Behavioral Health Summary – Healthy Communities Coalition

December 2016

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Department of Health and Human Services

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Demographic Snapshot

Table 1. Selected demographics for Healthy Communities Coalition, and Nevada.

	Lyon	Mineral	Storey	Nevada
Population, 2015 estimate*	54,078	4,610	4,044	2,874,075
Population, 2010 estimate*	52,274	4,765	4,017	2,705,845
Population, percent change*	3.5%	-3.3%	0.7%	6.2%
Male persons, estimated percent 2015*	50.3%	50.2%	50.4%	50.3%
Female persons, estimated percent 2015*	49.7%	49.8%	49.6%	49.7%
Land area (square miles), 2010**	2,001	3,753	263	109,781
Median household income**	$47,143	$38,664	$64,835	$52,800
Persons below poverty level, percent**	13.7%	19.0%	8.4%	15.0%

*Source: Nevada State Demographer's Office

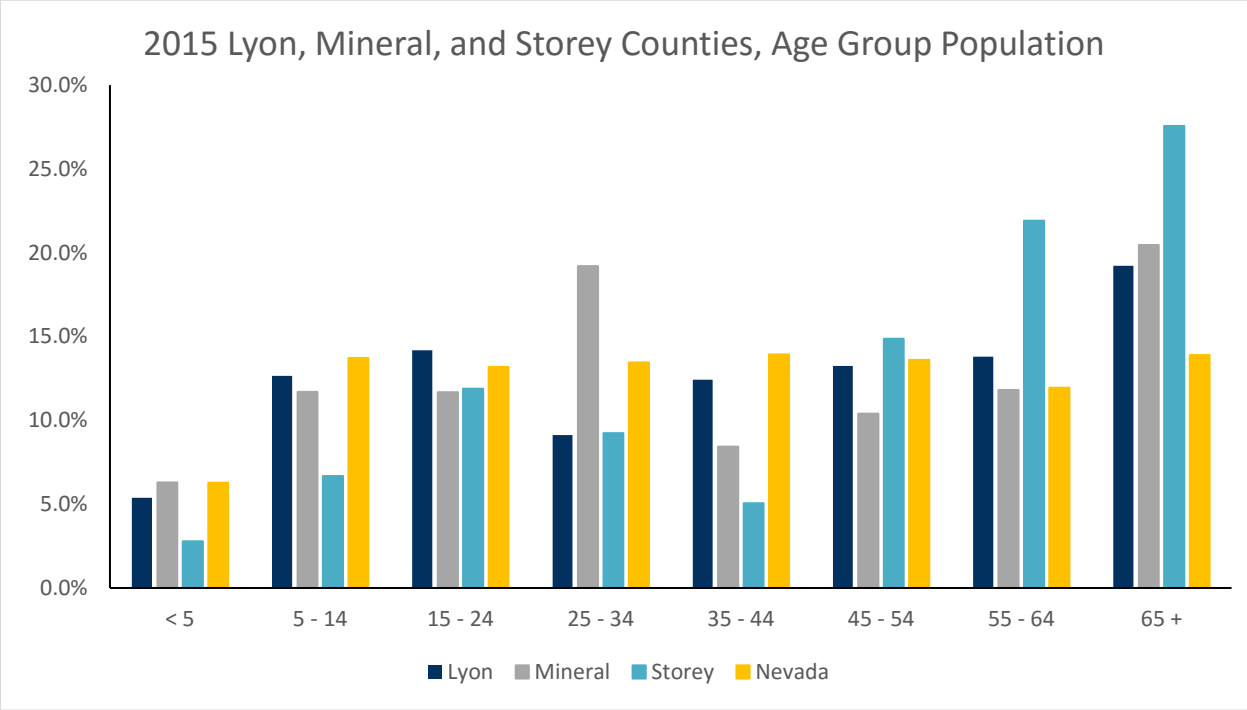
**Source: US Census Bureau

In 2015, the estimated population for Lyon County, Nevada was 54,078, a 3.5% increase from the 2010 estimated population. The population is made up of approximately 50% males and 50% females. The median household income is $47,143 with approximately 14% of the population living below the poverty level. Lyon County's land area is approximately 2,001 square miles and represents 1.8% of Nevada's total land area.

In 2015, the estimated population for Mineral County, Nevada was 4,610, a 3.3% decrease from the 2010 estimated population. The population is made up of approximately 50% males and 50% females. The median household income is $38,664 with approximately 19% of the population living below the poverty level. Mineral County's land area is approximately 3,753 square miles and represents 3.4% of Nevada's total land area.

In 2015, the estimated population for Storey County, Nevada was 4,044, a 0.7% increase from the 2010 estimated population. The population is made up of approximately 50% males and 50% females. The median household income is $64,835 with approximately 8.4% of the population living below the poverty level. Storey County's land area is approximately 263 square miles and represents 0.2% of Nevada's total land area.

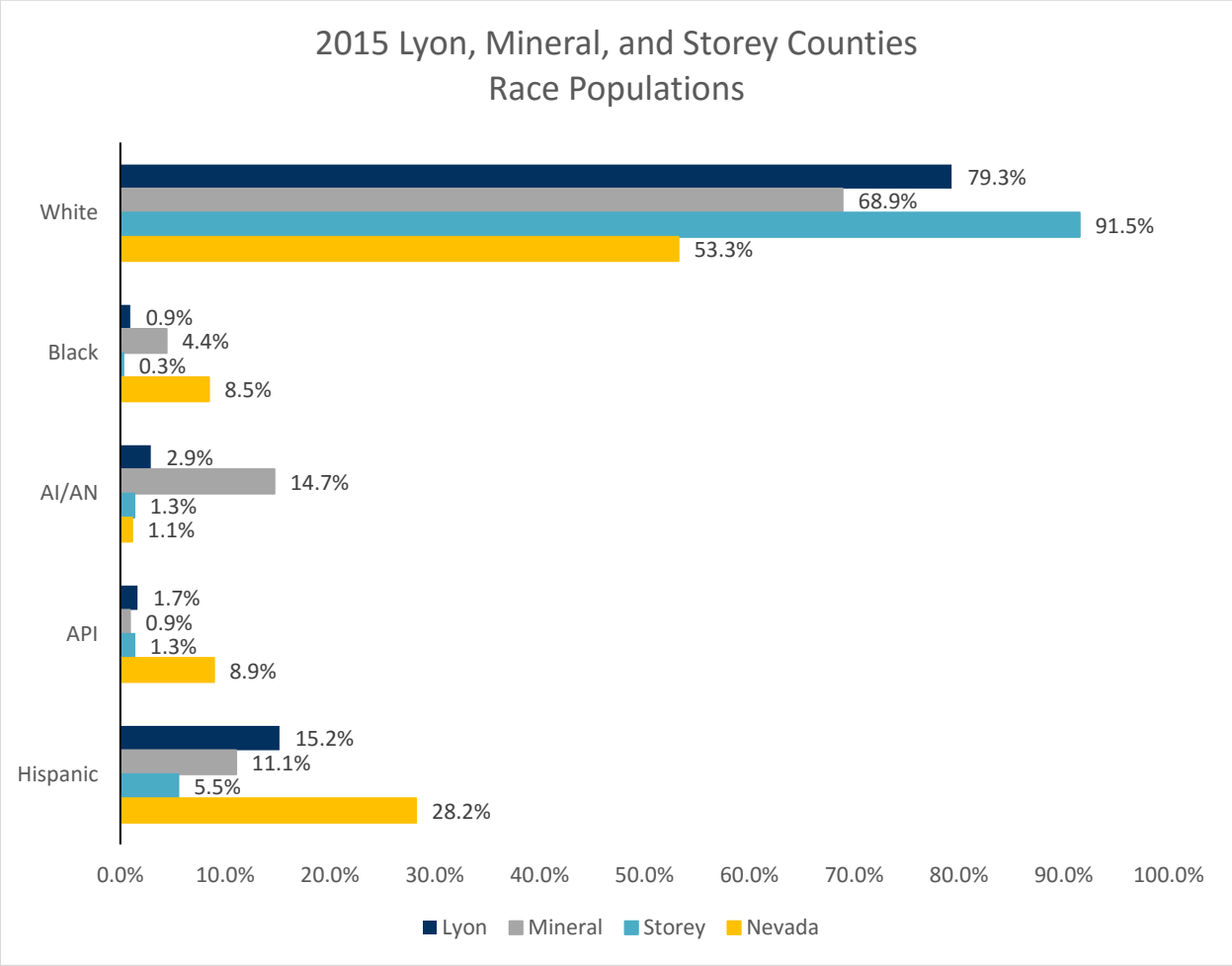
Figure 1. Healthy Communities Coalition, and Nevada populations by age group, 2015.



Source: Nevada State Demographer

Age population breakdowns for Lyon, Mineral, and Storey Counties vary from each other and from Nevada in a majority of the age groups. The 25-34 year old age group accounted for only 13.4% of Nevada population, but accounted for 19.2% of Mineral's population. The 65 and older age group accounted for 13.9% of Nevada's population, whereas it accounted for 19.2%, 20.5%, and 27.6% of Lyon's, Mineral's, and Storey's populations, respectively.

Figure 2. Healthy Communities Coalition, and Nevada racial/ethnic breakdowns for 2015.



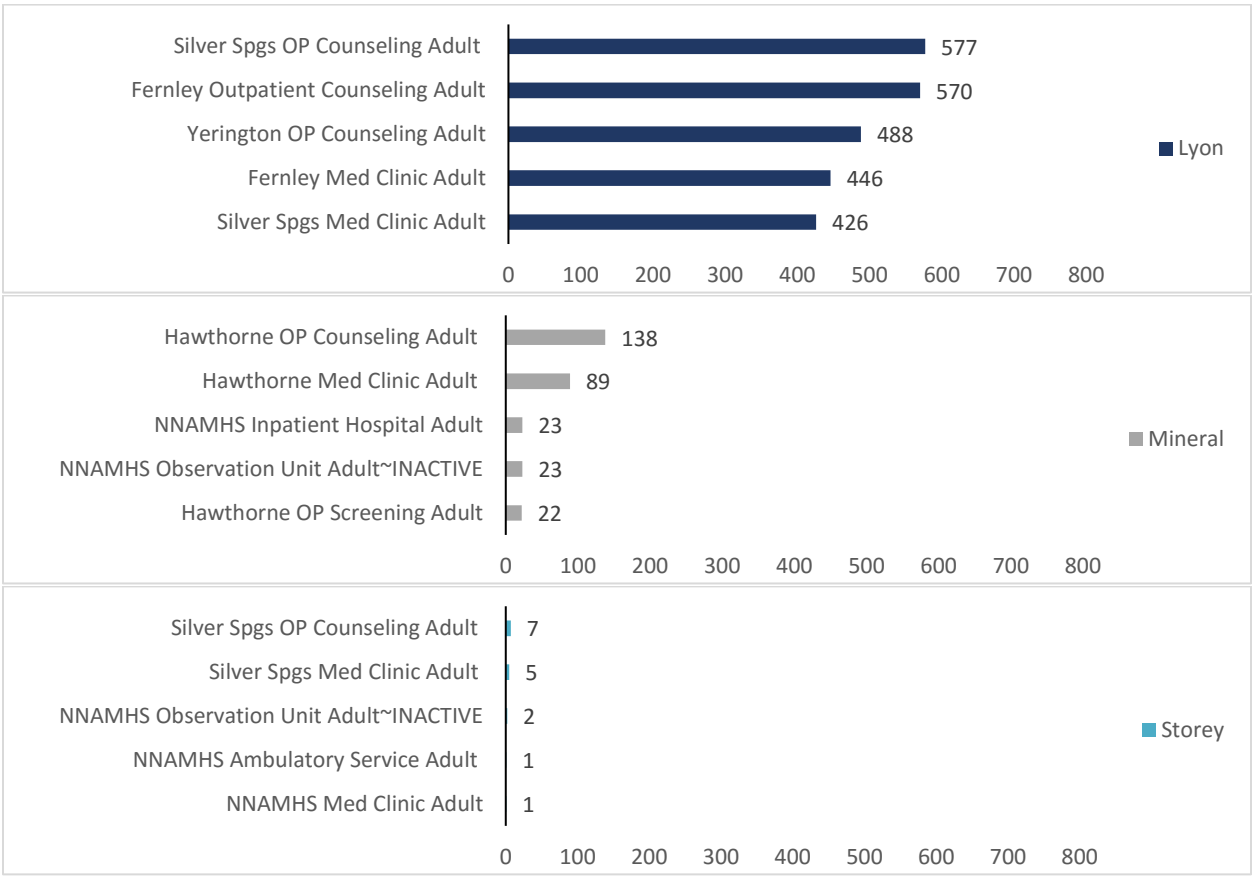
Source: Nevada State Demographer

The Lyon, Mineral and Storey county racial/ethnic breakdown compared to Nevada's shows that these counties have a greater proportion of White populations while Nevada's population as a whole has a greater proportion of Hispanic, Asian, and Black populations.

Mental Health Clinics

The data in this section comes from Avatar, an electronic mental health medical record system used by the Division of Public and Behavioral Health (DPBH). DPBH is the largest provider of mental health services in Nevada. In northern Nevada, DPBH clinics are categorized as Northern Nevada Adult Mental Health Services (NNAMHS).

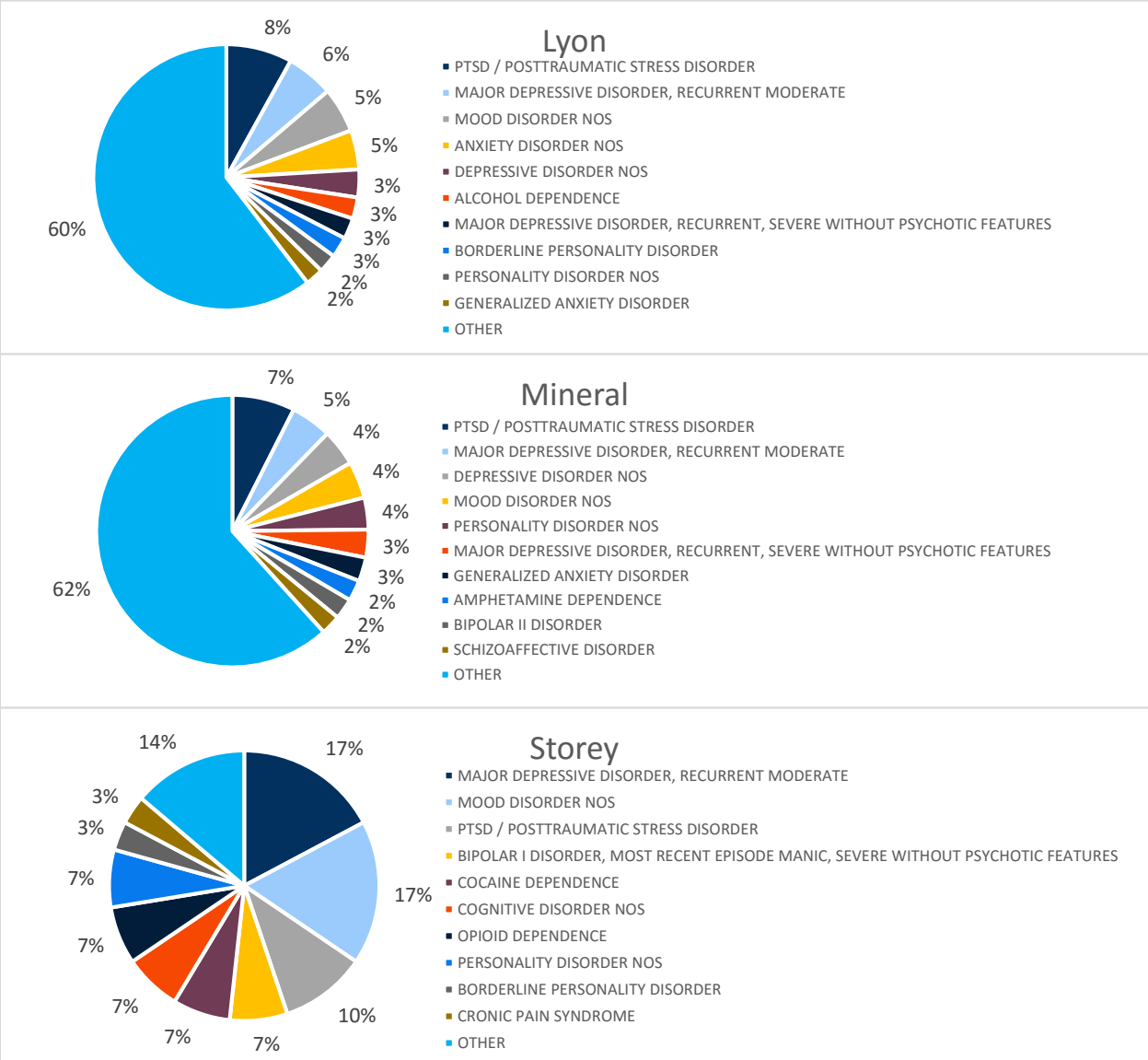
Figure 3. Top 5 mental health clinic services for Healthy Communities Coalition residents with number of patients served, 2010-2014.



*Source: Nevada Avatar. De-duplicated patients. However, a patient can use more than one service during one admission period; while the services are de-duplicated, a patient can occur in more than one service.

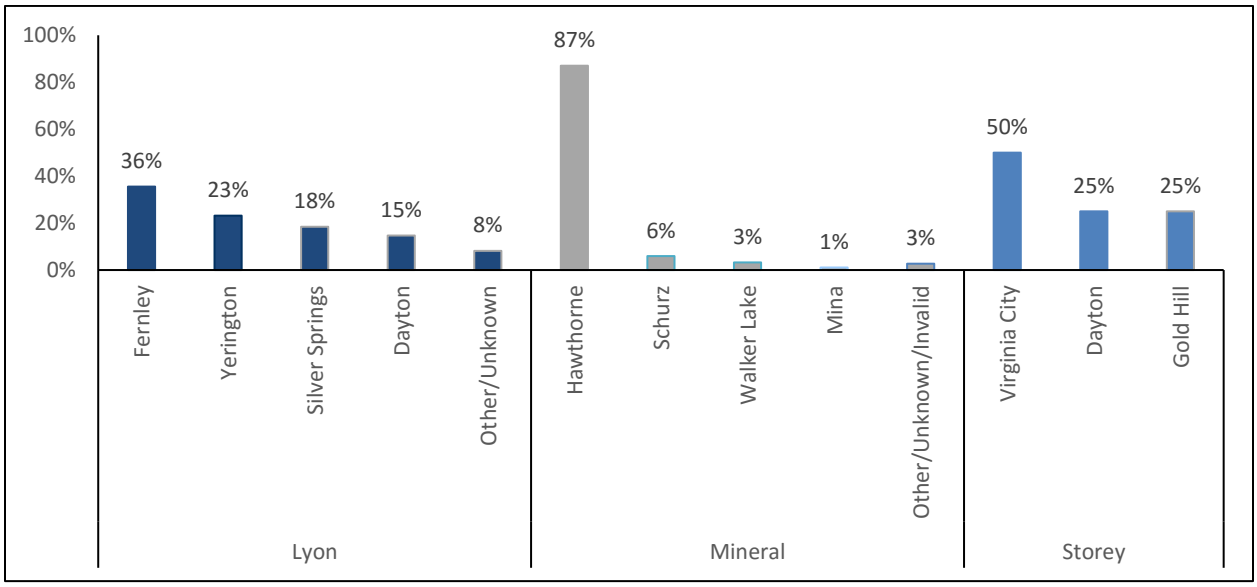
During the time from 2010 to 2014, 2,520 Healthy Communities Coalition residents received mental health services from DPBH. Overall services totaled 10,079, as many patients used multiple services. The most common location of services occurred in an out-patient counseling setting, followed by medication clinic within each county.

Figure 4. Most Common Diagnosis among Healthy Communities Coalition residents, 2010-2014.



During the period of 2010 to 2014, in the Healthy Communities Coalition, PTSD, mood disorder, and posttraumatic stress disorder appeared in the top three most common mental health diagnoses in each county. Patients may have multiple diagnoses noted during the course of their treatment, but the primary diagnosis noted is the most dominant.

Figure 5. Healthy Communities Coalition residents who access mental health clinics city of residence, 2010-2014.



Of the county residents in the Healthy Communities Coalition accessing DPBH mental health services between 2010 and 2014, populations reside within multiple cities in each county. 36% of Lyon residents resided in Fernley, 87% of Mineral resided in Hawthorne, and 50% of Storey resided in Virginia City.

Table 2. Demographics of Healthy Communities Coalition residents who accessed state funded adult mental health clinics, 2010-2014.

	2010	2011	2012	2013	2014
Sex					
Female	572	582	518	570	697
Male	349	349	342	365	437
Unknown	4	1	3	4	2
Total	925	932	863	939	1136
Age					
0-17	173	174	169	192	239
18-30	162	168	153	172	214
31-50	348	362	299	317	391
51-65	208	203	213	227	243
66-100	34	25	29	31	49
Unknown	0	0	0	0	0
Total	925	932	863	939	1136
Race					
White	746	736	691	711	792
Black	13	14	10	14	14
Asian	5	6	8	8	6
Alaskan Native/American Indian	11	13	10	16	16
Native Hawaiian/Pacific Islander	5	3	4	4	4
Two or more races	22	29	27	31	43
Other	34	29	23	29	35
Unknown	89	102	90	126	226
No Entry	0	0	0	0	0
Total	925	932	863	939	1136
Ethnicity					
Hispanic or Latino	54	47	45	43	46
Not Hispanic or Latino	728	741	691	716	641
Unknown/No Entry	143	144	127	180	449
Total	925	932	863	939	1136
Education					
=< 12th Grade - No Diploma	266	247	234	248	275
High School Graduate	194	188	197	218	256
GED	79	86	68	82	75
Some College	150	155	142	133	157
Undergraduate Degree	28	24	20	11	18
Graduate Degree	16	21	16	18	14
No Formal Education	8	11	7	10	16
Other	184	200	179	219	325
Total	925	932	863	939	1136

During the 5-year period of 2010 to 2014, there were 2,520 Healthy Communities Coalition adult residents that accessed mental and/or behavioral health services from DPBH state funded facilities. The totals in Table 2 above equal 4,795, reflecting that the some individuals used DPBH services during more than one year. Females comprised 61% of the patient population and males comprised 38%. White non-Hispanic made up 77% of the population. The most populous age group was the 31-50 year olds, accounting for 36% of the patients. Patients with less than 12th grade education or no diploma accounted for 27% of the patients, followed by "Other" (23%).

Hospital Emergency Room Data

The data provided in this section are from the hospital emergency room (ER) billing data compiled by the University of Nevada, Las Vegas, Center for Health Information Analysis (CHIA). The data are based on visits, not patients, therefore a single person may represent multiple visits. The ER data are broken into three parts: mental conditions (anxiety, PTSD, suicidal ideations, etc.), suicide attempts by method (hanging, jumping, firearms, etc.) and alcohol and drug-related visits.

The following ICD-9 codes were used for analysis of mental disorders: anxiety 300.00-300.09; depression 296.20-296.36, and 311.00; bipolar disorder 296.40-296.89; PTSD 309.81; schizophrenia 295.00-295.90 and V11.0; suicidal tendencies 300.90; suicidal ideation V62.84.

The following ICD-9 codes were used for analysis of suicide attempts by method: suicide by solid or liquid E950-E950.9; suicide by gases in domestic use E951-E951.8; suicide by other gases and vapors E952-E952.9; suicide by hanging, strangulation and suffocation E953-E953.9; suicide by drowning E954; suicide by firearms, air guns and explosives E955-E955.9; suicide by cutting and piercing instrument E956; suicide by jumping from high place E957-E957.9; suicide by other unspecified means E958-E958.9.

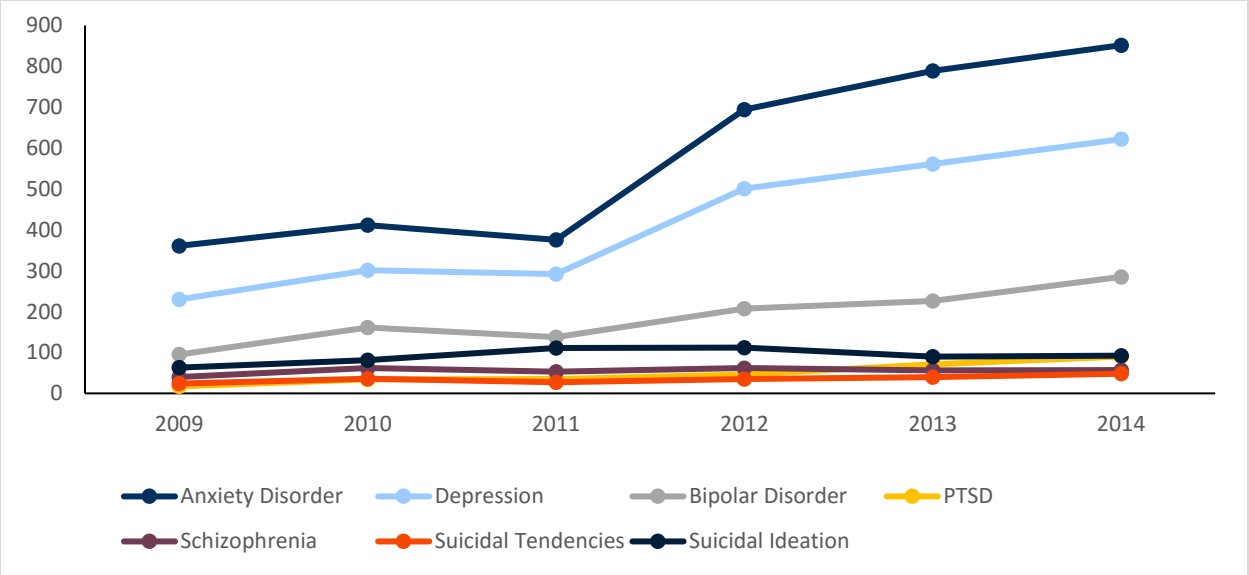
The following ICD-9 codes were used for analysis of alcohol-related admissions: 291-291.9, 303-303.93, 305.0-305.03, 535.3-353.31, 571-571.3, 980-980.9, 357.5, 425.5, 790.3, and E860-E860.9.

The following ICD-9 codes were used for analysis of substance-related admissions: 292-292.9, 304-304.93, 305.2-305.93, 965-965.99, and 967-970.99

There were a total of 10,440 visits related to mental health and substance use disorders among Healthy Communities Coalition residents between 2009 and 2014 for the reasons listed above. Since an individual can have more than one diagnosis during a single ER 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. Diagnoses related to mental disorders occurred in 7,057 ER

visits, there were 2,513 ER visits related to alcohol-related issues, 2,152 ER visits with diagnoses for drug-related issues, and 326 ER visit with diagnoses codes related to suicide attempts.

Figure 6. Number of Visits per Year for Select Mental Disorders, Healthy Communities Coalition, 2009-2014.



Anxiety is the most common mental disorder seen in the emergency rooms (ER) among Healthy Communities Coalition residents, related to for 49.4% of the 7,052 visits in the categories listed in Figure 6. The number of anxiety-related ER visits increased 136% from 2009 to 2014. The largest percent increase was among patient visits for issues related to PTSD which increased 429% with 17 visits in 2009 to 90 in 2014. All visits for the selected mental disorders increased over the six year period.

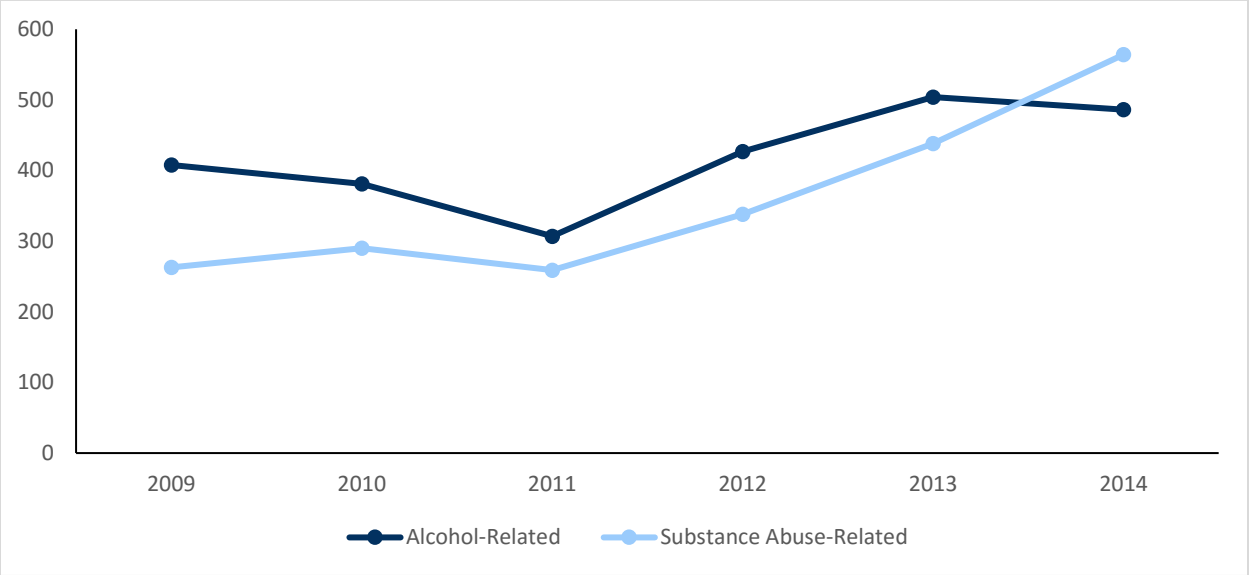
Table 3. Demographics of Healthy Communities Coalition resident visits to the ER for select behavioral disorders 2009-2014.

Condition*	Female		Male		Unknown		Total
	N	Row %	N	Row %	N	Row %	
Anxiety	2,507	72.0%	977	28.0%	0	0.0%	3,484
Depression	1,767	70.5%	740	29.5%	0	0.0%	2,507
Bipolar	774	69.6%	338	30.4%	0	0.0%	1,112
PTSD	182	62.1%	111	37.9%	0	0.0%	293
Schizophrenia	195	59.1%	135	40.9%	0	0.0%	330
Suicidal Tendencies	120	57.1%	90	42.9%	0	0.0%	210
Suicidal Ideation	293	53.4%	256	46.6%	0	0.0%	549
Alcohol Related	952	37.9%	1,561	62.1%	0	0.0%	2,513
Substance Abuse Related	1,166	54.2%	986	45.8%	0	0.0%	2,152
Suicide - Solid or Liquid	127	75.6%	41	24.4%	0	0.0%	168
Suicide - Gases in Domestic Use	0	0.0%	1	100.0%	0	0.0%	1
Suicide - Other Gases and Vapors	0	0.0%	1	100.0%	0	0.0%	1
Suicide - Hanging, Strangulation, & Suffocation	2	22.2%	7	77.8%	0	0.0%	9
Suicide - Cutting & Piercing Instrument	78	67.2%	38	32.8%	0	0.0%	116
Suicide - Firearms, Air Guns, & Explosives	1	16.7%	5	83.3%	0	0.0%	6
Suicide - Jumping from High Place	1	100.0%	0	0.0%	0	0.0%	1
Suicide - Other Unspecified Means	16	57.1%	12	42.9%	0	0.0%	28

*Categories are not mutually exclusive

Females made up the majority of Healthy Communities Coalition residents who visited the ER for anxiety (72%), depression (70%), bipolar (70%), PTSD (62%), and schizophrenia (59%).

Figure 7. Trend of Healthy Communities Coalition residents' visits to ER for alcohol and drug-related issues, 2009-2014.



Healthy Communities Coalition ER visits increased for both alcohol-related and substance abuse-related issues from 2009 to 2014. Alcohol-related visits increased from 408 visits in 2009 to 486 visits in 2014, a 19% increase. Drug-related increased from 263 visits in 2009 to a high of 564 visits in 2014, a 114% increase.

Table 4. Demographics of Healthy Communities Coalition resident visits to the ER for alcohol and drug-related disorders, 2009-2014.

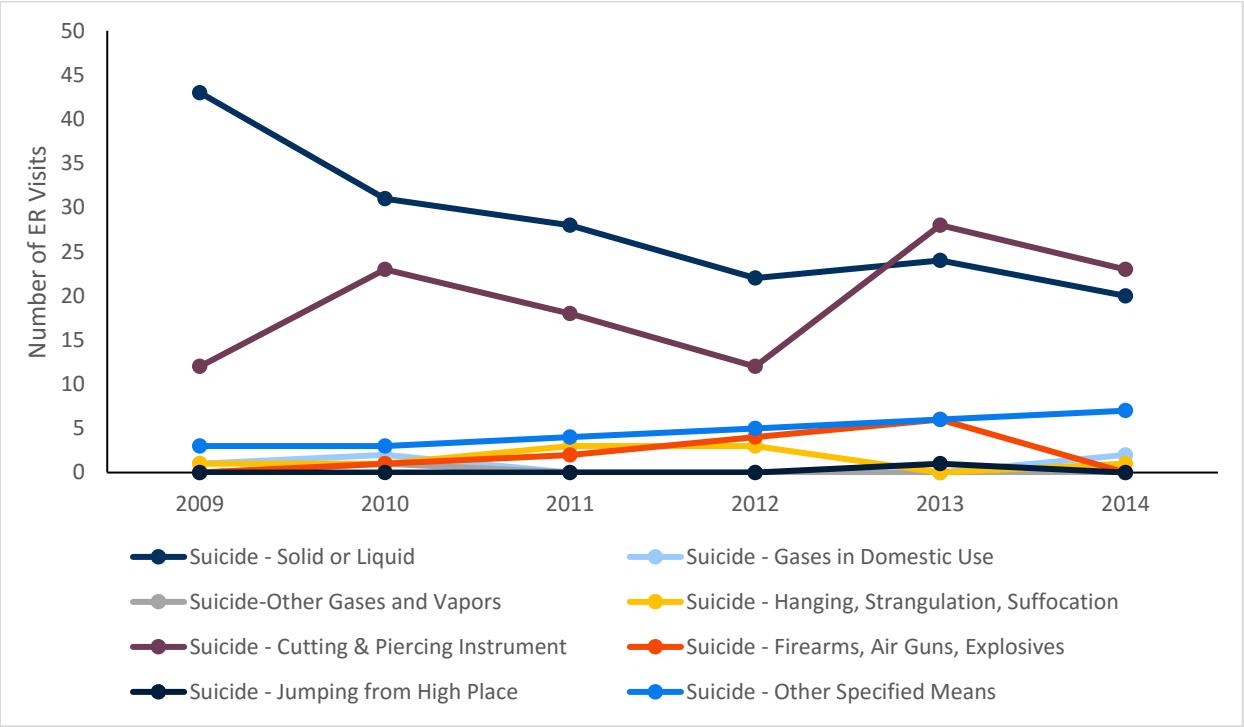
	Alcohol-Related		Drug- Related	
	N	Column %	N	Column %
Sex				
Female	952	37.9%	1,166	54.2%
Male	1,561	62.1%	986	45.8%
Race				
White	1,976	78.6%	1,768	82.2%
Native American	217	8.6%	67	3.1%
Hispanic	84	3.3%	98	4.6%
Asian/Pacific	2	0.1%	11	0.5%
Black	25	1.0%	49	2.3%
Other	32	1.3%	20	0.9%
Unknown	177	7.0%	139	6.5%
Age				
0-14	11	0.4%	51	2.4%
15-24	280	11.1%	449	20.9%
25-34	354	14.1%	538	25.0%
35-44	482	19.2%	374	17.4%
45-54	674	26.8%	394	18.3%
55-64	362	14.4%	230	10.7%
65-74	232	9.2%	79	3.7%
75-84	104	4.1%	27	1.3%
85+	14	0.6%	10	0.5%

Males accounted for a greater percentage over females for alcohol-related ER visits (62%) and females accounted for a greater percentage of drug-related visits (54%) among Healthy Communities Coalition residents between 2009 and 2014.

Whites made up the majority of alcohol and substance abuse-related ER visits, 79% and 82% of visits, respectively.

Alcohol-related ER visits was highest among the 45-54 (27%) and 35-44 (19%) year age groups. In general, ER visits declined progressively as ages increased.

Figure 8. Trend of Healthy Communities Coalition visits to the ER for Suicides, 2009-2014.

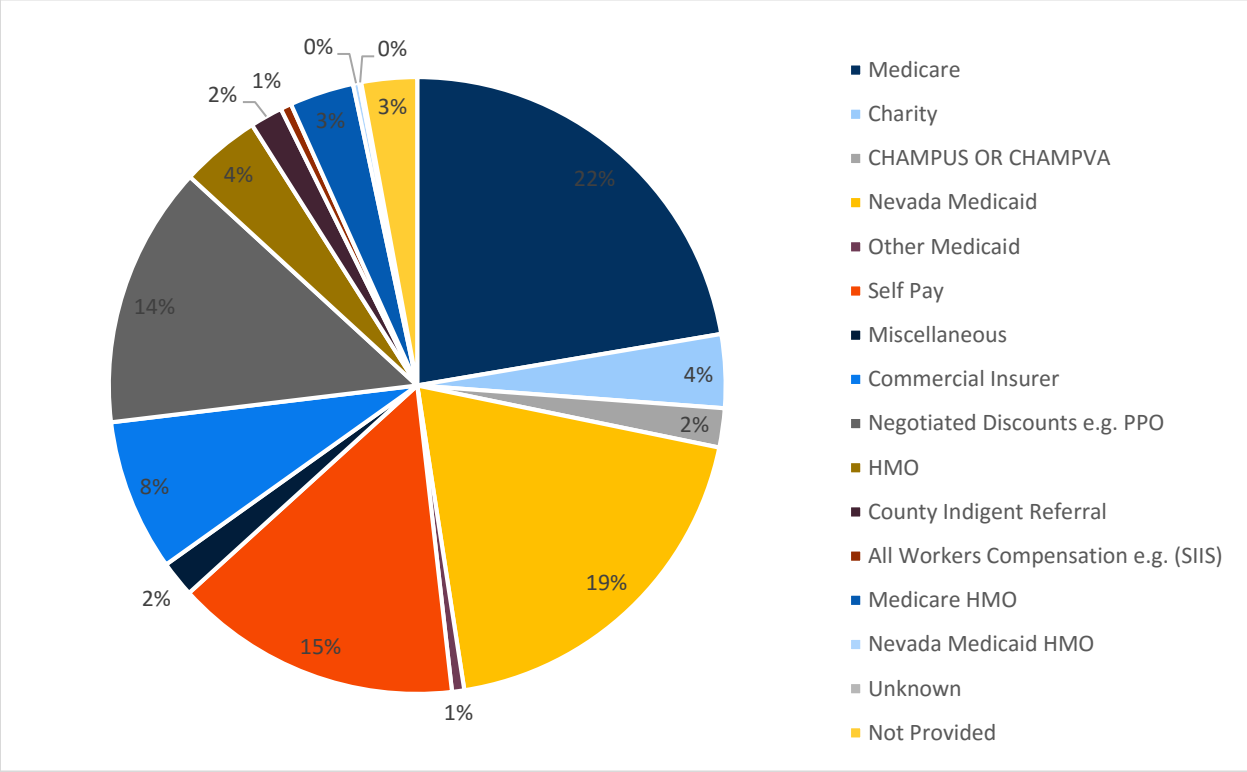


Overall number of visits to the ER for suicide among Healthy Communities Coalition residents has decreased by 17% from 2009-2014, from 59 visits in 2009 to 49 in 2014. The lowest number was in 2012 with 43 visits.

Suicide by solid or liquid was the top method of suicide and suicide attempts resulting in an ER visit in Healthy Communities Coalition, accounting for 52% of all suicide-related ER visits from 2009-2014. In 2009, there were 46 ER visits resulting from suicide by solid or liquid and 20 visits in 2014, a decrease of 53%. The high was in 2009 with 43 visits. Suicide by solid or liquid includes all suicides where an individual entered liquid into his or her body, such as alcohols (ethanol, butanol, propanol, and methanol), fuel oil, petroleum, pesticides, herbicides, paints, dyes, and glues; or solids such as prescription pills and illegal drugs.

The second most common suicide ER visit was for those involving cutting and piercing instruments, accounting for 36% of all suicide-related visits from 2009-2014. The high 28 visits in 2013 and the low was 12 visits in 2009 and 2012.

Figure 9. Percentages of Healthy Communities Coalition resident visits to the ER for mental health and substance-related disorders by payment source, 2009-2014.



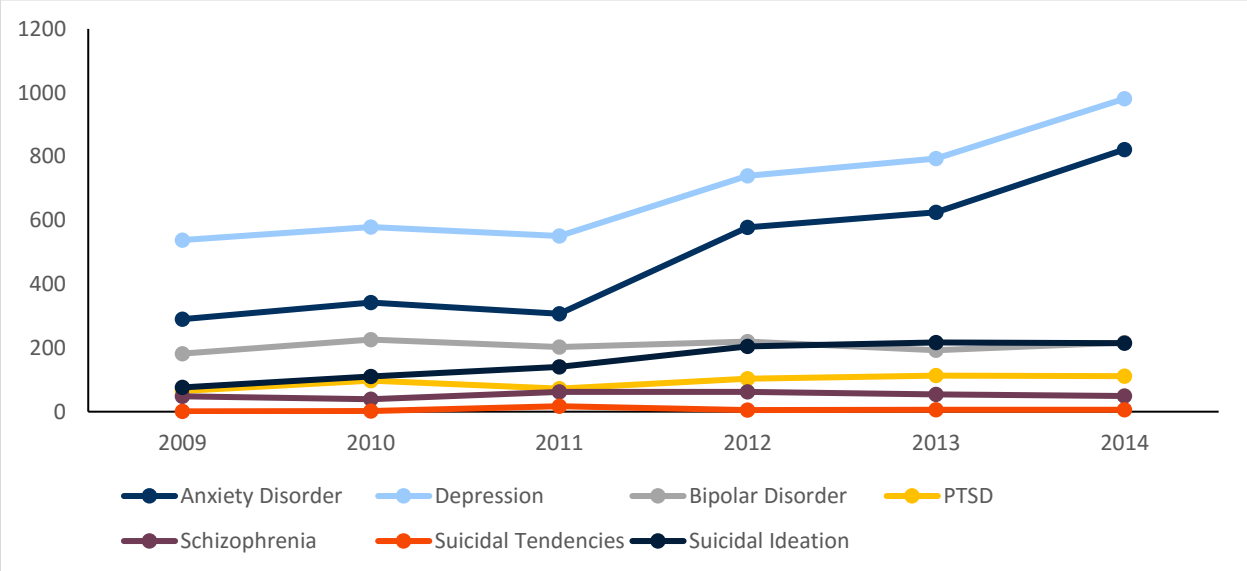
Nevada Medicare accounted for 25% of sources of payment for ER visits among Healthy Communities Coalition residents with mental health and substance-related disorders. Medicaid accounted for 20% of payment types, Self-Pay represented 15%, and PPO represented 14%.

Hospital Inpatient Admissions

The data provided in this section are from the hospital inpatient billing data, collected by the University of Nevada, Las Vegas, Center for Health Information Analysis (CHIA). The data are based on admissions, not patients, therefore a single person may represent multiple admissions. The inpatient data are broken into three parts: mental conditions (anxiety, PTSD, suicidal ideations, etc.), suicide attempts by method (hanging, jumping, firearms, etc.) and alcohol- and drug-related admissions. The same ICD-9 codes were used for analysis as were used in hospital ER visit analysis.

There were a total of 9,443 inpatient admissions related to mental health and substance use disorders among Healthy Communities Coalition residents between 2009 and 2014 for the reasons listed above. 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. Diagnoses related to mental disorders occurred in 7,155 inpatient admissions, there were 2,677 inpatient admissions related to alcohol-related issues, 2,114 inpatient admissions for drug-related issues, and 237 inpatient admissions with diagnoses codes related to suicide attempts.

Figure 10. Trend of Healthy Communities Coalition inpatient admissions for select mental health disorders, 2009-2014.



Depression was the most common mental health disorder for inpatient admissions for Healthy Communities Coalition residents between 2009 and 2014, related to for 58% of the admissions from the disorders listed above in Figure 10. Depression inpatient admissions has increased from 538 admissions in 2009 to 981 in 2014, an 82% increase.

Anxiety was the second most common mental health disorder seen in inpatient admissions. Inpatient admissions has increased steadily over the six year period, from 290 admissions in 2009 to 822 in 2014, a 183% increase.

Bipolar disorder is the third most common mental health disorder seen in inpatient admissions among Healthy Communities Coalition residents, related to 17% of admissions for the mental health conditions listed in Figure 10. There was a 19% increase from 2009 to 2014.

Inpatient admissions for suicidal tendencies experienced the greatest percent change from 2009 to 2014 with a 500% increase. The inpatient admission counts increased from 1 in 2009 to 6 in 2014.

Table 5. Demographics of Healthy Communities Coalition resident inpatient admissions for top four mental health disorders, 2009-2014.

Inpatient	Depression		Anxiety		Bipolar		Suicidal Ideation	
	N	Column %	N	Column %	N	Column %	N	Column %
Sex								
Female	2,765	66.1%	2,078	70.1%	922	74.3%	590	61.3%
Male	1,416	33.9%	886	29.9%	319	25.7%	373	38.7%
Race								
White	3,308	79.1%	2,445	82.5%	854	68.8%	455	47.2%
Black	38	0.9%	26	0.9%	4	0.3%	5	0.5%
Native American	81	1.9%	49	1.7%	18	1.5%	27	2.8%
Asian/Pacific	14	0.3%	11	0.4%	4	0.3%	3	0.3%
Hispanic	93	2.2%	65	2.2%	30	2.4%	15	1.6%
Other	48	1.1%	36	1.2%	17	1.4%	31	3.2%
Unknown	599	14.3%	332	11.2%	314	25.3%	427	44.3%
Age								
0-14	91	2.2%	40	1.3%	44	3.5%	67	7.0%
15-24	390	9.3%	186	6.3%	164	13.2%	271	28.1%
25-34	301	7.2%	254	8.6%	151	12.2%	118	12.3%
35-44	407	9.7%	313	10.6%	215	17.3%	140	14.5%
45-54	620	14.8%	478	16.1%	241	19.4%	152	15.8%
55-64	849	20.3%	600	20.2%	267	21.5%	125	13.0%
65-74	835	20.0%	603	20.3%	119	9.6%	55	5.7%
75-84	488	11.7%	347	11.7%	36	2.9%	29	3.0%
85+	200	4.8%	143	4.8%	4	0.3%	6	0.6%

Females accounted for a greater percent of inpatient admissions over males for the top mental health disorders in Healthy Communities Coalition, ranging from 62% of admissions for suicidal ideations to 75% of bipolar admissions.

A majority of inpatient admissions are white, such as with depression admissions (79%), anxiety admissions (83%), and bipolar (69%). There is a relatively large portion of “unknown” races for all selected mental health disorders, especially for admissions for suicidal ideation where unknown accounts for 44% of all admissions.

The largest age groups varied depending on the mental health disorder. Residents 55-74 accounted for the most admissions in depression and anxiety, 45-64 in bipolar, and 15-24 in suicidal ideation.

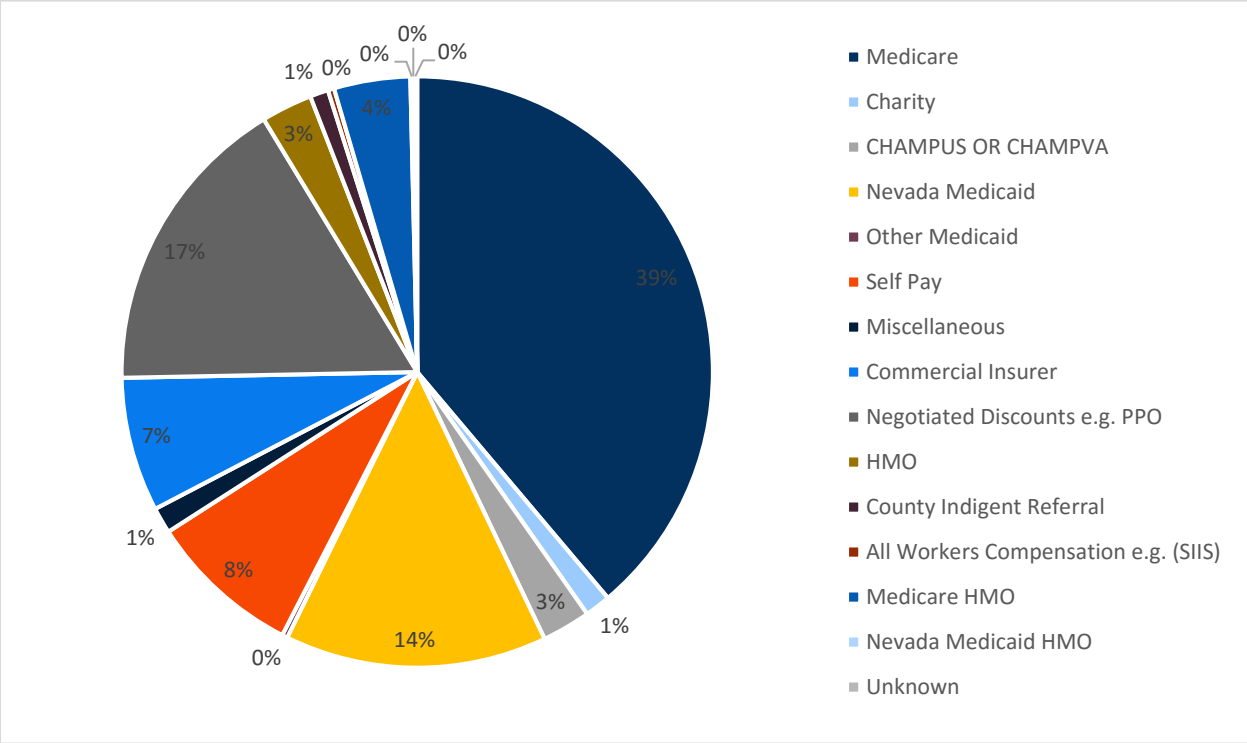
Table 6. Demographics of Healthy Communities Coalition resident's inpatient admissions by suicide attempts, 2009-2014.

Inpatient	Solid or Liquid		Cutting and Piercing Instrument		Firearms, Air Guns and Explosives	
	N	Column %	N	Column %	N	Column %
Sex						
Female	116	61.4%	24	75.0%	2	18.2%
Male	73	38.6%	8	25.0%	9	81.8%
Race						
White	158	83.6%	24	75.0%	8	72.7%
Black	4	2.1%	0	0.0%	0	0.0%
Native American	8	4.2%	3	9.4%	1	9.1%
Asian/Pacific	2	1.1%	0	0.0%	0	0.0%
Hispanic	11	5.8%	2	6.3%	0	0.0%
Other	3	1.6%	0	0.0%	0	0.0%
Unknown	3	1.6%	3	9.4%	2	18.2%
Age						
0-14	3	1.6%	0	0.0%	0	0.0%
15-24	28	14.8%	4	12.5%	0	0.0%
25-34	31	16.4%	9	28.1%	2	18.2%
35-44	26	13.8%	5	15.6%	3	27.3%
45-54	45	23.8%	7	21.9%	4	36.4%
55-64	37	19.6%	5	15.6%	0	0.0%
65-74	16	8.5%	1	3.1%	0	0.0%
75-84	3	1.6%	1	3.1%	1	9.1%
85+	0	0.0%	0	0.0%	1	9.1%

Females led in suicide attempts by solid or liquid (61%) and attempts by cutting and piercing instrument (75%). Whites represent 84% of suicide inpatient admissions by solid or liquid, about 75% of suicide by cutting and piercing instrument and 73% of suicide by firearms, air guns and explosives.

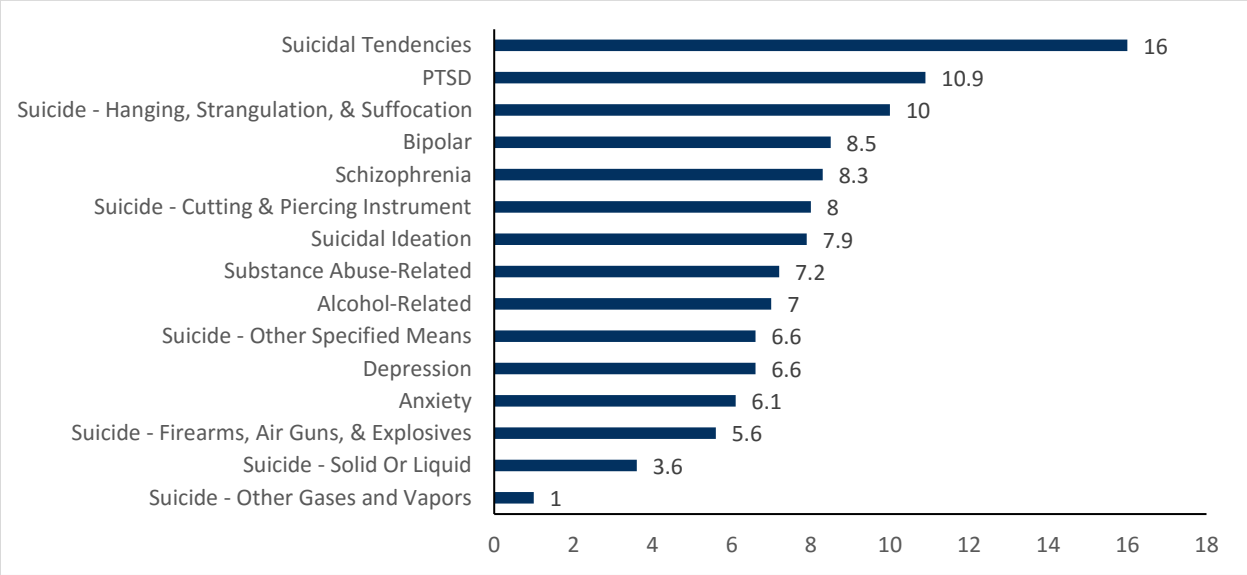
The largest age group representing suicide-related inpatient admissions by solid or liquid is 45 to 54 (24%). The age group representing the most admissions due to suicide attempts by cutting and piercing instrument was the 25-34 age group (28%).

Figure 11. Percentages of Healthy Communities Coalition resident inpatient admissions for mental health and substance-related disorders by payment type, 2010-2014.



The most common payment source of mental health and substance-related inpatient admissions for Healthy Communities Coalition residents was Medicare (43%). Negotiated Discounts accounted for 17%, and Nevada Medicaid accounted for 14%. The remainder of payment methods are each 8% or less of inpatient admissions.

Figure 12. Average length of stay for Healthy Communities Coalition resident inpatient admissions for mental health and substance-related disorders, 2009-2014.



Note: Since an individual can have more than one of the above diagnoses during an inpatient admission, a single hospitalization may be included in multiple categories, and would contribute to the average length of stay in each of these categories.

From 2009 to 2014, inpatient admissions for suicide tendencies had the longest average length of stay at 16 days. PTSD had an average length of stay of 11 days. Inpatient admissions for suicide by hanging, strangulation and suffocation had an average stay of about 10 days.

Substance Abuse Treatment Facilities

The data in this section is reflective of services received by Lyon, Mineral, and Storey residents at treatment facilities funded by the DPBH's Substance Abuse Treatment and Prevention Agency (SAPTA). This is not comprehensive, accounting for only Lyon, Mineral, and Storey county residents who receive substance use treatment in state funded facilities. The data are based on admissions, not patients, therefore a single person may represent multiple admissions.

Table 7. Top 5 substances by admissions to Nevada substance abuse treatment facilities, Lyon, Mineral, and Storey County residents, 2010-2014.

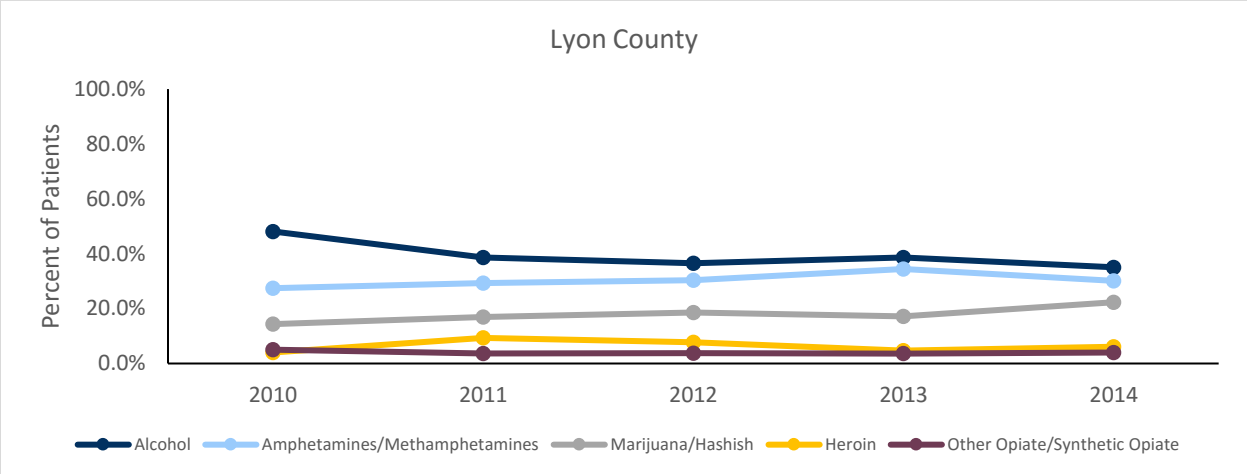
Lyon (2014 Only)		
Rank	**Substance**	**Percent**
1	Alcohol	35.1%
2	Amphetamines/Methamphetamines	30.1%
3	Marijuana/Hashish	22.3%
4	Heroin	6.1%
5	Other Opiates/Synthetic Opiates	4.1%

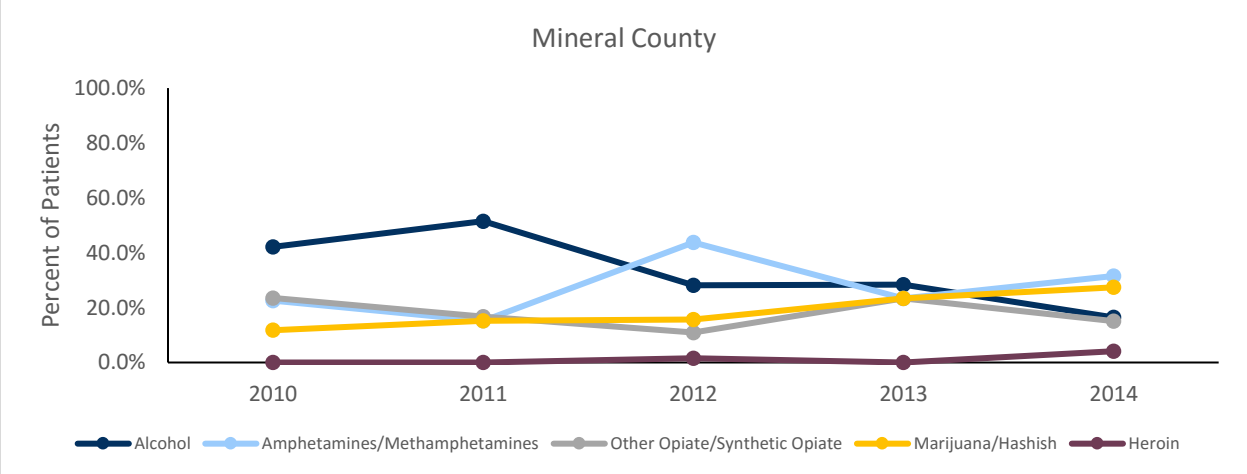
Mineral (2010-2014 Aggregate)		
Rank	**Substance**	**Percent**
1	Alcohol	33.3%
2	Amphetamines/Methamphetamines	27.3%
3	Marijuana/Hashish	18.7%
4	Other Opiates/Synthetic Opiates	17.9%
5	Heroin	1.1%

Storey (2010-2014 Aggregate)		
Rank	**Substance**	**Percent**
1	Alcohol	46.9%
2	Amphetamines/Methamphetamines	22.8%
3	Other Opiates/Synthetic Opiates	10.1%
4	Heroin	8.6%
5	Marijuana/Hashish	8.0%

All listed counties had the same top five most common substances abused. Alcohol was most common substance abused in all counties, range from 33.3% to 46.9%. Amphetamines/Methamphetamines ranged from 22.8% to 30.1%, and marijuana/hashish ranged from 8.0% to 22.3%.

Figure 13. Trends of Healthy Communities Coalition residents in Nevada state funded substance abuse treatment facilities by select substances, 2010-2014.





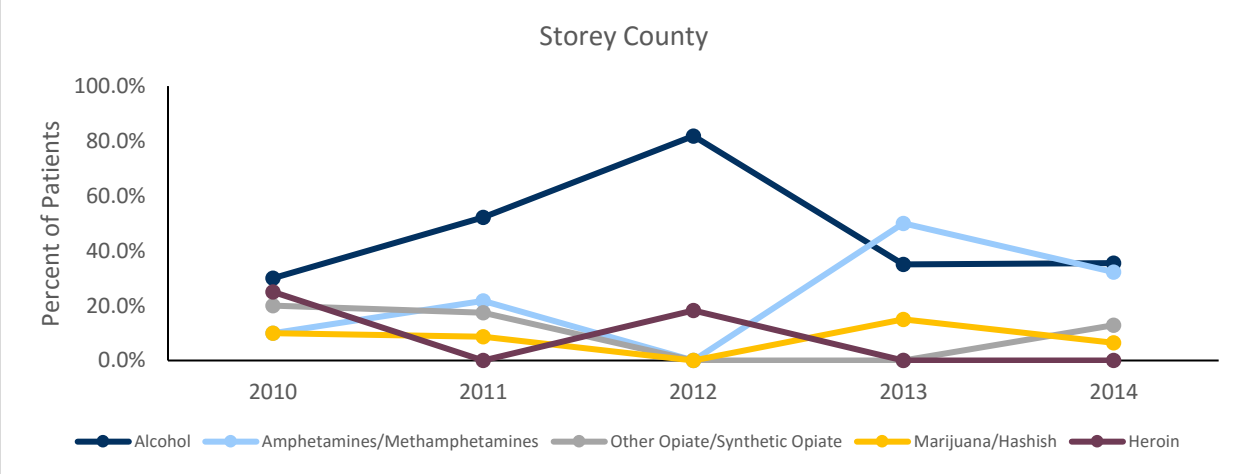


Table 8. Demographics of Healthy Communities Coalition residents in Nevada substance abuse treatment facilities, 2010-2014.

	N	Column %
Sex		
Female	999	41.5%
Male	1,407	58.5%
Age		
0-14	51	2.1%
15-24	883	36.7%
25-34	690	28.7%
35-44	360	15.0%
45-54	291	12.1%
55-64	101	4.2%
65+	30	1.2%
Unknown	0	0.0%
Race/Ethnicity		
White non-Hispanic	1,760	73.2%
Black non-Hispanic	46	1.9%
Hispanic	351	14.6%
American Indian/Native Am/Alaska Native non-Hispanic	89	3.7%
Asian, Hawaiian, PI non-Hispanic	12	0.5%
Other/Unknown	148	6.2%
Tobacco Use		
Yes	1,446	60.1%
No	755	31.4%
Unknown	205	8.5%

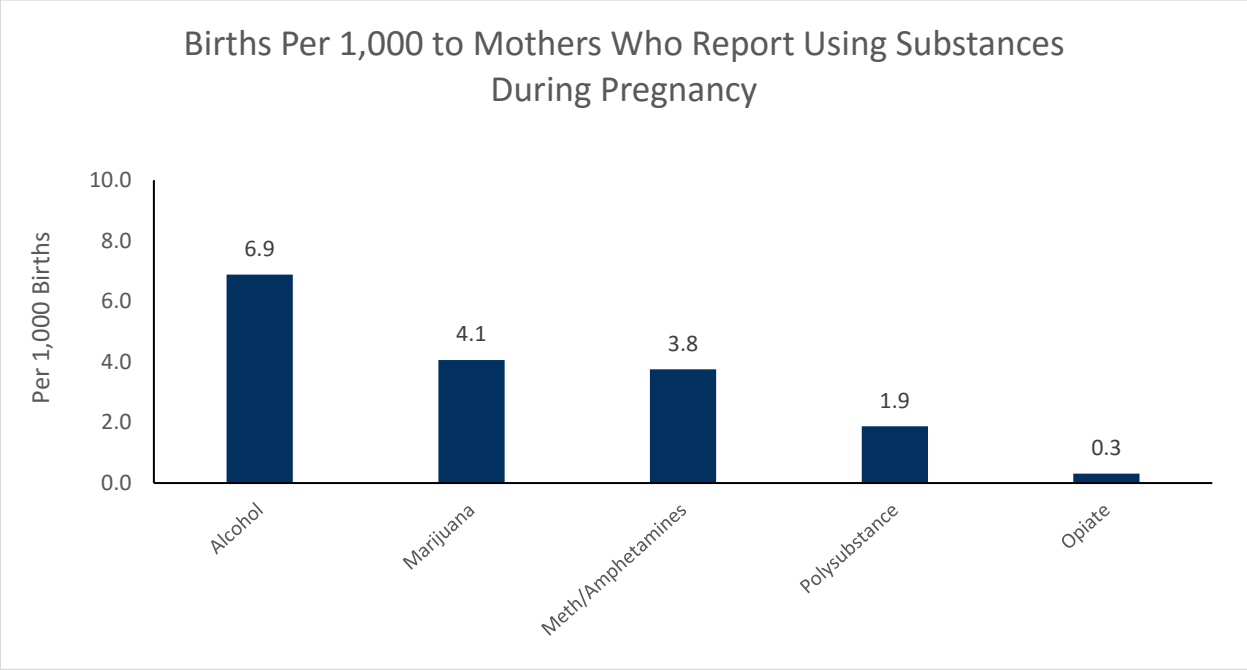
There were a total of 2,406 admissions for Healthy Communities Coalition residents to Nevada state funded substance abuse treatment facilities from 2010-2014. This number is exclusive to SAPTA-funded facilities and does not include privately funded facilities. By age group, the most common groups that received treatment were between 15 to 34 years (65%). More than half were male patients (59%). For race/ethnicity, white non-Hispanics made up the largest proportion of admissions, with 73%. Tobacco use was indicated on 60% of admissions.

Since this data is exclusive to only SAPTA-funded providers, the data may not reflect statewide trends.

Prenatal Substance Use

The data in this section is reflective of self-reported information provided by the mother on the birth record.

Figure 14. Prenatal substance abuse birth rate (self-reported), Healthy Communities Coalition, 2010-2014.

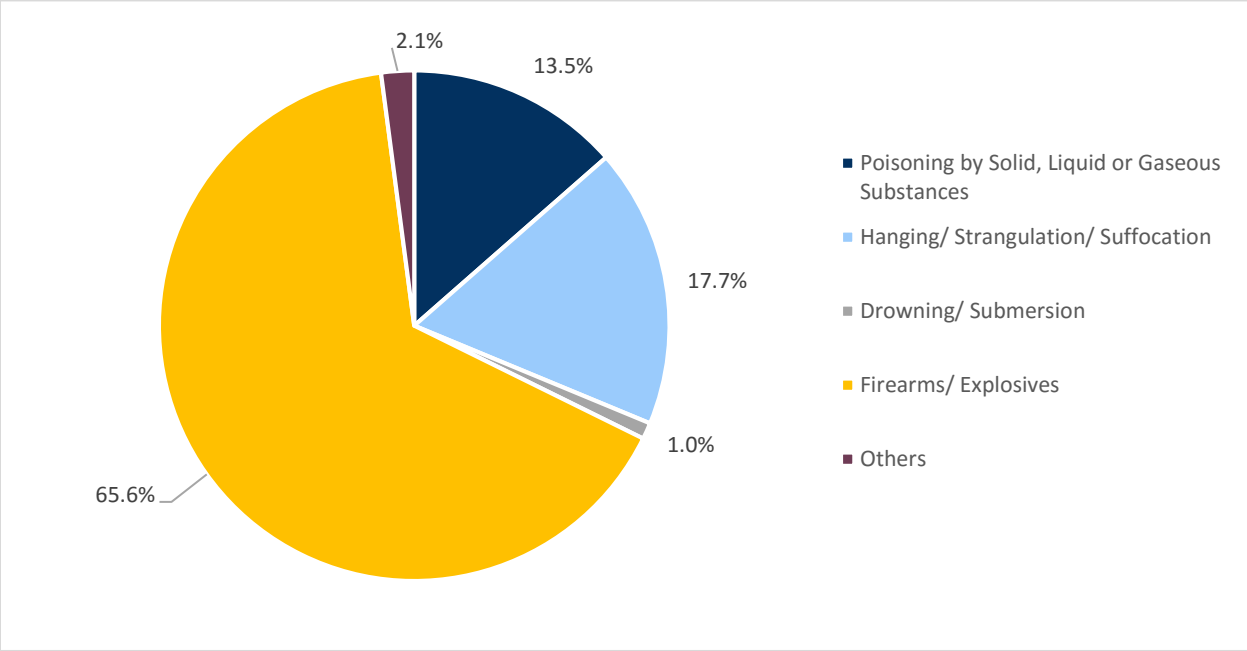


Of the Healthy Communities Coalition mothers who gave birth between 2010 and 2014 that self-reported using a substance while pregnant, alcohol has the highest prenatal substance abuse birth rate at 6.9 per 1,000 births. A rate of 4.1 per 1,000 self-reported using marijuana, 3.8 per 1,000 reported using amphetamines/methamphetamines, and 1.9 per 1,000 births reported polysubstance. These numbers are grossly underestimated because data is self-reported by the mothers, and they may be reluctant to be forthcoming on the birth record for many reasons.

Mental and Substance Abuse Deaths

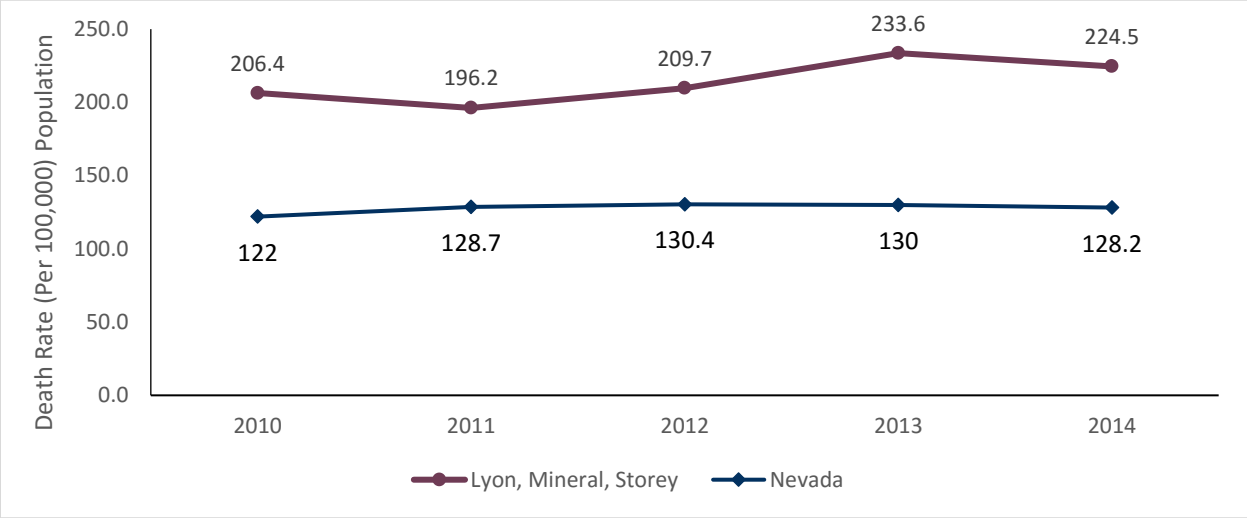
The data in this section are from the electronic death registry at DPBH. The Substance Abuse and Mental Health Service Administration (SAMHSA) reports suicide and mental illness are highly correlated with as many as 90% of those persons who die of suicide completion having a diagnosable mental illness.

Figure 15. Immediate cause of death by suicide, Healthy Communities Coalition, 2010-2014 (n=96).



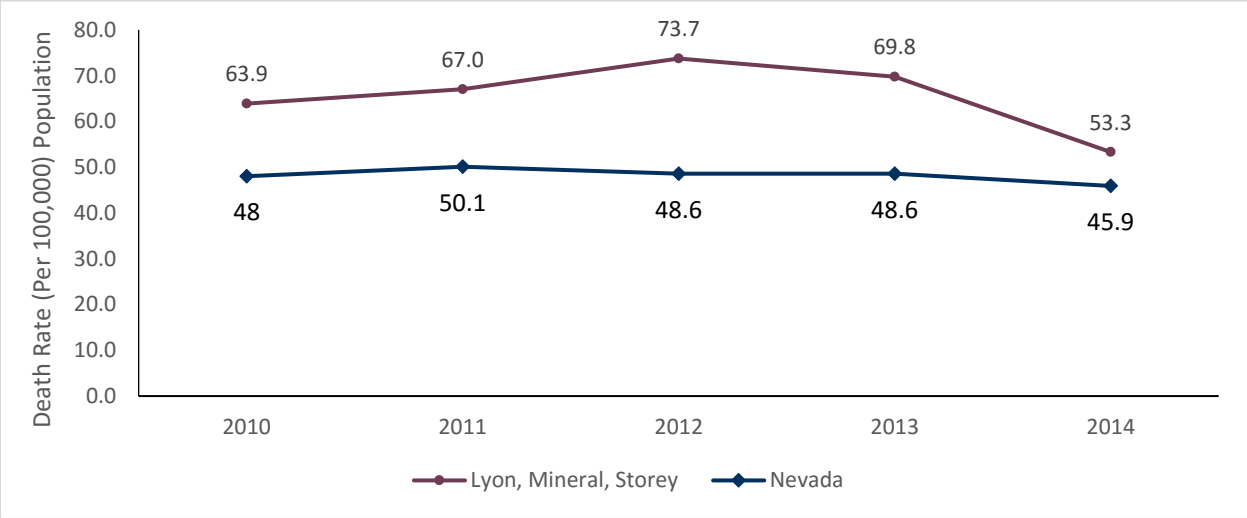
Among Healthy Communities Coalition residents who died of a suicide between 2010 and 2014, the most common method of suicide was firearms/explosives (66%), followed by hanging/strangulation/suffocation (18%), and poisoning solid, liquid or gaseous substance (14%).

Figure 16. Trend of Mental and Behavioral Disorders Deaths, Healthy Communities Coalition, 2010-2014.



Healthy Communities Coalition's death rate for mental and behavioral related deaths in 2010 was 206.4 per 100,000. This means that for every 100,000 deaths, around 206 deaths are primarily related to mental and behavioral health disorders. There was an overall percent increase of 9% between 2010 and 2014 and the rate increased to 224.5. Overall, Healthy Communities Coalition mental and behavioral related death rates are higher than the Nevada rate.

Figure 17. Trend of substance-related deaths, Healthy Communities Coalition, 2010-2014.



There were 201 substance-related deaths in the Healthy Communities Coalition between 2010 and 2014. Between 2010 and 2014 the rate decreased from 63.9 deaths per 100,000 to 53.3 deaths per 100,000. Healthy Communities Coalition's combined substance-related death rates are higher than Nevada's rate every year.

Table 9. Demographics of Substance Related Deaths, Healthy Communities Coalition, 2010-2014.

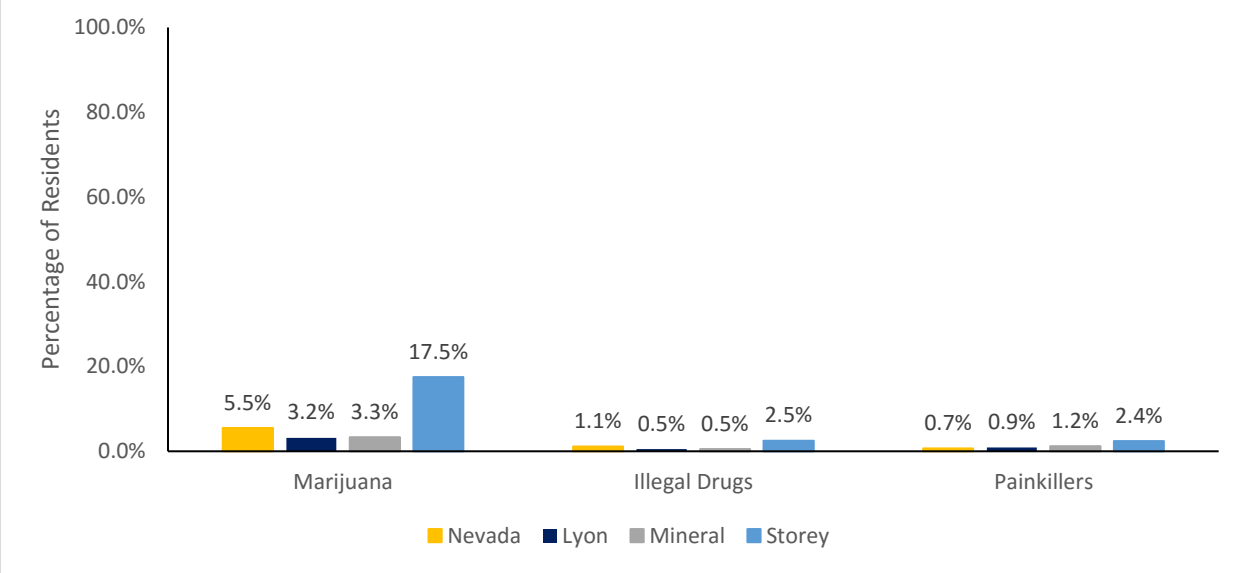
	N	Column %
Sex		
Female	79	39.3%
Male	122	60.7%
Race		
White	176	87.6%
Black	1	0.5%
Native American	7	3.5%
Hispanic	9	4.5%
Asian/Pacific	0	0.0%
Other	0	0.0%
Unknown	8	4.0%
Age		
<1	0	0.0%
1-4	0	0.0%
5-14	0	0.0%
15-24	7	3.5%
25-34	12	6.0%
35-44	15	7.5%
45-54	53	26.4%
55-64	68	33.8%
65-74	35	17.4%
75-84	7	3.5%
85+	4	2.0%

In Healthy Communities Coalition, the most common demographic groups to die of a substance-related death included: males (61%), Whites (88%), and those aged 55 to 64 years of age (34%).

Behavioral Risk Factor Surveillance System

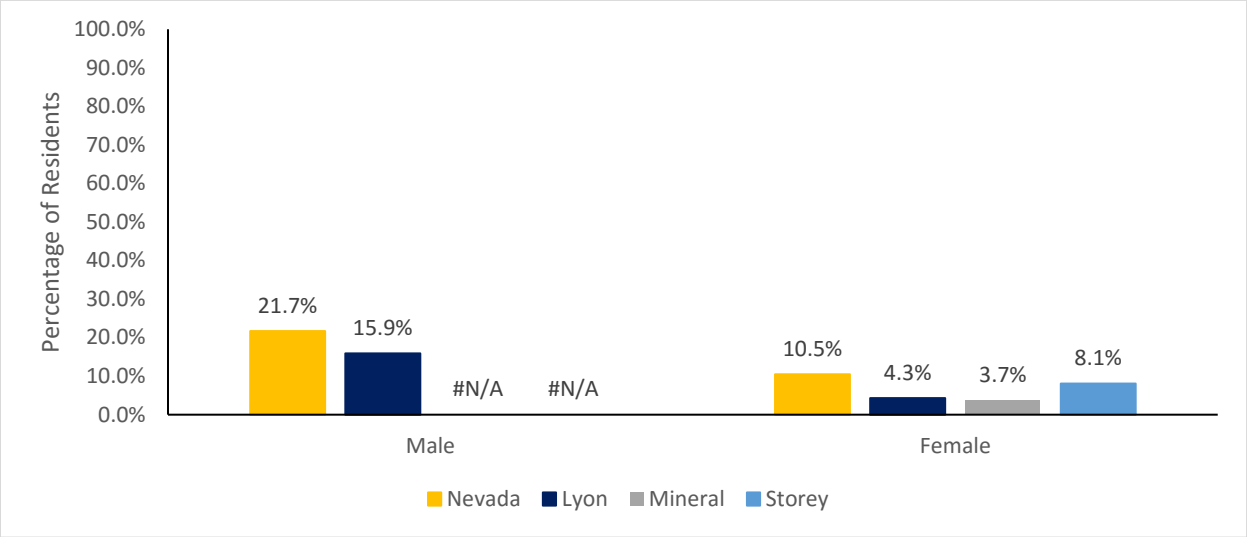
Data in this section are from Behavioral Risk Factor Surveillance System (BRFSS). The BRFSS is the nation's premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. BRFSS collects data for adults aged 18 years and older. It allows for representative data to be analyzed at the county-level for many indicators.

Figure 18. 2011-2014 BRFSS: Percentage of adult Lyon, Mineral, and Storey County residents who used illegal substances, or painkillers 'to get high,' in the last 30 days (aggregate 2011-2014 data).



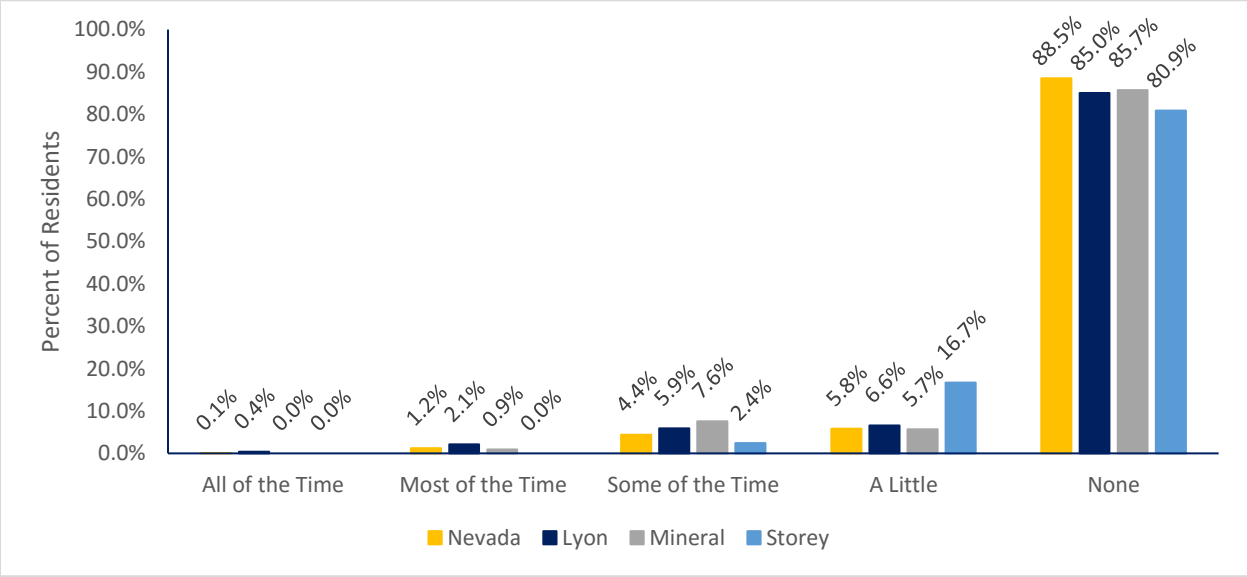
Although 5.5% of adults in Nevada and 3% of adults in Lyon and Mineral County reported using marijuana illegally in the last 30 days, over 17.5% of Storey County residents reported doing the same.

Figure 19. 2011-2014 BRFSS: Percentages of adult Lyon, Mineral, and Storey County residents who are considered "heavy drinkers" - more than one drink (females) or two drinks (males) per day.



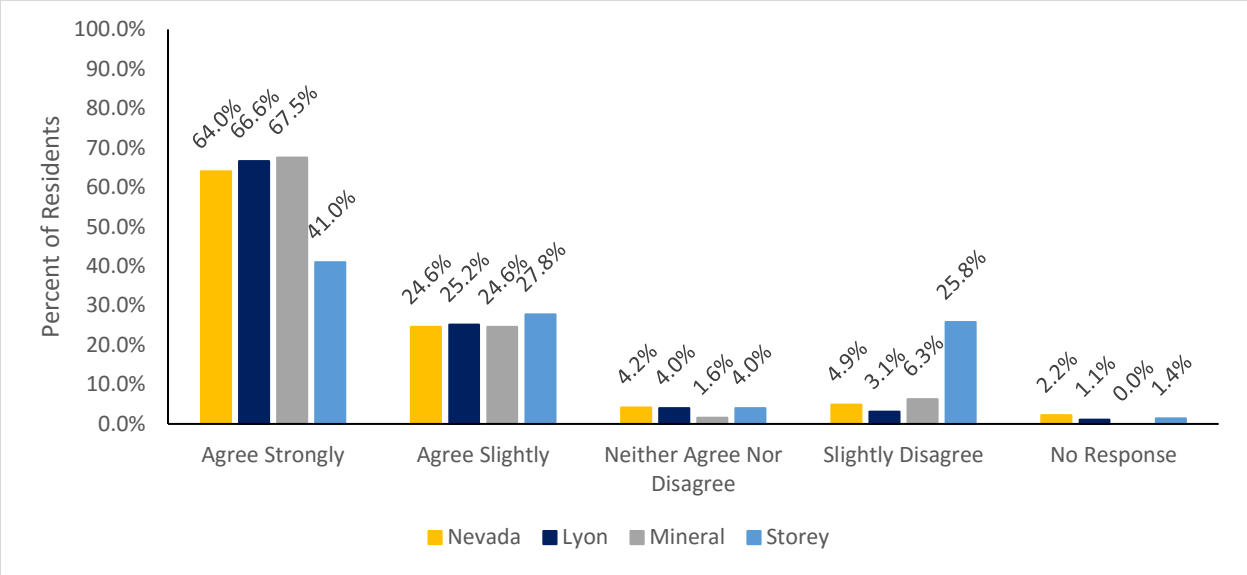
Nevada adult males and females more often reported being heavy drinkers compared to males and females in both all counties. Heavy drinking consists of males consuming more than two alcoholic beverages a day and females consuming more than one alcoholic beverage a day.

Figure 20. Percentages of how often adult Lyon, Mineral, and Storey County residents have felt depressed in the past 30 days, 2012-2014.



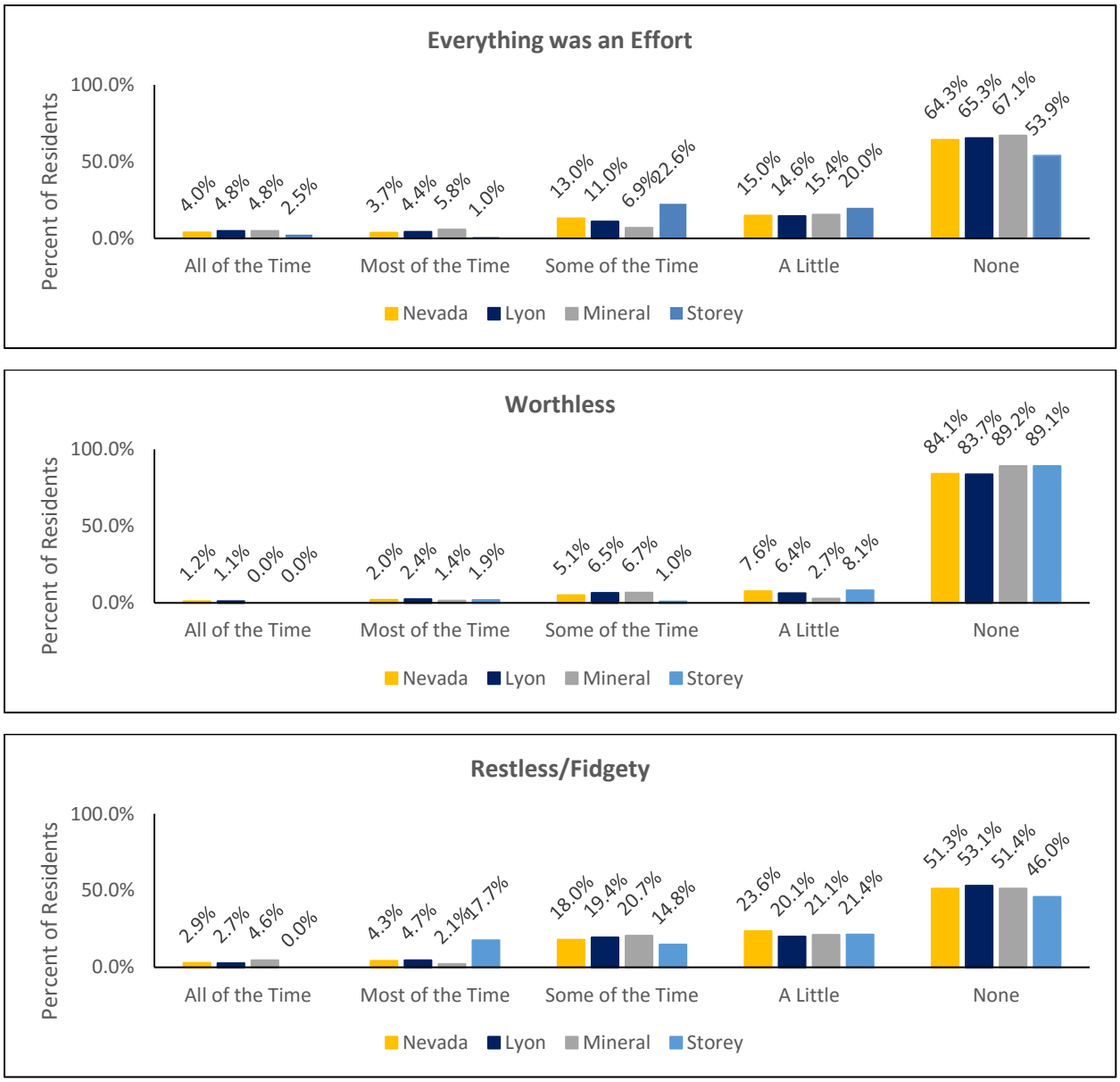
From 2012 to 2014, adult residents in Lyon, Mineral, and Storey, and Nevada almost equally reported not experiencing depression in the last 30 days (81%-89%). The rest of the residents reported experiencing a little depression (6%-17%), experiencing depression some of the time (2%-8%), most of the time (0%-2%), and all of the time (<1%).

Figure 21. 2012-2014 BRFSS: Percentages of adult Lyon, Mineral, and Storey residents who agree that with treatment, people with a mental illness can live normal lives.



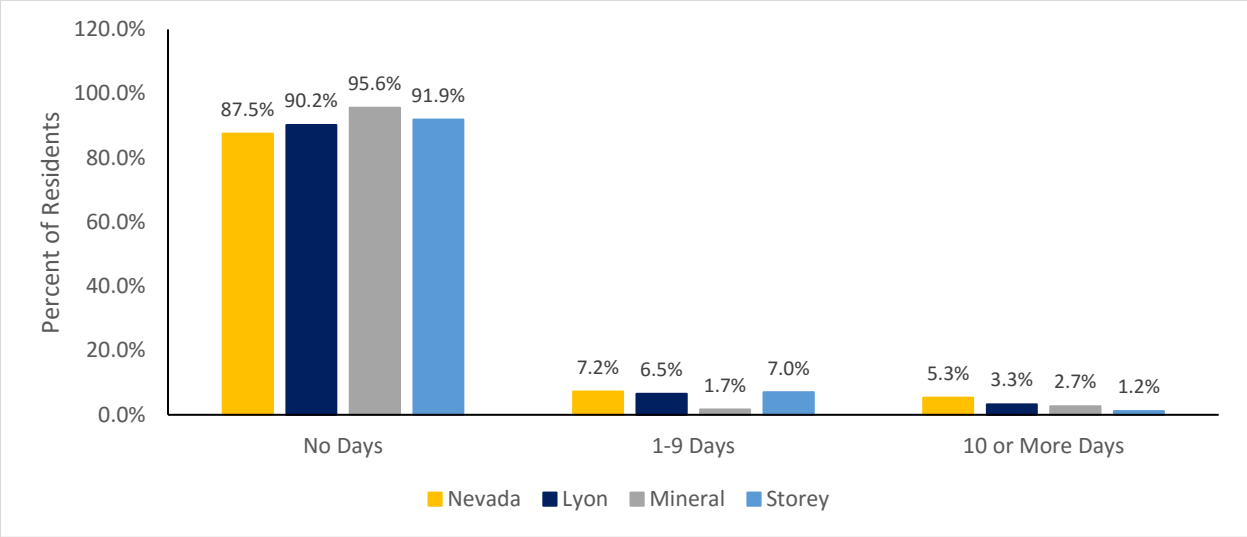
From 2012 to 2014, BRFSS data was collected on perception related to the efficacy of mental health treatment. In Nevada, Lyon, and Mineral, approximately 89%-92% of adults agreed in some capacity that those with mental disorders can live a normal life with treatment, but only 69% of adult residents in Storey agreed.

Figure 22. 2012-2014 BRFSS: Percentages of adult Lyon, Mineral, and Storey residents who have experienced the following mental health concerns in the past 30 days.



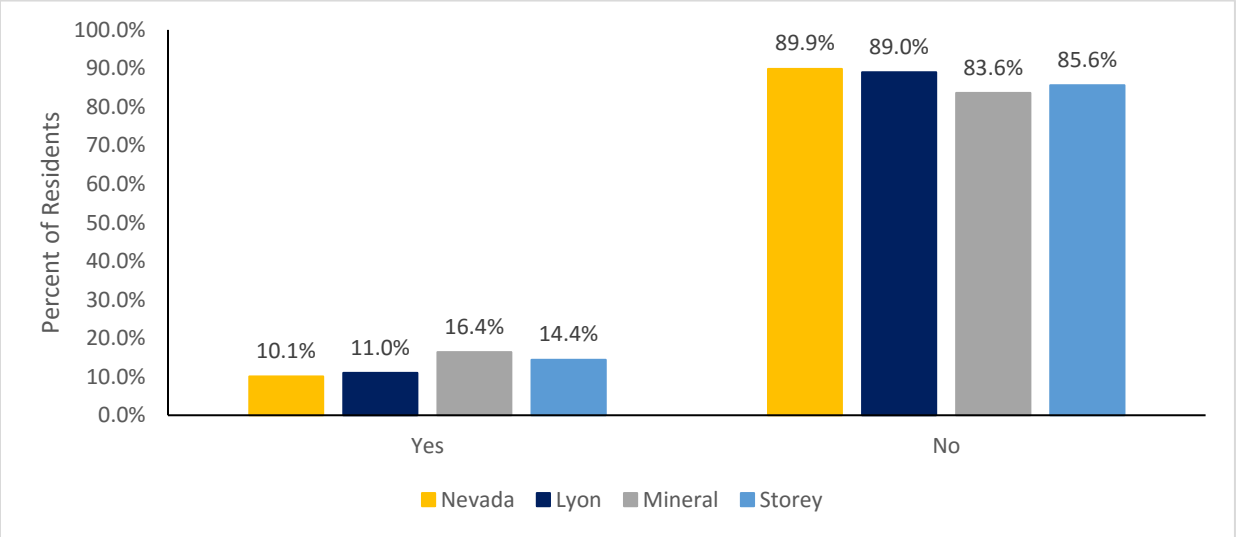
There are a number of BRFSS questions that collect data on feelings/emotions. From 2012 to 2014, 33%-46% of adults in Lyon, Mineral, and Storey reported feeling everything they did took effort, 11%-16% felt worthless, and 47%-54% felt restless and or fidgety.

Figure 23. 2012-2014 BRFSS: Percentages of adult Lyon, Mineral, and Storey residents who experienced that a mental health condition or emotional problem kept them from doing their work or other usual activities, by number of days.



Lyon, Mineral, and Storey residents were asked how many days, if any, did a mental health condition or emotional problem keep them from doing their work duties or other usual activities. Approximately 90%-96% reported missing no days of work or activities, 2%-7% experiencing missing one to nine days, and 1%-3% missed 10 or more days.

Figure 24. 2012-2014 BRFSS: Percentages of adult Lyon, Mineral, and Storey residents who are taking medication or receiving treatment for any type of mental health condition or emotional problem.

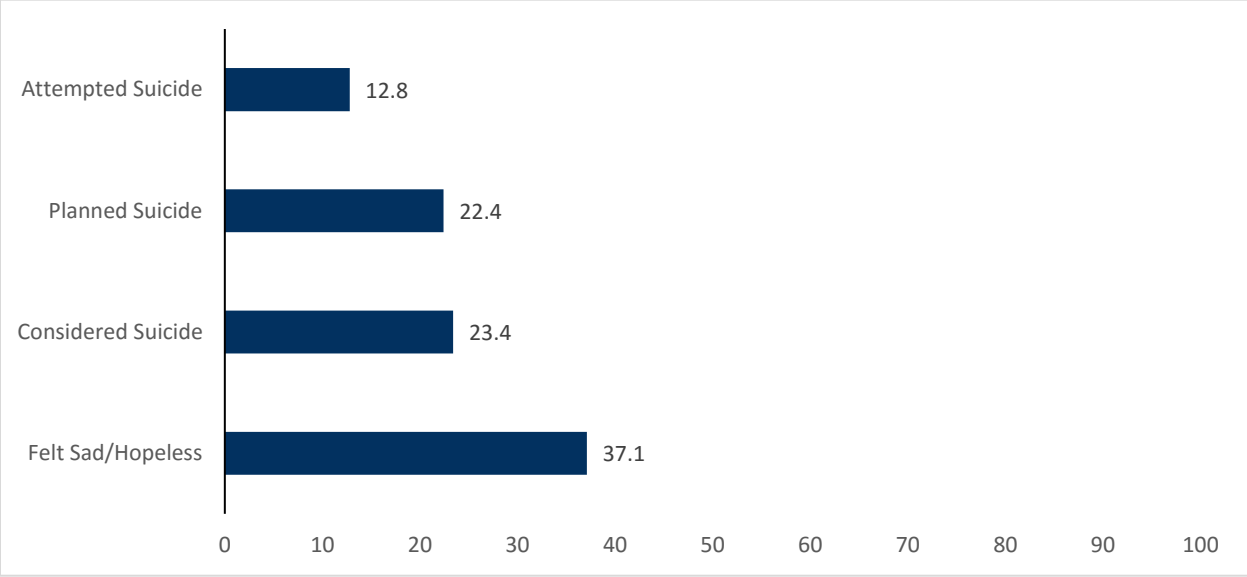


Lyon, Mineral, and Storey residents were asked if they were taking medication or receiving treatment from a doctor or other health professional for any type of mental health condition or emotional problem. Approximately 84%-89% reported that they were not.

Youth Risk Behavior Surveillance System

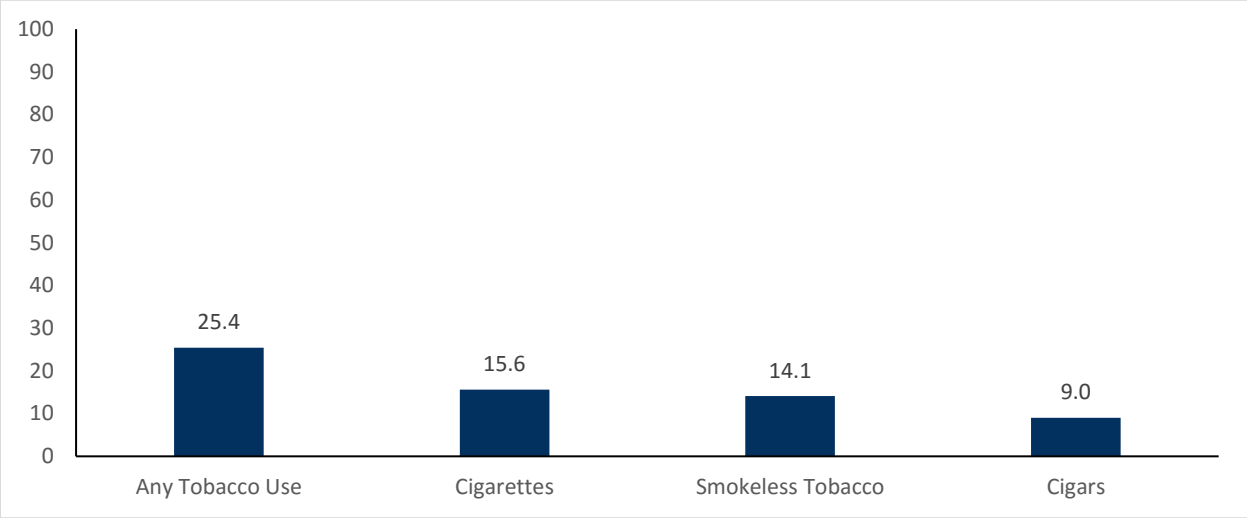
The data in this section is provided through a survey from the Youth Risk Behavioral Surveillance System (YRBSS) at a regional level for Lyon, Mineral, and Storey high school students. YRBSS is a national surveillance system that was established in 1991 by the Centers for Disease Control (CDC) and Prevention to monitor the prevalence of health risk behaviors among youth. It is an anonymous and voluntary survey of students in grades 9 through 12.

Figure 25. Percentages of high school students' mental health status (last 12 months), Healthy Communities Coalition, 2015.



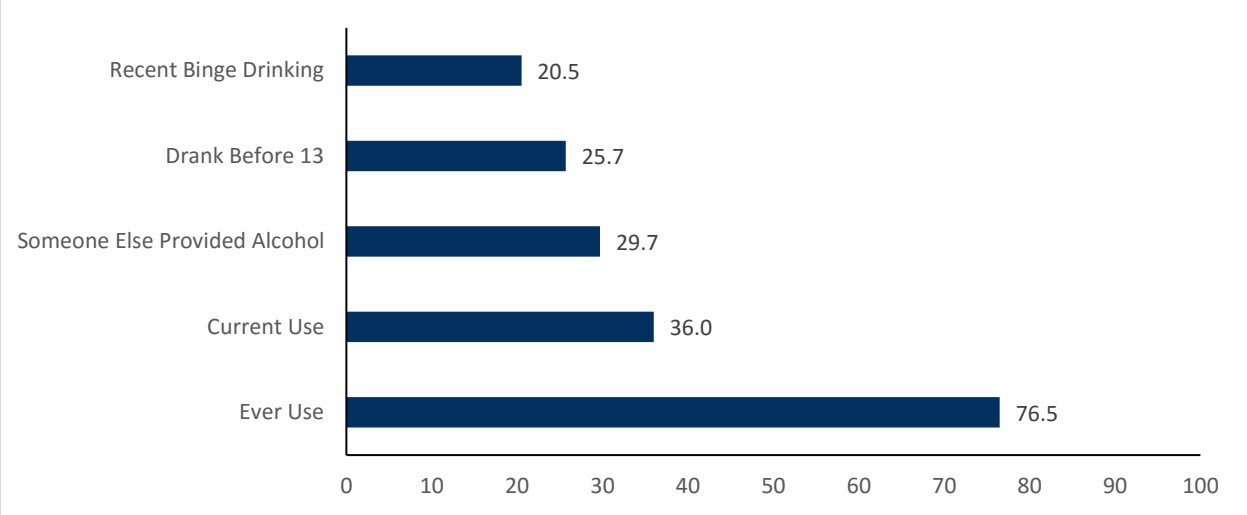
Approximately 37% of Healthy Communities Coalition high school students have felt sad or hopeless in the last 12 months. About 23% of students have considered suicide, while 22% have actually planned their suicide. Approximately 13% of high school students have actually attempted suicide.

Figure 26. Percentages of High School Students Current Tobacco Use, Healthy Communities Coalition, 2015.



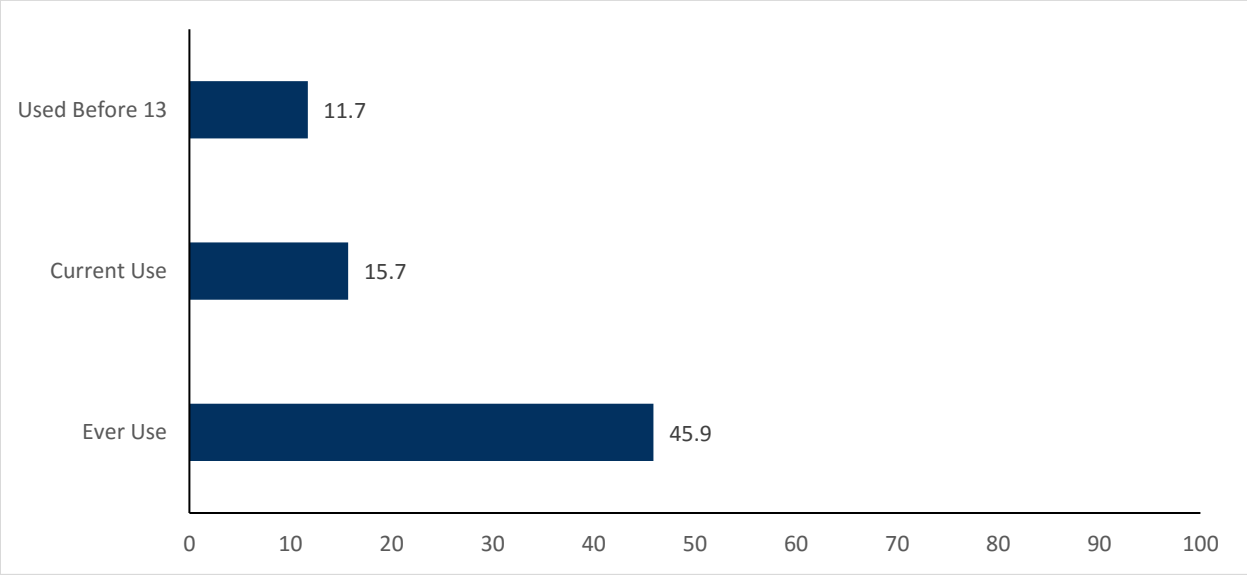
Around 25% of high school students in Healthy Communities Coalition are currently using tobacco. About 16% of these high school students smoke cigarettes, while 9% are currently smoking cigars. About 14% are using smokeless tobacco products.

Figure 27. Percentages of High School Students - Alcohol Behavior Summary, Healthy Communities Coalition, 2015.



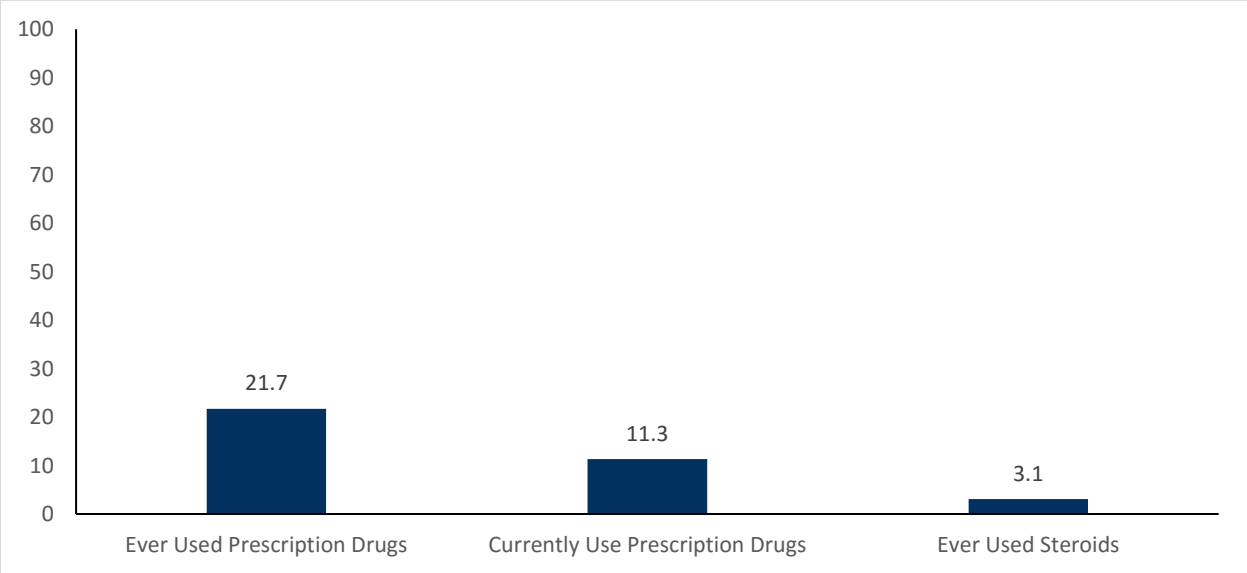
Approximately 77% of high school students in Healthy Communities Coalition have had at least one drink of alcohol (more than a few sips). About 36% of high school students currently drink. Nearly 30% of high schools students had alcohol provided to them by someone else. About 26% of high school students had alcohol before the age of 13 years, and approximately 21% of students had a recent binge drinking experience (had at least 5 drinks in a couple of hours in the past 30 days).

Figure 28. Percentages of High School Students - Marijuana Behavior Summary, Healthy Communities Coalition, 2015.



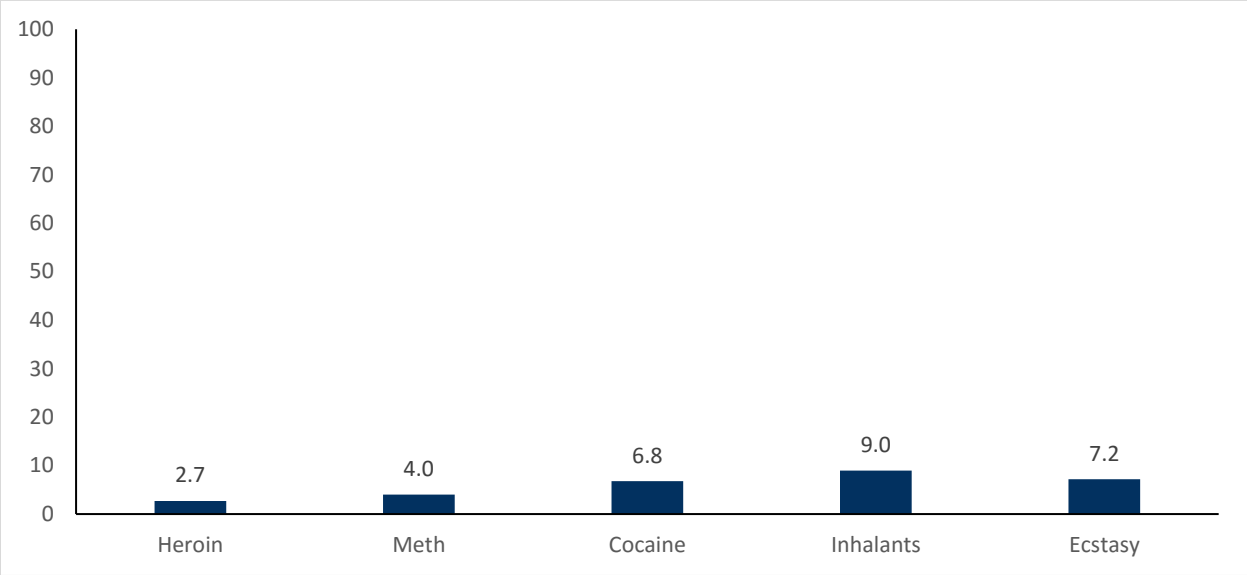
Approximately 46% of high school students in Healthy Communities Coalition reported trying marijuana, and 16% are currently using. Approximately 12% of high school students have tried marijuana before the age of 13 years.

Figure 29. Percentages of High School Students Nonprescription Substance Use Summary, Healthy Communities Coalition, 2015.



Approximately 22% of high school students have already tried prescription drugs that were not prescribed to them in their lifetime. About 3% have tried non-prescribed steroids.

Figure 30. Percentages of High School Students - Substance Abuse Summary, Healthy Communities Coalition, 2015.

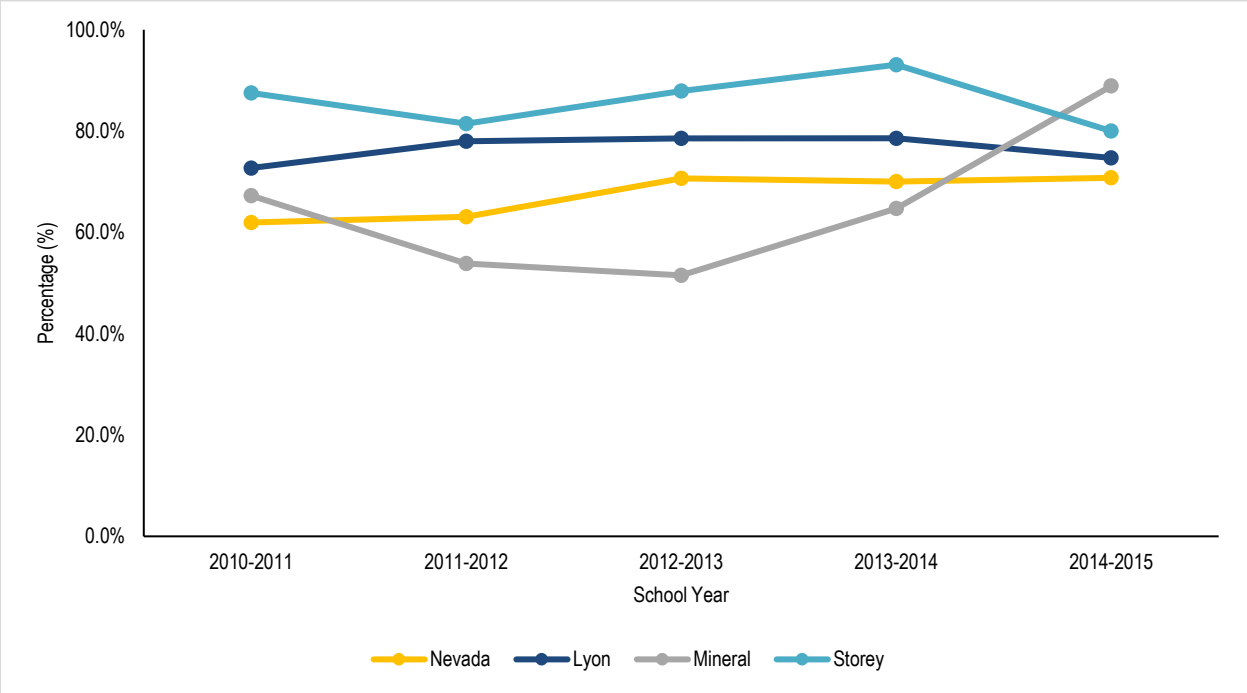


In terms of substance abuse among high school students in Healthy Communities Coalition, nearly 9% have used inhalants, the highest percentage of the select substances. About 7% have used ecstasy, 7% cocaine, and 4% of students have tried methamphetamines.

School Success

When students' behavioral health needs are not identified, they are more likely to experience difficulties in school, including higher rates of suspensions, expulsions, dropouts, and truancy, as well as lower grades. Nationally, 50% of students age 14 and older who are living with a mental illness drop out of high school. This is the highest dropout rate of any disability group.

Figure 31. High School Graduation Rates, Lyon, Mineral, and Storey County, 2011 – 2015 by Class Cohort.



Similar to Nevada, graduation rates have increased in all counties from the 2010-2011 class cohort to the 2014-2015 class cohort, except in Storey County. Graduation rates in the Lyon and Mineral are consistently higher than overall Nevada graduation rates for most years.

Conclusion

This report is intended to provide an overview of behavioral health in Lyon, Mineral, and Storey Counties. The analysis could be used to identify issues of concern and areas that may need to be addressed.

One finding is the number of visits to the ER by residents of the Healthy Communities Coalition for all mental disorders, and alcohol and drug-related issues have all increased during the time period from 2009 to 2014. Visits for PTSD had a percent change of 429%, the largest increase among the seven disorders. The ER visits for mental health disorders and treatment in SAPTA facilities appear to be sex-specific. For example, females made up a majority of ER visits for anxiety, depression, bipolar disorder, PTSD, and schizophrenia.

From 2009 to 2014, the trend for death rates in mental health-related deaths has increased. Similar to Nevada, mental and behavioral health-related deaths have increased from 206.4 to 224.5 deaths per 100,000 in the Healthy Communities Coalition.

For more information and additional publications, please visit Nevada Division of Public and Behavioral Health at http://dpbh.nv.gov/.