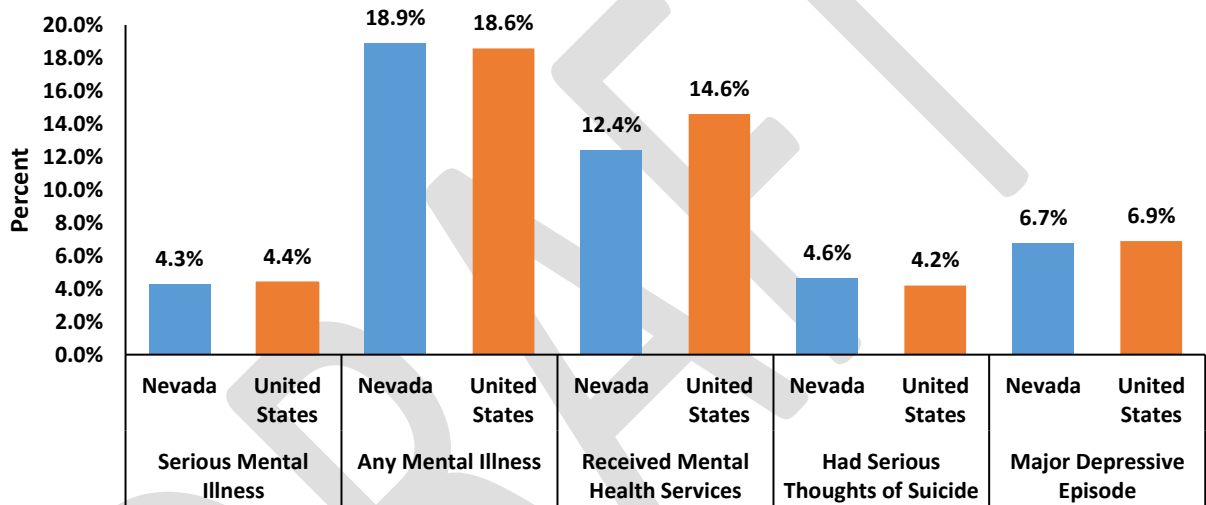
# Mental Health

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 8. Percent of Mental Health Measures, Nevada and United States, 2016-2017.**



*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.*

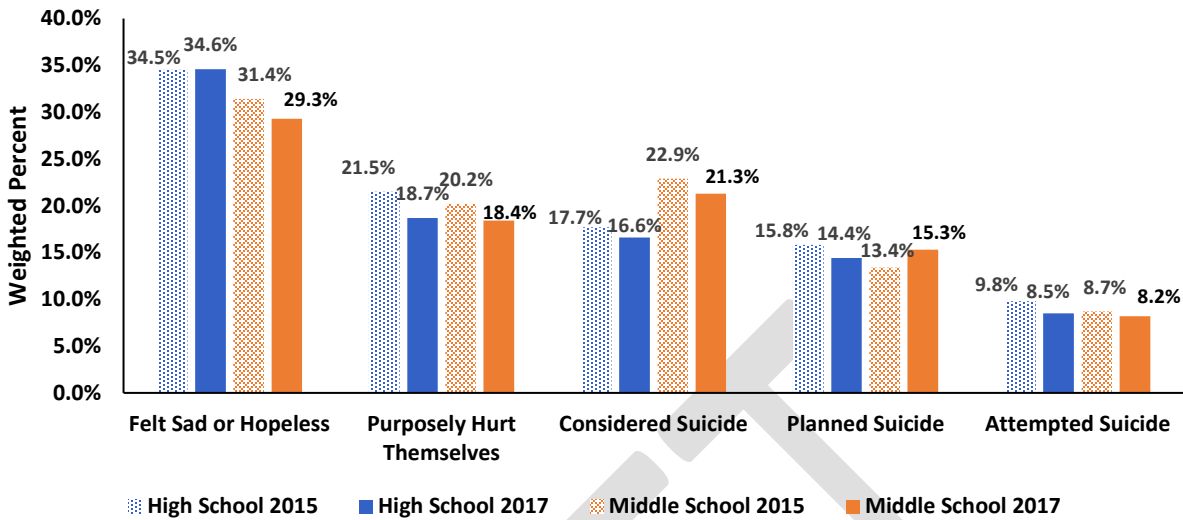
Nevada has remained within a percent of the Nation for most mental health issues. Nevada was slightly higher than the national measure with “any mental illness” and “had serious thoughts of suicide”.

## 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, 5,336 high school, and 5,464 middle school students participated in the YRBS. The University of Nevada, Reno maintain the YRBS data and publishes data on each survey. For more information on the YRBS survey, please go to the following site: [UNR YRBS](#).



Figure 9. Mental Health Behaviors, Nevada Middle and High School Students, 2015 and 2017.



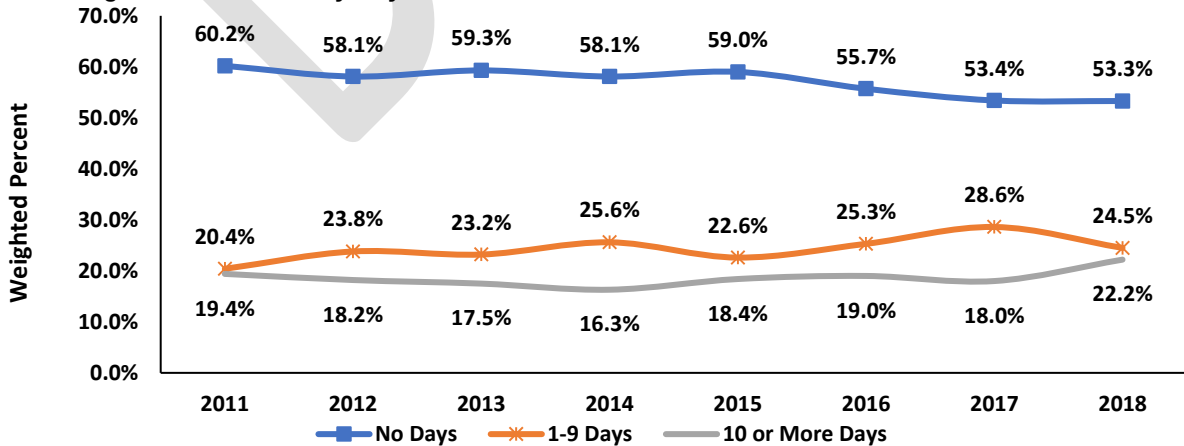
Source: Nevada Youth Risk Behavior Survey (YRBS).  
 Chart scaled to 40% to display differences among groups.

Female high school students are significantly higher for having felt sad or hopeless almost every day for two or more weeks than males, at 45.9% and 24.0% respectively. Likewise, females have a significantly higher percent for considering suicides (21.7%), planning a suicide (18.2%), and purposely hurting themselves (24.4%). Similarly, female middle school students are significantly higher for having felt sad or hopeless almost every day for two or more weeks (38.3%), purposely hurting themselves (26.6%), considering suicide (28.7%), planning suicide (20.7%), and attempting suicide (12.0%).

### Behavioral Risk Factor Surveillance System (BRFSS)

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

Figure 10. Percentages of Adults Who Experienced Poor Mental or Physical Health that Prevented Them from Doing Usual Activities by Days Effected, Nevada Residents, 2011-2018.



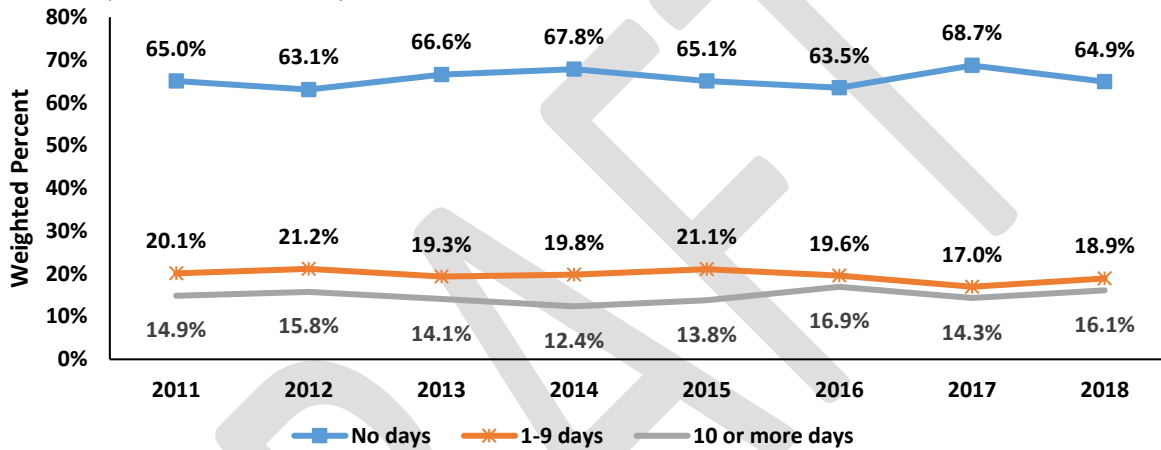
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Source: Behavioral Risk Factor Surveillance System.  
 Chart scaled to 70% to display differences among groups.

Females have significantly higher days of poor physical or mental health than males, at 26.0%. Those who are divorced, separated, or widowed have significantly higher days of poor health than those who are married, 30.7% and 19.6% respectively.

The Frontier Community Coalition (FCC) reported 5.2% of respondents missing 10 or more days of work, while the Nye Communities Coalition (NCC) had the highest percent at 28.7%. All coalition except FCC were within the confidence of interval of Nevada (22.2% [19.3-25.1]). This may be due to low response rate in the rural counties.

**Figure 11. Percentages of Adults in which Their Mental Health was Not Good by Number of Days Experienced, Nevada Residents, 2011-2018.**

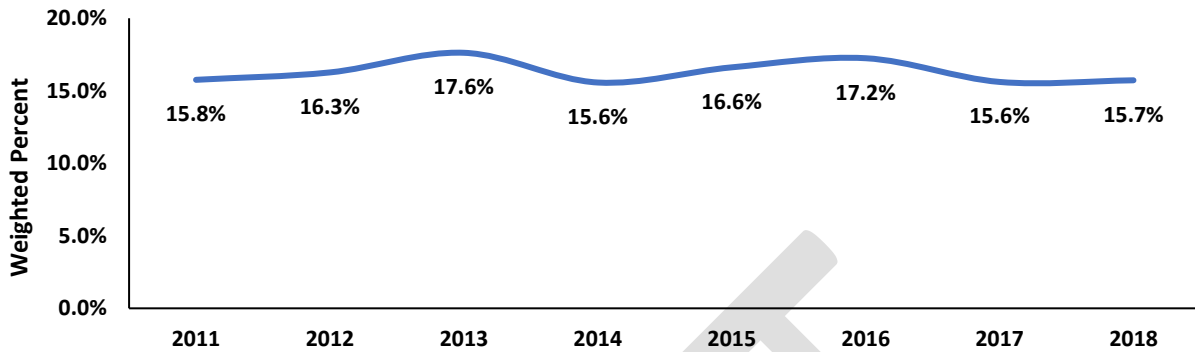


Source: Behavioral Risk Factor Surveillance System.  
 Chart scaled to 80% to display differences among groups.

In 2018, 16.1% of Nevada residents reported 10 or more days of poor mental health. Nevada residents aged 18-24 had the highest percent of poor mental health days at 27.1%. Females (20.7%) were significantly higher than males (11.6%) with poor mental health days.

Residents of the Healthy Community Coalition (HCC) had significantly higher days of poor mental health at 32.8%. All other coalitions were within or significantly lower than Nevada.

**Figure 12. Percentages of Adults Who Ever Been Told They have a Depressive Disorder, Including Depression, Major/Minor Depression, or Dysthymia, Nevada Residents, 2011-2017.**



Source: Behavioral Risk Factor Surveillance System.  
 Chart scaled to 20% to display differences among groups.

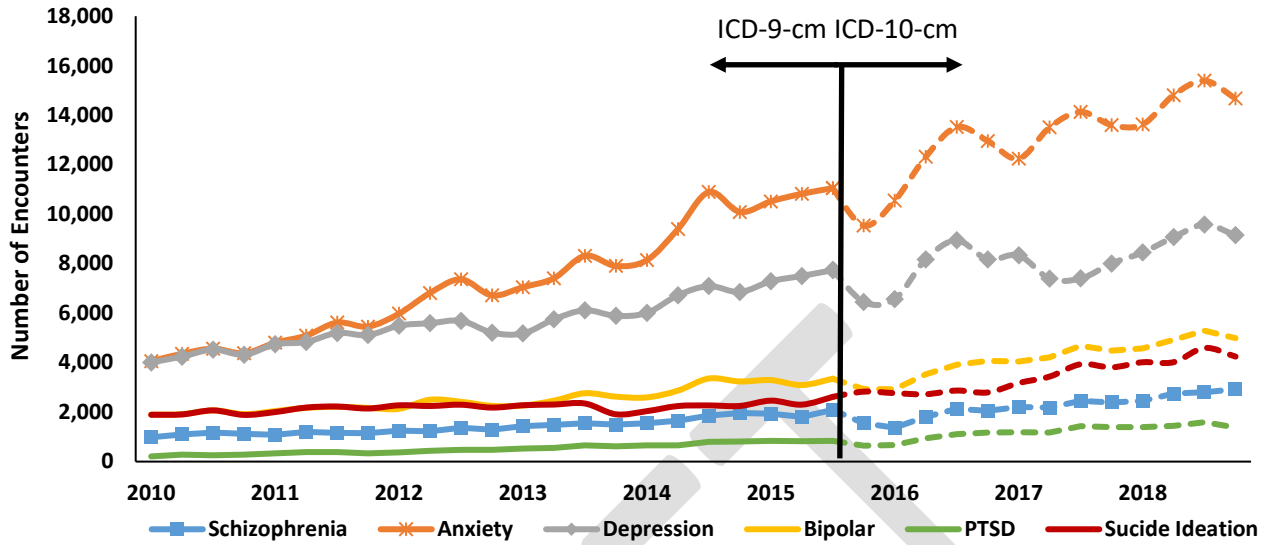
Roughly 15% of Nevadans have been told they have a depressive disorder in 2018. Females (20.1%) are significantly higher than males (11.3%), and Hispanics are significantly lower than other race/ethnicities, at 8.7%.

Nevada 211 is a phone number that helps Nevadans connect with services they need including mental health-related services. During the 2019 fiscal year (July 1, 2018 -June 30, 2019), Nevada 211 received 2,257 calls relating to mental health, excluding suicide-related calls. The most calls received were for general counseling services.

### Hospital Emergency Department Encounters

The hospital emergency department billing data includes data for emergency room patients for Nevada’s non-federal hospitals. There were 108,318 visits related to mental health disorders among 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 13. Mental Health-Related Emergency Department Encounters, 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.

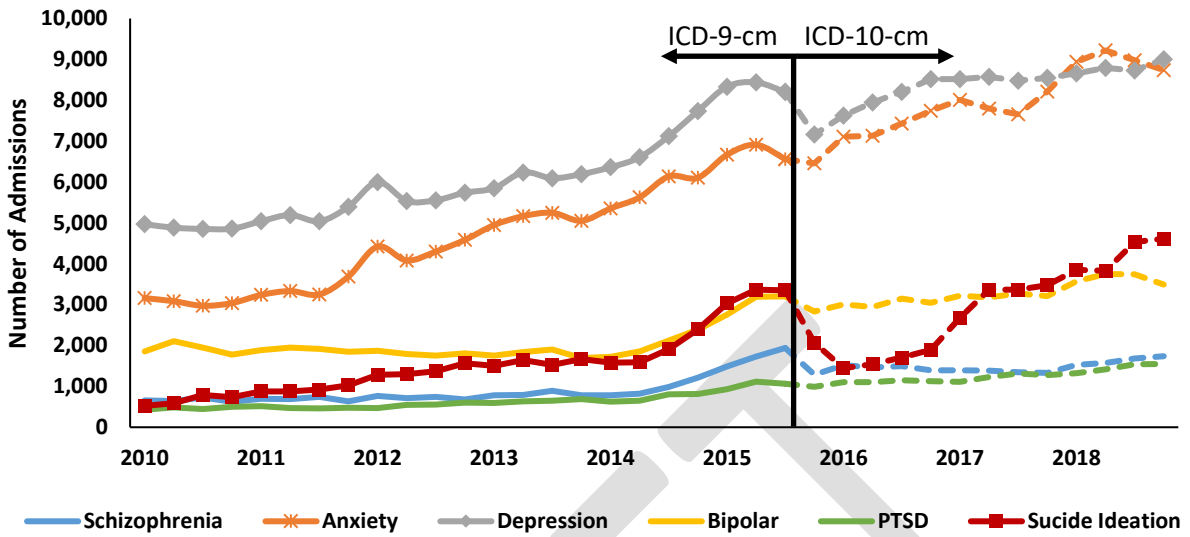
Anxiety has been the leading mental health-related diagnosis since 2012 in emergency department encounters. Anxiety-related encounters increased significantly from 2010 to 2018 in both counts and rates. Males have significant higher visits for schizophrenia (66.2%) and suicide ideation (62.4%), whereas females have significant higher visits for anxiety, depression, bipolar disorder, and PTSD (64.6%, 61.8%, 53.9% and 56.2% respectively).

The counties in CCC and PACE coalitions had significantly higher rates for emergency department visits for anxiety and depression. Similarly, the county of PCC had a significantly higher rate for anxiety, and JTNN for depression.

## Hospital Inpatient Admissions

Hospital Inpatient Billing data includes data for patients discharged from Nevada’s non-federal hospitals. There were 75,429 inpatient admissions related to mental health disorders among 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 14. Mental Health-Related Inpatient Admissions, 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. All the mental health-related diagnosis for hospital inpatient admissions increased significantly from 2010 to 2018. Females inpatient admissions for anxiety and depression were significantly higher than males, whereas males have significantly higher admissions for suicide ideation and schizophrenia.

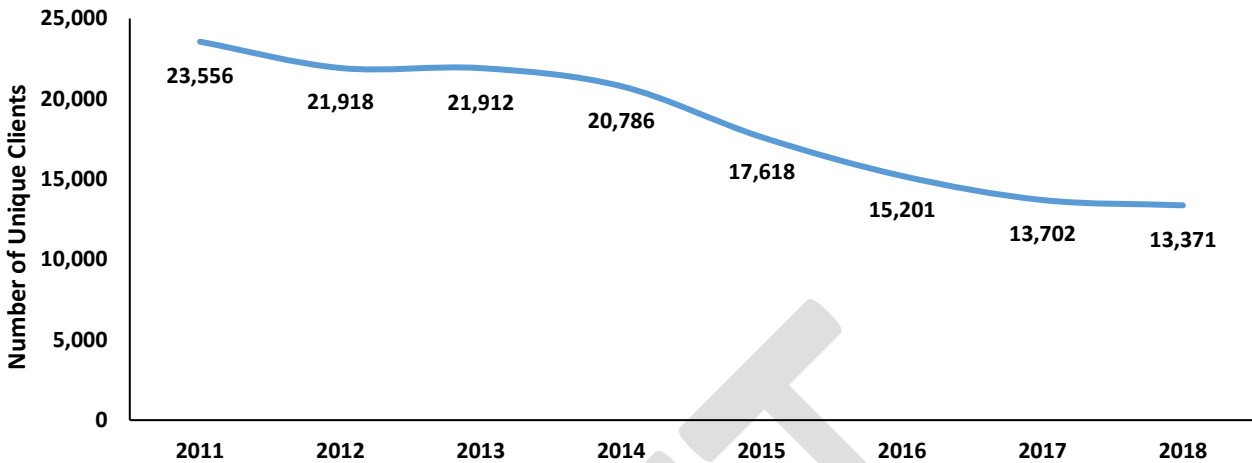
Suicide ideation also increased from 2009 to 2017 but should be noted that in 2016 inpatient admissions statewide dropped and then increased in 2017. This may be due to ICD-9-CM conversion to ICD-10-CM or another change in medical billing.

The PACT/CARE coalition has significantly higher admissions for schizophrenia, bipolar disorder, and suicide ideation. The CCC and HCC coalitions have significantly higher admissions from anxiety and PTSD. The JTNN coalition area has significantly higher admissions for PTSD, whereas PCC has significantly higher admissions for anxiety, depression, bipolar disorder, PTSD and suicide ideation.

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

Figure 15. Unique Clients\* Served at State-Funded Mental Health Clinics, 2011-2018.



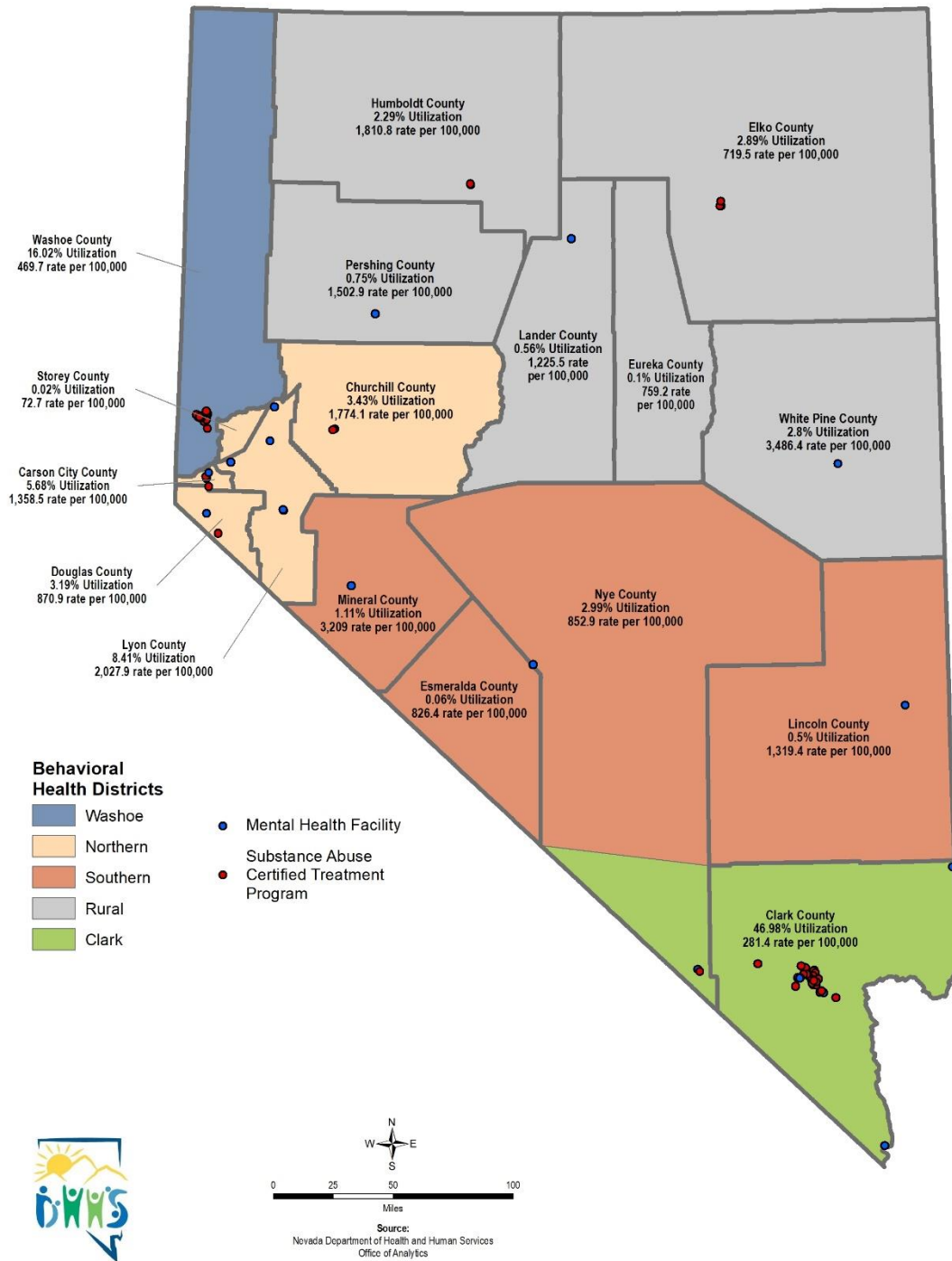
Source: Avatar.

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

The number of unique clients served by state-funded mental health facilities continues to decline. There were 13,371 clients served in 2018, which has decreased significantly from 2011 (23,556). The Affordable Care Act (ACA) went into effect in 2014. Therefore, many Nevada residents are now able to access non-state-funded facilities through the expansion of Medicaid. This likely contributes to the decline of the clients represented in the above chart.

Of the Nevada residents accessing DPBH mental health services in 2018, 47.0% lived in Clark County and 16.0% lived in Washoe County. White Pine County had the highest rate of adults accessing state mental health services, 3,486 per 100,000 population.

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



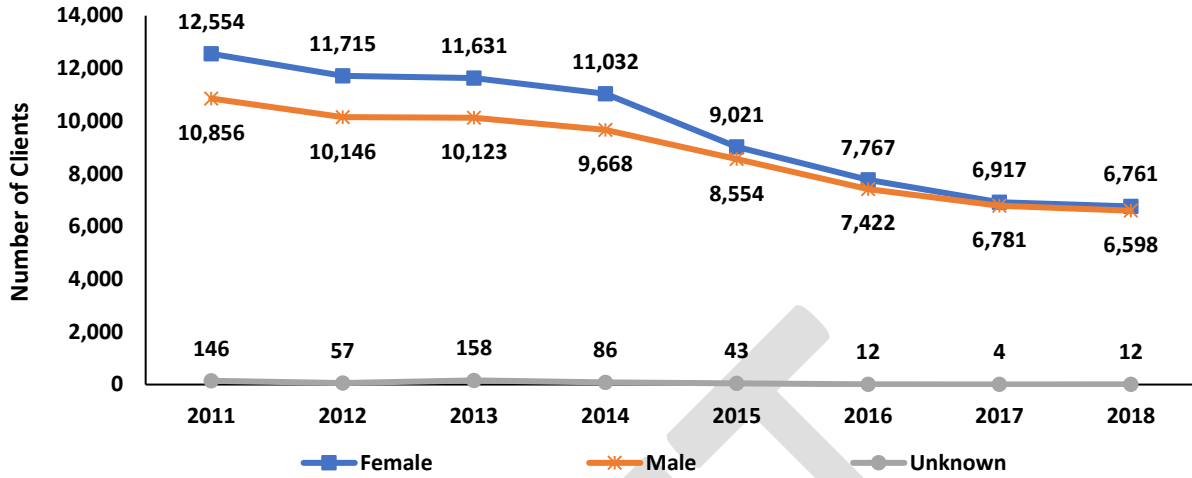
Source: Avatar.

\*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, 2011-2018.

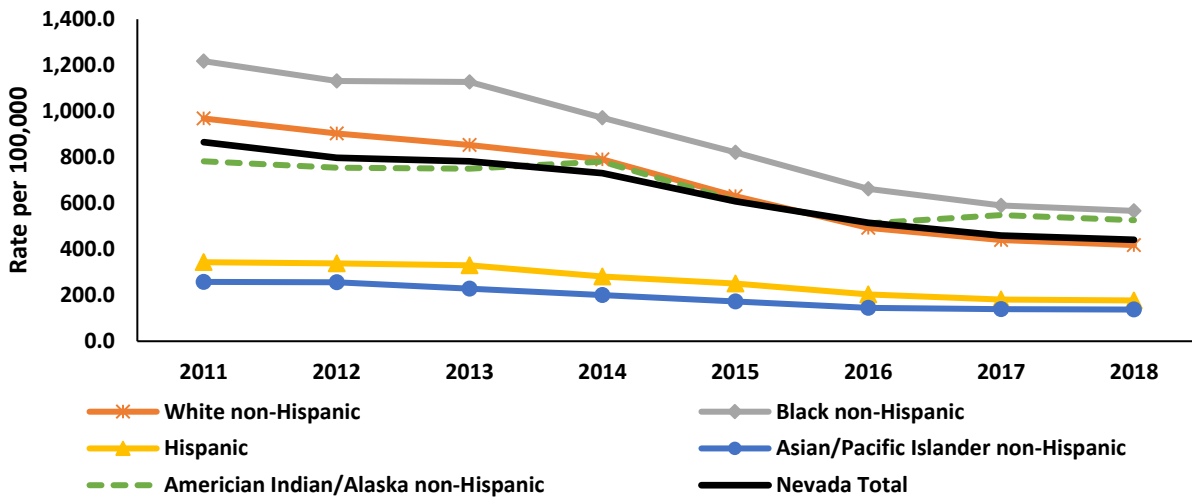


Source: Avatar.  
 \*A client is counted only once per year. Clients may be counted more than once across years.

From 2011 to 2018, females significantly utilized the state-funded mental health clinics more than males except in 2017 and 2018, where the difference between male and female is not significant (95% confidence interval). In 2018, 434.3 per 100,000 male population utilized the state-funded mental health clinics, compared females at 446.9 per 100,000 female population.

Of patients that utilized state-funded mental health services, the most common age group was 25-34 years old, on average accounting for 19.7% of patients. High school graduates accounted for 21.5% of patients, followed by those with those with less than 12<sup>th</sup> grade, no diploma education at 19.6% in 2018.

Figure 18. State-Funded Mental Health Clinics Utilization\* by Race/Ethnicity Crude Rates, 2011-2018.



Source: Avatar and the Nevada State Demographer (vintage 2017)  
 Race "Unknown" not included in analysis.  
 \*A client is counted only once per year. Clients may be counted more than once across years.

The Affordable Care Act (ACC) went into effect in 2014. Therefore, many Nevada residents are now able to access non-state-funded facilities through the expansion of Medicaid. This likely contributes to the decline of the clients represented in the above chart. The patient utilization crude rate has gone down



significantly across all races from 2011 to 2018. The Black non-Hispanic population had the highest rate over the seven-year period at 566.7 per 100,000 population, whereas Asian and Pacific Islander have the lowest rate at 137.7 per 100,000 population.

**Figure 19. Top Mental Health Clinic Services by Number of Patients Served\*, 2011-2018.**

Program	Year							
	2011	2012	2013	2014	2015	2016	2017	2018
SNAMHS Medication Clinic Adult	8,492	8,081	8,481	8,082	5,500	4,307	3,891	3,397
NNAMHS Medication Clinic Adult	3,790	3,678	3,838	3,508	3,149	2,310	1,920	1,922
SNAMHS Inpatient Hospital Adult	2,106	2,222	2,359	2,592	2,685	1,960	1,881	1,842
SNAMHS Ambulatory Service Coordination Adult	3,331	3,137	2,711	1,520	823	1,843	1,517	1,234
SNAMHS Observation Unit Adult~	4,458	4,736	3,106	~	~	~	~	~
NNAMHS Ambulatory Service Adult	1,369	1,537	1,822	1,560	1,326	692	56	16
SNAMHS Service Coordination Adult	698	742	1,052	1,051	867	644	521	631
SNAMHS Outpatient Counseling Adult	1,061	967	673	649	526	575	566	448

Source: Avatar.

~Program no longer active.

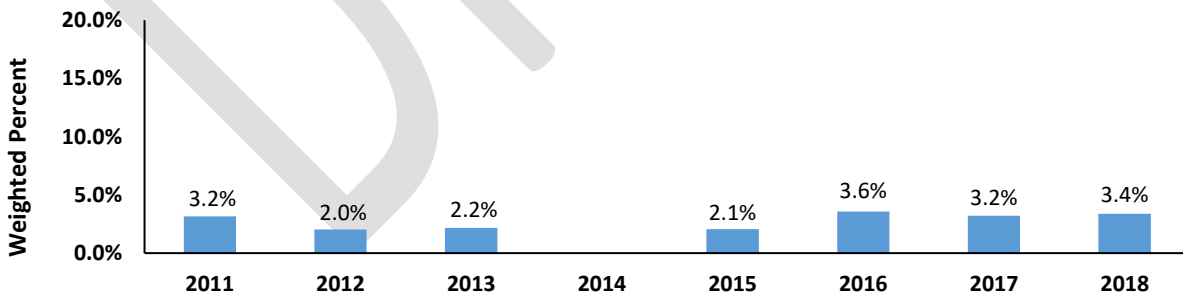
\*A client is counted only once per year. Clients may be counted more than once across years.

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

## Suicide

While suicide 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 20. Percentage of Adult Nevada Residents Who Have Seriously Considered Attempting Suicide, 2011-2018.**



Source: Behavioral Risk Factor Surveillance System (BRFSS).

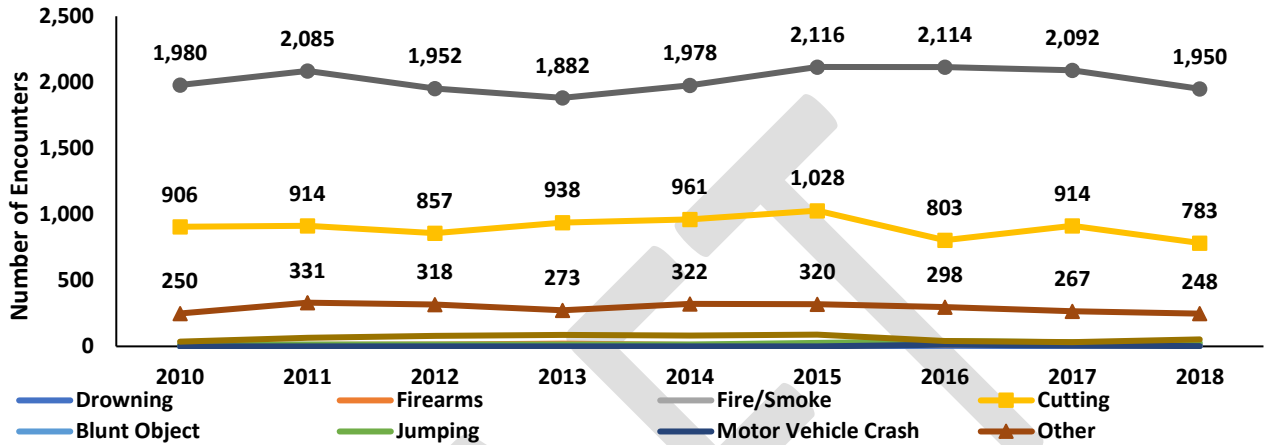
Chart scaled to 20% to display differences among groups.

Indicator was not measured in 2014.

When asked “have you seriously considered attempting suicide during the past 12 months,” 3.4% of Nevada residents responded yes in 2018. Between 2011 and 2018, the average prevalence for suicide consideration in the state of Nevada is 2.7%. This indicator was not measured in 2014.

Nevada 211 is a phone number that helps Nevadans connect with services they need crisis hotlines. During the 2019 fiscal year (July 1, 2018 - June 30, 2019), Nevada 211 received 363 calls relating to suicide. This included referrals to suicide survivors support groups (n=15), prevention hotlines (n= 161), in person intervention (n=22), and mobile response teams (n=165).

**Figure 21. Suicide Attempt Emergency Department Encounters by Method, Nevada Residents, 2010-2018.**



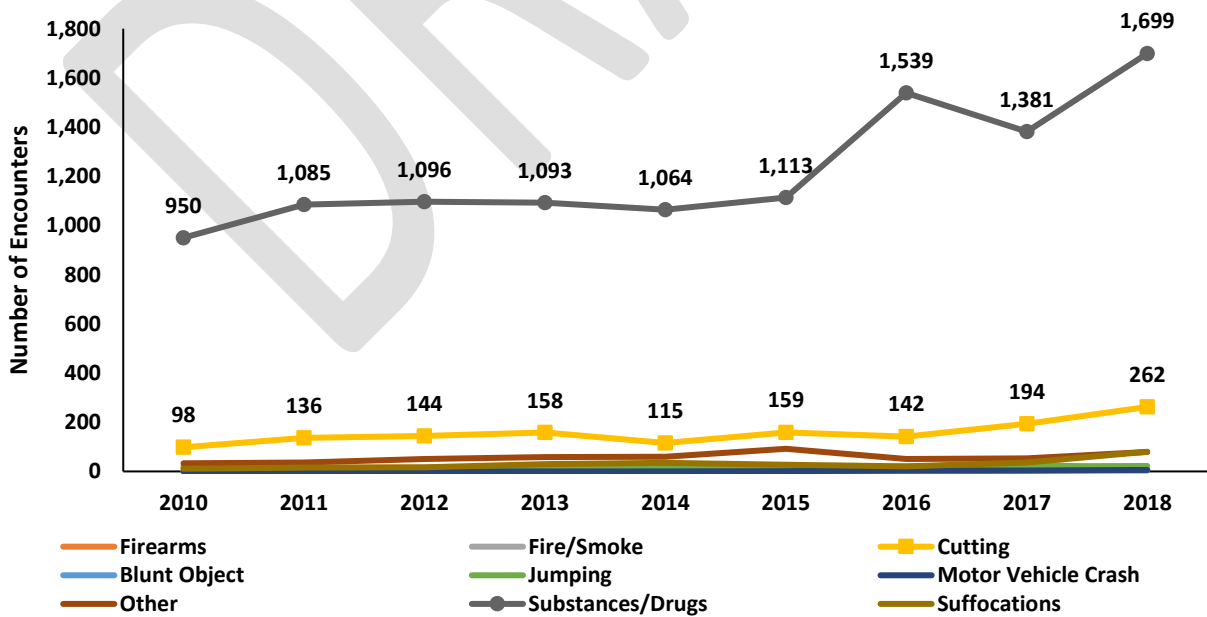
Source: Hospital Emergency Department Billing.

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.

Emergency department encounters related to suicide attempt, where the patient did not expire at the hospital, have remained steady from 2010 to 2018. The most common method for attempted suicide is a substance or drug overdose attempt. The NCC and CCC coalitions have significantly higher emergency department encounters for substance use suicide attempts.

**Figure 22. Suicide Attempt Inpatient Admissions by Method, Nevada Residents, 2011-2018.**

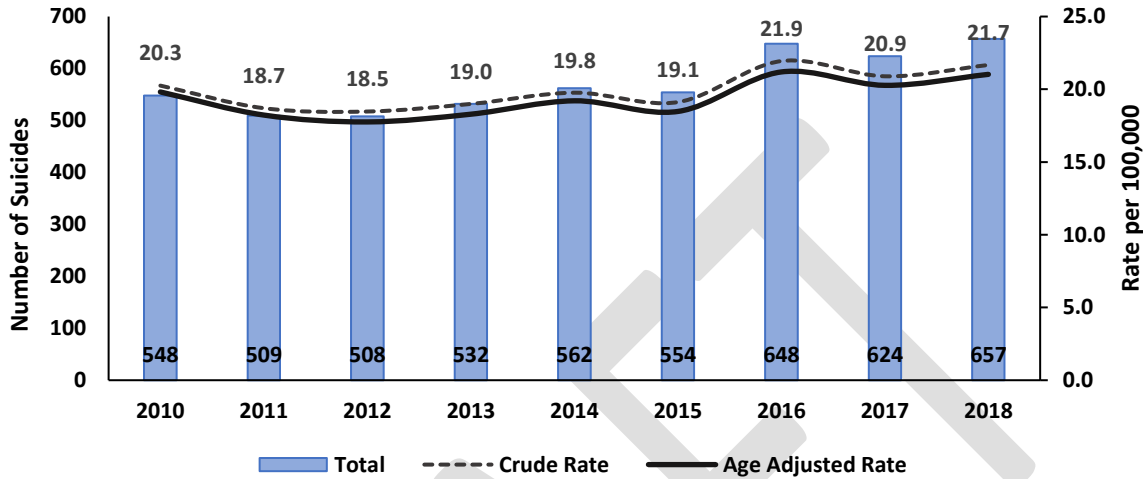


Source: Hospital Inpatient Billing.

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 suicide where the patient was admitted and did not expire at the hospital have increased where the method was substances or drugs. Both the PCC and JTNN coalitions counties were significantly higher for inpatient admissions.

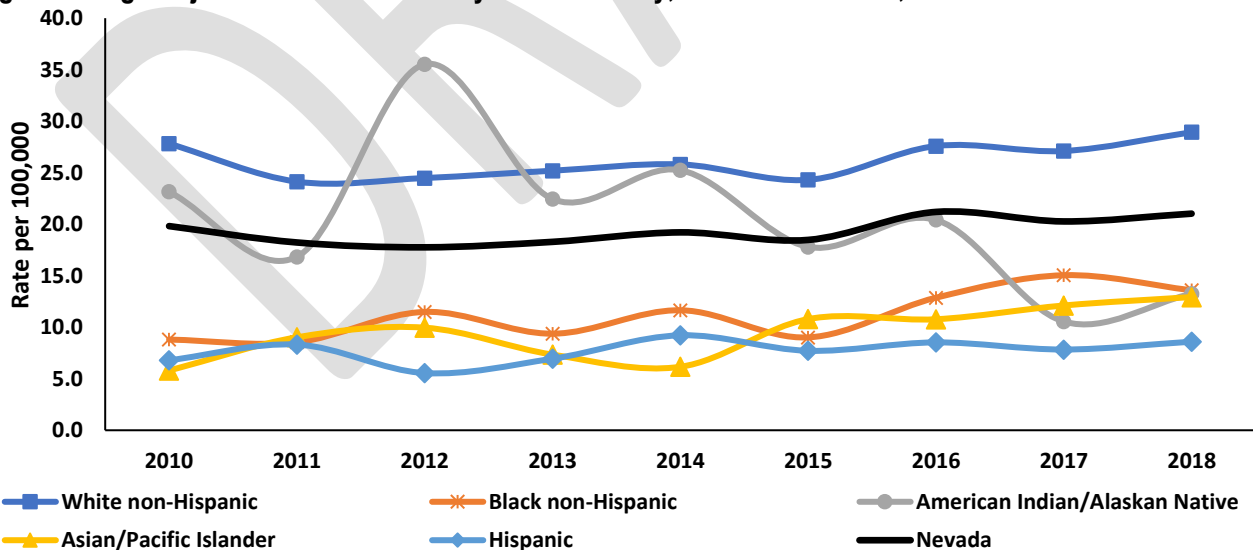
Figure 23. Number of Suicides and Age-Adjusted Rates, Nevada Residents, 2010-2018.



Source: Nevada Electronic Death Registry System.

The age-adjusted suicide rate for 2018 in Nevada was 21.7 per 100,000 population. The NCC coalition has a significantly higher crude rate for suicide in 2018 at 43.4 per 100,000 population. Suicides in Nevada are highest among those in the 45-54 age group, with 121 suicides in 2018, and among persons with a high school degree, with 266 suicides in 2018.

Figure 24. Age-Adjusted Suicides Rates by Race/Ethnicity, Nevada Residents, 2010-2018.

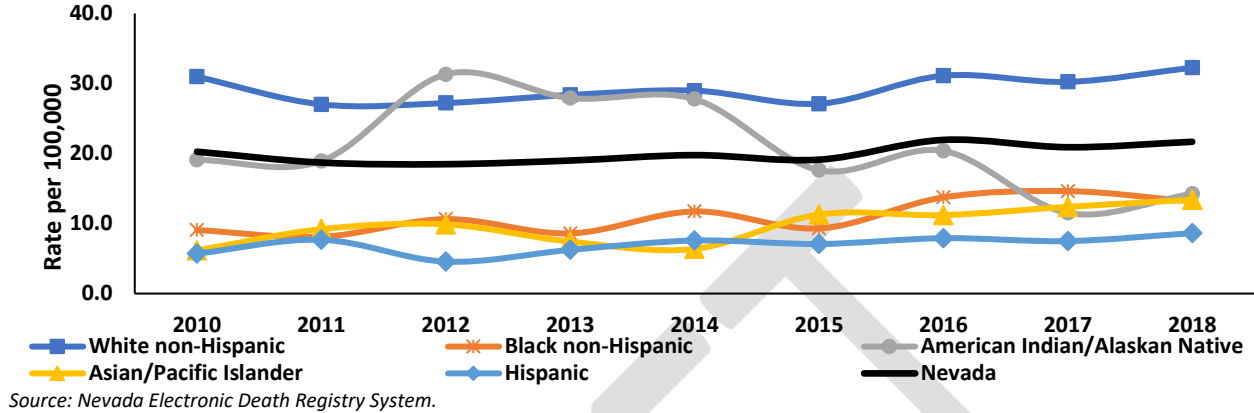


Source: Nevada Electronic Death Registry System.

The age-adjusted suicide rates for White non-Hispanics were significantly higher than the Nevada overall rate for each year from 2010 to 2018, with 28.9 per 100,000 population in 2018. The age-adjusted suicide

rate for American Indian/Alaskan Native was above the total Nevada rate (2010, 2012, 2013, 2014), but was not significantly higher based on 95% confidence intervals. Rates among Hispanics are significantly lower than overall Nevada rates for all years.

Figure 25. Crude Suicides Rates by Race/Ethnicity, Nevada Residents, 2010-2018.

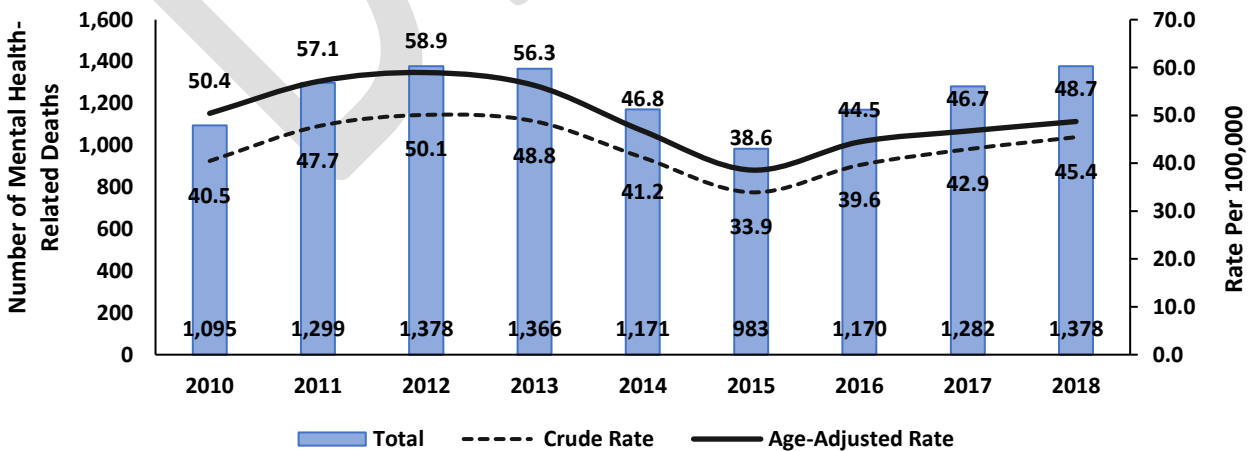


## Mental Health-Related Deaths

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 26. Mental Health-Related Deaths and Age-Adjusted Rates, Nevada Residents, 2010-2018.

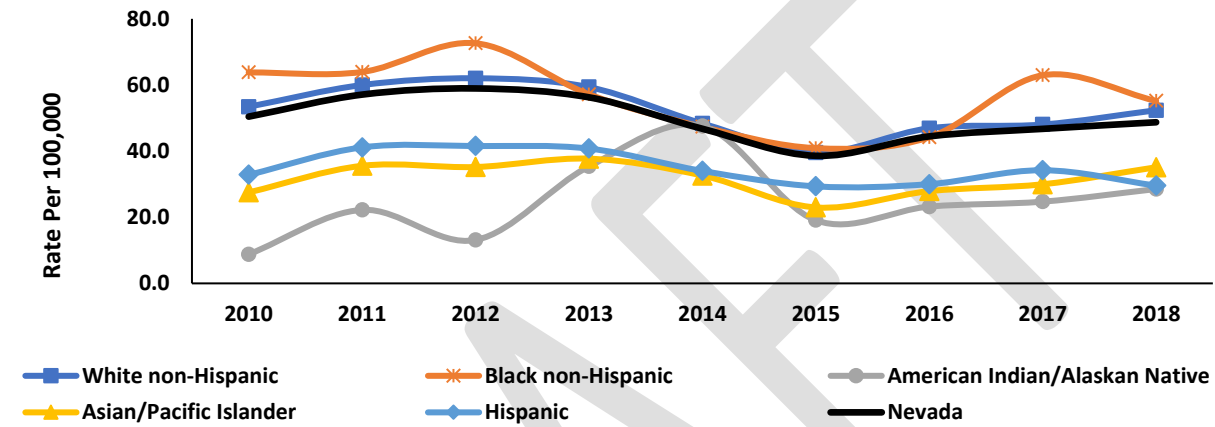


Source: Nevada Electronic Death Registry System.

There were nine mental health-related deaths among individuals under 45 years old in 2018. The most common age group for mental health-related deaths were those aged 85 and above with 726 deaths in 2018. Mental health-related deaths were highest among individuals who had high school diplomas.

The PCC coalition mental health-related deaths are significantly higher than the state at the age-adjusted rate of 103.4 per 100,000 population, and JTNN also have a significantly higher age-adjusted rate at 60.3 per 100,000 population.

**Figure 27. Age-Adjusted Mental Health-Related Death Rates by Race/Ethnicity, Nevada Residents, 2010-2018.**



Source: Nevada Electronic Death Registry System.

There are no significant differences between the age-adjusted mental health-related death rates among races/ethnicities for 2018.

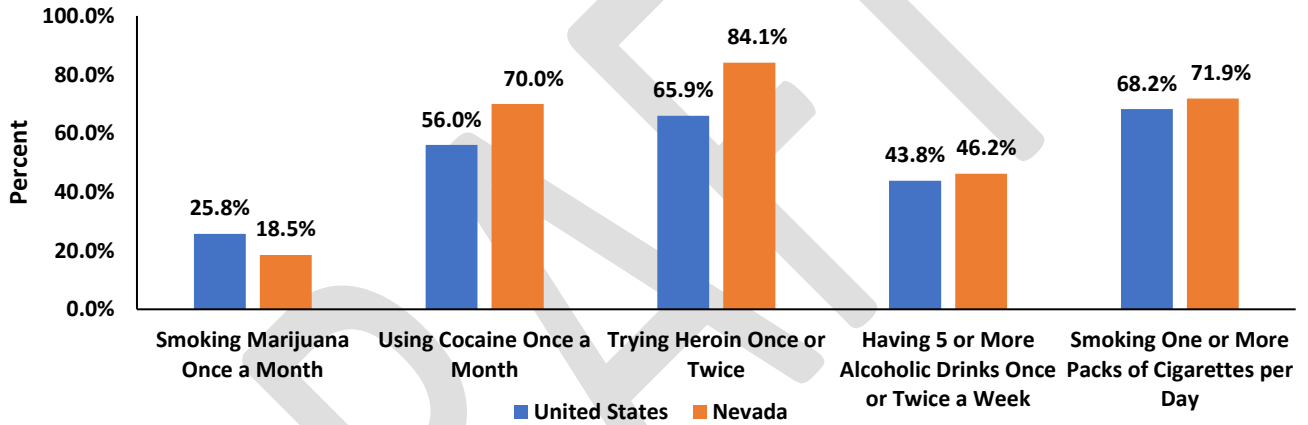
# Substance Abuse

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.

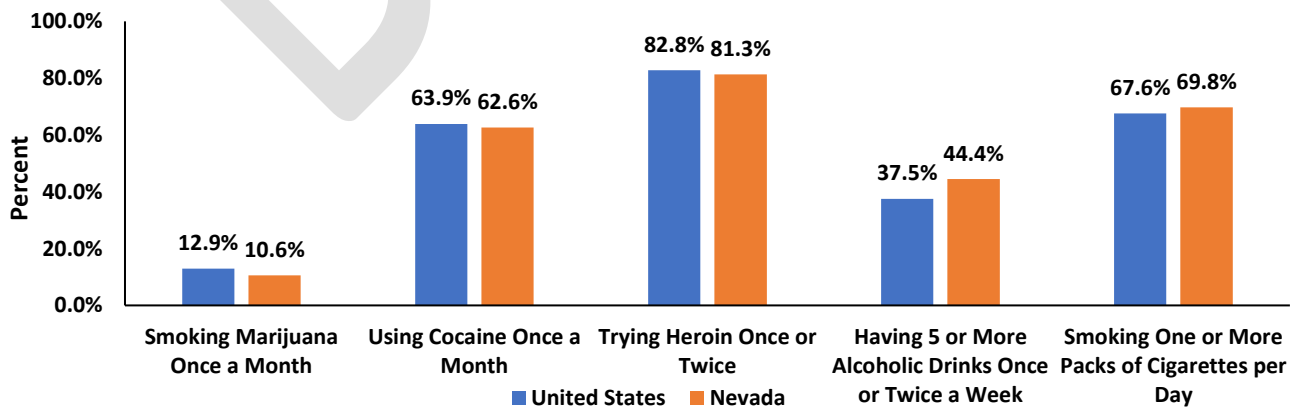
**Figure 28. Perceptions of Great Risk from Alcohol or Substance, Aged 12-17, Nevada and the United States, 2017.**



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

Nevadan teens perceived risk for using cocaine, trying heroin, drinking more than 5 drinks, and smoking as greater than the United States with perceived risk. Young adults (Figure 28) perceived risk as lower than the United States for using cocaine and trying heroin.

**Figure 29. Perceptions of Great Risk from Alcohol or Substance, Aged 18-25, Nevada and the United State, 2017.**



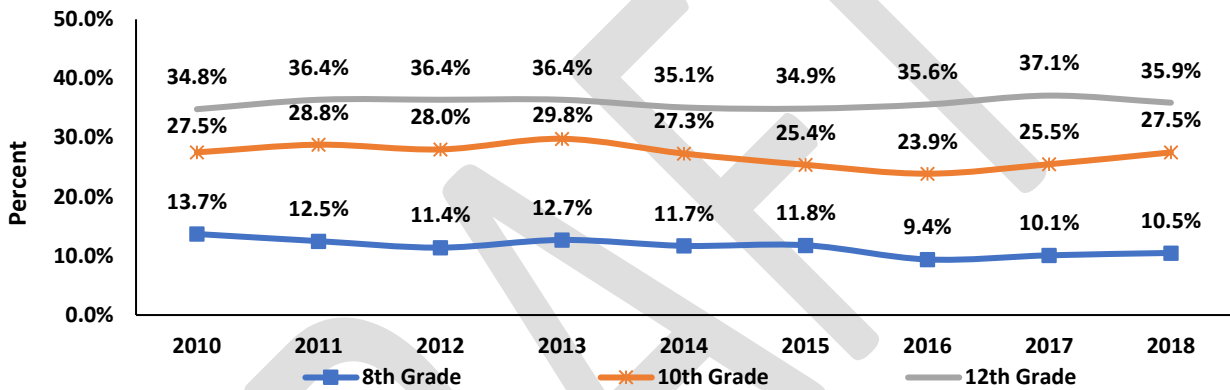
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2017.

## Monitoring the Future Survey

Monitoring the Future is an ongoing study of the behaviors, attitudes, and values of American secondary school students, and young adults. Each year, a total of approximately 50,000 students in 8<sup>th</sup>, 10<sup>th</sup> and 12<sup>th</sup> grades are surveyed. The Monitoring the Future Study is funded under a series of investigator-initiated competing research grants from the National Institute on Drug Abuse, a part of the National Institutes of Health. Monitoring the Future Survey is conducted at the Survey Research Center in the Institute for Social Research at the University of Michigan. This data is collected nationally, and state level is not provided.

Vaping was included in the survey in 2017 and 2018. In 2018 the percent of students vaping increased for all ages. Approximately 37% of 12<sup>th</sup> graders, 32% of 10<sup>th</sup> graders, and 18% of 8<sup>th</sup> graders reported vaping in 2018.

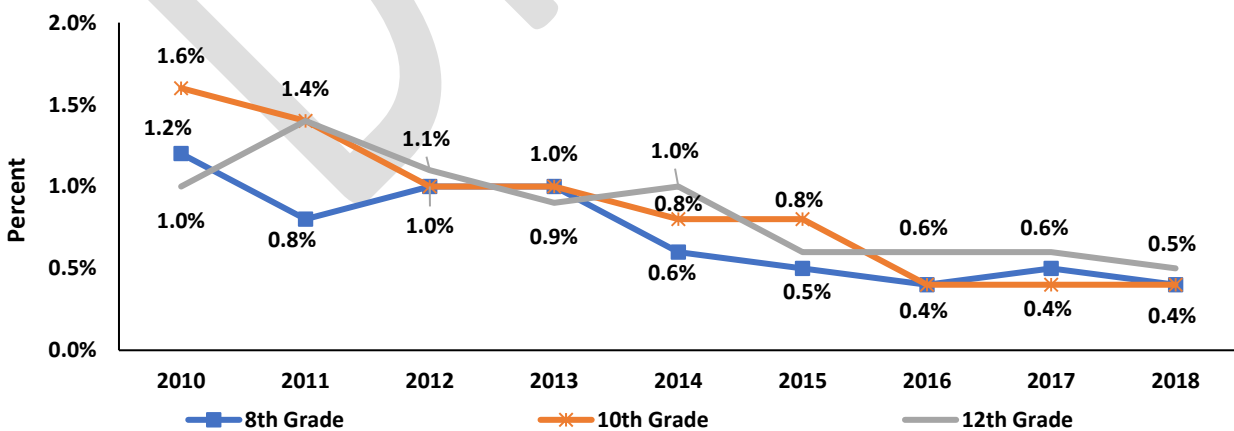
**Figure 30. Annual Prevalence of Marijuana/Hashish Use, United States, 2010-2018.**



Source: Monitoring the Future Survey.  
 Chart scaled to 50% to display differences among groups.

On average, approximately 36% of 12<sup>th</sup> graders, 27% of 10<sup>th</sup> graders, and 12% of 8<sup>th</sup> graders have reported using marijuana/hashish in the United States.

**Figure 31. Annual Prevalence of Methamphetamine Use, United States, 2010-2018.**

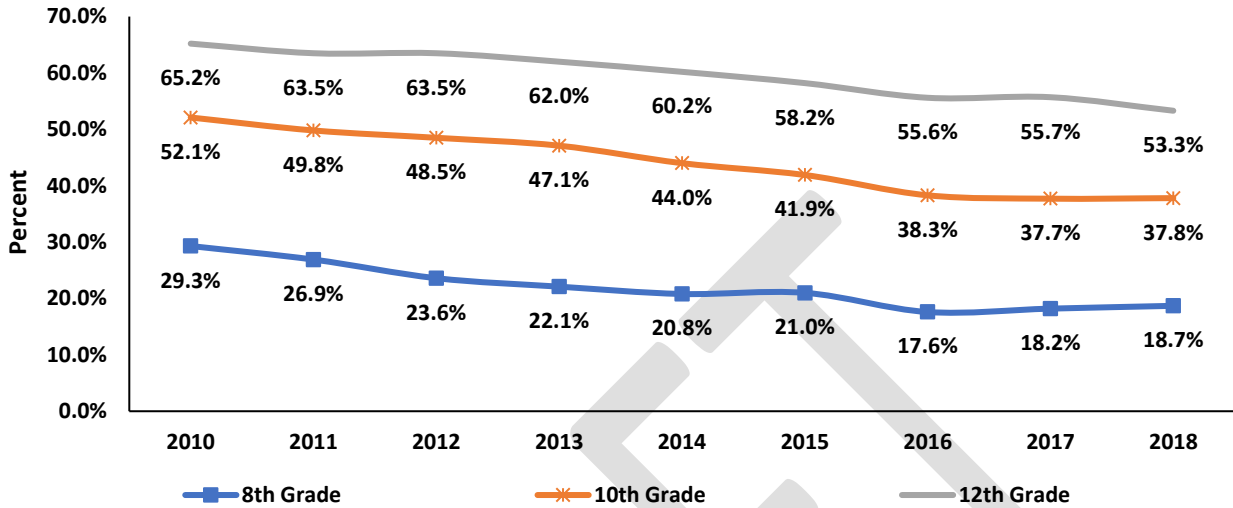


Source: Monitoring the Future Survey.  
 Chart scaled to 2% to display differences among groups.

## Nevada SAPTA EPI Profile

Methamphetamine use has decreased by an average of 64% among all three surveyed grades since 2010 in the United States.

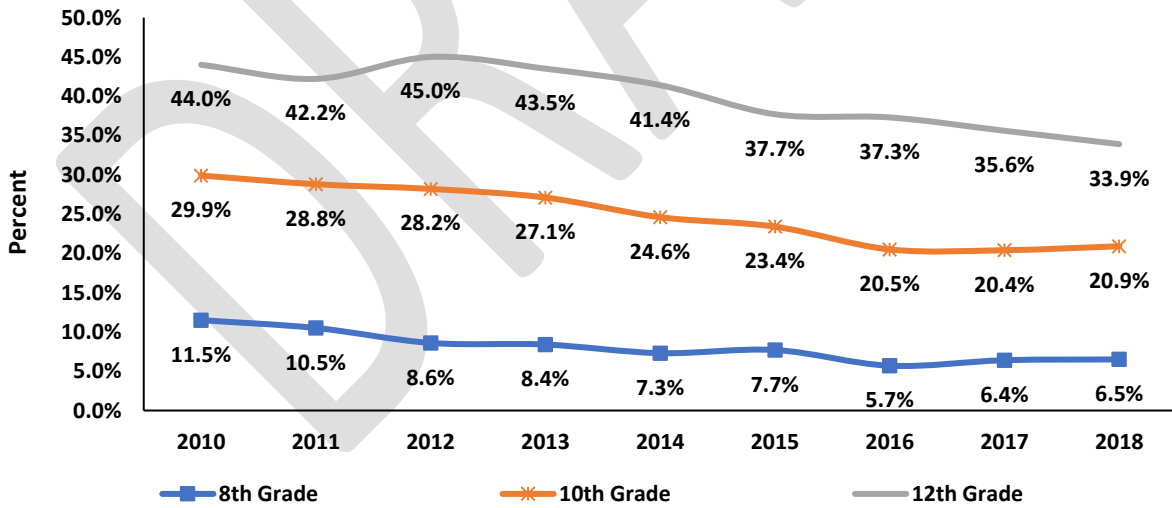
**Figure 32. Annual Prevalence of Alcohol Use, United States, 2010-2018.**



Source: Monitoring the Future Survey.  
 Chart scaled to 70% to display differences among groups.

The prevalence of alcohol use including being drunk from alcohol has decreased in all grades since 2010 through 2015 in the United States. Since 2015, the prevalence has remained steady among all grades.

**Figure 33. Annual Prevalence of Being Drunk from Alcohol, United States, 2010-2018.**

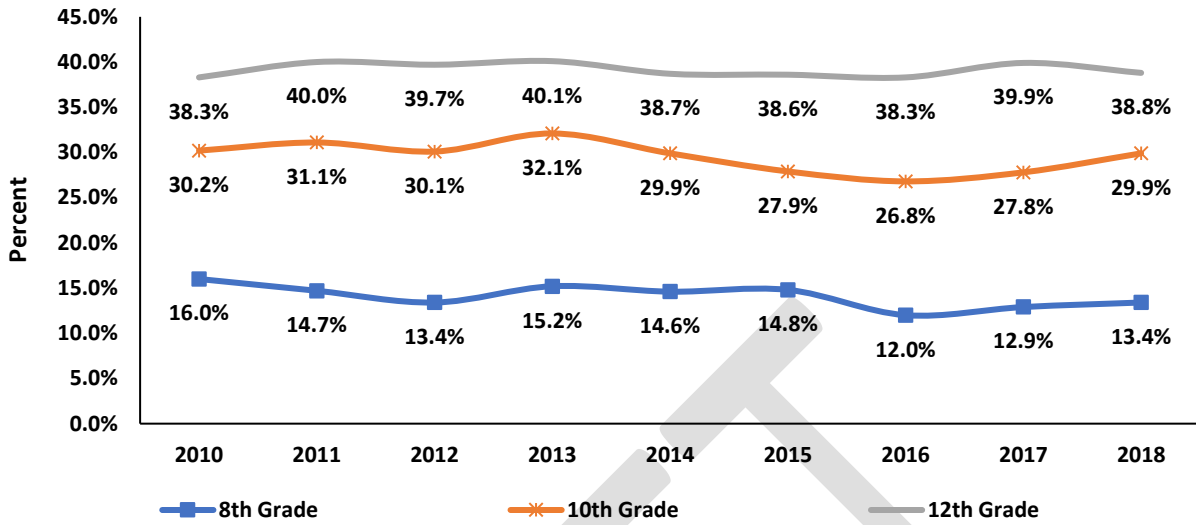


Source: Monitoring the Future Survey.  
 Chart scaled to 50% to display differences among groups.

On average, approximately 40% of 12<sup>th</sup> graders, 25% of 10<sup>th</sup> graders, and 8% of 8<sup>th</sup> graders in the United States have reported being drunk from 2010-2018.



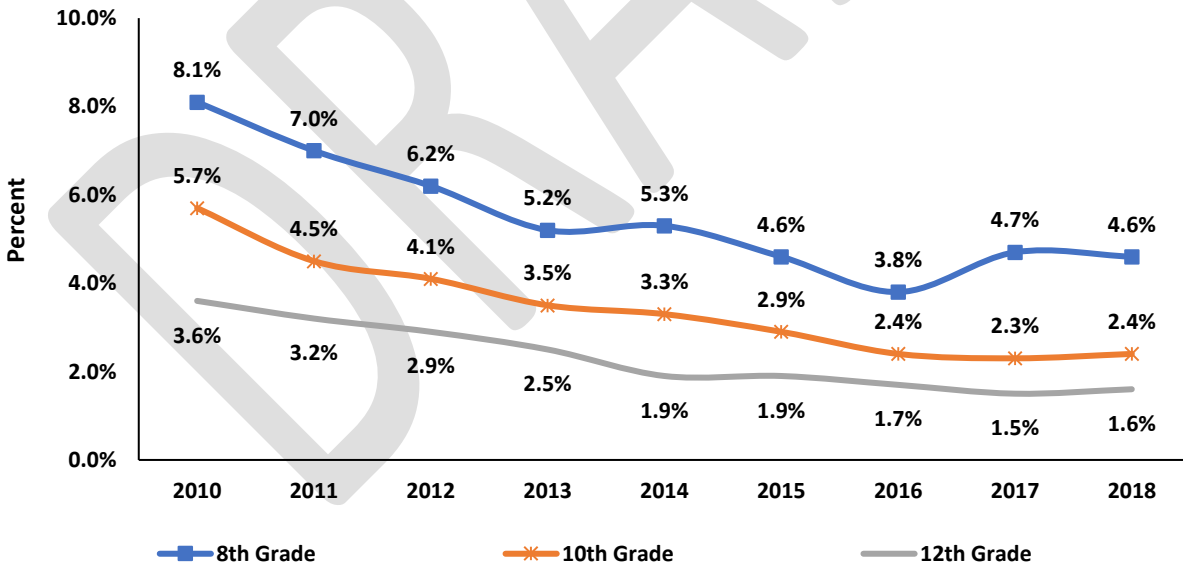
Figure 34. Annual Prevalence of Any Illicit Drug Use, United States, 2010-2018.



Source: Monitoring the Future Survey.  
 Chart scaled to 50% to display differences among groups.

On average, approximately 40% of 12<sup>th</sup> graders, 30% of 10<sup>th</sup> graders, and 14% of 8<sup>th</sup> graders in the United States have reported using any form of illicit drugs from 2010-2018. This number has remained steady during this time.

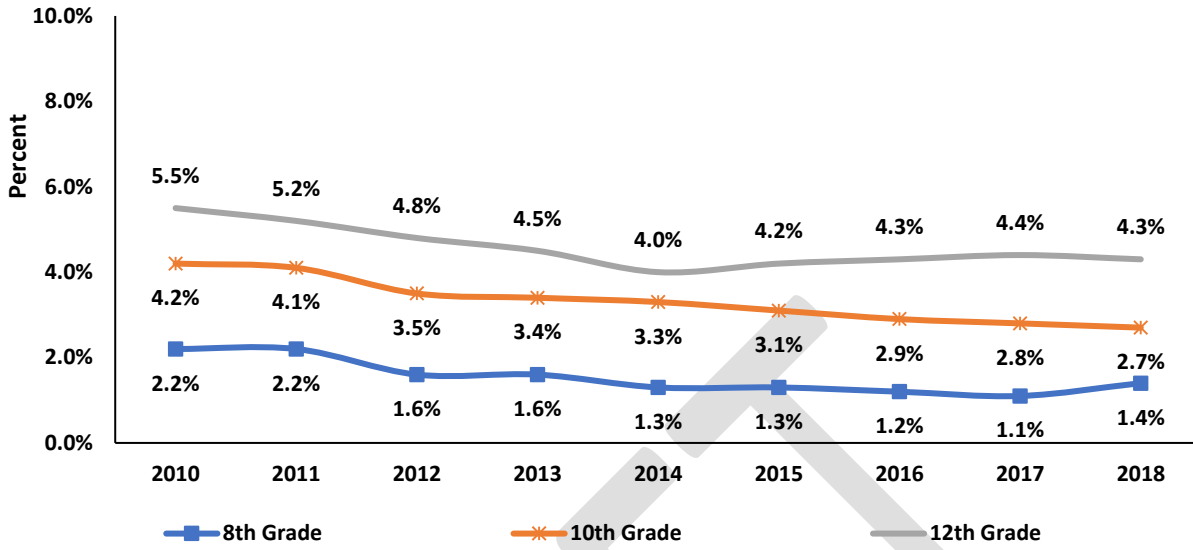
Figure 35. Annual Prevalence of Inhalant Use, United States, 2010-2018.



Source: Monitoring the Future Survey.  
 Chart scaled to 10% to display differences among groups.

The prevalence of inhalant use has decreased among all grades since 2010 through 2015 in the United States.

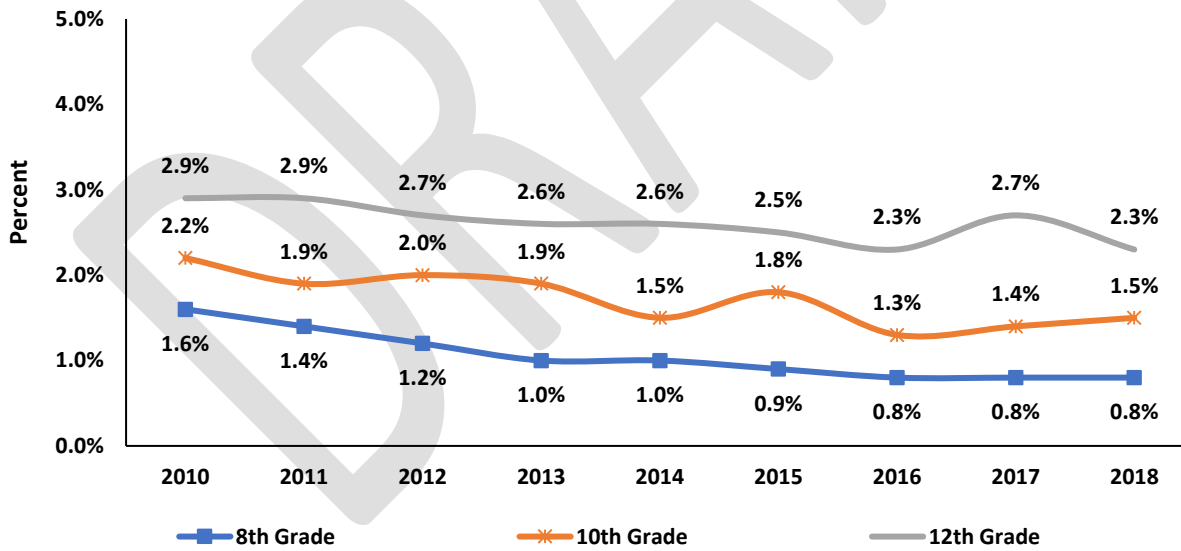
Figure 36. Annual Prevalence of Hallucinogen Use, United States, 2010-2018.



Source: Monitoring the Future Survey.  
 Chart scaled to 10% to display differences among groups.

On average, approximately 3% of the grade surveyed have reported using hallucinogens in the United States from 2010-2018.

Figure 37. Annual Prevalence of Cocaine Use, United States, 2010-2018.

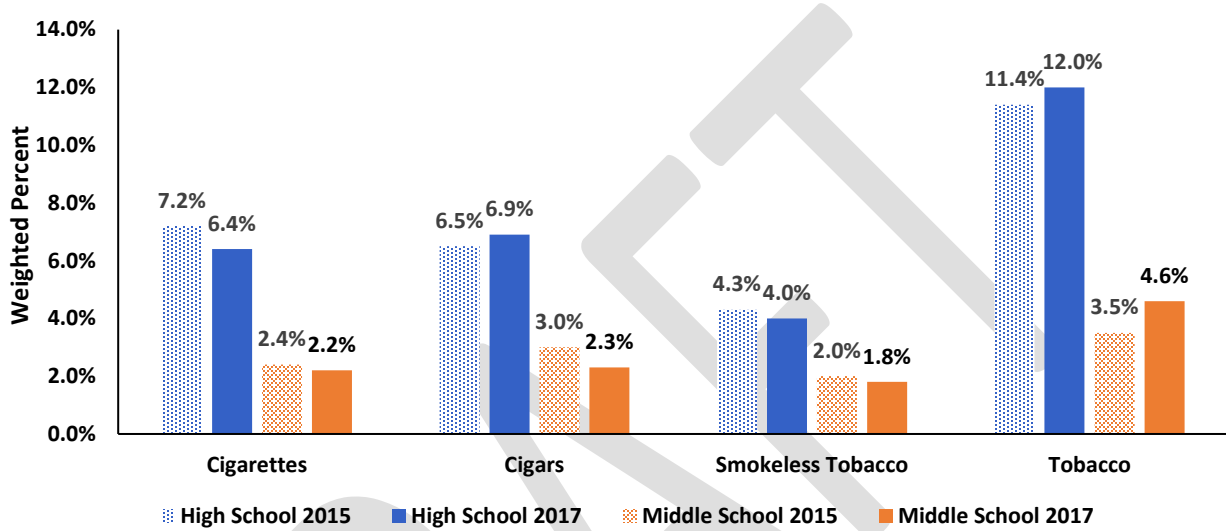


Source: Monitoring the Future Survey.  
 Chart scaled to 5% to display differences among groups.

## 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, 5,336 high school, and 5,464 middle school students participated in the YRBS. The University of Nevada, Reno maintain the YRBS data and publishes data on each survey. For more information on the YRBS survey, please go to the following site: [UNR YRBS](#).

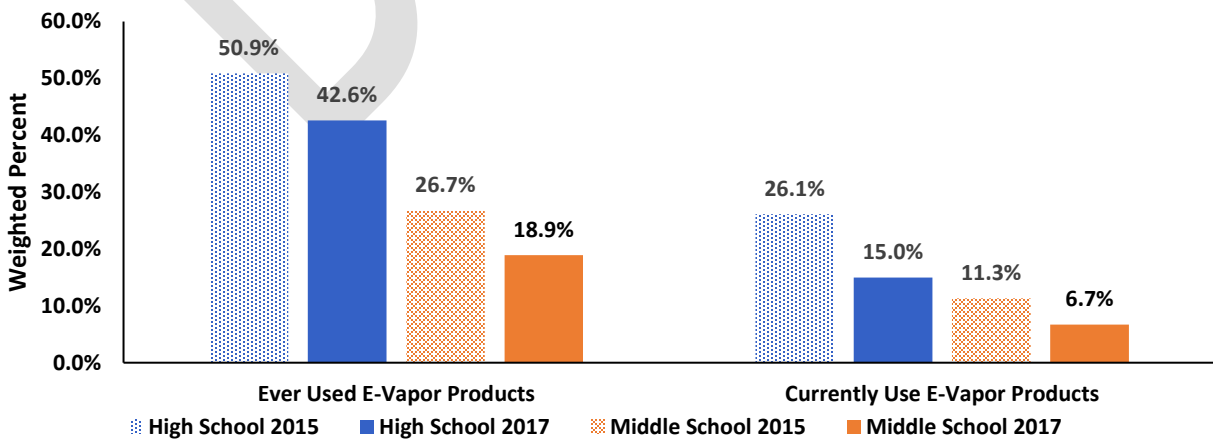
**Figure 38. Tobacco Use, Nevada Middle and High School Students, 2015 and 2017.**



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

There is no significant change in tobacco use from 2015 and 2017 in both middle and high school students. Of Nevada high school students in 2017, 12% have used tobacco at one time; this is lower than the nation at 14%. Twelfth grade students to have ever smoked cigarettes are significantly higher, 34.5%, than 9<sup>th</sup> and 10<sup>th</sup> grade students. Among middle school students to have smoked cigarettes, those 14 or older are significantly higher than other ages.

**Figure 39. Electronic Vapor Product Use, Nevada Middle and High School Students, 2015 and 2017.**

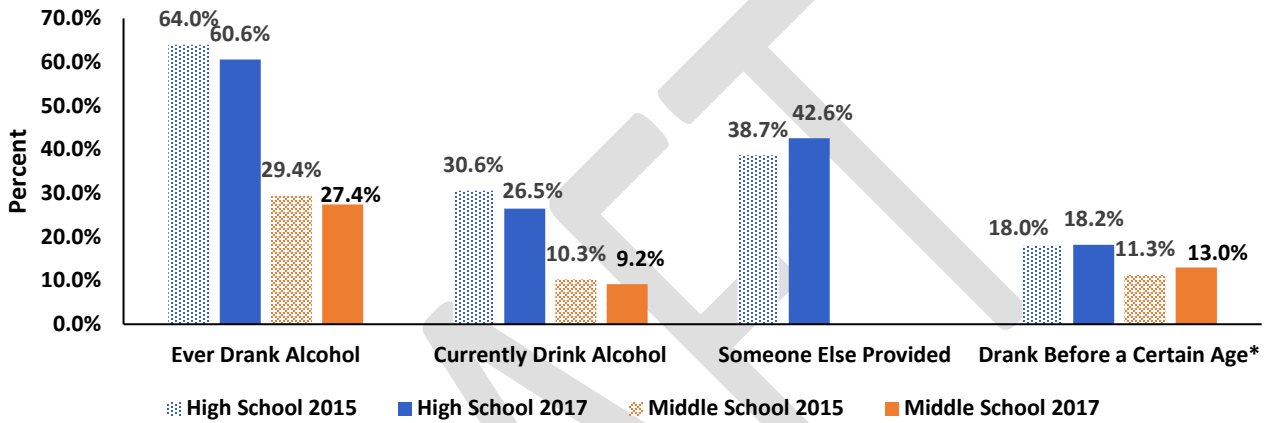


## Nevada SAPTA EPI Profile

Source: Nevada Youth Risk Behavior Survey.  
 Chart scaled to 60% to display differences among groups.

There is a significant decrease in electronic cigarette use from 2015 to 2017. In Nevada, 15.0% of high school students reported using E-vapor products, which is higher than the nation (13.2%). High school students from the Lyon, Mineral, and Storey Counties region have significantly higher reports of using electronic cigarettes, 56.7%, and those 18 years or older also reported higher use at 52.8%. Among middle school students, those 14 years or older were significantly higher than younger ages, at 31.0% who reported ever using an electronic cigarette.

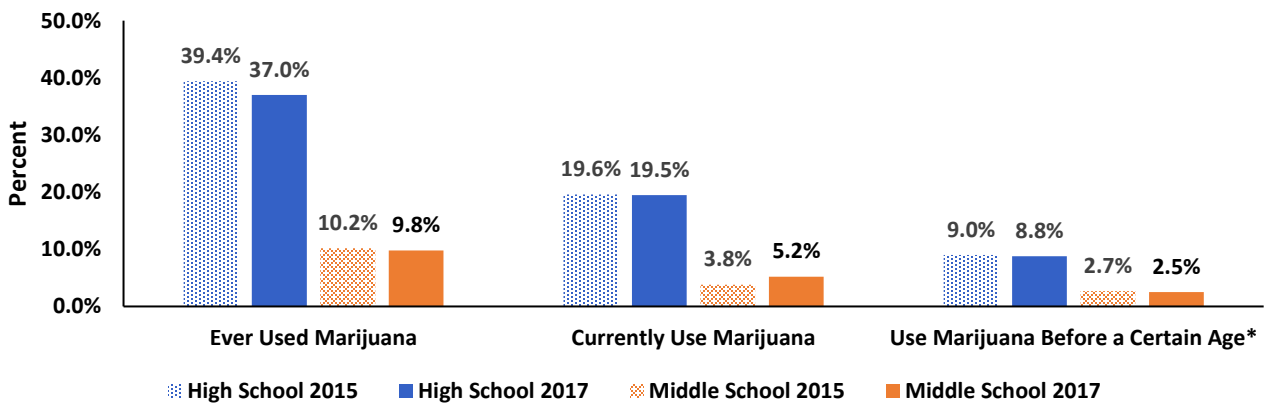
**Figure 40. Alcohol Use, Nevada Middle and High School Students, 2015 and 2017.**



Source: Nevada Youth Risk Behavior Survey.  
 Chart scaled to 70% 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.

There was a significant decrease in high school students from both ever drinking alcohol and current use of alcohol. In high school students, the Douglas County region had a significantly higher percent of students who ever drank alcohol, 74.4%, whereas in middle school students, the following county regions were significantly higher: Churchill, Humboldt, Pershing, and Lander Counties (38.0%) and Lyon, Mineral, and Storey Counties (38.0%).

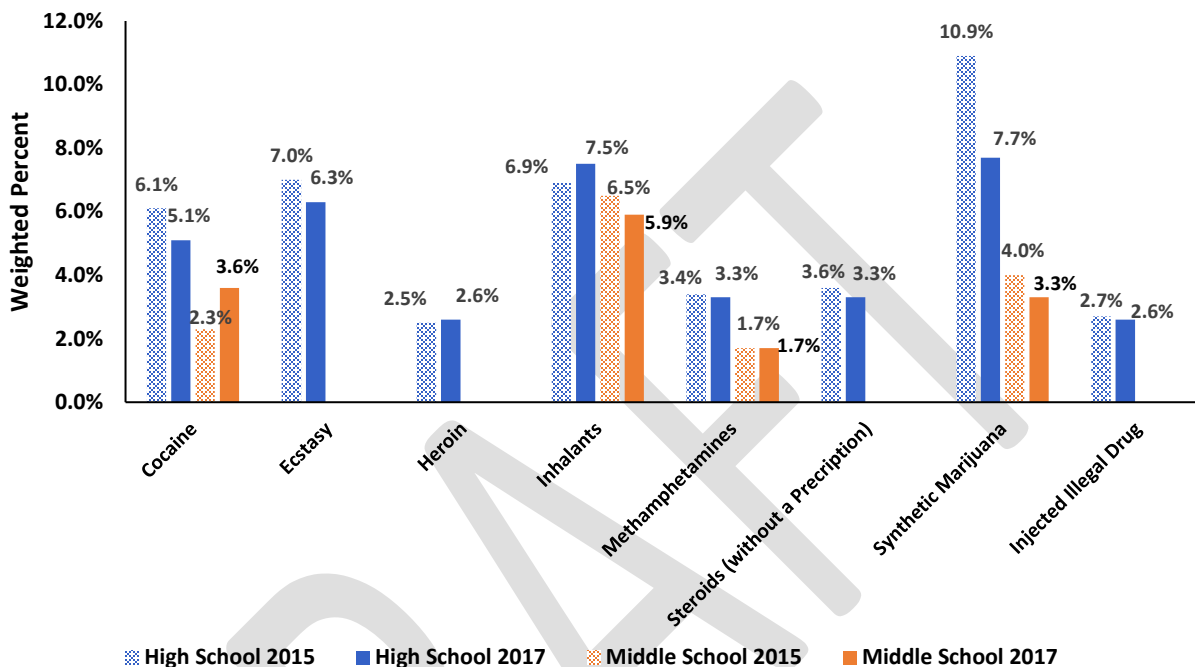
**Figure 41. Marijuana Use, Nevada Middle and High School Students, 2015 and 2017.**



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 is no significant change for marijuana use from 2015 to 2017. Nevada is comparable to the nation which is 35.6% for marijuana use in high school students. Older high school students, 12<sup>th</sup> grade, and 18 years or older have a significantly higher percent for ever using marijuana before, 49.2%, and 51.5% respectively. Middle school students in 8<sup>th</sup> grade and those 14 years or older have a significantly higher percent for ever using marijuana before, 15.1% and 18.7% respectively.

**Figure 42. Lifetime Drug Use, Nevada Middle and High School Students, 2015 and 2017.**



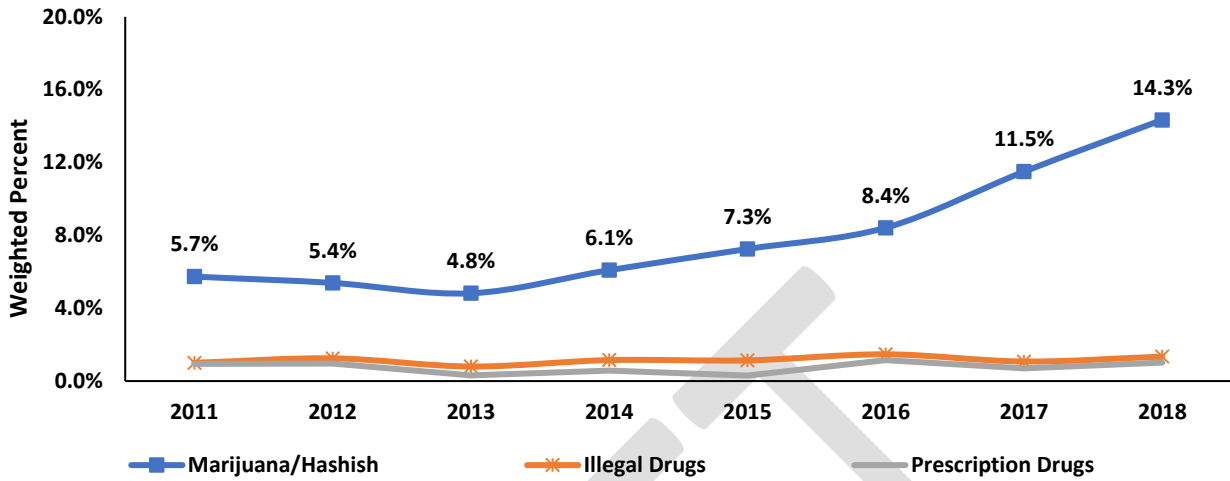
Source: Nevada Youth Risk Behavior Survey.  
 Chart scaled to 12% to display differences among groups.

There was a significant decrease for synthetic marijuana use from 2015 to 2017. Drug use among high school students is slightly higher in Nevada than the nation. Of Nevada high school students, 7.5% have use inhalants, while the national percentage is lower at 6.2%.

## 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 43. Adult Nevada Residents Who Used Illegal Substances, Marijuana/Hashish or Painkillers to Get High in the Last 30 days, 2011-2018.**



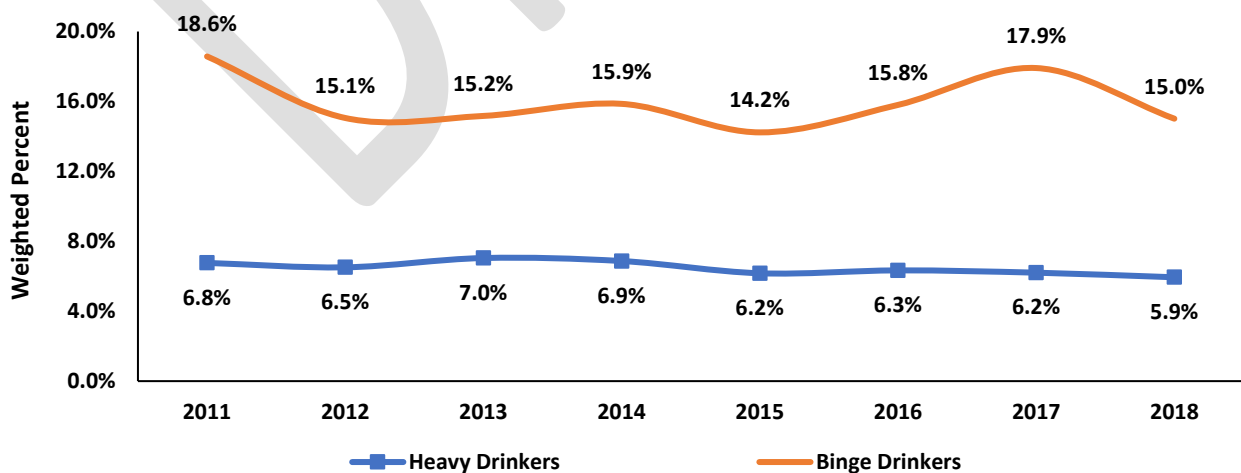
Source: Behavioral Risk Factor Surveillance System.  
 Chart scaled to 10% to display differences among groups.

Marijuana use has more than double since 2011. In 2018, 14.3% have used marijuana in the past 30 days from 5.7% in 2011. Marijuana use is expected to increase as marijuana was legalized in Nevada in 2017. Of Nevadans surveyed, 0.7% (on average) used painkillers to get high in the last 30 days and 1.2% used other illegal drugs to get high in the last 30 days.

In 2018, Nevada residents aged 25-34 were significantly higher than Nevada with 22.6% with using marijuana/hash within the last 30 days and marijuana use among those not married (22.8%) was greater than those married (9.5%).

There were no significantly higher coalition areas with reported higher marijuana/hashish use, but Join Together Northern Nevada had the most reported use at 16.8%, which is significantly higher than the Frontier Community Coalition.

**Figure 44. Percentage of Adults Who are Considered Binge Drinkers or Heavy Drinkers, 2011-2018.**



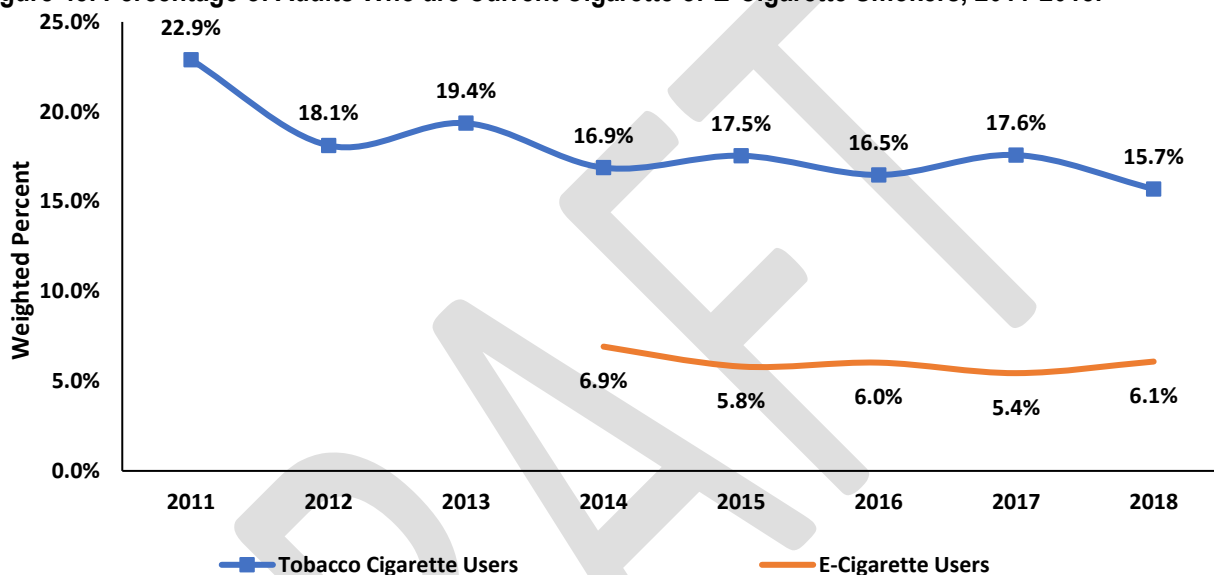
Source: Behavioral Risk Factor Surveillance System.  
 Chart scaled to 20% to display differences among groups.

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

Binge drinking is higher among those aged 18-54. Males are significantly higher in both heavy and binge drinking, 6.2% and 20.4% respectively.

Binge drinking is significantly higher among the Join Together Northern Nevada at 19.4% in 2018.

**Figure 45. Percentage of Adults Who are Current Cigarette or E-Cigarette Smokers, 2011-2018.**



Source: Behavioral Risk Factor Surveillance System.  
 Chart scaled to 20% to display differences among groups.  
 E-cigarette use was not collected until 2014.

In 2018, 15.7% of adults were current cigarette smokers, which has decreased significantly since 2011, at 22.9%. E-cigarette use is higher among those never married and among young adults aged 18-24 at 16.5%.

The PACE coalition region was significantly higher with reported cigarette use at 26.5%.

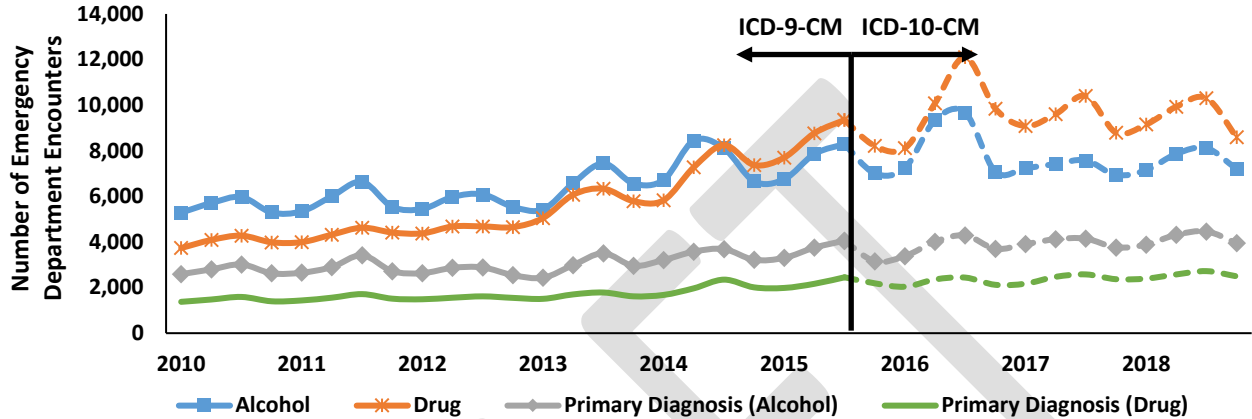
Nevada 211 is a phone number that connects Nevadans with needed services. Substance use services including alcohol support and medication-assisted treatment for opioid disorders. During the 2019 fiscal year (July 1, 2018 -June 30, 2019), Nevada 211 received 1,111 calls relating to substance use services, including 285 for drug detoxification support.

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 15 new cases of HIV/AIDS that were transmitted through IDU. In 2018, there were 805 individuals in Nevada who are living with HIV/AIDS that was contracted through 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 50. Alcohol and Drug-Related Emergency Department Encounters by Quarter and Year, 2010-2018.**



Source: Hospital Emergency Department Billing.

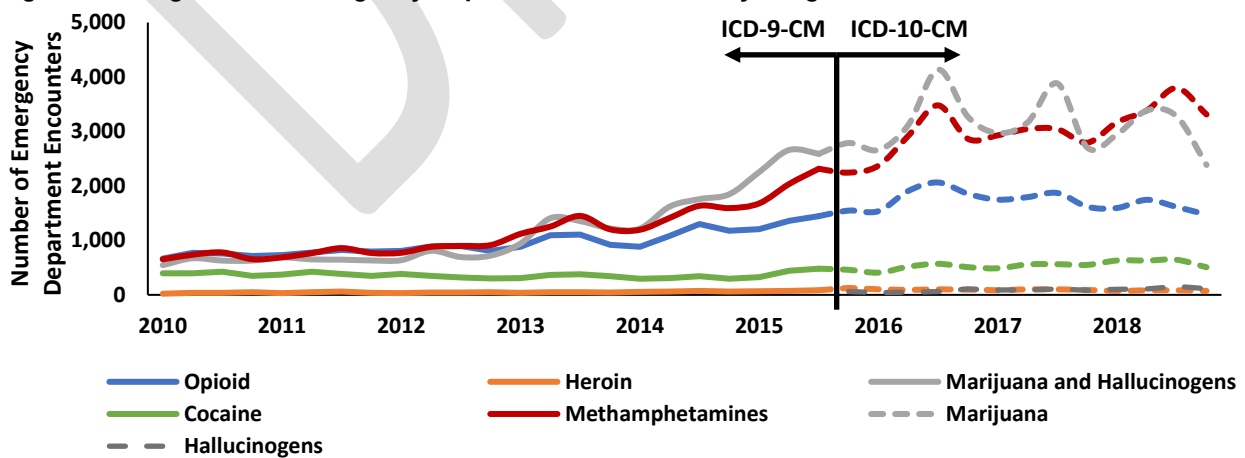
Categories are not mutually exclusive.

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/drugs were listed in any of the diagnoses.

Alcohol visits were more common than drug visits until 2014 where drugs visits to the emergency department surpassed alcohol and have remained higher through 2018. In 2018, there were a total of 64,502 alcohol and drug-related emergency department encounters. Out of these encounters, 16,617 were related to alcohol (primary diagnosis) and 10,187 were drug-related (primary diagnosis).

**Figure 51. Drug-Related Emergency Department Encounters 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.



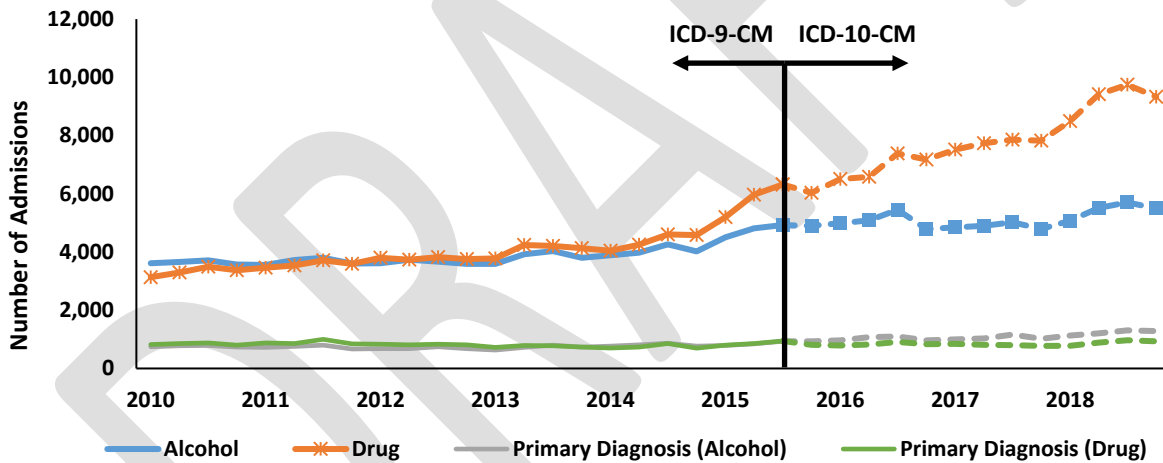
Hallucinogens and marijuana were grouped together for ICD-9-CM, but in 2015 were separated into different groups in the ICD-10-CM codes. Heroin, cocaine, methamphetamines, and hallucinogens drug use rates were significantly higher in 2018 than in 2017. Males had significantly higher emergency department encounters for cocaine, methamphetamines, marijuana/cannabis, and hallucinogens use for 2018.

The following coalitions had significantly higher marijuana use compared to the state: PACT/CARE, NCC, PACE, and PCC. Other drugs that had had significantly higher use were hallucinogens in the PCC coalition; opioid use in JTNN coalition; and both cocaine and hallucinogens in the PACT/CARE coalitions, Clark County.

## 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 Nevada hospitals for drug-related issues than for alcohol-related issues. Of the 52,632 alcohol and drug-related admissions, 21,786 was alcohol-related and 36,990 were drug-related.

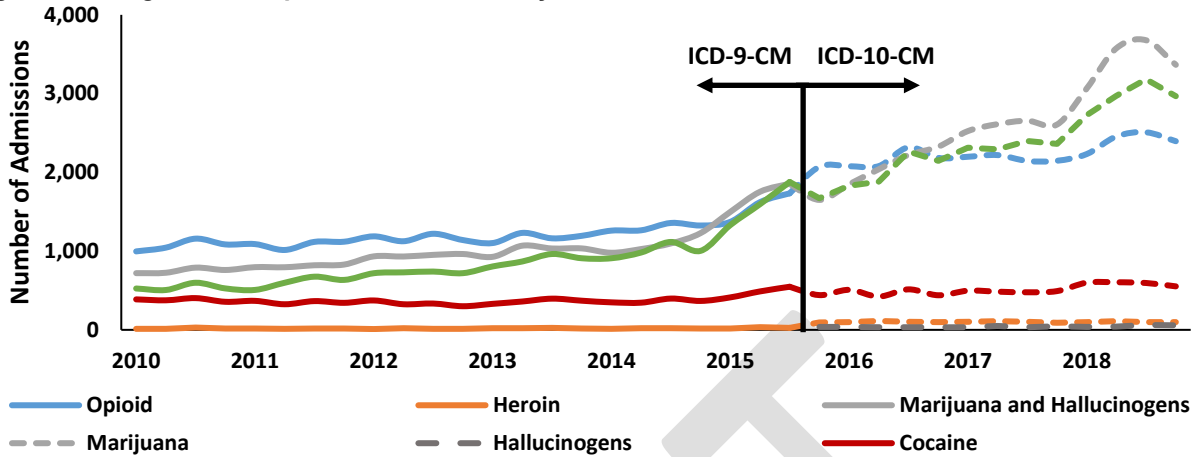
**Figure 52. Alcohol and/or Drug-Related Inpatient Admissions by Quarter and Year, 2010-2018.**



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 until 2011 where drug-related admissions surpassed alcohol and have remained higher through 2018. In 2018, there was a total of 52,632 alcohol and drug-related inpatient admissions. Out of this number, 4,934 were related to alcohol (primary diagnosis) and 3,563 were drug-related (primary diagnosis).

Figure 53. Drug-Related Inpatient Admissions 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.

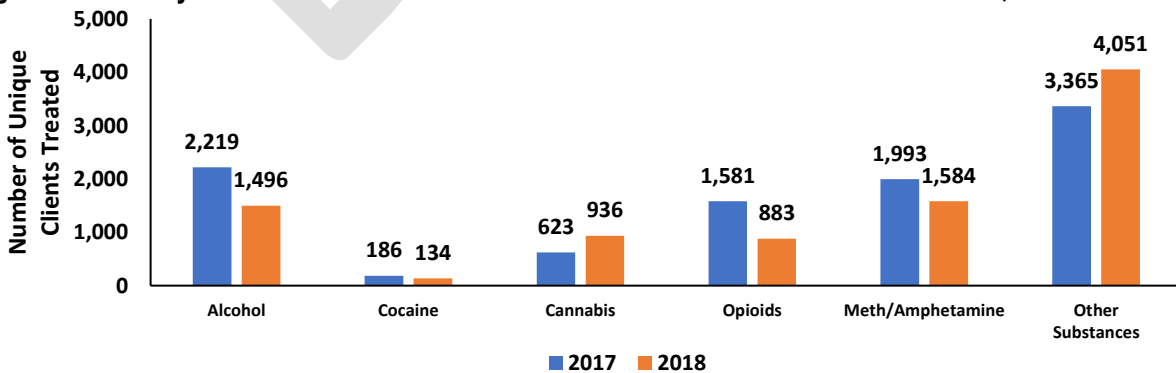
Hallucinogens and marijuana were grouped together for ICD-9-CM, but in 2015 were separated into different groups in the ICD-10-CM codes. Opioids, cocaine, and methamphetamines inpatient admission increased significantly from 2017 to 2018. Inpatient admission for males in 2018 were significantly higher than females overall, and with cocaine, methamphetamines, and marijuana-related admissions.

The PCC coalition had significantly higher inpatient admission rates compared to Nevada for opioid, methamphetamine, and marijuana use. The JTNN coalition had significantly higher inpatient admission rates for opioid, heroin, and methamphetamine use. Similarly, the HCC coalition had significantly higher rates for opioid and heroin use. Finally, PACT/CARE had a significantly higher inpatient admission rate for cocaine use.

## Substance Abuse Treatment Centers

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

Figure 54. Primary Substance Used for Clients at Substance Abuse Treatment Centers, 2017 and 2018.



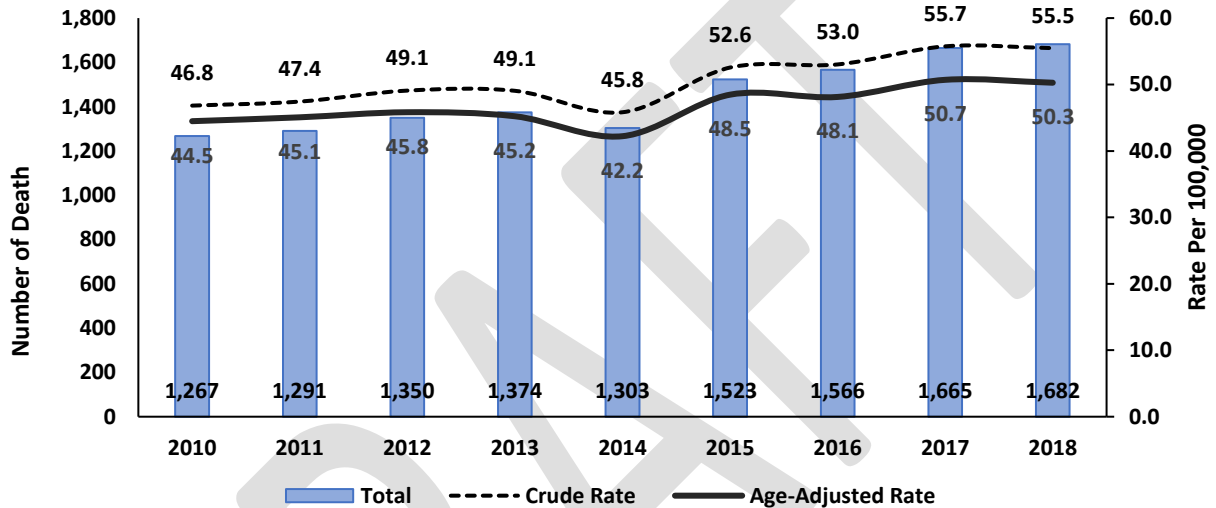
Data Source: Treatment Episode Data Sets.

Of the total treatment episodes for males, 23% are for alcohol whereas for females visits only 15% are for alcohol-related use and 22% for methamphetamines. Alcohol is the primary substance for use among all races, except Asian/Pacific Islanders, where the primary substance is methamphetamines (40%).

## Alcohol and/or Drug-Related Deaths

Alcohol and/or drug-related deaths include deaths where alcohol/drugs are listed as the cause of death. In previous reports, contributing causes of death for alcohol/drugs were included; therefore, counts will be lower than in the previous report. In 2018, 1,682 deaths were related to alcohol and drugs.

**Figure 55. Alcohol and/or Drug-Related Deaths and Age-Adjusted Rates, 2010-2018.**

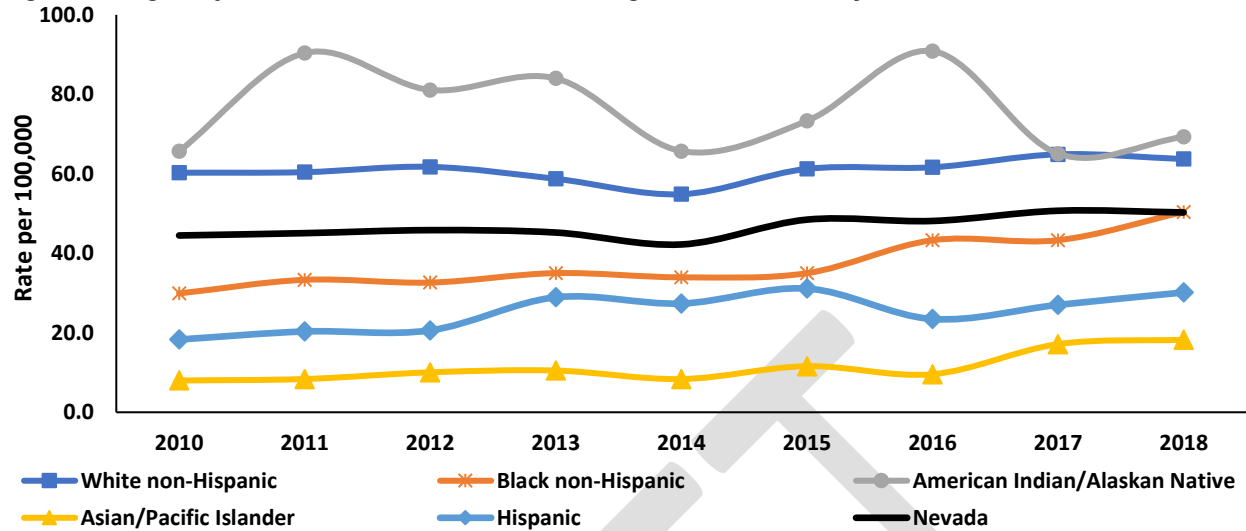


Source: Electronic Death Registry System.

The alcohol and/or drug-related age-adjusted rate increased significantly in 2015 from previous years (95% confidence interval) and has remained at a significantly higher rate through 2017. Males have a significantly higher death rate than females, with 70.2 per 100,000 age specific population and 31.0 per 100,000 age specific population, respectively. The 55-64 age group has the highest rate and is significantly higher than all other age groups at 141.7 deaths per 100,000 population.

None of the coalitions had a significantly higher rate for alcohol/drug-related deaths in 2018, but the PACT/CARE coalition had significantly lower rate for 2018.

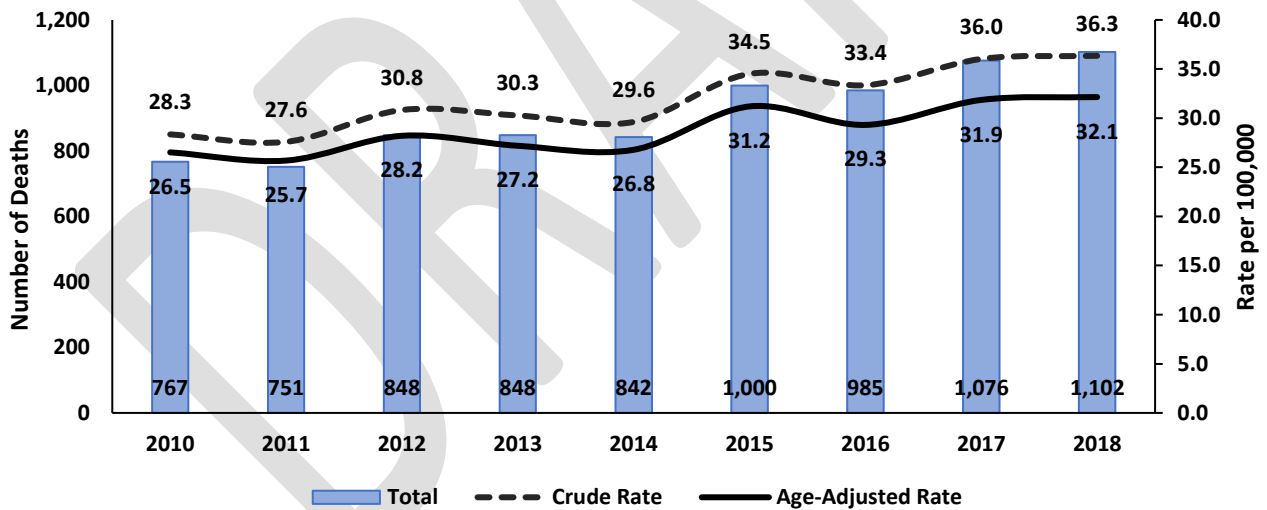
Figure 56. Age-Adjusted Rate for Alcohol and/or Drug-Related Deaths by Race, 2010-2018.



Source: Electronic Death Registry System.

The White non-Hispanic population had a significantly higher rate of alcohol and/or drug-related deaths in 2018. While deaths in the Native American population increased in 2011 and 2016, these deaths are not statistically significant (95% confidence interval) due to the relatively small population size.

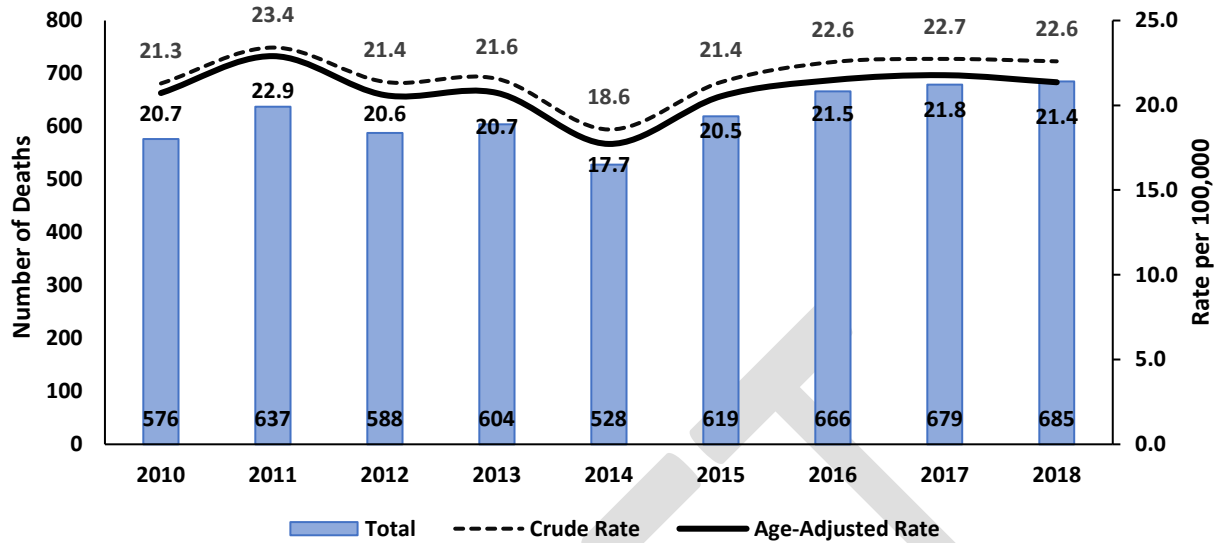
Figure 57. Alcohol-Related Deaths and Age-Adjusted Rates, 2010-2018.



Source: Electronic Death Registry System.

Alcohol-related deaths have not increased significantly between 2010 to 2018. Females have significantly lower rates than males. The age groups between 45-84 were significantly higher for alcohol-related deaths. The JTNN coalition had a significantly higher rate than other coalitions for alcohol-related deaths.

Figure 58. Drug-Related Deaths and Age-Adjusted Rates, 2010-2018.



Source: Electronic Death Registry System.

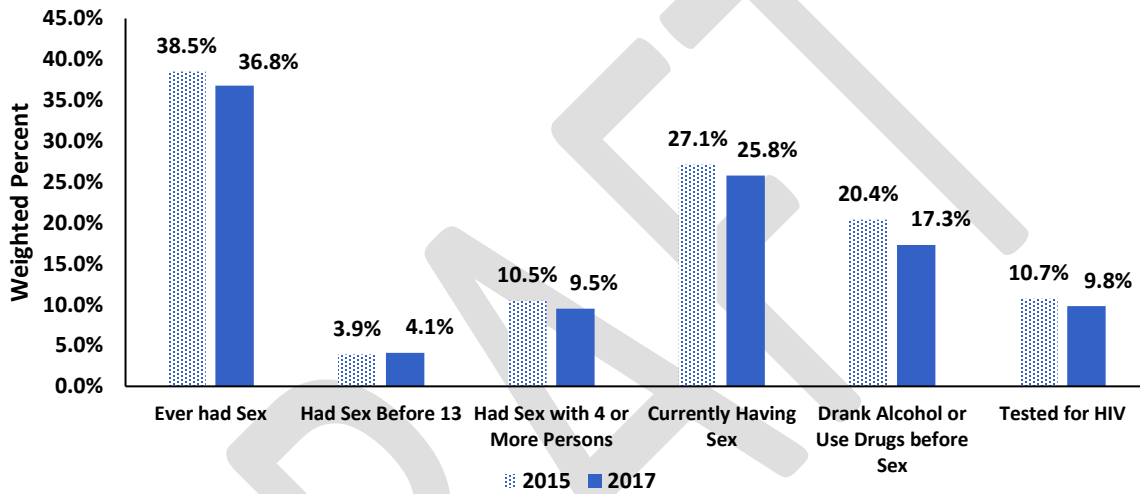
In 2018, males had significantly higher deaths due to drugs than females, at 27.4 and 15.3 per 100,000 age-specific population respectively. The age groups between 25-74 had significantly higher rates than other age groups for drug-related deaths. No coalitions had significantly higher drug-related death rates.

# Special 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, 5,336 high school, and 5,464 middle school students participated in the YRBS.

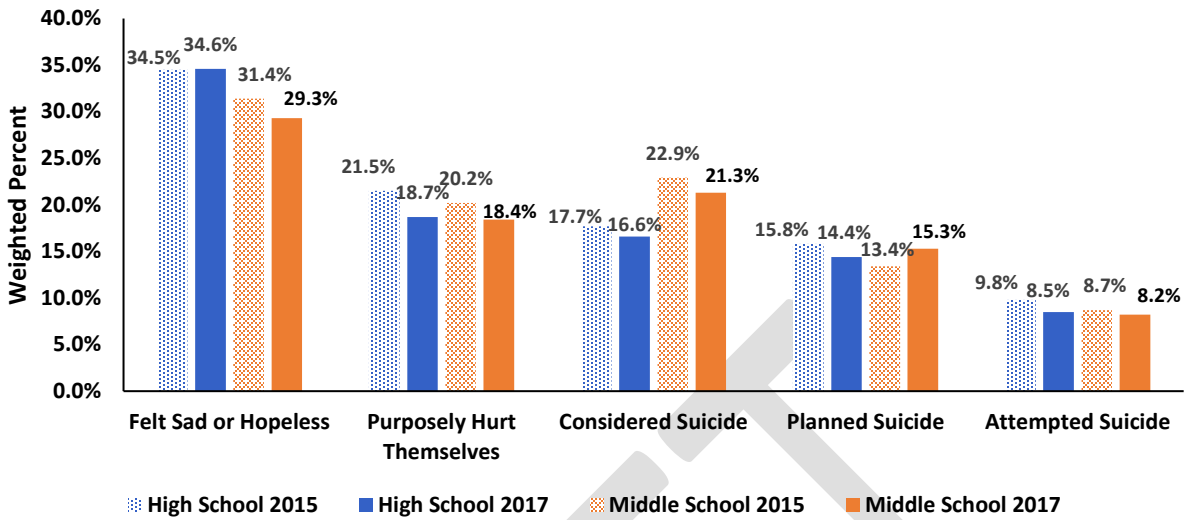
**Figure 59. Sexual Behaviors Among Students, Nevada High School Students, 2015 and 2017.**



Source: Nevada Youth Risk Behavior Survey.  
 Chart scaled to 45% to display differences among groups.

High school students from Churchill, Humboldt, Pershing, and Lander Counties (grouped), and Lyon, Mineral, and Storey Counties (grouped) have significantly high percents of ever having sexual intercourse, 48.8% and 50.4% respectively. Similarly, Churchill, Humboldt, Lander, and Pershing County high school students are significantly higher for having more than four sexual partners, and currently having sex (17.4% and 36.1% respectively).

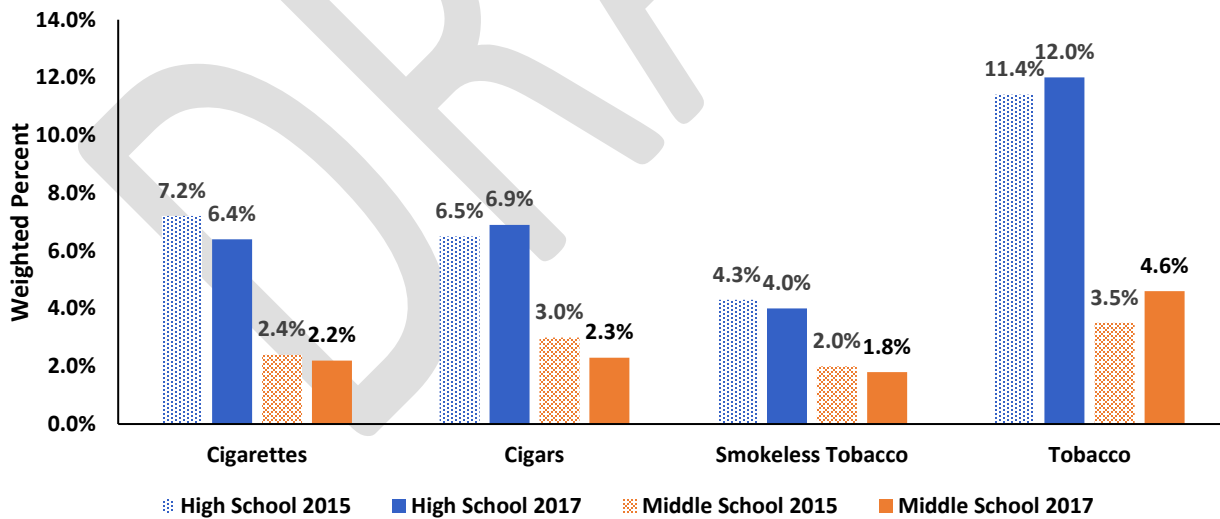
Figure 60. Mental Health Behaviors, Nevada Middle and High School Students, 2015 and 2017.



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

Female high school students have a significantly higher percent who felt sad or hopeless than males, at 45.9% and 24.0% respectively. Likewise, females had significantly higher percents for considering suicides (21.7%) planning a suicide (18.2%), and purposely hurting themselves (24.4%). Similarly, female middle school students are significantly higher with feeling sad or hopeless (38.3%), purposely hurting themselves (26.6%), considering suicide (28.7%), planning suicide (20.7%), and attempting suicide (12.0%).

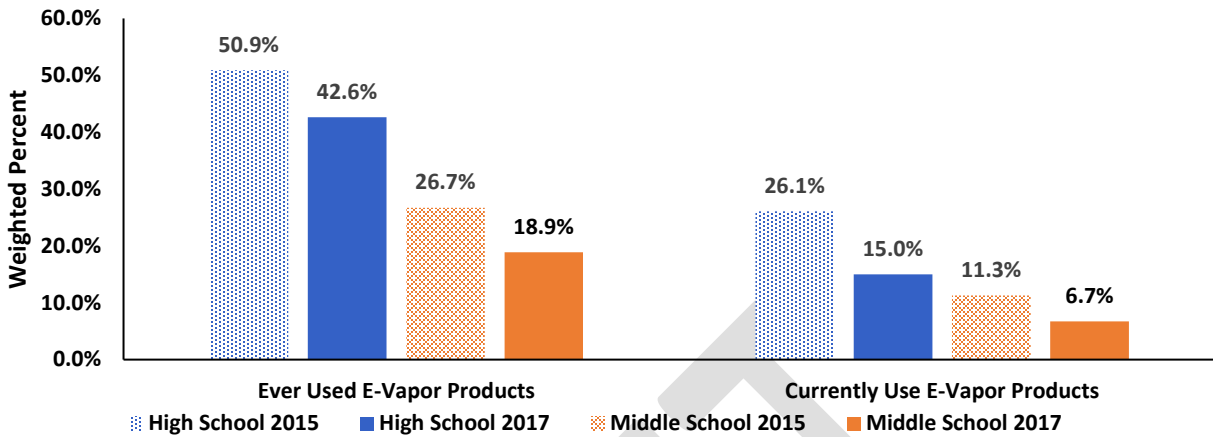
Figure 61. Tobacco Use, Nevada Middle and High School Students, 2015 and 2017.



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

There is no significant change from 2015 and 2017 in both middle and high schools. Of Nevada high school students in 2017, 12.0% have used tobacco at one time; this is lower than the nation at 14.0%. Twelfth grade students are significantly higher, 34.5%, than 9<sup>th</sup> and 10<sup>th</sup>, to having ever smoked cigarettes. Among middle school students, those 14 or older were significantly higher to have smoked cigarettes.

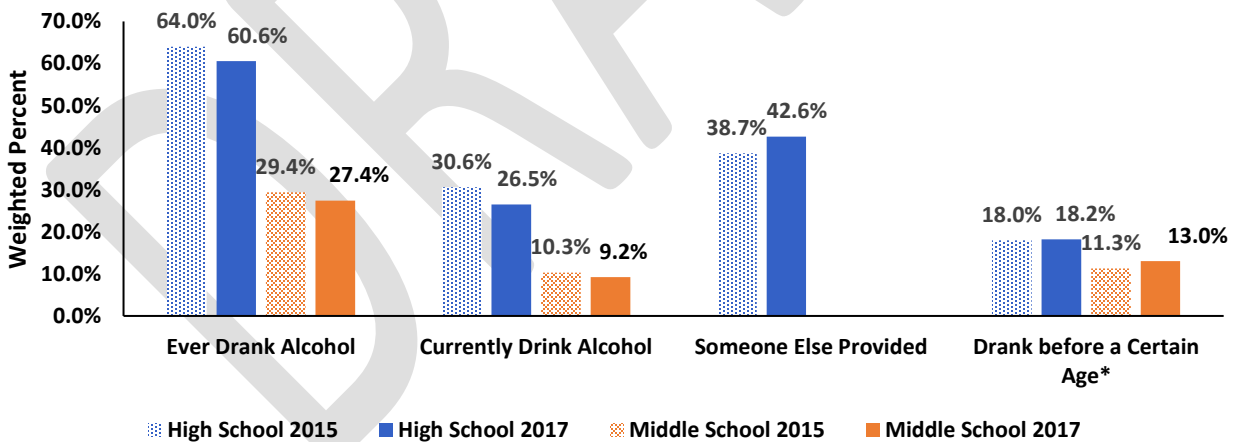
Figure 62. Electronic Vapor Product Use, Nevada Middle and High School Students, 2015 and 2017.



Source: Nevada Youth Risk Behavior Survey.  
 Chart scaled to 60% to display differences among groups.

There is a significant decrease from 2015 to 2017 with electronic cigarette use. In Nevada 15.0% of high school students reported using E-vapor products, which is higher than the nation (13.2%). High school students from the Lyon, Mineral, and Storey counties region have significantly higher reports of using electronic cigarettes, 56.7% and those 18 years or older also reported higher use at 52.8%. In middle school students, those 14 years or older were significantly higher than younger ages at 31.0% reported ever using an electronic cigarette.

Figure 63. Alcohol Use, Nevada Middle and High School Students, 2015 and 2017.

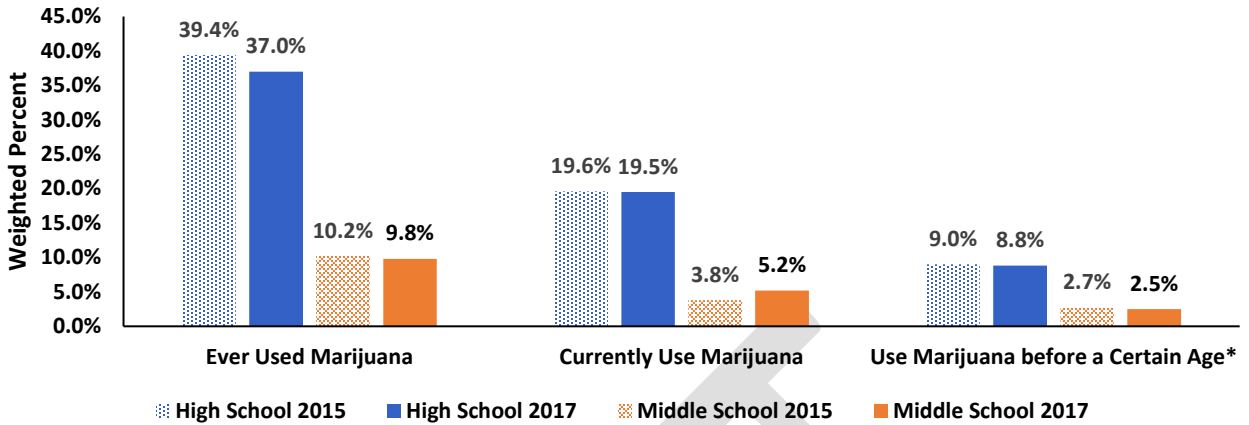


Source: Nevada Youth Risk Behavior Survey.  
 Chart scaled to 70% to display differences among groups.  
 \*In high school students, if they ever drank before age 13, and in middle school students if they ever drank before age 11.

There was a significant decrease in high school students from both ever drinking alcohol and current use. In high school students, the Douglas County region had significantly higher percent of students who ever drank alcohol, 74.4%, whereas in middle school students the following county regions were significantly higher, Churchill, Humboldt, Pershing, and Lander Counties (38.0%) and Lyon, Mineral, and Storey Counties (38.0%).



Figure 64. Marijuana Use, Nevada Middle and High School Students, 2015 and 2017.



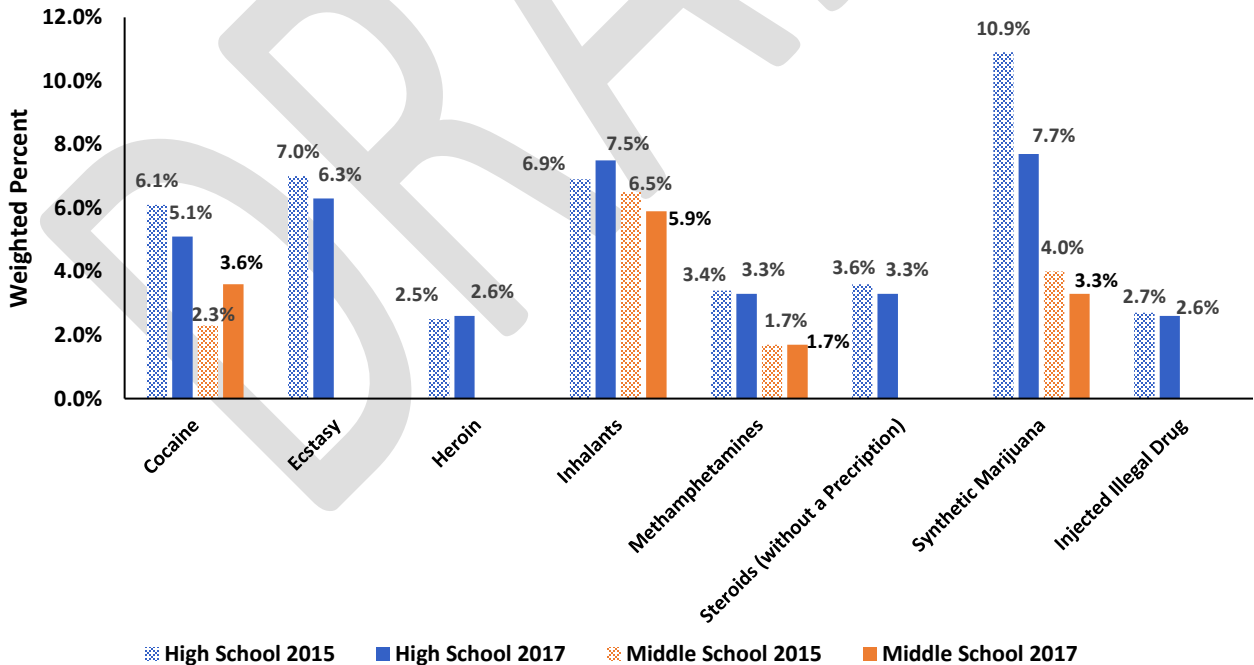
Source: Nevada Youth Risk Behavior Survey.

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 is no significant change for marijuana use from 2015 to 2017. Nevada is comparable the nation which is 35.6% for marijuana use in high school students. Older high school students, 12<sup>th</sup> grade, and 18 years or older are significantly higher for ever using marijuana before, 49.2%, and 51.5% respectively. Middle school students in 8<sup>th</sup> grade and those 14 years or older are significantly higher for ever using marijuana before, 15.1% and 18.7% respectively.

Figure 65. Lifetime Drug Use, Nevada Middle and High School Students, 2015 and 2017.



Source: Nevada Youth Risk Behavior Survey.

Chart scaled to 12% to display differences among groups.

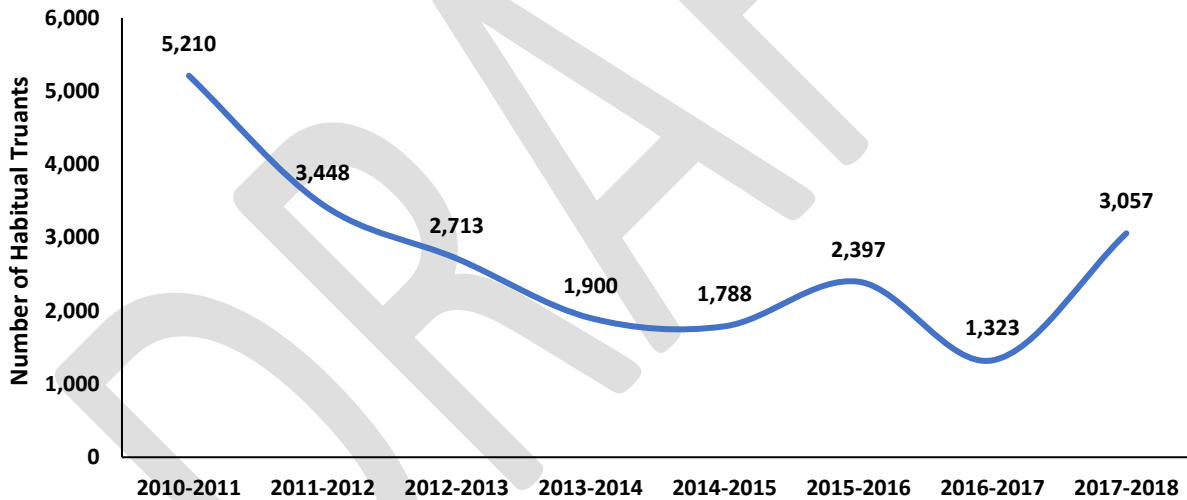
There was a significant decrease for life synthetic marijuana use from 2015 to 2017. Drug use among high school students is slightly higher in Nevada than the nation. Of Nevada high school students, 7.5% have used inhalants, while the national percentage is lower at 6.2%.

## Nevada Report Card

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

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

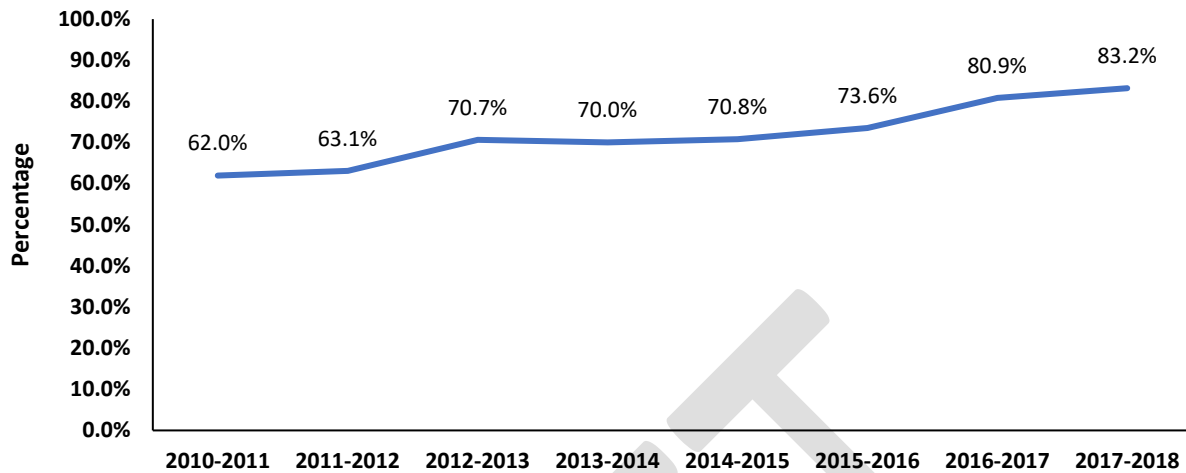
**Figure 66. Number of Habitual Truants, Nevada, Class Cohorts 2010–2018.**



Source: Nevada Department of Education, Report Card.

Nevada’s numbers of habitual truant students have been decreasing since the peak of 5,210 truant students during the 2010-2011 school year. Nevada recorded the lowest number of 1,323 truant students during the 2016-2017 school year. In 2017-2018 school year the number of truants more than doubled to 3,057.

Figure 67. High School Graduation Percentage, Nevada, Class Cohorts 2010–2018.



Source: Nevada Department of Education, Report Card.

Graduation rate is defined as the rate at which 9<sup>th</sup> graders graduate by the end of the 12<sup>th</sup> 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). Nevada high schools posted the highest graduation rate at 83.2% for the class of 2018.

## Suicide

Suicide among the youth (18 and younger), was highest in 2018, but it is not a significant increase (95% confidence interval). Of the emergency department encounters and inpatient admissions, females comprise nearly 75% of the visits, whereas among successful suicide deaths, 75% are males.

Year	Suicide Attempts				Suicides	
	Emergency Department Encounter		Inpatient Admission		N	Rate
	N	Rate	N	Rate		
2010	525	74.6	123	17.5	11	1.6
2011	579	82.4	128	18.2	27	3.8
2012	601	85.3	135	19.2	8	1.1
2013	643	90.5	163	22.9	18	2.5
2014	724	101.0	145	20.2	16	2.2
2015	820	111.2	211	28.6	24	3.3
2016	775	103.7	236	31.6	21	2.8
2017	802	106.7	257	34.2	21	2.8
2018	780	103.0	410	54.1	32	4.2

Source: Hospital Emergency department billing and Inpatient Billing, and Electronic Death Registry System.

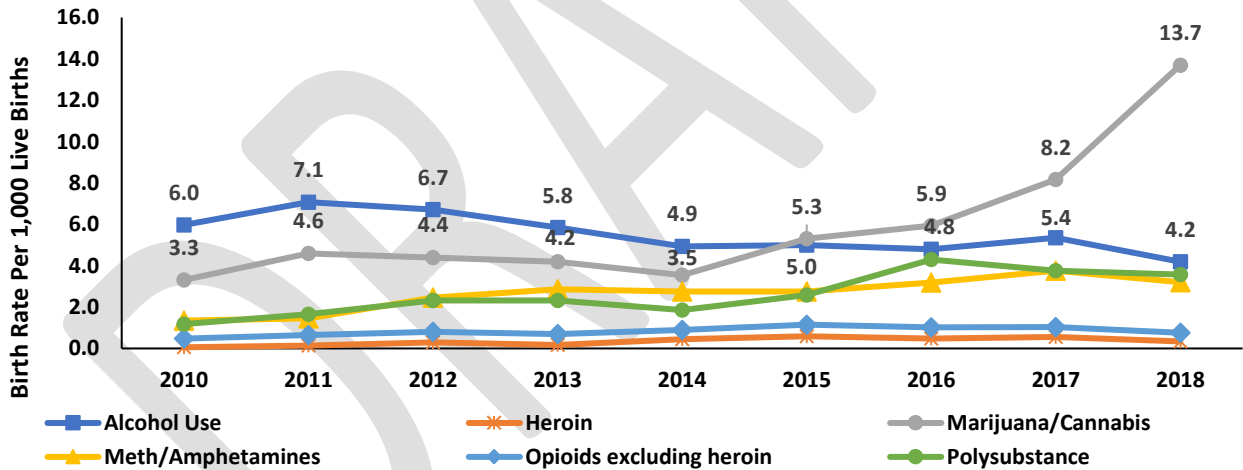
# Special Population: Maternal and Child Health

Nevada 211 is a phone number that helps Nevadans connect with services they need, including pregnancy-related mental health services. During the 2019 fiscal year (July 1, 2018 -June 30, 2019), Nevada 211 received 33 calls relating to mental health. The most calls received were for information regarding parent support groups and parent counseling.

## Substance Use Among Pregnant Women (Birth)

The data in this section is reflective of self-reported information provided by the mother on the birth record. On average, there are 35,394 live births per year to Nevada residents between 2010 and 2018. In 2018, 149 birth certificates indicated alcohol use, 487 birth certificates indicated marijuana use, 114 indicated meth/amphetamine use, 27 indicated opiate use, and 12 indicated heroin use during pregnancy.

**Figure 68. Prenatal Substance Abuse Birth Rates (Self-Reported) for Select Substances, Nevada Residents, 2010-2018.**



Source: Nevada Electronic Birth Registry System.

Of the self-reported substance use during pregnancy among Nevada mothers who gave birth between 2010 and 2018, the highest rate was with marijuana use in 2018, at 13.7 per 1,000 live births. Since 2015, the marijuana use rate has surpassed the alcohol use rate, which was 4.2 per 1,000 births in 2018. In 2018, a rate of 3.2 per 1,000 live births was reported for meth/amphetamines, which is higher than 2010 at 1.3 per 1,000 live births. Polysubstance use (more than one substance) has increased from 2.6 per 1,000 live births in 2015 to 3.6 per 1,000 live births in 2018.

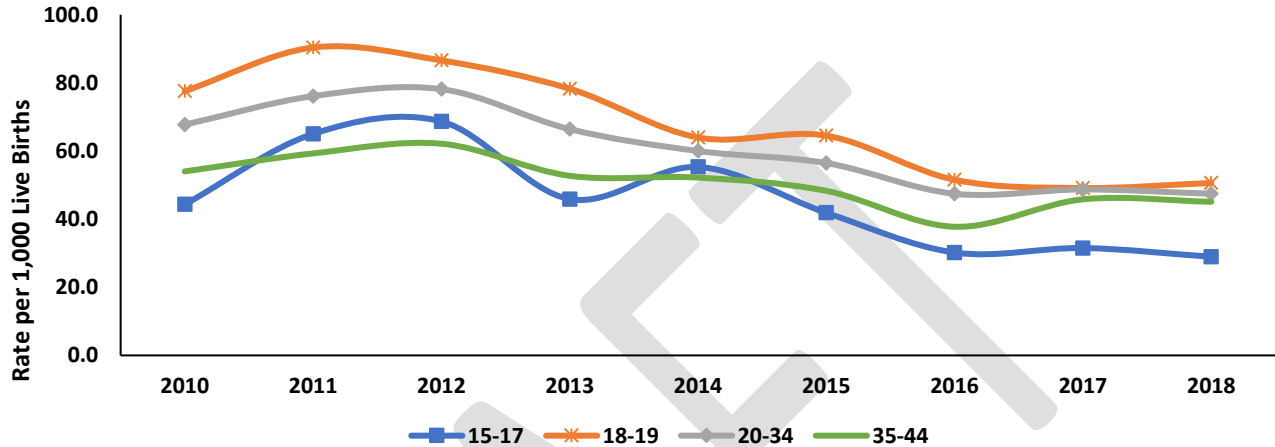
Marijuana/cannabis use among pregnant females was significant in the 20-24 age group, at 23.4 per 1,000 live births (age specific) and among black non-Hispanic woman at 31.1 per 1,000 live births (race specific).

## Nevada SAPTA EPI Profile

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.

There is a significant increase in marijuana /cannabis use for the PACT/CARE coalition counties from 2017 to 2018, at 8.2 to 13.8 women using marijuana/cannabis per 1,000 live births.

**Figure 69. Prenatal Tobacco Use Birth Rates (Self-Reported), Nevada Residents, 2010-2018.**



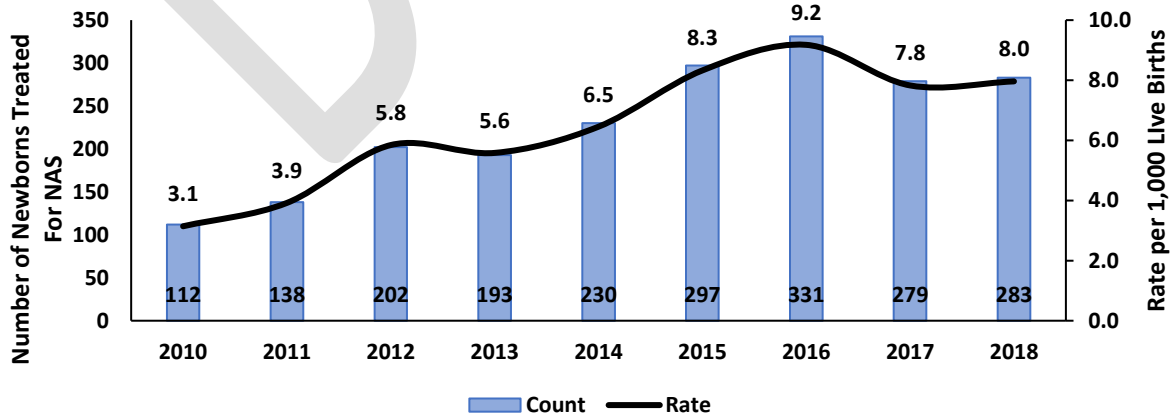
Source: Nevada Electronic Birth Registry System.

Woman over 45 were not included in the above graph but did have a significant decrease in tobacco use during pregnancy from 2010-2015 (244.8 to 189.4 per 1,000 live birth respectively). In 2018 the tobacco use during pregnancy was 42.1 per 1,000 live births for woman over 45. Teens aged 15-17 who gave birth had a significantly lower tobacco use rate in 2018 than all other age groups at 29.0 per 1,000.

When pregnant women were surveyed for BRFSS they had significantly lower use for tobacco smoking, at 1.9%, from non-pregnant women 14.0%.

## Neonatal Abstinence Syndrome

**Figure 70. Neonatal Abstinence Syndrome, Nevada Residents, 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.

## Nevada SAPTA EPI Profile

Neonatal abstinence syndrome (NAS) is a group of problems that occur in a newborn who was exposed to addictive illegal or prescription drugs while in the mother's womb. Withdrawal or abstinence symptoms develop shortly after birth. Inpatient admissions for NAS has doubled since 2011, from 112 newborns admitted to 283 newborns admitted in 2018.

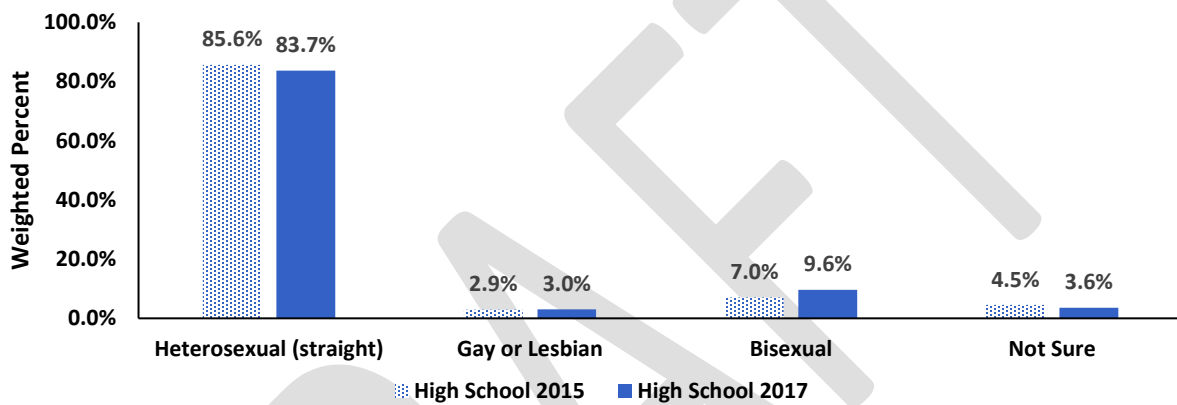
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# Special Population: Lesbian, Gay, Bisexual, and Transgender

## 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.

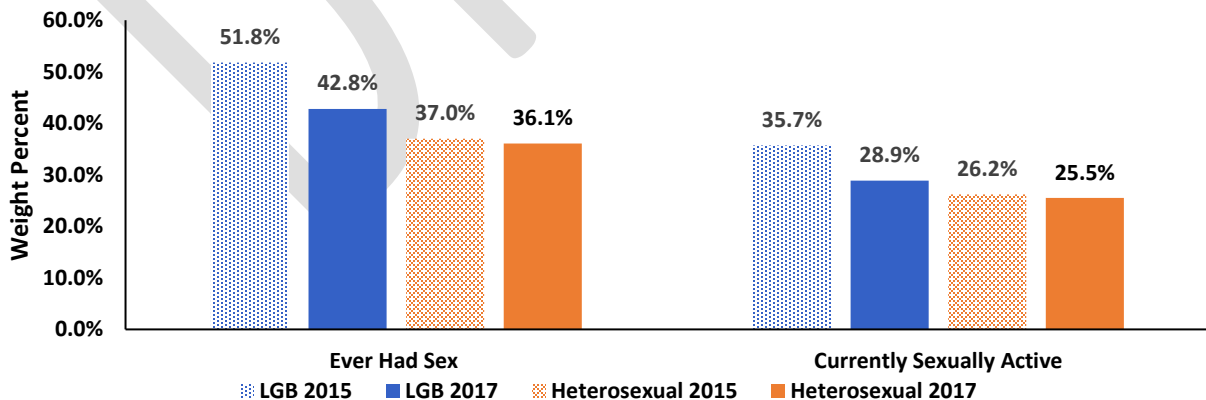
**Figure 71. Sexual Orientation, Nevada High School Population, 2015 and 2017.**



Source: Nevada Youth Risk Behavior Survey.  
 Chart scaled to 90% to display differences among groups.

In Nevada high schools, 3.0% of the students identify as gay or lesbian, 9.6% bisexual, and 3.6% are not sure of their sexual orientation.

**Figure 72. Sexual Behaviors Among Students, Nevada High School Students, 2015 and 2017.**



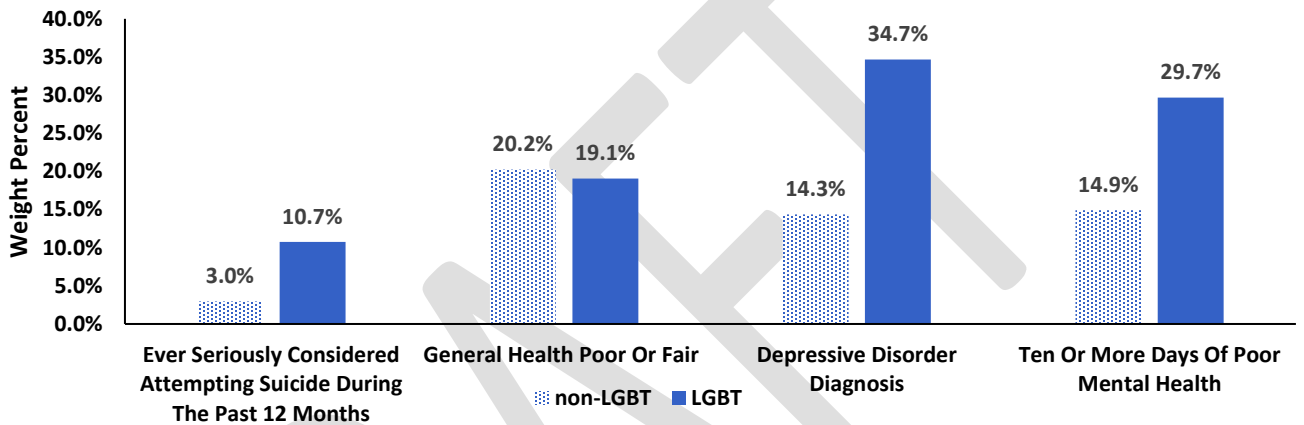
Source: Nevada Youth Risk Behavior Survey.  
 Chart scaled to 60% to display differences among groups.

In 2017, 42.8% of gay, lesbian, or bisexual (LGB) high school students have previously had sex, and 28.9% LBG students are currently having sex.

## 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.

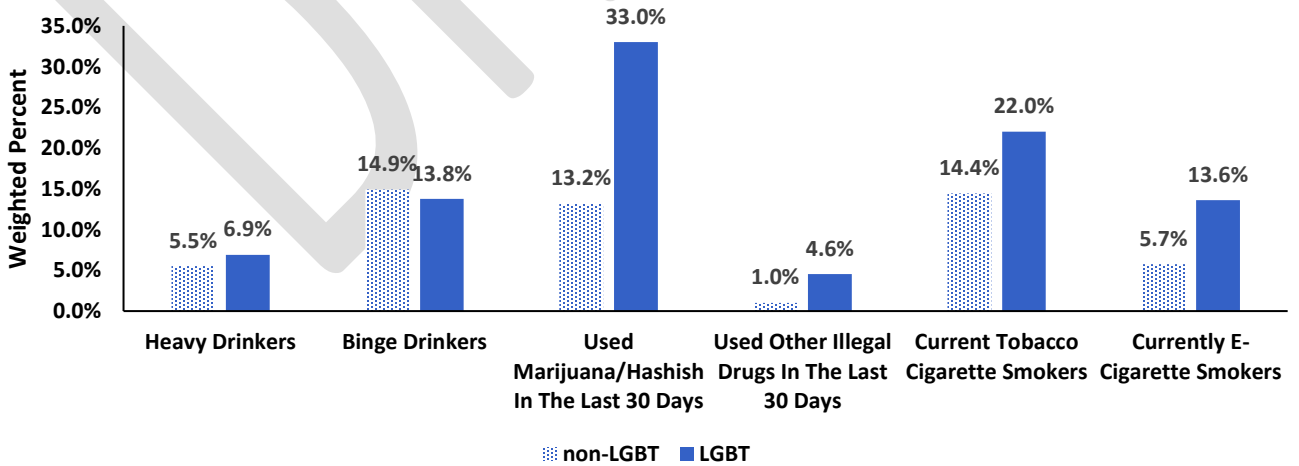
**Figure 73. Mental Health Behaviors, by LGBT and non-LGBT Nevada Adults, 2018.**



Source: Behavioral Risk Factor Surveillance System.  
Chart scaled to 40% to display differences among groups.

The LGBT population had significantly higher percent's for both depressive disorder diagnoses and days of poor mental health.

**Figure 74. Substance Use-Related Risk Factors, by LGBT and non-LGBT Nevada Adults, 2018.**



Source: Behavioral Risk Factor Surveillance System.  
Chart scaled to 35% to display differences among groups.

The LGBT population had a significantly higher percent of current marijuana/hashish use.



## Nevada SAPTA EPI Profile

The highest rate of transmission of HIV/AIDS occurs through male sex with male (MSM). In 2018, there were 338 newly diagnosed individuals where the transmission was MSM; of these individuals, 26 were intravenous drug users (IDU) as well. In 2018, there were 7,780 individuals in Nevada who are living with HIV/AIDS that was contracted through MSM; of these individuals, 752 were IDU as well.

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# Special Topic: Gambling

In 2018, the BRFSS survey added two questions relating to gambling:

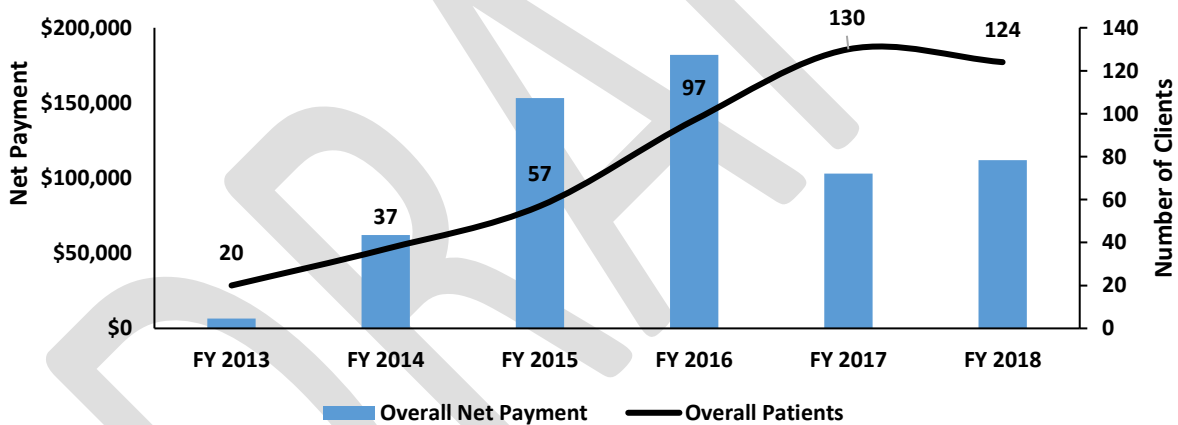
*In the past 12 months, how often have you bet money or possessions on any of the following activities? Casino gaming including slot machines and table games; or lottery including scratch tickets pull tabs and lotto; sports betting; internet gambling; bingo; or any other type of wagering.*

*Has the money you spent gambling led to financial problems and/or has the time you spent gambling led to problems in your family, work, or personal life?*

Among Nevadans, 8.6% participate in heavy gambling, (once a week or more). Those 65 years or older were significantly higher than the state, at 14.8%. Males are significantly higher than females, at 10.7% and 6.5% respectively.

Medicaid patients can access services for pathological gambling.

**Figure 75. Clients with Pathological Gambling Diagnosis, Clients and Payment, Fiscal Year 2013-2018.**



Sources: DSS and Medicaid Data Warehouse.  
This includes the costs for all claims that had a Pathological Gambling Diagnosis. Net Payment represents only paid claims.

Of the 124 patients treated during the 2018 fiscal year, 61% were male, 63% were from Clark County, and 25% were from Washoe County.

In October 2015, ICD-10-CM codes were implemented. Previous to 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.

# Appendix

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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 versus 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 for hospital encounters and admissions:

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)  
 Alcohol: E860 291, 303, 980, 305.0, 357.5, 425.5, 535.3, 571.0, 571.1, 571.2, 571.3, 790.3 (9); F10, K70, G62.1, I42.6, K29.2, R78.0, T51 (10).  
 Drug: 292, 304, 965, 967, 968, 969, 970, 305.2, 305.3, 305.4, 305.5, 305.6, 305.7, 305.8, 305.9 (9); F11- F16, T39, T40, T43, F18, F19 T410, T41.1, T41.2, T41.3, T41.4, T42.3, T43.4, T42.6, T42.7, T42.8 (10).

The following ICD-10 codes were used for deaths data:

Suicide-related deaths: X60-X84, Y87.0  
 Mental and Behavioral-related deaths: F00-F09, and F20-F99.  
 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.  
 Drug-related Deaths: X40-X44, X60-S64, X85, Y10-Y14.

Nevada SAPTA EPI Profile

**Table 1. Population Distribution, Nevada, 2010-2018.**

	2010	2011	2012	2013	2014	2015	2016	2017	2018
Nevada	2,705,845	2,721,794	2,750,217	2,800,966	2,843,301	2,897,684	2,953,377	2,986,656	3,031,919
<b>Sex</b>									
Female	1,338,008	1,347,169	1,362,145	1,388,602	1,410,857	1,440,920	1,470,250	1,488,221	1,512,700
Male	1,367,837	1,374,625	1,388,072	1,412,364	1,432,444	1,456,765	1,483,127	1,498,435	1,519,219
<b>Age</b>									
<1	36,579	35,112	34,516	34,389	35,964	35,453	36,460	37,252	37,731
1-4	160,891	155,936	149,531	146,081	144,034	145,106	146,339	146,925	149,642
5-14	361,591	368,234	376,669	386,142	391,533	405,007	407,823	408,426	408,361
15-24	363,570	364,218	368,737	375,934	379,820	387,182	394,928	395,471	400,823
25-34	377,553	374,494	372,983	376,947	381,591	396,649	407,260	416,478	425,942
35-44	387,788	387,069	389,725	395,766	399,542	398,838	403,408	405,872	410,862
45-54	372,166	373,149	375,197	379,995	385,828	387,647	394,646	396,403	397,010
55-64	310,919	318,128	323,370	331,756	338,075	344,172	351,960	356,916	362,800
65-74	207,114	212,292	223,092	233,677	241,857	248,456	254,595	260,147	268,415
75-84	95,725	99,748	101,759	104,280	108,183	111,916	117,805	123,615	130,392
85+	31,950	33,416	34,638	35,998	36,876	37,258	38,153	39,151	39,941
<b>Race/Ethnicity</b>									
White non-Hispanic	1,508,507	1,510,392	1,514,399	1,523,159	1,528,666	1,530,902	1,539,684	1,541,655	1,547,186
Black non-Hispanic	220,374	222,186	225,778	232,837	238,788	247,229	254,921	259,779	266,109
Native American	31,417	31,707	31,941	32,250	32,424	34,075	34,353	34,787	35,115
Asian/Pacific Islander	227,115	228,367	232,862	242,606	250,934	265,838	276,711	282,653	291,200
Hispanic	718,432	729,142	745,238	770,113	792,488	819,641	847,708	867,782	892,309
<b>Behavioral Health Region</b>									
Clark County	1,959,491	1,967,722	1,988,195	2,031,723	2,069,450	2,118,353	2,166,177	2,193,818	2,232,176
	72.4%	72.3%	72.3%	72.5%	72.8%	73.1%	73.3%	73.5%	73.6%
Northern Region	183,903	185,429	185,042	185,445	184,943	184,942	186,445	187,866	190,228
	6.8%	6.8%	6.7%	6.6%	6.5%	6.4%	6.3%	6.3%	6.3%
Rural Region	90,213	91,827	94,345	96,185	96,141	95,803	96,130	95,845	95,919
	3.3%	3.4%	3.4%	3.4%	3.4%	3.3%	3.3%	3.2%	3.2%
Southern Region	54,902	55,223	54,931	55,289	55,970	56,640	56,318	57,204	57,558
	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	1.9%	1.9%	1.9%
Washoe County	417,336	421,593	427,704	432,324	436,797	441,946	448,307	451,923	456,038
	15.4%	15.5%	15.6%	15.4%	15.4%	15.3%	15.2%	15.1%	15.0%
<b>Coalition</b>									
Churchill Community Coalition (CCC)	25,055	25,136	25,238	25,322	25,103	25,126	25,256	25,387	25,816
	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%	0.9%
Frontier Community Coalition (FCC)	29,141	29,970	30,618	30,682	30,662	30,054	29,767	29,921	29,673
	1.1%	1.1%	1.1%	1.1%	1.1%	1.0%	1.0%	1.0%	1.0%
Healthy Communities Coalition (HCC)	61,056	61,167	61,027	61,639	61,902	61,859	62,343	63,415	64,164
	2.3%	2.2%	2.2%	2.2%	2.2%	2.1%	2.1%	2.1%	2.1%
Join Together Northern Nevada (JTNN)	417,336	421,593	427,704	432,324	436,797	441,946	448,307	451,923	456,038
	15.4%	15.5%	15.6%	15.4%	15.4%	15.3%	15.2%	15.1%	15.0%
Nye Communities Coalition (NCC)	50,137	50,622	50,252	50,627	51,386	52,101	51,744	52,530	52,946
	1.9%	1.9%	1.8%	1.8%	1.8%	1.8%	1.8%	1.8%	1.7%
Partners Allied for Community Excellence (PACE)	61,072	61,857	63,727	65,503	65,479	65,749	66,363	65,924	66,246
	2.3%	2.3%	2.3%	2.3%	2.3%	2.3%	2.2%	2.2%	2.2%
PACT Coalition for Safe and Drug free Communities/CARE	1,959,491	1,967,722	1,988,195	2,031,723	2,069,450	2,118,353	2,166,177	2,193,818	2,232,176
	72.4%	72.3%	72.3%	72.5%	72.8%	73.1%	73.3%	73.5%	73.6%
Partnership Carson City (PCC)	55,360	56,066	55,441	54,668	53,969	54,273	55,183	55,438	55,945
	2.0%	2.1%	2.0%	2.0%	1.9%	1.9%	1.9%	1.9%	1.8%
Partnership Douglas County (PDC)	47,197	47,661	48,015	48,478	48,553	48,223	48,237	48,300	48,915
	1.7%	1.8%	1.7%	1.7%	1.7%	1.7%	1.6%	1.6%	1.6%

Source: Nevada State Demographer, Vintage 2018.

## Nevada SAPTA EPI Profile

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

Indicator	JTNN	FCC	CCC	PCC	HCC	PDC	PACE	NCC	PACT/CARE (Clark County)	Nevada
Ever seriously considered attempting suicide during the past 12 months	4.4% (2.8-6.0)	1.5% (0.0-3.8)	3.5% (0.0-7.7)	7.3% (2.1-12.4)	6.6% (2.8-10.3)	0.0% (0.0-0.0)	7.7% (1.8-13.7)	2.5% (0.0-5.1)	2.9% (1.6-4.2)	3.4% (2.4-4.4)
Heavy Drinkers	7.4% (5.6-9.1)	5.2% (0.7-9.7)	12.5% (1.3-23.7)	3.6% (0.4-6.8)	3.1% (0.7-5.5)	7.7% (2.6-12.9)	7.4% (2.6-12.2)	10.9% (4.7-17.1)	5.5% (4.0-7.0)	5.9% (4.8-7.1)
Binge Drinkers	19.4% (16.4-22.4)	24.6% (13.1-36.1)	20.6% (7.9-33.4)	11.9% (5.2-18.7)	11.5% (6.6-16.4)	14.2% (6.9-21.5)	23.1% (15.4-30.7)	11.5% (5.2-17.8)	13.9% (11.5-16.3)	15.0% (13.2-16.9)
General Health Poor or Fair	18.4% (15.5-21.4)	26.0% (15.2-36.8)	22.3% (9.9-34.8)	26.2% (17.3-35.0)	23.9% (16.6-31.2)	24.1% (12.9-35.2)	18.6% (12.1-25.1)	23.8% (14.8-32.8)	20.6% (18.0-23.2)	20.6% (18.5-22.6)
Depressive Disorder Diagnosis	16.7% (13.7-19.6)	10.8% (3.4-18.2)	21.7% (10.7-32.7)	21.9% (13.7-30.2)	21.6% (15.0-28.1)	11.5% (1.6-21.4)	13.6% (7.3-19.8)	16.4% (8.2-24.5)	15.3% (13.0-17.6)	15.7% (14.0-17.5)
Ten or more days of poor mental health	19.1% (16.0-22.2)	5.2% (0.0-10.9)	20.8% (9.5-32.2)	16.1% (8.8-23.4)	32.8% (24.0-41.7)	12.0% (2.0-22.1)	17.1% (10.7-23.4)	12.7% (6.6-18.9)	15.2% (12.7-17.6)	16.1% (14.3-18.0)
Ten or more days of poor mental or physical health kept from usual activities	19.4% (15.5-23.3)	5.7% (0.0-12.5)	20.4% (7.6-33.2)	26.9% (15.1-38.6)	25.3% (15.8-34.8)	25.0% (9.0-41.0)	21.1% (12.2-29.9)	28.7% (17.4-40.0)	22.8% (18.8-26.7)	22.2% (19.3-25.1)
Used marijuana/hashish in the last 30 days	16.8% (13.9-19.8)	6.0% (0.0-13.0)	11.7% (0.3-23.0)	15.8% (8.9-22.7)	17.6% (11.0-24.2)	8.7% (2.4-15.1)	14.1% (6.8-21.3)	13.6% (7.3-20.0)	13.9% (11.2-16.7)	14.3% (12.3-16.4)
Used other illegal drugs in the last 30 days	1.7% (0.8-2.6)	0.0% (0.0-0.0)	0.0% (0.0-0.0)	2.6% (0.0-6.2)	1.4% (0.0-3.2)	6.8% (0.0-17.1)	4.4% (0.0-9.5)	0.8% (0.0-2.2)	1.1% (0.4-1.7)	1.3% (0.8-1.9)
Used prescription drugs/pain killer to get high in last 30 days	0.7% (0.1-1.3)	0.0% (0.0-0.0)	0.0% (0.0-0.0)	0.0% (0.0-0.0)	0.4% (0.0-1.3)	5.3% (0.0-15.2)	1.3% (0.0-4.0)	0.8% (0.0-2.2)	1.0% (0.3-1.8)	1.0% (0.4-1.6)
Current tobacco cigarette smokers	15.2% (12.5-18.0)	24.2% (13.1-35.3)	19.5% (8.3-30.6)	17.7% (9.7-25.7)	15.3% (9.3-21.3)	16.4% (5.6-27.2)	26.0% (18.3-33.7)	26.5% (17.6-35.3)	15.0% (12.6-17.4)	15.7% (13.9-17.5)
Currently e-cigarette smokers	7.0% (4.9-9.0)	3.7% (0.0-8.4)	4.0% (0.0-10.6)	4.3% (0.7-7.9)	9.0% (3.6-14.3)	8.7% (2.1-15.3)	7.4% (2.1-12.6)	7.1% (1.6-12.6)	5.8% (4.0-7.5)	6.1% (4.8-7.4)
Difficulty doing errands alone because of physical, mental, or emotional condition	8.2% (5.9-10.4)	6.1% (0.7-11.6)	5.3% (0.6-10.0)	12.2% (5.3-19.0)	8.7% (4.2-13.2)	10.9% (0.8-21.0)	7.9% (3.4-12.4)	5.4% (2.1-8.6)	7.0% (5.4-8.7)	7.4% (6.1-8.6)
Serious difficulty concentrating, remembering, or making decisions because of physical, mental, or emotional condition	13.1% (10.3-15.9)	12.9% (3.8-21.9)	13.9% (5.2-22.5)	15.3% (8.2-22.4)	15.9% (9.6-22.2)	12.6% (2.1-23.0)	13.7% (7.7-19.8)	10.9% (5.3-16.5)	13.0% (10.6-15.4)	13.1% (11.2-14.9)

Source: Behavioral Risk Factor Surveillance System (BRFSS).

For more information about BRFSS indicators: [Office of Analytics Reports](#).

Nevada SAPTA EPI Profile

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

Coalition	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicide Ideation
Churchill Community Coalition (CCC)	231.5 (171.4-291.6)	2,504.5 (2,312.1-2,696.9)	1,874.2 (1,708.3-2,040.2)	495.4 (408.2-582.6)	236.4 (177.5-295.2)	500.4 (411.3-589.6)
Frontier Community Coalition (FCC)	146.4 (101.0-191.7)	1,259.5 (1,132.5-1,386.5)	1,147.5 (1,023.5-1,271.5)	344.2 (275.7-412.7)	145.9 (101.2-190.6)	359.4 (288.6-430.2)
Healthy Communities Coalition (HCC)	90.5 (67.0-114.0)	1,591.5 (1,494.2-1,688.8)	845.0 (774.8-915.1)	409.3 (359.2-459.4)	121.2 (93.4-149.0)	234.0 (193.8-274.3)
Join Together Northern Nevada (JTNN)	344.3 (327.2-361.5)	1,953.1 (1,912.7-1,993.6)	1,326.3 (1,293.3-1,359.3)	650.9 (627.5-674.4)	244.9 (230.5-259.4)	445.6 (426.0-465.1)
Nye Communities Coalition (NCC)	226.2 (182.5-269.8)	1,629.9 (1,520.8-1,738.9)	921.0 (838.8-1,003.3)	498.6 (433.5-563.8)	165.4 (129.2-201.7)	620.7 (548.5-692.9)
Partners Allied for Community Excellence (PACE)	241.3 (203.4-279.1)	3,598.4 (3,452.4-3,744.5)	3,041.8 (2,907.9-3,175.8)	711.5 (644.2-778.7)	505.9 (448.7-563.0)	483.4 (429.7-537.2)
PACT Coalition for Safe and Drug free Communities/CARE	394.3 (386.1-402.5)	1,897.9 (1,879.9-1,915.9)	1,128.1 (1,114.3-1,142.0)	680.6 (669.8-691.4)	181.8 (176.2-187.4)	620.6 (610.2-631.0)
Partnership Carson City (PCC)	178.7 (140.9-216.5)	2,128.4 (2,001.8-2,255.0)	807.9 (730.4-885.3)	658.7 (586.5-731.0)	185.4 (147.1-223.7)	204.1 (162.4-245.8)
Partnership Douglas County (PDC)	42.5 (25.5-59.5)	939.7 (853.8-1,025.7)	352.2 (301.2-403.2)	205.4 (160.7-250.1)	48.3 (27.1-69.4)	148.8 (110.8-186.7)
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.  
Categories are not mutually exclusive.

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

Coalition	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicide Ideation
Churchill Community Coalition (CCC)	220.8 (163.5-278.1)	2,521.7 (2,328.0-2,715.4)	1,898.0 (1,730.0-2,066.1)	480.3 (395.8-564.9)	240.2 (180.4-299.9)	468.7 (385.2-552.2)
Frontier Community Coalition (FCC)	134.8 (93.0-176.6)	1,273.9 (1,145.5-1,402.3)	1,108.8 (988.9-1,228.6)	326.9 (261.8-392.0)	138.2 (95.9-180.5)	333.6 (267.9-399.4)
Healthy Communities Coalition (HCC)	88.8 (65.8-111.9)	1,602.1 (1,504.2-1,700.1)	868.1 (796.0-940.2)	399.0 (350.1-447.9)	113.8 (87.7-139.9)	202.6 (167.8-237.4)
Join Together Northern Nevada (JTNN)	339.7 (322.7-356.6)	1,965.8 (1,925.2-2,006.5)	1,360.6 (1,326.8-1,394.5)	649.3 (625.9-672.7)	241.6 (227.4-255.9)	436.1 (417.0-455.3)
Nye Communities Coalition (NCC)	194.5 (157.0-232.1)	1,620.5 (1,512.1-1,729.0)	910.4 (829.1-991.6)	425.0 (369.4-480.5)	151.1 (118.0-184.2)	536.4 (474.0-598.8)
Partners Allied for Community Excellence (PACE)	235.5 (198.5-272.4)	3,520.2 (3,377.3-3,663.1)	2,990.4 (2,858.7-3,122.1)	649.1 (587.7-710.4)	454.4 (403.0-505.7)	469.5 (417.3-521.6)
PACT Coalition for Safe and Drug free Communities/CARE	396.5 (388.2-404.7)	1,913.4 (1,895.2-1,931.5)	1,146.4 (1,132.3-1,160.4)	684.0 (673.1-694.8)	181.5 (175.9-187.1)	616.0 (605.7-626.3)
Partnership Carson City (PCC)	153.7 (121.2-186.2)	1,941.2 (1,825.7-2,056.6)	747.2 (675.5-818.8)	570.2 (507.6-632.8)	160.9 (127.6-194.1)	164.4 (130.8-198.1)
Partnership Douglas County (PDC)	49.1 (29.4-68.7)	938.4 (852.5-1,024.2)	374.1 (319.9-428.3)	165.6 (129.5-201.7)	40.9 (23.0-58.8)	120.6 (89.8-151.4)
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.  
Categories are not mutually exclusive.

Nevada SAPTA EPI Profile

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

Coalition	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicide Ideation
Churchill Community Coalition (CCC)	87.7 (49.3-126.1)	1,603.5 (1,455.2-1,751.8)	1,232.6 (1,100.6-1,364.6)	369.2 (295.3-443.0)	275.0 (210.1-339.8)	513.7 (422.5-604.8)
Frontier Community Coalition (FCC)	50.0 (24.7-75.3)	614.5 (525.7-703.3)	762.1 (664.9-859.4)	179.6 (129.3-229.8)	72.6 (41.5-103.6)	276.9 (215.8-337.9)
Healthy Communities Coalition (HCC)	57.8 (40.1-75.5)	1,267.6 (1,185.6-1,349.6)	1,146.7 (1,068.7-1,224.6)	389.5 (342.2-436.8)	297.9 (254.6-341.1)	516.2 (458.4-573.9)
Join Together Northern Nevada (JTNN)	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)
Nye Communities Coalition (NCC)	171.8 (135.3-208.3)	1,172.6 (1,090.4-1,254.9)	1,098.3 (1,017.0-1,179.6)	495.7 (435.5-555.8)	214.5 (175.4-253.5)	450.5 (390.9-510.0)
Partners Allied for Community Excellence (PACE)	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)
PACT Coalition for Safe and Drug free Communities/CARE	250.3 (243.8-256.8)	1,142.3 (1,128.5-1,156.1)	1,113.2 (1,099.6-1,126.8)	505.1 (495.9-514.3)	173.6 (168.1-179.0)	581.4 (571.5-591.4)
Partnership Carson City (PCC)	152.0 (118.7-185.3)	1,993.8 (1,874.2-2,113.4)	1,893.6 (1,779.2-2,008.0)	744.4 (668.3-820.6)	464.1 (402.9-525.2)	803.0 (722.0-883.9)
Partnership Douglas County (PDC)	44.5 (26.3-62.7)	1,016.2 (935.7-1,096.8)	956.3 (877.1-1,035.5)	256.2 (211.5-300.9)	236.1 (189.8-282.3)	386.4 (327.8-445.0)
Nevada	210.3 (205.2-215.4)	1,117.2 (1,105.6-1,128.8)	1,102.0 (1,090.4-1,113.5)	466.2 (458.6-473.8)	189.5 (184.7-194.4)	556.8 (548.4-565.2)

Source: Hospital Inpatient Billing.  
Categories are not mutually exclusive.

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

Coalition	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicide Ideation
Churchill Community Coalition (CCC)	77.5 (43.5-111.4)	1,739.2 (1,578.4-1,900.1)	1,297.6 (1,158.7-1,436.6)	371.9 (297.5-446.3)	267.3 (204.2-330.3)	472.6 (388.7-556.4)
Frontier Community Coalition (FCC)	50.6 (25.0-76.1)	620.1 (530.5-709.7)	795.3 (693.9-896.8)	165.1 (118.9-211.4)	70.8 (40.5-101.0)	266.2 (207.5-324.9)
Healthy Communities Coalition (HCC)	63.9 (44.3-83.5)	1,430.7 (1,338.2-1,523.3)	1,295.1 (1,207.1-1,383.2)	406.8 (357.4-456.1)	283.6 (242.4-324.9)	478.5 (424.9-532.0)
Join Together Northern Nevada (JTNN)	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)
Nye Communities Coalition (NCC)	160.5 (126.4-194.7)	1,475.1 (1,371.6-1,578.5)	1,324.0 (1,226.0-1,422.0)	493.0 (433.1-552.8)	219.1 (179.2-259.0)	415.5 (360.6-470.4)
Partners Allied for Community Excellence (PACE)	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)
PACT Coalition for Safe and Drug free Communities/CARE	255.9 (249.3-262.5)	1,183.9 (1,169.6-1,198.2)	1,149.5 (1,135.4-1,163.5)	519.0 (509.5-528.4)	176.5 (171.0-182.0)	584.1 (574.1-594.1)
Partnership Carson City (PCC)	143.0 (111.7-174.3)	1,909.0 (1,794.5-2,023.5)	1,880.4 (1,766.8-1,994.1)	656.0 (588.9-723.1)	395.0 (342.9-447.1)	675.7 (607.5-743.8)
Partnership Douglas County (PDC)	47.0 (27.8-66.2)	1,251.1 (1,152.0-1,350.3)	1,144.8 (1,050.0-1,239.7)	257.6 (212.6-302.6)	204.4 (164.4-244.5)	341.4 (289.6-393.2)
Nevada	214.8 (209.6-220.1)	1,183.6 (1,171.4-1,195.9)	1,160.7 (1,148.6-1,172.8)	479.8 (472.0-487.6)	192.1 (187.1-197.0)	554.8 (546.4-563.2)

Source: Hospital Inpatient Billing.  
Categories are not mutually exclusive.

Nevada SAPTA EPI Profile

**Table 5. Suicide Attempts and Suicides by Leading Method and Coalition, Nevada Residents, 2018.**

Coalition	Suicide Attempts						Suicides		
	Emergency Department Encounters			Inpatient Admissions			Substance	Hanging/ Suffocation	Firearms/ Explosives
	Substance	Cutting	Hanging/ Suffocation	Substance	Cutting	Hanging/ Suffocation			
Churchill Community Coalition (CCC)	120.1 (77.8-162.4)	42.6 (17.4-67.8)	0.0 -	46.5 (20.2-72.8)	23.2 (4.6-41.8)	0.0 -	3.9 (0.0-11.5)	7.7 (0.0-18.5)	15.5 (0.3-30.7)
Frontier Community Coalition (FCC)	87.6 (53.9-121.3)	33.7 (12.8-54.6)	0.0 -	47.2 (22.5-71.9)	3.4 (0.0-10.0)	0.0 -	3.4 (0.0-10.0)	3.4 (0.0-10.0)	33.7 (12.8-54.6)
Healthy Communities Coalition (HCC)	51.4 (33.9-69.0)	31.2 (17.5-44.8)	0.0 -	76.4 (55.0-97.7)	23.4 (11.5-35.2)	3.1 (0.0-07.4)	0.0 -	3.1 (0.0-07.4)	20.3 (9.2-31.3)
Join Together Northern Nevada (JTNN)	64.5 (57.1-71.8)	11.4 (8.3-14.5)	3.9 (2.1-05.8)	66.7 (59.2-74.2)	11.0 (7.9-14.0)	0.9 (0.0-01.7)	3.7 (2.0-05.5)	2.4 (1.0-03.8)	10.5 (7.5-13.5)
Nye Communities Coalition (NCC)	98.2 (71.5-124.9)	56.7 (36.4-76.9)	0.0 -	45.3 (27.2-63.5)	11.3 (2.3-20.4)	3.8 (0.0-09.0)	7.6 (0.2-15.0)	5.7 (0.0-12.1)	30.2 (15.4-45.0)
Partners Allied for Community Excellence (PACE)	78.5 (57.2-99.8)	28.7 (15.8-41.6)	3.0 (0.0-07.2)	37.7 (22.9-52.5)	0.0 -	3.0 (0.0-07.2)	3.0 (0.0-07.2)	1.5 (0.0-04.5)	18.1 (7.9-28.4)
PACT Coalition for Safe and Drug free Communities/CARE	63.7 (60.4-67.0)	28.3 (26.1-30.5)	1.4 (0.9-01.9)	53.3 (50.3-56.3)	7.2 (6.1-08.3)	3.0 (2.3-03.8)	3.0 (2.3-03.8)	5.0 (4.1-05.9)	10.5 (9.2-11.9)
Partnership Carson City (PCC)	34.0 (18.7-49.2)	14.3 (4.4-24.2)	3.6 (0.0-08.5)	100.1 (73.9-126.3)	26.8 (13.2-40.4)	0.0 -	8.9 (1.1-16.8)	3.6 (0.0-08.5)	16.1 (5.6-26.6)
Partnership Douglas County (PDC)	40.9 (23.0-58.8)	2.0 (0.0-06.1)	0.0 -	49.1 (29.4-68.7)	16.4 (5.0-27.7)	4.1 (0.0-09.8)	4.1 (0.0-09.8)	8.2 (0.2-16.2)	14.3 (3.7-24.9)
Nevada	64.3 (61.5-67.2)	25.8 (24.0-27.6)	1.8 (1.3-02.3)	56.0 (53.4-58.7)	8.6 (7.6-09.7)	2.6 (2.1-03.2)	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.

**Table 6. Suicides (Crude) Rates by Age, Race/Ethnicity and Coalition, Nevada Residents, 2018.**

	JTNN	FCC	CCC	PCC	HCC	PDC	PACE	NCC	PACT/CARE (Clark County)	Nevada
<b>Age Group</b>										
Less than 15	0.0 -	0.0 -	0.0 -	0.0 -	0.0 -	0.0 -	0.0 -	40.5 (0.0-86.4)	1.8 (0.5-3.0)	1.8 (0.8-2.9)
15-24	11.3 (2.9-19.8)	0.0 -	0.0 -	16.3 (0.0-48.3)	12.6 (0.0-37.4)	21.0 (0.0-62.1)	51.4 (6.3-96.4)	0.0 -	17.5 (12.7-22.3)	16.7 (12.7-20.7)
25-34	12.4 (3.8-20.9)	18.0 (0.0-53.3)	0.0 -	38.6 (0.0-82.3)	25.5 (0.0-60.9)	38.5 (0.0-91.9)	15.9 (0.0-38.0)	50.8 (0.0-108.4)	24.3 (18.8-29.8)	23.2 (18.7-27.8)
35-44	22.4 (10.2-34.6)	67.1 (0.0-160.2)	70.4 (0.0-167.9)	52.6 (0.0-112.2)	28.7 (0.0-68.5)	61.5 (0.0-131.0)	15.7 (0.0-46.4)	0.0 -	24.2 (18.8-29.6)	25.8 (20.9-30.7)
45-54	32.5 (17.5-47.5)	52.7 (0.0-125.8)	62.7 (0.0-149.7)	23.6 (0.0-56.3)	36.3 (0.0-77.4)	0.0 -	47.1 (0.9-93.3)	49.9 (0.0-106.4)	27.6 (21.6-33.5)	30.5 (25.0-35.9)
55-64	24.0 (11.4-36.6)	79.5 (0.0-169.4)	0.0 -	56.8 (1.1-112.4)	22.2 (0.0-52.9)	48.7 (1.0-96.4)	12.8 (0.0-38.0)	60.3 (7.4-113.2)	28.4 (21.9-34.9)	30.0 (24.4-35.7)
65-74	33.7 (16.6-50.8)	119.0 (0.0-253.6)	44.1 (0.0-130.4)	42.9 (0.0-91.4)	38.4 (0.0-81.7)	0.0 -	32.4 (0.0-77.4)	90.1 (23.4-156.9)	22.4 (15.6-29.3)	30.2 (23.6-36.7)
75-84	25.5 (3.1-47.8)	0.0 -	154.7 (0.0-369.0)	34.3 (0.0-101.6)	22.5 (0.0-66.6)	46.4 (0.0-110.8)	36.5 (0.0-108.0)	19.2 (0.0-56.8)	36.2 (23.6-48.7)	34.5 (24.4-44.6)
85+	64.3 (1.3-127.3)	301.3 (0.0-891.8)	0.0 -	56.4 (0.0-167.0)	181.6 (0.0-433.2)	70.9 (0.0-209.8)	0.0 -	72.7 (0.0-215.3)	30.2 (9.3-51.1)	45.1 (24.2-65.9)
<b>Race/Ethnicity</b>										
White non-Hispanic	25.8 (20.0-31.7)	55.6 (22.7-88.5)	34.9 (9.1-60.8)	42.1 (22.1-62.2)	27.7 (13.2-42.2)	27.9 (11.4-44.3)	23.3 (9.5-37.1)	50.3 (28.8-71.9)	14.0 (9.4-18.7)	32.3 (29.4-35.1)
Black non-Hispanic	0.0 -	0.0 -	0.0 -	0.0 -	0.0 -	0.0 -	0 -	0.0 -	31.7 (28.2-35.2)	13.2 (8.8-17.5)
Native American/ Alaskan Native	0.0 -	0.0 -	0.0 -	0.0 -	41.3 (0.0-122.2)	158.6 (0.0-378.4)	0 -	0.0 -	6.7 (0.0-19.7)	14.2 (1.8-26.7)
Asian/Pacific Islander	12.6 (0.3-25.0)	0.0 -	0.0 -	0.0 -	0.0 -	0.0 -	0 -	0.0 -	13.1 (8.6-17.5)	13.4 (9.2-17.6)
Hispanic	4.4 (0.5-08.2)	13.5 (0.0-39.9)	0.0 -	8.2 (0.0-24.3)	10.6 (0.0-31.4)	0.0 -	36.4 (4.5-68.4)	26.3 (0.0-62.9)	8.6 (6.5-10.8)	8.6 (6.7-10.6)
Total	18.4 (14.5-22.4)	40.4 (17.6-63.3)	27.1 (7.0-47.2)	32.2 (17.3-47.0)	24.9 (12.7-37.2)	26.6 (12.1-41.0)	24.2 (12.3-36.0)	43.4 (25.7-61.2)	20.1 (18.3-22.0)	21.7 (20.0-23.3)

Source: Electronic Death Registry System.



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**Table 7. Mental Health-Related Age-Adjusted Rates by Coalition, Nevada Residents, 2018.**

Coalition	White non-Hispanic	Black non-Hispanic	Native American/ Alaskan Native	Asian/Pacific Islander	Hispanic	Total
Churchill Community Coalition (CCC)	75.7 (43.3-108.1)	0.0 -	95.4 (0.0-282.4)	0.0 -	0.0 -	71.3 (41.5-101.2)
Frontier Community Coalition (FCC)	64.6 (30.8-98.5)	0.0 -	56.2 (0.0-166.5)	0.0 -	0.0 -	56.3 (27.8-84.8)
Healthy Communities Coalition (HCC)	41.7 (27.2-56.1)	0.0 -	51.4 (0.0-152.0)	139.0 (0.0-411.3)	10.2 (0.0-30.2)	40.6 (27.2-54.1)
Join Together Northern Nevada (JTNN)	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)
Nye Communities Coalition (NCC)	32.6 (20.7-44.4)	0.0 -	0.0 -	0.0 -	0.0 -	29.5 (18.7-40.2)
Partners Allied for Community Excellence (PACE)	35.6 (18.7-52.5)	0.0 -	0.0 -	0.0 -	9.4 (0.0-27.9)	31.4 (16.9-45.9)
PACT Coalition for Safe and Drug free Communities/CARE	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)
Partnership Carson City (PCC)	106.5 (84.0-129.0)	248.8 (0.0-736.5)	41.8 (0.0-123.8)	0.0 -	168.5 (3.4-333.7)	103.4 (82.3-124.6)
Partnership Douglas County (PDC)	45.1 (29.5-60.7)	0.0 -	0.0 -	0.0 -	24.4 (0.0-72.2)	46.6 (31.1-62.0)
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.

**Table 7a. Drug-Related Emergency Department Encounters Age-Adjusted Rates by Drug Type and Coalition, Nevada Residents, 2018.**

Coalition	Opioids	Heroin	Cocaine	Methamphetamines	Marijuana	Hallucinogens
Churchill Community Coalition (CCC)	165.9 (115.1-216.6)	10.0 (0.0-21.4)	0.0 -	229.8 (170.1-289.4)	158.7 (110.7-206.6)	8.0 (0.0-19.2)
Frontier Community Coalition (FCC)	149.4 (106.2-192.6)	10.4 (0.2-20.6)	12.0 (0.2-23.7)	262.2 (202.1-322.4)	192.7 (145.5-239.9)	3.9 (0.0-11.6)
Healthy Communities Coalition (HCC)	181.0 (148.5-213.6)	8.7 (1.7-15.6)	29.3 (14.9-43.6)	295.7 (250.3-341.1)	306.7 (262.3-351.2)	1.8 (0.0-5.2)
Join Together Northern Nevada (JTNN)	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)
Nye Communities Coalition (NCC)	234.9 (191.8-278.0)	10.4 (3.2-17.6)	22.5 (8.6-36.5)	446.7 (385.8-507.5)	669.0 (593.9-744.1)	10.2 (0.2-20.2)
Partners Allied for Community Excellence (PACE)	174.2 (142.8-205.7)	12.6 (3.9-21.3)	17.2 (7.5-26.9)	312.3 (269.8-354.9)	459.2 (408.9-509.4)	0.0 -
PACT Coalition for Safe and Drug fee Communities/CARE	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)
Partnership Carson City (PCC)	221.7 (183.3-260.2)	10.6 (2.8-18.5)	21.3 (8.7-33.9)	382.7 (328.1-437.3)	555.5 (490.7-620.3)	5.6 (0.0-11.9)
Partnership Douglas County (PDC)	202.9 (163.4-242.5)	5.0 (0.0-10.7)	48.7 (25.6-71.9)	161.0 (122.4-199.5)	173.3 (131.8-214.8)	8.7 (0.0-18.6)
Nevada	207.4 (202.3-212.5)	10.1 (9.0-11.2)	78.6 (75.5-81.8)	463.0 (455.3-470.8)	401.1 (393.9-408.2)	16.3 (14.8-17.7)

Source: Hospital Emergency Department Billing.

Categories are not mutually exclusive.

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**Table 7b. Drug-Related Emergency Department Encounters Crude Rates by Drug Type and Coalition, Nevada Residents, 2018.**

Coalition	Opioids	Heroin	Cocaine	Methampetamines	Marijuana	Hallucinogens
Churchill Community Coalition (CCC)	158.8 (110.2-207.4)	11.6 (0.0-24.8)	0.0 -	220.8 (163.5-278.1)	162.7 (113.5-211.9)	7.7 (0.0-18.5)
Frontier Community Coalition (FCC)	155.0 (110.2-199.8)	13.5 (0.3-26.7)	13.5 (0.3-26.7)	246.0 (189.6-302.5)	215.7 (162.8-268.5)	3.4 (0.0-10.0)
Healthy Communities Coalition (HCC)	185.5 (152.1-218.8)	9.4 (1.9-16.8)	24.9 (12.7-37.2)	254.0 (215.0-293.0)	285.2 (243.9-326.5)	1.6 (0.0-4.6)
Join Together Northern Nevada (JTNN)	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)
Nye Communities Coalition (NCC)	215.3 (175.8-254.8)	15.1 (4.6-25.6)	18.9 (7.2-30.6)	391.0 (337.7-444.2)	576.1 (511.4-640.7)	7.6 (0.2-15.0)
Partners Allied for Community Excellence (PACE)	178.1 (146.0-210.3)	12.1 (3.7-20.4)	18.1 (7.9-28.4)	312.5 (269.9-355.0)	484.6 (431.5-537.6)	0.0 -
PACT Coalition for Safe and Drug fee Communities/CARE	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)
Partnership Carson City (PCC)	228.8 (189.2-268.4)	12.5 (3.2-21.8)	19.7 (8.0-31.3)	337.8 (289.7-386.0)	504.1 (445.2-562.9)	5.4 (0.0-11.4)
Partnership Douglas County (PDC)	206.5 (166.2-246.7)	6.1 (0.0-13.1)	34.8 (18.2-51.3)	137.0 (104.2-169.8)	137.0 (104.2-169.8)	6.1 (0.0-13.1)
Nevada	212.0 (206.8-217.2)	10.3 (9.2-11.5)	79.5 (76.3-82.7)	450.7 (443.1-458.2)	395.5 (388.4-402.6)	15.7 (14.3-17.1)

Source: Hospital Emergency Department Billing.  
Categories are not mutually exclusive.

**Table 8a. Drug-Related Inpatient Admissions Age-Adjusted Rates by Drug Type and Coalition, Nevada Residents, 2018.**

Coalition	Opioids	Heroin	Cocaine	Methampetamines	Marijuana	Hallucinogens
Churchill Community Coalition (CCC)	295.7 (231.3-360.1)	9.1 (0.0-19.4)	31.7 (8.2-55.2)	261.6 (197.0-326.2)	424.7 (343.1-506.4)	7.4 (0.0-17.6)
Frontier Community Coalition (FCC)	172.2 (127.1-217.3)	21.6 (6.6-36.5)	17.3 (0.3-34.2)	253.3 (196.0-310.7)	212.6 (159.3-266.0)	11.5 (0.0-24.4)
Healthy Communities Coalition (HCC)	379.7 (333.7-425.7)	32.0 (18.3-45.7)	30.7 (16.9-44.5)	400.2 (348.0-452.3)	500.9 (444.3-557.4)	8.6 (1.1-16.2)
Join Together Northern Nevada (JTNN)	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)
Nye Communities Coalition (NCC)	155.0 (124.6-185.4)	7.4 (0.9-14.0)	25.0 (11.9-38.1)	297.3 (248.4-346.2)	462.6 (406.1-519.2)	2.3 (0.0-6.8)
Partners Allied for Community Excellence (PACE)	96.8 (73.2-120.3)	3.3 (0.0-7.0)	17.1 (6.5-27.8)	185.6 (153.6-217.7)	198.2 (164.5-231.9)	1.8 (0.0-5.3)
PACT Coalition for Safe and Drug fee Communities/CARE	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)
Partnership Carson City (PCC)	495.7 (439.2-552.2)	9.9 (2.0-17.8)	63.0 (41.8-84.2)	718.1 (644.5-791.6)	706.6 (637.4-775.8)	6.3 (0.0-13.5)
Partnership Douglas County (PDC)	337.8 (290.1-385.6)	12.9 (4.5-21.3)	24.4 (9.3-39.6)	266.8 (216.0-317.6)	337.4 (281.1-393.6)	11.9 (0.2-23.6)
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.  
Categories are not mutually exclusive.

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**Table 8b. Drug-Related Inpatient Admissions Crude Rates by Drug Type and Coalition, Nevada Residents, 2018.**

Coalition	Opioids	Heroin	Cocaine	Methamphetamines	Marijuana	Hallucinogens
Churchill Community Coalition (CCC)	313.8 (245.4-382.1)	11.6 (0.0-24.8)	27.1 (7.0-47.2)	244.0 (183.8-304.3)	402.9 (325.4-480.3)	7.7 (0.0-18.5)
Frontier Community Coalition (FCC)	188.7 (139.3-238.2)	27.0 (8.3-45.6)	13.5 (0.3-26.7)	252.8 (195.6-310.0)	205.6 (154.0-257.2)	10.1 (0.0-21.6)
Healthy Communities Coalition (HCC)	408.3 (358.9-457.8)	32.7 (18.7-46.7)	29.6 (16.3-42.9)	352.2 (306.3-398.1)	469.1 (416.1-522.1)	7.8 (1.0-14.6)
Join Together Northern Nevada (JTNN)	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)
Nye Communities Coalition (NCC)	188.9 (151.9-225.9)	9.4 (1.2-17.7)	26.4 (12.6-40.3)	268.2 (224.1-312.3)	485.4 (426.1-544.7)	1.9 (0.0-5.6)
Partners Allied for Community Excellence (PACE)	98.1 (74.3-122.0)	4.5 (0.0-9.7)	15.1 (5.7-24.5)	194.7 (161.1-228.3)	200.8 (166.6-234.9)	1.5 (0.0-4.5)
PACT Coalition for Safe and Drug fee Communities/CARE	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)
Partnership Carson City (PCC)	529.1 (468.8-589.4)	10.7 (2.1-19.3)	60.8 (40.3-81.2)	654.2 (587.2-721.2)	716.8 (646.6-786.9)	5.4 (0.0-11.4)
Partnership Douglas County (PDC)	392.5 (337.0-448.0)	18.4 (6.4-30.4)	20.4 (7.8-33.1)	216.7 (175.4-258.0)	282.1 (235.1-329.2)	8.2 (0.2-16.2)
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.  
Categories are not mutually exclusive.

**Table 9. Drug- and Alcohol-Related Age-Adjusted Death Rates by Race/Ethnicity and Coalition, Nevada Residents, 2018.**

Coalition	White non-Hispanic	Black non-Hispanic	Native American/Alaskan Native	Asian/Pacific Islander	Hispanic	Total
Churchill Community Coalition (CCC)	71.3 (37.4-105.1)	0.0 -	0.0 -	0.0 -	40.1 (0.0-118.8)	62.6 (33.7-91.5)
Frontier Community Coalition (FCC)	85.5 (43.6-127.4)	0.0 -	166.0 (0.0-353.9)	0.0 -	54.4 (0.0-129.7)	71.1 (40.7-101.6)
Healthy Communities Coalition (HCC)	65.7 (47.6-83.7)	138.1 (0.0-408.8)	51.4 (0.0-152.0)	0.0 -	35.5 (0.0-84.6)	63.0 (46.5-79.5)
Join Together Northern Nevada (JTNN)	69.2 (60.7-77.6)	78.3 (20.3-136.3)	150.9 (65.5-236.3)	14.7 (1.8-27.7)	32.6 (19.8-45.3)	58.4 (51.9-65.0)
Nye Communities Coalition (NCC)	71.6 (50.2-92.9)	89.9 (0.0-214.4)	0.0 -	0.0 -	46.1 (0.0-98.2)	68.3 (49.2-87.4)
Partners Allied for Community Excellence (PACE)	34.7 (19.1-50.2)	0.0 -	77.3 (0.0-184.5)	0.0 -	43.6 (8.7-78.4)	41.7 (26.3-57.2)
PACT Coalition for Safe and Drug fee Communities/CARE	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)
Partnership Carson City (PCC)	83.8 (59.3-108.2)	0.0 -	0.0 -	0.0 -	40.0 (0.8-79.3)	70.8 (50.9-90.6)
Partnership Douglas County (PDC)	31.4 (16.5-46.3)	0.0 -	0.0 -	0.0 -	21.1 (0.0-62.4)	29.8 (16.0-43.5)
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.