



2020 ANNUAL REPORT

RURAL REGIONAL BEHAVIORAL HEALTH POLICY BOARD

March 2021

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Rural Regional Behavioral Health Policy Board Members

December 2020

Fergus Laughridge
Board Chair
EMS Representative
Humboldt County

Amy Adams
Drug and Alcohol Counselor
White Pine County

Senator Pete Goicoechea
Elko, Eureka, White Pine
Counties

Matt Walker
CEO, William Bee Ririe
Hospital
White Pine County

Bryce Shields
Pershing County District
Attorney
Pershing County

Jeri Sanders
Sergeant, Eureka County
Sheriff's Office
Eureka County

Dr. Erika Ryst
Psychologist
Washoe County

Amanda Osborne
Director of Human Services
and Human Resources
Elko County

Brooke O'Byrne
Family Member
Representative
Washoe County

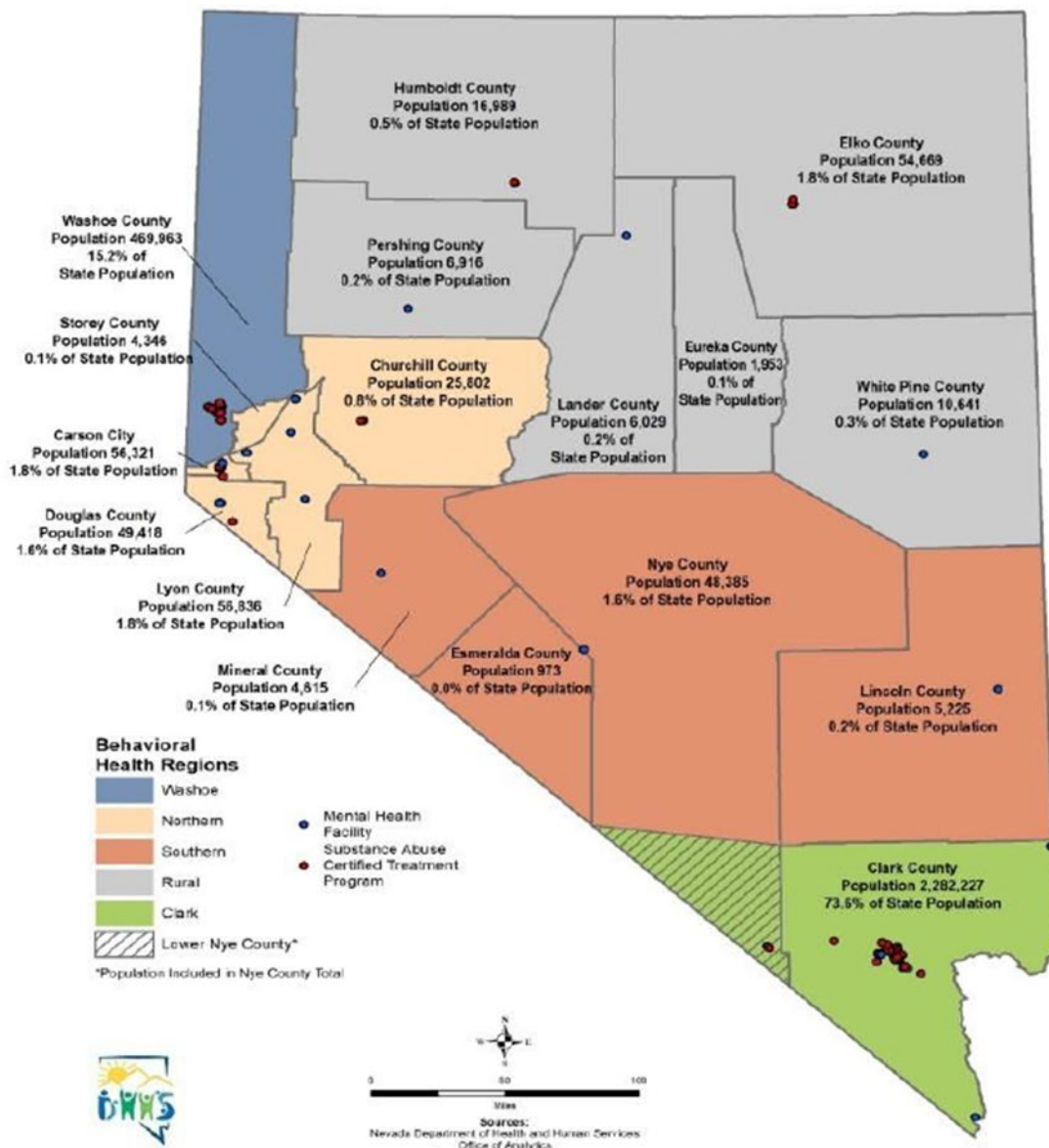
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Executive Summary

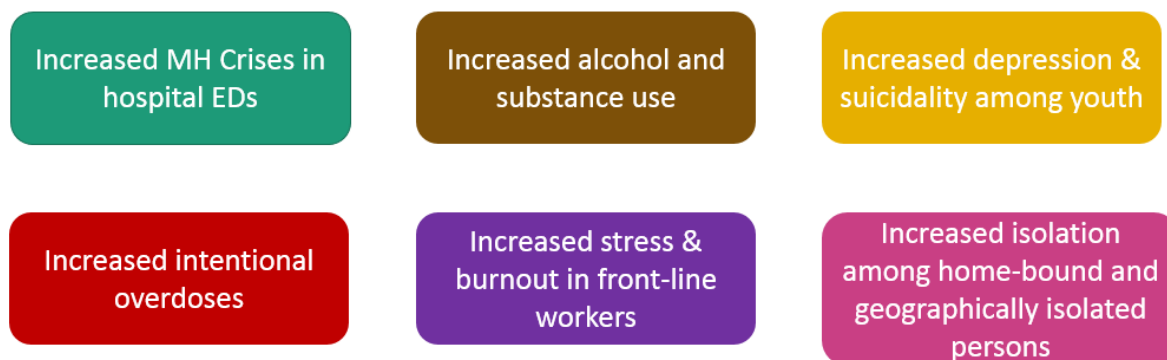
March 2021

The Rural Regional Behavioral Health Policy Board (Rural RBHPB) represents a six-county area in northeastern Nevada, including Elko, Eureka, Humboldt, Lander, Pershing, and White Pine Counties. The map below (Figure 2 from the 2020 Rural Behavioral Health Profile, which can be found in its entirety in Appendix B) illustrates the location of the Rural Region in grey, as well as the other four regions.



Like all other sectors, 2020 saw new challenges and increased strain on the regional behavioral health system due to the impacts of the COVID-19 pandemic and related response. As described in the next section, the region already experienced chronic shortages of behavioral health providers while facing increasing community need for treatment in the areas of anxiety, depression, substance misuse, and alcohol abuse. Many local healthcare providers reported to representatives of the Rural RBHPB or its unofficial support staff, the Rural Regional Behavioral Health Coordinator (Rural RBHC) that they experienced an initial wave of persons experiencing mental health crises presenting to local emergency departments (EDs) early in the pandemic, followed by a second wave of persons presenting to the EDs with emergencies related to substance or alcohol abuse. The list of major concerns voiced to the Rural RBHPB and the Rural RBHC are listed in the figure below.

Local Stakeholder Behavioral Health Concerns Related to COVID-19



Unfortunately, because all health care resources needed to be shifted to focus on COVID response and reporting, many of the databases used to collect this information have not been updated recently, and most of the information above is anecdotal. However, as communities are stabilizing in the Rural Region through early 2021, it is anticipated that data collection efforts will resume, and high-quality quantitative data will be available to back these concerns. However, it should be noted that the DOSE Reports (Appendix A) do support some of these concerns, which helps to substantiate other concerns voiced.

The Board itself also had difficulty meeting during 2020, as most Board members had “boots on the ground” responsibilities related to COVID response and limited staffing and resources. However, the Board focused its attention on the 81st session of the Nevada Legislature, and decided to build a BDR (now SB 44) to improve the paths to licensure for behavioral health providers wishing to practice in Nevada. At the time this report was written, the bill is moving through the legislative process and there has not been direct opposition voiced.

The Rural RBHC spent the majority of 2020 working with local stakeholders to connect them to new resources as they came available, and to help them build capacity for new programs and projects that would bolster access to behavioral health services. As Board members were tied up, the Rural RBHC also worked on behalf of the Board to hold workgroups to meet the Board’s

goals and address their priority areas. These included a BDR Development Workgroup resulting in development of the concepts for SB 44; a Statewide Behavioral Health Transportation Workgroup; participation in the Nevada Governor’s Challenge Team to end suicide among service members, veterans, and their families (SMVF) and advocating for two communities in the region to receive resources for “Expansion Teams”; collaboration with local prevention coalitions to utilize the Substance Misuse Specialist (SMS) program to connect Board priorities with local needs and projects; the development of technical assistance materials to aid local stakeholders in efforts to provide more high-quality programming; and many others.

Moving into 2021, the Board has the following recommendations to the Commission on Behavioral Health and any other state agency affecting behavioral health services in the Rural Region:

- I. Increase investments in Nevada Medicaid reimbursement for behavioral health services;**
- II. Increase resources and program choices to address the needs of high-risk populations, including youth, the elderly, and ethnic or racial minority groups;**
- III. Support programs that assist and support service members, veterans, and their families (SMVF) in a way that is competent to military culture;**
- IV. Support programs and funding that would increase the number of behavioral health providers across the state of Nevada;**
- V. And Support novel behavioral health transportation solutions and pilot programs.**

A full description of these recommendations begins on p. 25 of this report.

Data Highlights

While there are many sources of data which can be used to explore the current status of the behavioral health system and community needs across the region, this section will highlight resources that have been vetted as the most accurate and appropriate available.

Overdose Data to Action (OD2A) DOSE Reports, Sept-December 2020 (Appendix A)

The Nevada Overdose Data to Action (OD2A) program is granted by the CDC to the Division of Public and Behavioral Health (DPBH) in collaboration with the Nevada Public Health Training Center, seated within the University of Nevada, Reno. The overarching purpose of this program is to improve the quality of data reported regarding the frequency, location, and means of opioid and stimulant overdose across Nevada, and to then use that data to improve the quality, access, and connection to care.

One of the products of the OD2A program are monthly DOSE Reports, outlining suspected hospital emergency department visits related to drug use for the region, contrasted against the state as a whole. The reports that were publicly posted for the Rural Region in 2020 are those for September through December, and can be found in Appendix A.

What we can glean from the DOSE Reports is that there was an **overall increase in drug-related emergency department visits among hospitals in the Rural Region throughout 2020**. This matches anecdotal data reported by health care personnel who identified an increase in the number of persons that were presenting in local hospital emergency departments who were there for either suspected overdoses or for injuries that seemed to be exacerbated by substance use.

Learn more about this program at nvopioidresponse.org/od2a

Nevada Rural and Frontier Health Data Book, Tenth Edition (2021)

The Nevada Office of Statewide Initiatives released the updated addition of the Nevada Rural and Frontier Health Data book in March 2021, which included county-level data collected as recently as 2020 in some cases. Below are the highlights from this publication.

- Across the Rural Region, the percent of adults reporting excessive alcohol consumption slightly decreased from 2010 to 2018 for the counties with data recorded at both intervals, with the exception of White Pine County, which increased from 12.6% to 20.9% within that time frame (Table 4.5, p.82).
- Use of marijuana, vaping products, cigarettes, and reported binge drinking tended to be higher among high school students surveyed in 2019 than in counties outside the Rural Region (Table 4.6, p. 83).

- The percent of pregnant women abstaining from alcohol consumption in 2018 in Elko County was reported at only 66.1% and in White Pine County at 76.0%, while other counties within the Rural Region reported numbers well above 90% (Table 4.15, p.92).
- Suicide was the 9th leading cause of death across all rural and frontier Nevada counties in 2018 (Table 4.29, p.106).
- Across all rural and frontier counties in Nevada, there were six Psychiatric APRNs licensed and practicing in 2020. Four of which were located in Elko County, one in Pershing County, and one outside the Rural Region in Churchill County (Table 5.12, p.128).
- In 2020, all rural and frontier counties in Nevada were classified as Mental Health Professional Shortage Areas. Clark County was also included under the same classification (Map 5.3, p.137).
- All counties in the Rural Region have inadequate local availability of licensed Alcohol and Drug Counselors, Clinical Alcohol and Drug Counselors, and Certified Problem Gambling Counselors (Table 5.20, p.138)
- All counties in the Rural Region have inadequate local availability of Licensed Marriage and Family Therapists and Licensed Clinical Professional Counselors (Table 5.21, p.139).
- There are no licensed psychiatrists located in any counties included in the Rural Region (Table 5.23, p.141).
- There is only one licensed psychologist located within the Rural Region, in Elko County (Table 5.24, p.142).
- There are 29 Licensed Clinical Social Workers located within the Rural Region; 20 of which are located in Elko County (Table 5.26, p.144).

To see the Nevada Rural and Frontier Health Data Book (10th ed.) in its entirety, visit:

<https://med.unr.edu/statewide/reports-and-publications>

2020 Rural Behavioral Health Profile (Appendix B)

The points below summarize some of the highlights from the 2020 Rural Behavioral Health Profile, prepared by the SAPTA branch of the Nevada Division of Public and Behavioral Health (DPBH). The full profile can be found in Appendix B for reference.

- In 2019, high school students in the Rural Region reported an increase in feeling sad and hopeless over reports from 2017. However, there were decreases across the region in self-reported consideration of suicide, planning, and attempting suicide (Figure 8a).
- In 2019, middle school students in the Rural Region reported slight decreases in feeling sad or hopeless, consideration of suicide, and suicide plans or attempts (Figure 8b).
- In 2019, anxiety and depression were associated the majority of mental health-related emergency department encounters for adults across the Rural Region (Figure 12).
- In 2019, depression, followed closely by anxiety, was the highest contributing factor to mental health-related inpatient admissions among adults in the Rural Region (Figure 13).
- In 2019, white non-Hispanic persons from the Rural Region, followed closely by those identifying as American Indian/Alaskan Native non-Hispanic, were the highest utilizers of state-funded mental health clinical services (Figure 17).

- In 2019, the percentage of adults in the Rural Region reporting they had considered suicide slightly increased to 6.1% from 5.8% in 2018. In 2017, this prevalence was only 0.7% (Figure 19).
- From 2016 – 2019, the most notable means of attempting suicide utilized among adults in the Rural Region was the use of substances or drugs (Figure 20).
- In 2019, the reported prevalence of cigarette use among high school students in the Rural Region (36.1%) was approximately double that of the Nevada as a whole (18.0%) (Figure 30a).
- In 2019, the reported prevalence of cigarette use among middle school students was also higher in the Rural Region (15.7%) than the state as a whole (9.9%) (Figure 30b).
- Alcohol use among high school students in the Rural Region has consistently seen small decreases from 2015 through 2017 (Figure 32a).
- Marijuana use among Rural Region high school students has remained somewhat stable from 2015 to 2019 (Figure 33a), but in middle school students has increased in 2019 after decreases in 2017 (Figure 33b).
- In 2019, the misuse of prescription drugs (without a prescription) remains the highest reported means of lifetime drug use among high school students in the Rural Region (Figure 34a). The same goes for middle school students in the Rural Region (34b).
- In 2019, the prevalence of adults in the Rural Region who used marijuana or “hash” to get high thirty days prior to the survey increased to 21.5% from 11.6% in 2018 and 5.1% in 2017 (Figure 35).
- Drug-related inpatient hospital admissions among adults in the Rural Region overtook alcohol-related admissions in 2018 and remained the larger contributor during 2019 (Figure 40).
- Inpatient admissions related to marijuana and methamphetamine use among adults in the Rural Region have steadily increased since 2010 (Figure 41).
- Self-reported sexual activity and related behaviors have steadily decreased among high school students in the Rural Region from 2015 to 2019 (Figure 46).
- In 2019, self-reported prenatal alcohol use was overtaken by marijuana use by mothers who gave birth in the Rural Region in 2019 (Figure 50).
- The rate of neonatal abstinence syndrome (NAS) increased in 2019 to 4.2 per 1,000 births from 2.5 in 2018 (Figure 51).

2020 Rural Regional Behavioral Health Policy Board Activities

The following subsections describe the actions taken by the Rural Regional Behavioral Health Policy Board over the course of 2020 to improve the behavioral health system within the Rural Region.

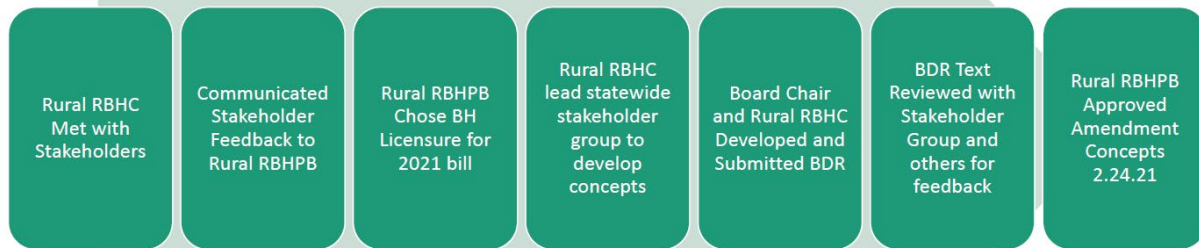
Development of Senate Bill 44

Throughout 2019 and 2020, the Rural Regional Behavioral Health Coordinator (Rural RBHC) met with local, regional, and state-level stakeholders to identify their challenges regarding behavioral health in the Rural Region. Provider shortages were consistently named one of the main challenges in building out more robust behavioral health programming. As 2020 began, the Rural RBHC started having more targeted conversations with stakeholders regarding what the Policy Board could focus on this legislative session to improve the behavioral health system. Requests to address the behavioral health licensing boards, particularly regarding licensure by endorsement, floated to the top as a primary concern that could be affected by NRS.

From there, the Rural RBHC and the Rural RBHPB collaborated regarding what issues stakeholders were experiencing and what policy changes could be made that would be appropriate material for the Board's bill during the 81st session of the Nevada Legislature. Additionally, several members of the Rural RBHPB had also experienced challenges when recruiting behavioral health providers to their organizations from out of state, and then finding that the process for them to gain Nevada licensure often took months at best, or at worst, they would be required to by their licensing boards to complete years of additional school or internship work, regardless of their past professional experience. Thus, on July 21, 2020, the Board voted to focus its bill for the 2021 legislative session on issues regarding behavioral health provider licensure and specifically, removing barriers to licensure for qualified professionals.

After this point, a statewide workgroup was launched to build out the concepts for the BDR that included a broad variety of stakeholders. When all was said and done, nearly 45 stakeholders who were invited to these workgroup meetings, approximately 25-35 of which participated. This stakeholder group included invitations out to the executive directors of each of the licensing boards that would be affected, as well as other members of their Boards as requested. Other stakeholders included representatives from peer advocacy organizations, such as NAMI Nevada, NAMI Western Nevada, and the Foundation For Recovery; Nevada Medicaid; behavioral health provider organizations and some providers themselves; rural hospitals and healthcare organizations; the office of statewide initiatives; Chairs from the other Regional policy boards and their RBHCs, and many others.

Bill Development Process



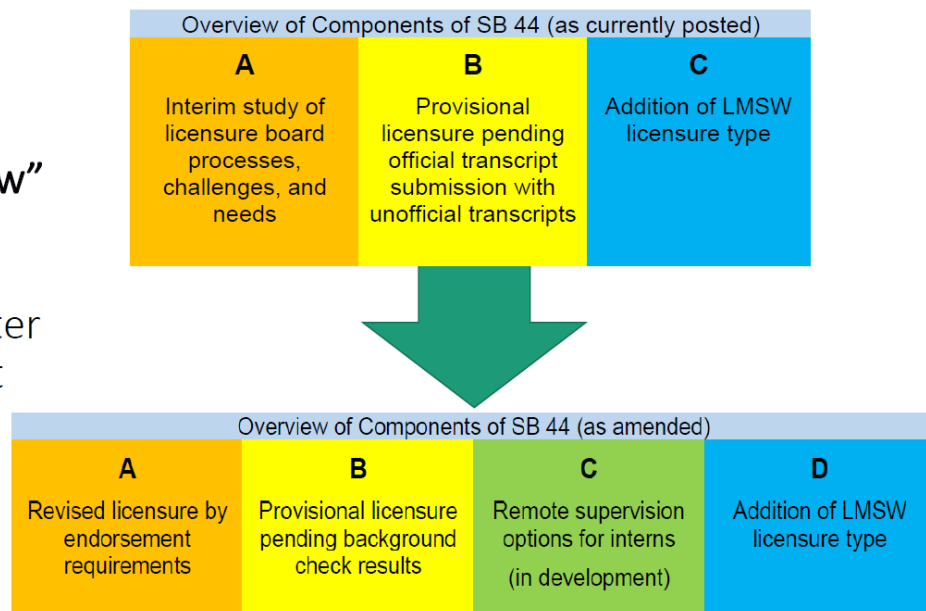
Based on the work completed within the BDR development workgroup, the Chair of the Rural Regional Behavioral Health Policy Board and the Rural RBHC developed and submitted the concepts of the BDR to the Legislative Counsel Bureau (LCB) for drafting. After the language for the bill had been published, the Chair and Rural RBHC held further meetings with key stakeholders to gain further feedback regarding next steps and possible amendments.

At the time of the writing of this report, amendments concepts have been submitted to the LCB in anticipation of upcoming work sessions on the bill. The following graphic illustrates how the Rural Regional Behavioral Health Policy Board intends the bill to change NRS as amended.

The Rural RBHPB hopes to improve and further expedite licensure by endorsement processes by streamlining language and removing unnecessary barriers to licensure by endorsement. Additionally, provisional licensure will be offered for applicants who have submitted fingerprints as per requirements but are awaiting results. It has come the attention of the Rural RBHPB that many organizations who manage fingerprinting are backlogged and this causes delays of several weeks and sometimes month in the receipt of results to licensing boards. Adding into statute that an otherwise qualified applicant may begin practice using a provisional licensure, pending these background check results, can assist in getting the applying provider integrated into their new practice and seeing clients much more quickly that current processes allow.

“40,000 ft. View”

What SB 44
Before and After
Amendment



Next the bill includes language that will codify in NRS that the licensing boards must make arrangements to allow for remote supervision of interns who are completing their professional practice work pre-licensure. While NSHE institutions have come together to offer online degree program options for rural residents, it then becomes nearly impossible for graduates of these programs to complete their required practice hours for licensure, due to a shortage of qualified supervisors. By providing options for remote supervision of interns, not only are rural interns more likely to be able to complete their practice hours and achieve licensure, but they will have more access to supervisors who utilize specific modalities or particular specialties (such as working with youth, minority populations, etc.).

Last, the bill includes language that creates a fourth licensure type to be offered by the Nevada Board of Examiners for Social Workers, the Licensed Master of Social Work (or LMSW). Nevada is currently one of only five states that do not offer this type of licensure, which makes challenges for the Board of Social Work to enter into interstate compacts for licensure reciprocity. Furthermore, without offering an LMSW licensure, there is no professional designation for licensure between social workers who hold only a bachelor's degree or a masters degree. Thus, the addition of the LMSW provides an opportunity for social workers who have taken the extra step to complete an approved advanced degree in social work to have a professional distinction. The LMSW licensure also serves as an intermediate step between the bachelors level certification, LSW, and more advanced designations required to work with behavioral health clients, such as the Licensed Clinical Social Worker, or LCSW. This language was developed by the Board of Social Work itself, and also allows for current LSWs licensed in Nevada who hold a masters level degree or higher to be smoothly transitioned over to the LMSW licensure type without any action on their part, if SB 44 is to be passed.

Board Meetings and Presentations

Meeting Title, Date and Location	Topic
Regular Board Meeting February 25, 2020, Division of Public and Behavioral Health Building, Carson City, NV and via Zoom	Reappointment of Board members; approval of the Board's 2019 Annual Report; regional updates and RBHC activities.
Regular Board Meeting April 28, 2020, via Zoom only	Letter of Support for Nevada Office of Suicide Prevention grant application; Discussion regarding the development of Board bi-laws; regional behavioral health system updates and RBHC activities.
Regular Board Meeting June 23, 2020, via Zoom only	CANCELLED – Quorum not met
Regular Board Meeting July 21, 2020, via Zoom only	Development of the Rural Regional Behavioral Health Policy Board's BDR for the 81 st session of the Nevada Legislature; RBHC activities; DPBH updates.

Like their counterparts who comprise other regional policy boards, the members of the Rural Regional Behavioral Health Policy Board are decision makers, influencers, or otherwise work within an administrative capacity in their chosen professions. However, the organizations the board members work for in the Rural Region tend to be much smaller, and so their work is less insulated from the “boots on the ground” demands of responding to COVID-19. This is further exacerbated by chronic shortages of qualified personnel to fill skilled positions and staff turnover or absences due to quarantine or illness. Thus, it was very difficult for the Board to meet and achieve a quorum throughout most of the pandemic response.

Knowing this, the Board granted the Board Chair and the Rural RBHC permission to develop and submit the bill draft request (BDR) on behalf of the Board, knowing that another meeting might not be feasible without making quorum. For more information regarding the process of BDR development, please see the above section.

Rural Regional Behavioral Health Coordinator Activities

The section below outlines the many of the activities undertaken by the Rural Regional Behavioral Health Coordinator (Rural RBHC) throughout 2020.

Effects of COVID-19

Before discussing the projects below, it must be acknowledged that the advancement of most projects over 2020 were stunted by the COVID-19 pandemic. While the Rural RBHC was not directly involved in pandemic response, nearly all the partners involved in these projects were forced to turn their attention and resources to COVID, allowing little time or bandwidth to move forward with existing behavioral health projects. Furthermore, staff turnover due to burnout or personal crises, compounded by staff who were sidelined for quarantine or illness, further restricted the resources available to partner organizations, and thus further stunted progress.

Travel

Due to the COVID-19 pandemic, travel across the region was severely limited for almost all of 2020. Luckily, most programs and meetings that were not put on hold to focus resources on pandemic response were able to continue through the use of online meeting platforms, such as Zoom, GoToMeeting, or Microsoft Teams.

Due to medical issues, it is unlikely that the Rural RBHC will be able to begin normal travel until later summer or fall 2021.

Overdose Data to Action (OD2A) Program – Substance Misuse Specialists (SMS)

One of the overarching goals of implementing the Substance Misuse Specialist (SMS) positions through the OD2A program is to provide assistance to the Regional Behavioral Health Policy Boards and their RBHCs to achieve the Board's objectives. The SMSs are seated within local prevention coalitions and provide boots-on-the-ground assistance and local expertise for projects undertaken in conjunction with the RBHC or Board.

The Rural RBHC collaborated with the directors of PACE Coalition (serving Elko, Eureka, and White Pine Counties) and Frontier Communities Coalition (also called FCC, which serves Pershing, Humboldt, and Lander Counties) to build out workplans for the SMSs that included the following strategies: to assist with the improvement of local data collection and reporting related to behavioral health, with the goal of having timely and accurate information about the current status of behavioral health needs in local communities; to assist with building out and piloting local behavioral health task forces and multi-disciplinary teams (MDTs); and to provide other technical assistance to community groups regarding best practices and connecting community members in need to care for substance misuse or co-occurring disorders.

In the first quarter of the calendar year, advances were made in creating connections with law enforcement and local hospitals to explore options regarding data that could be collected. It was the intent to work with law enforcement to collect dispatch data related to behavioral health calls on a monthly basis. Data regarding the incidence of mental health crisis holds (previously known as “Legal 2000 holds” or “L2Ks”) are available from Nevada Rural Hospital Partners from their member hospitals, which include four of the five hospitals located within the Rural Region. However, to get a full picture of the scope of behavioral health issues within a community, sub-crisis data is also needed to fully understand the burden of mental illness and substance misuse in these communities. The team of SMSs and the Rural RBHC contacted local hospitals to identify what primary care and inpatient data might be readily available for analysis, focusing on categories of ICD-10 codes.

During this same time, the Rural RBHC and the SMS reached out to identify the appetite and stakeholders for the development of behavioral health task forces (BHTFs) in White Pine and Eureka Counties.

However, as response to the COVID-19 pandemic increased its intensity across the Rural Region the law enforcement and health care partners with which we were working had to focus their attention and resources on protecting their respective communities. As time wore on, we found that staff turnover and overwhelm at hospitals had left quite a bit of data reporting lagging that didn’t relate to COVID-19 directly. Additionally, while the behavioral health needs of communities increased, the pressure to manage COVID response kept these stakeholders from being able to engage in activities that would build capacity for BHTFs and connection to care.

The Rural RBHC and the SMS team pivoted to shift focus on developing technical assistance materials that would be easily digestible for partner organizations when they were ready to re-engage in behavioral-health focused initiative. One of these projects was the development of a listing of training regarding program planning and evaluation, as skill in these areas is becoming increasingly important in writing successful grant applications for these badly needed programs. Some local stakeholders have requested funding for programs, but in many cases, have not been awarded grants due to the lack of preparation and knowledge of adequate program and evaluation plans to be submitted for highly competitive grants. A one-page flyer and webpage were worked on through fall 2020 and completed in early 2021.

Another project undertaken at this time was to compile a comprehensive listing of call lines available to residents within the Rural Region. While some of these call lines are specific to communities and towns within the region, many of which are statewide and available to all Nevadans. This project is set to be completed in late March or early April 2021.

It is hoped that over the course of 2021 that the efforts to build out more robust data collection programs and BHTFs in the region will be salvaged and the Rural RBHC and SMSs can resume discussions and partnerships to improve information sharing, referral networks, and connection of community members to care.

Zero Suicides

The Rural RBHC worked throughout the year to assist the State’s Zero Suicides Program Coordinator to engage health care partners in the Rural Region. Furthermore, the Rural RBHC

performed two seminars within the Nevada Zero Suicides Academy (which had been modified to an online format to accommodate social distancing protocols) regarding strategic planning for Zero Suicides initiatives and organizational policy development. These seminars and their supporting materials are archived in the Nevada Zero Suicides Box that is available to all participants of the academy.

The Rural RBHC was also contacted by the Statewide Zero Suicides Coordinator to assist Humboldt General Hospital (Winnemucca, NV) with their efforts to launch the initiative. The hospital underwent leadership and staffing changes throughout 2020 that further supported implementation. While progress towards development and roll-out of the initiative remained slow over the course of the year to accommodate for increased volumes of persons presenting to the hospital in crisis, small steps forward were made and contact was maintained through the end of 2020. It is hoped that as the hospital rolls out expanded behavioral health programming by the end of 2021, the Zero Suicides initiative will move through the rest of the hospital simultaneously.

It has been more difficult for the other hospitals and health care organizations in the Rural Region to maintain efforts to incorporate the Zero Suicides model into their policies and practices, but contact has been maintained with the Statewide Coordinator and further assistance is available.

Collaboration with Other Regional Behavioral Health Coordinators

The Rural RBHC maintained consistent contact and continued to build relationships with the other RBHCs remotely throughout the year. Collaborative efforts of note included:

- Scheduling of all-RBHC and Board Chair BDR check-in groups leading up to the legislative session to ensure communication and collaboration regarding each Board's bill
- Collaboration with the Southern RBHC on rural transportation options; recorded webinar available at the Rural RBHC YouTube page: "Nevada Rural Regional Behavioral Health Coordinator" (<https://www.youtube.com/channel/UCNiNco2y8Y2QhtiGXsUbr-q>)
- Collaboration with the Northern RBHC to build out a Multi-Disciplinary Team (MDT) Guidebook for use by communities interested in launching an MDT

The Rural RBHC also collaborated with the other RBHCs as needed on countless other projects, programs and needs throughout the course of the year.

Governor's Challenge Team and Expansion Teams

In early 2020, Nevada was granted participation in the SAMHSA and VA joint initiative of having a Governor's Challenge Team to end suicide among service members, veterans, and their families (SMVF). The purpose of these teams is to utilize a multi-disciplinary approach to change policies and programs at the state level to decrease the number of suicides seen in the SMVF population. The Rural RBHC participated in the Nevada Governor's Challenge Team and had the opportunity to travel to Washington D.C. for the multi-state policy academy to kick-off

the initiative and begin to form the Team's strategic plan. The Nevada Team focused on the following strategies: improving transitions from military to civilian life; promote connectedness and caring contacts; and identify SMVF and screen for (suicide) risk. While the work of the Nevada Team was temporarily paused to make time for members to adequately participate in COVID-19 response, the work of the team picked back up at the end of 2020 and the Rural RBHC will be attending the implementation academy and participating in other presentations in 2021.

Based on Nevada's success with the Governor's Challenge Team and two Mayor's Challenge Teams (Truckee Meadows – Reno/Sparks, and Las Vegas), Nevada was offered the opportunity for two expansion teams. The Rural RBHC worked with staff at the Nevada Department of Veterans' Services who is leading the other initiatives and identified Elko and Winnemucca as the most appropriate and prepared sites for the expansion teams.

The expansion teams are preparing to launch in Spring 2021.

Evidence-Based Practices and Programs

While there are many evidence-based programs (EBP) available for use at the local level to address substance use disorder, substance misuse, and mental illness, many local agencies may be at a loss to sift through these resources to find one that best fits the needs of the population they're serving and meet intended program goals if not prescribed by a funding agency. To improve access to reputable programs and communicate them to larger populations, the Rural RBHC began compiling EBPs into an online guide page. Resources included in this guide include those from SAMHSA, Federal DHHS, CIT International, KnowCrisis.org, University of Columbia's Lighthouse Project, the VA, USDA, PsychHub, Zero Suicides, and many others. The EBPs are organized by target audience to assist users in selecting the practice that works best for their proposed grant program or project.

The project is nearing completion and is set to launch by the end of March 2021.

Engagement with Prevention Coalitions

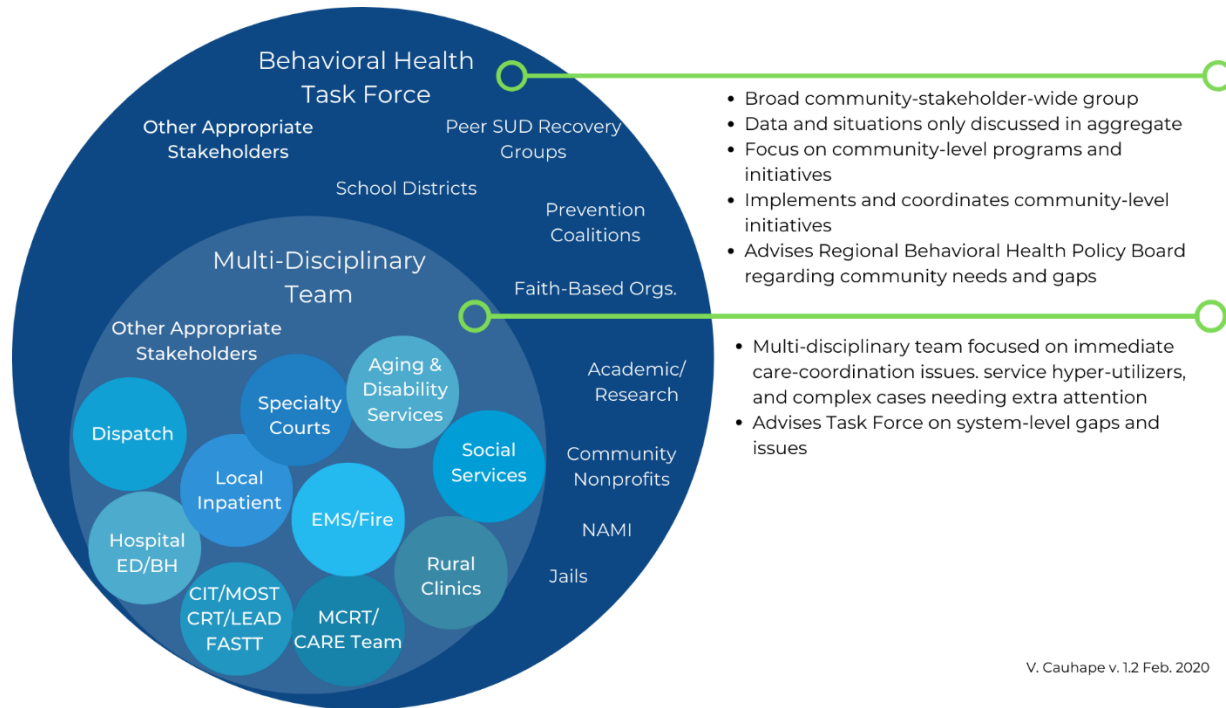
Throughout 2020, the Rural RBHC concentrated on increasing collaboration and communication with the local prevention coalitions, PACE Coalition (Elko, Eureka, and White Pine Counties) and Frontier Communities Coalition (Pershing, Humboldt, and Lander Counties). This improved communication proved crucial as State programs focusing on community response to COVID-19 began to materialize and direct ties within the local communities were needed. Examples of this collaboration include: the SMS program, the Nevada Resilience Project roll-out, exploration of behavioral health task forces (BHTFs), letters of support written by the Rural RBHC on behalf of grants written by the coalitions for behavioral health funding programs, and others.

Relationships with both coalitions remain strong going into 2021.

Task Forces and Multi-Disciplinary Teams

As previously discussed in the previous sections, some progress has been made over the past year in developing behavioral health task forces (BHTFs) and multi-disciplinary teams (MDTs).

Feedback from stakeholders was taken into consideration to update the graphic below that describes the difference between BHTFs and MDTs.



Additionally, the table below summarizes the current status of BHTFs and MDTs across the Rural Region:

County	Task Force and MDT Status
Humboldt County	Humboldt County Task Force – Undergoing strategic planning. No MDT yet. Interested in piloting MDT Toolkit materials upon completion.
Elko County	Multiple community groups which complete the activities of a Task Force. Progress on MDT formation paused due to focus on COVID response.
Eureka County	Early meetings held; progress paused due to COVID response.
White Pine County	
Pershing County	Pershing FCC meeting designated as Task Force. Development efforts paused for COVID response.
Lander County	Outreach difficult; efforts paused due to COVID response.

Assistance with HGH Crisis Center

After leadership changes at Humboldt General Hospital (HG) in Winnemucca, NV, the hospital resolved to address the increased pressure for crisis services entering the emergency department by bolstering behavioral health services offered by the hospital itself. The hospital decided to first open a behavioral health clinic within the main facility, followed by opening a crisis stabilization center on the hospital campus to serve the Interstate 80 corridor by the end of 2021.

The Rural RBHC has worked with HGH administration and staff to ensure they have access to information to assist with opening the crisis stabilization center in a way that aligns with the Crisis Now model.

Statewide Transportation Workgroup

Gaps in the availability of appropriate and accessible transportation to and from behavioral health services is a major problem across Nevada, regardless of community or level of urbanity. After discussing possibilities with the other RBHCs, the Rural RBHC started the Statewide Behavioral Health Transportation Workgroup to open a forum for statewide discussion of challenges and resources, as well as a way to communicate solutions that may otherwise remained siloed.

The workgroup began meeting in the summer of 2020, and was comprised of stakeholders from local coalitions, the Nevada Department of Transportation, hospitals, advocacy groups, Nevada Medicaid, the other RBHCs, and many others. By the end of 2020, the workgroup had split focus onto three priority areas: (1) development of a statewide resource guide for behavioral health services; (2) work with Regional Transportation Authorities to ensure that community behavioral health needs are included in local and regional transportation plans; and (3) exploration of a collective transportation model for behavioral health transportation that would bring multiple jurisdictions together to create a seamless network for safe and secure services.

At the end of 2020, meetings had been paused until the statewide resource guide was ready to be presented to the workgroup. Meetings will resume upon completion of the resource guide.

Closing

The sections above highlight the larger projects undertaken by the Rural RBHC during 2020. However, for the sake of brevity, this description is not completely exhaustive and there were many smaller projects and activities undertaken to support the improvement of the behavioral health system in the Rural Region not listed here.

2021 Rural Regional Behavioral Health Board Priorities

At the Board's meeting on February 24, 2021, members reviewed the Board's 2020 priorities and updated and adjusted them for 2021. The following priorities will guide the work of both the Board and its Regional Behavioral Health Coordinator.



Transportation

The Rural Region is characterized by large distances from larger towns and cities, which often carry the majority of specialized behavioral health services. Currently, community members in crisis who require inpatient care must travel to Reno, Las Vegas, Twin Falls (Idaho), or Salt Lake City (Utah). If they are able to get to these services, it usually by way of law enforcement protective escort, ambulance (which may not be secure), or by emergency medical flight. These means of transportation are not appropriate for the needs of the patient, limit the resources available in the community for other emergencies, and are overly costly. Furthermore, they may not be covered by private or public insurance, causing patients or providers to shoulder the financial burden.

Once a person is stabilized and released from inpatient crisis care, they may not have a means to travel to their home community if they do not have a friend or family member who can pick them up and bring them home. For example, persons released from treatment in Las Vegas who need to return to counties within the Rural Region may have to take a series of buses, oftentimes with layovers or connections in Salt Lake City, Utah. Without access to necessary medications, this lengthy trip home may result in the person becoming unstabilized, disoriented, and sometimes even missing connections and getting "lost" in an unknown city.

While efforts have been made to improve the access to non-emergency behavioral health transportation to care for persons who may not otherwise be able to drive themselves or find a ride to regular appointments, most services still fall short in meeting this need. Additionally, it is difficult for special populations, such as veterans and youth, to access these services in a way that also allows them to stay stable in their work and/or school lives in most communities.



Medicaid/CMS Reimbursement for Behavioral Health Services

At the beginning of 2020, the Rural Regional Behavioral Health Policy Board targeted increasing the reimbursement rates for behavioral health services that could be billed to Nevada Medicaid as one of their priorities. However, with the closures related to the COVID-19 pandemic, the efforts of most behavioral health-focused advocacy groups shifted to protecting reimbursement and coverage for existing services, as state agencies were asked to make devastating cuts to services.

Previous to COVID, the majority of persons within the rural region seeking the most urgent, and thus most expensive, services were covered by Medicaid. As 2020 wore on through the pandemic, the volume of persons in crisis increased, most of whom were still those covered by public insurance, such as Medicaid or Medicare.

As the Nevada economy stabilizes, the Board is re-focusing on attempting to improve provider reimbursement for all behavioral health services to help improve the ability of providers to take these patients. As it stands, overhead costs for provider organizations cannot be met on Medicaid or Medicare reimbursement alone, and so the number of these patients that providers are able to see is often limited. By improving reimbursement rates, it is theorized that existing providers may be able to take on more Medicaid and/or Medicare patients in their practices, and thus better meet the needs of our rural Communities.



Behavioral Health Workforce Development

Nevada faces a chronic shortage of providers for nearly all types of health care and wellness services, and unfortunately, behavioral health is not exempt from this shortage. It can be difficult to recruit experienced providers from out of state to move their practice to Nevada for several reasons, one of them includes difficulty in attaining Nevada licensure.

The Rural Regional Behavioral Health Policy Board is working to ameliorate this issue by using their bill for the 2021 legislative session affecting language in statute regarding licensure by endorsement (that for providers coming from out of state), as well as to provide better options for interns in Nevada to gain access to appropriate supervisors in order to complete their practice hours and achieve licensure.

However, the Board realizes that there are many factors that affect the availability of the behavioral health professionals in the rural

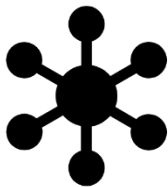
region, and across Nevada as a whole. Efforts will be made to identify further strategies that may be undertaken outside of the legislative session to bolster the number of appropriate behavioral health professionals available to meet the needs of Nevadans.



Data Quality

The quality of data that is available continues to be a tripping point in Nevada as organizations work to assess population or community needs, and how they can best be met. While state agencies have made great strides in improving data collection processes, there is a great deal more that can be done, most of which can be addressed at the local level.

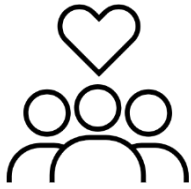
The Rural Regional Behavioral Health Policy Board and its RBHC will work to support local stakeholders in identifying ways that locally-collected data can be improved for quality, as well as to help some stakeholders find value in additional data collection efforts.



Interagency Communication and Partnership

As many stakeholder organizations are busy undertaking their work, there may not be a great deal of time or perceived necessity for communication with outside stakeholders regarding program developments or challenges. Many local-level stakeholders depend on community provider meetings hosted by prevention coalitions as forums for open communication regarding updates, which has resulted in many fruitful partnerships and program developments over the last several years. However, there is still a need for improved data sharing, referral processes, and other forms of partnership that fall outside the responsibility of the prevention coalitions. Taking these partnerships to a more formal level, such as the use of Memorandums of Understanding (MOUs) or other forms of business agreements, will help improve communications within the system between organizations regionally, as well as better prepare local stakeholders to apply for larger grants that can assist with much-needed programming.

The Rural Regional Behavioral Health Policy Board and its RBHC will work to identify ways they can support and encourage local stakeholders to take these next steps in improving the formality and strength of local and state partnerships.



Youth, Elder, and Minority Services

Over the course of 2020, it became apparent that while all community members have been impacted by shutdowns and other changes related to the COVID-19 response, particular concerns arose regarding specific populations, including youth and young adults, the elderly, and racial or ethnic minority groups such as members of indigenous tribes or Hispanic groups. Data provided by the Division of Public and Behavioral Health (Appendix B) indicates that these populations may be the most vulnerable to increased suicidality or substance use in the wake of the COVID-19 pandemic, and care must be made to provide high-quality and appropriate services to these community members.

The Rural Regional Behavioral Health Policy Board has chosen to include improving access to culturally, linguistically, and/or age-appropriate services to these community members as one of their priorities.



Veterans' Services

It has been brought to the Board's attention by the Nevada Office of Veterans' Services that the Rural Region has a high proportion of community members who are currently or have previously served in the U.S. Armed Forces. However, many service members, veterans, and their families (SMVF) have limited provider options if they are covered by Tricare, and most specialty services for Veterans are only offered at facilities located in Reno, Las Vegas, or Salt Lake City, UT, requiring hours or days of travel for appointments or even minor procedures. Furthermore, data from the Division of Public and Behavioral Health (Appendix B) shows that there was a greater incidence of persons presenting to hospitals with apparent PTSD per 100,000 population that in other regions. The Board feels that this indicates a greater need for access to high quality care for individuals who have served within our region.

The Rural Regional Behavioral Health Policy Board wishes to honor the service of the SMVF population and to find ways to improve the quality and accessibility of services available.

Current Recommendations to the Commission on Behavioral Health

The Rural Regional Behavioral Health Policy Board is making the following recommendations to the Commission on Behavioral Health. These recommendations align with the Board's priorities and will not only improve the behavioral health system in the Rural Region, but the state as a whole.

I. Increase investments in Nevada Medicaid reimbursement for behavioral health services

While the business closures and other restrictions related to controlling the spread of COVID-19 in Nevada heavily impacted state budgets, the need for behavioral health services by Nevadans covered by Medicaid have been more dire than ever. Improving investments in these services now may help to mitigate more long-term negative effects to population mental health and substance use outcomes across the state in the wake of the COVID-19 pandemic.

II. Increase resources and program choices to address the needs of high-risk populations, including youth, the elderly, and ethnic or racial minority groups.

Specific populations had been seeing greater issues related to behavioral health in Nevada previous to the COVID-19 pandemic, much of which has been exacerbated during the pandemic response. These groups include the elderly, children, adolescents, and young adults of all racial or ethnic groups, as well as BIPOC communities specifically. Programs and policies to address these needs must focus on being culturally competent (or moreover, culturally respectful) and age appropriate (including use of technology).

III. Support programs that assist and support service members, veterans, and their families (SMVF) in a way that is competent to military culture.

While Nevada is widely considered a "veteran-friendly state", it is sometimes forgotten that the armed forces instills their own cultures and values, which often stay with members and their families long after service is over. In terms of behavioral health, some strategies that may work for the general population do not work for SMVF populations, and special considerations must be made. Examples of foundational work to be done include: (1) Encouraging or mandating non-veteran organizations such as hospitals, schools, or others to ask upon admission whether or not the individual has ever served, or if they are a part of a military family; (2) changing language on intake forms from "Are you a veteran?" to "Have you ever served in the U.S. Armed Forces?", as many U.S. veterans may not consider themselves such if they never saw combat; (3)

providing ways to increase and/or expedite access for SMVF populations to access behavioral health services; and (4) understanding that the use and relationship to lethal means and reduction of which for suicide prevention is influenced by military culture, and special considerations may need to be made.

IV. Support programs and funding that would increase the number of behavioral health providers across the state of Nevada.

While the Rural Regional Behavioral Health Policy Board has worked to positively affect the availability of behavioral health professionals in the state through the development and introduction of SB 44, much more work is needed to resolve chronic provider shortages across the health care system as a whole, and behavioral health care systems specifically. Partners that will need to be involved in developing these solutions include NSHE institutions, existing provider organizations, licensing boards, public and private insurers, health care organizations, and others. While the Rural Regional Behavioral Health Policy Board will continue work to address provider shortages, a statewide effort must be made to address this statewide issue.

V. Support novel behavioral health transportation solutions and pilot programs

There are few states who share Nevada's geographic mix of large urban centers surrounded by large rural and frontier areas. Thus, there are few "tried and true" solutions to rural transportation problems that can be modeled, and those available are from states with different payor mixes and funding streams than what is available in Nevada. Piloting new programs to address behavioral health transportation needs should be encouraged through the availability of flexible funding and assistance with program planning and evaluation. Engagement with NSHE institutions for this assistance could be a means of providing high-quality assistance in a cost-effective manner.

APPENDIX A: OD2A DOSE REPORTS

Suspected Nevada Drug Overdose Surveillance Monthly Report

September 2020: Rural Region – *For internal planning purposes only*

The Centers for Disease Control and Prevention (CDC) Overdose Data to Action (OD2A) is a program that supports state, territorial, county, and city health departments in obtaining more comprehensive and timelier data on overdose morbidity and mortality. The program is meant to enhance opioid overdose surveillance, reporting, and dissemination efforts to better inform prevention and early intervention strategies. The information contained in this monthly report highlights suspected overdose morbidity within rural region counties (Humboldt, Pershing, Lander, Eureka, Elko, and White Pine) in Nevada utilizing emergency department (ED) visits data from the National Syndromic Surveillance Program as of: August 31, 2020.

Report Highlights:

- Suspected drug-related ED visit rates increased by approximately 33% from July to August 2020 in the Rural Region.
- Suspected drug-related ED visit rates increased by approximately 43% from August 2019 to August this year in the Rural Region.

Figure 1. Suspected monthly rates for drug-related ED visits in Nevada and Rural Region (per 10,000 population)

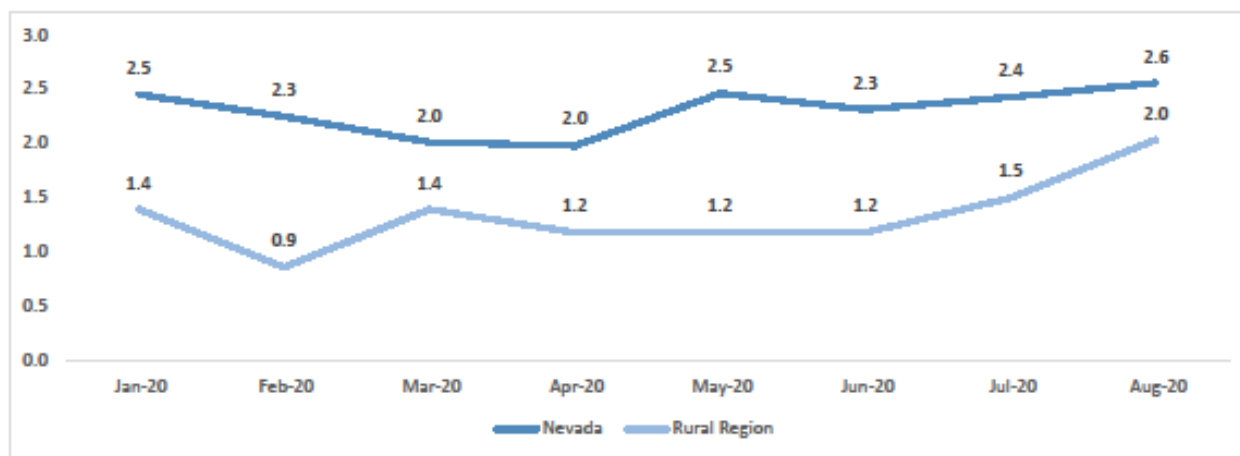
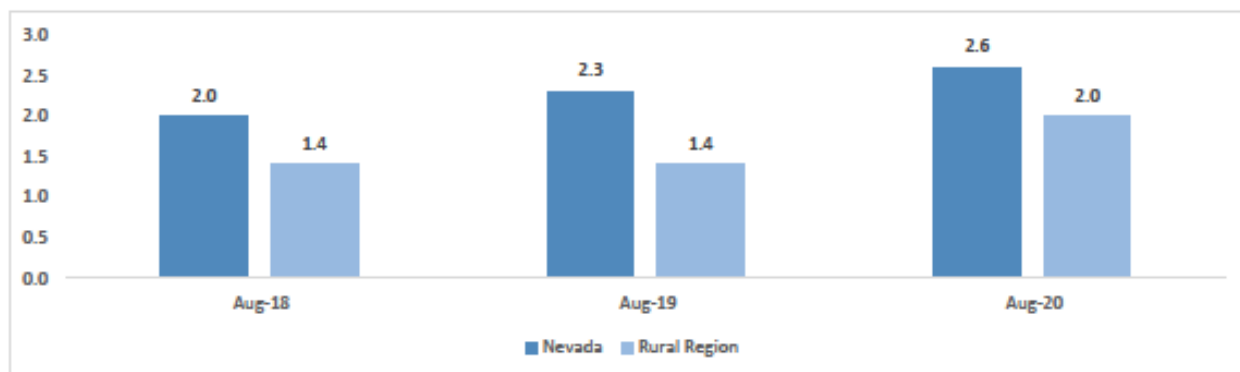


Figure 2. Suspected rates for drug-related ED visits in Nevada and Rural Region, August 2018-2020 (per 10,000 population)



Technical Notes:

Data Sources: National Syndromic Surveillance Program is a near real-time method of categorizing visits to the ED across Nevada based on a patient's chief complaint and/or discharge diagnosis.

Case definitions: Case definitions and queries for suspected all drug ED visits are created and provided by CDC and include chief complaint keywords and ICD-10-CM discharge diagnosis codes.

Analysis: ED visit rates per 10,000 population were calculated using 2019 Census Bureau data. ED visit counts with less than 10 counts for any month were not included.

Limitations: Statewide, the National Syndromic Surveillance Program is estimated to capture approximately 80% of Nevada emergency department visits, and thus may underestimate the occurrence of overdoses across the state. Since not everyone who overdoses is able to make it to the ED, this report may underestimate the total overdose burden in the state.

Address questions/comments to Nevada OD2A's opioid epidemiologist, Shawn Thomas, MPH, at shawnt@unr.edu.



Suspected Nevada Drug Overdose Surveillance Monthly Report

October 2020: *Rural Region* – For internal planning purposes only

The Centers for Disease Control and Prevention (CDC) Overdose Data to Action (OD2A) is a program that supports state, territorial, county, and city health departments in obtaining more comprehensive and timelier data on overdose morbidity and mortality. The program is meant to enhance opioid overdose surveillance, reporting, and dissemination efforts to better inform prevention and early intervention strategies. The information contained in this monthly report highlights suspected overdose morbidity within rural region counties (Humboldt, Pershing, Lander, Eureka, Elko, and White Pine) in Nevada utilizing emergency department (ED) visits data from the National Syndromic Surveillance Program as of: September 30, 2020.

Report Highlights:

- Suspected drug-related ED visit rates remained stable from August to September 2020 in the Rural Region.
- Suspected drug-related ED visit rates increased by 11% from September 2019 to September this year in the Rural Region.

Figure 1. Suspected monthly rates for drug-related ED visits in Nevada and Rural Region (per 10,000 population)

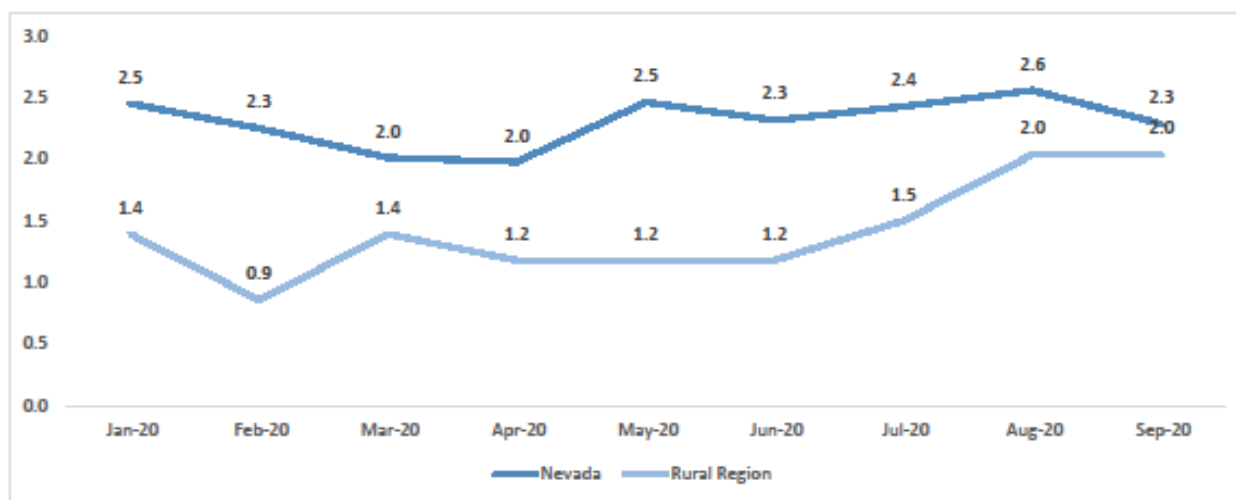
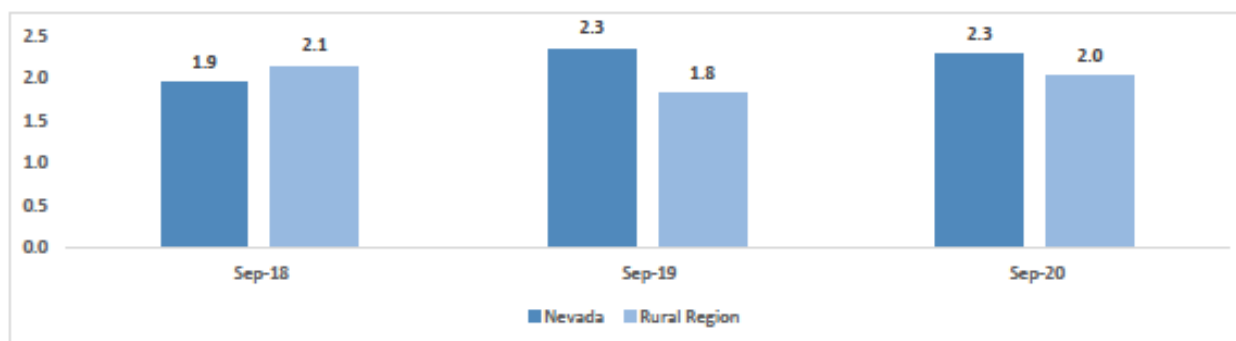


Figure 2. Suspected rates for drug-related ED visits in Nevada and Rural Region, September 2018-2020 (per 10,000 population)



Technical Notes:

Data Sources: National Syndromic Surveillance Program is a near real-time method of categorizing visits to the ED across Nevada based on a patient's chief complaint and/or discharge diagnosis.

Case definitions: Case definitions and queries for suspected all drug ED visits are created and provided by CDC and include chief complaint keywords and ICD-10-CM discharge diagnosis codes.

Analysis: ED visit rates per 10,000 population were calculated using Census Bureau estimates. ED visit counts with less than 10 counts for any month were not included.

Limitations: Statewide, the National Syndromic Surveillance Program is estimated to capture approximately 80% of Nevada emergency department visits, and thus may underestimate the occurrence of overdoses across the state. Since not everyone who overdoses is able to make it to the ED, this report may underestimate the total overdose burden in the state.

Address questions/comments to Nevada OD2A's opioid epidemiologist, Shawn Thomas, MPH, at shawnt@unr.edu.



Suspected Nevada Drug Overdose Surveillance Monthly Report

November 2020: Rural Region

The Centers for Disease Control and Prevention (CDC) Overdose Data to Action (OD2A) is a program that supports state, territorial, county, and city health departments in obtaining more comprehensive and timelier data on overdose morbidity and mortality. The program is meant to enhance opioid overdose surveillance, reporting, and dissemination efforts to better inform prevention and early intervention strategies. The information contained in this monthly report highlights suspected overdose morbidity within rural region counties (Humboldt, Pershing, Lander, Eureka, Elko, and White Pine) in Nevada utilizing emergency department (ED) visits data from the National Syndromic Surveillance Program as of: **October 31, 2020**.

Report Highlights:

- Suspected drug-related ED visit rates **decreased by 15%** from September to October 2020 in the Rural Region.
- Suspected drug-related ED visit rates **decreased by 19%** from October 2019 to October this year in the Rural Region.

Figure 1. Suspected monthly rates for drug-related ED visits in Nevada and Rural Region (per 10,000 population)

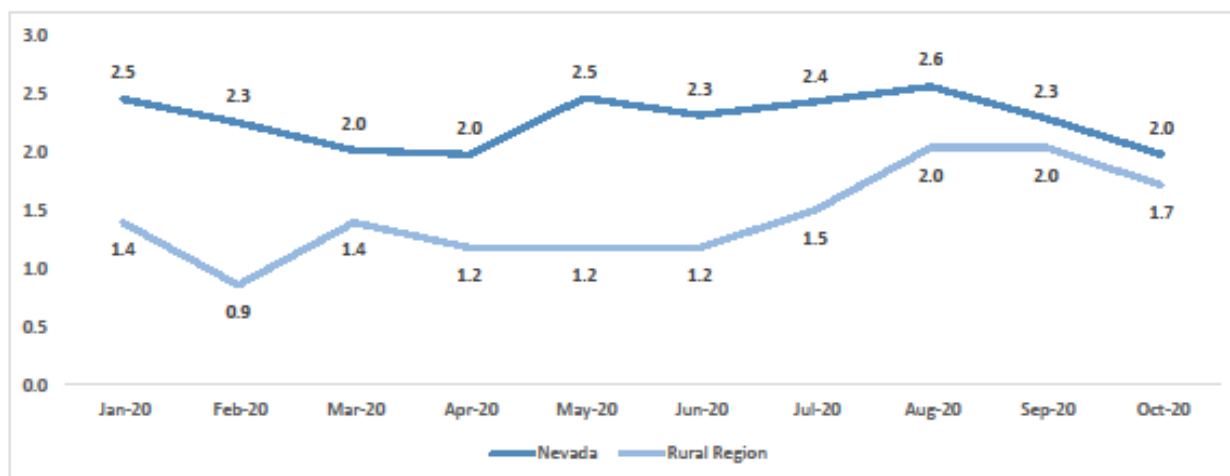
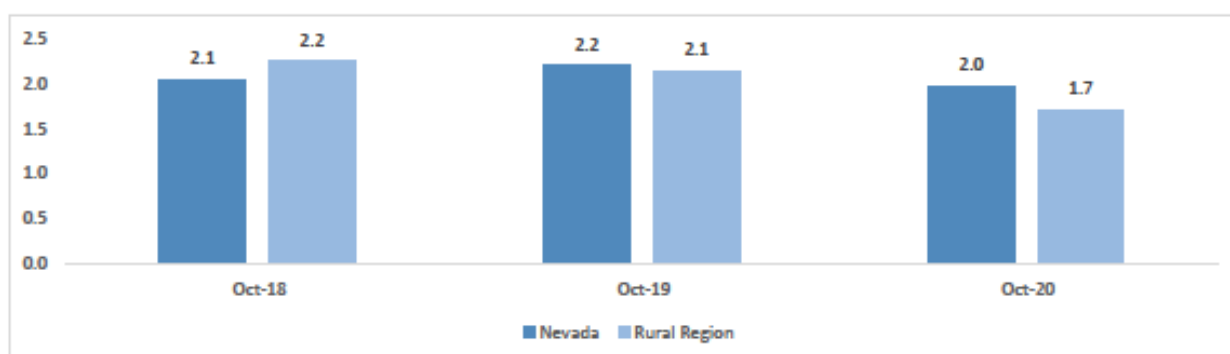


Figure 2. Suspected rates for drug-related ED visits in Nevada and Rural Region, October 2018-2020 (per 10,000 population)



Technical Notes:

Data Sources: National Syndromic Surveillance Program is a near real-time method of categorizing visits to the ED across Nevada based on a patient's chief complaint and/or discharge diagnosis.

Case definitions: Case definitions and queries for suspected all drug ED visits are created and provided by CDC and include chief complaint keywords and ICD-10-CM discharge diagnosis codes.

Analysis: ED visit rates per 10,000 population were calculated using Census Bureau estimates. ED visit counts with less than 10 counts for any month were not included.

Limitations: Statewide, the National Syndromic Surveillance Program is estimated to capture approximately 80% of Nevada emergency department visits, and thus may underestimate the occurrence of overdoses across the state. Since not everyone who overdoses is able to make it to the ED, this report may underestimate the total overdose burden in the state.

Address questions/comments to Nevada OD2A's opioid epidemiologist, Shawn Thomas, MPH, at shawnt@unr.edu.



Suspected Nevada Drug Overdose Surveillance Monthly Report

December 2020: Rural Region

The Centers for Disease Control and Prevention (CDC) Overdose Data to Action (OD2A) is a program that supports state, territorial, county, and city health departments in obtaining more comprehensive and timelier data on overdose morbidity and mortality. The program is meant to enhance opioid overdose surveillance, reporting, and dissemination efforts to better inform prevention and early intervention strategies. The information contained in this monthly report highlights suspected overdose morbidity within rural region counties (Humboldt, Pershing, Lander, Eureka, Elko, and White Pine) in Nevada utilizing emergency department (ED) visits data from the National Syndromic Surveillance Program as of: November 30, 2020.

Report Highlights:

- Suspected drug-related ED visit rates **increased by 10%** from October 2020 to November 2020 in the Rural Region.
- Suspected drug-related ED visit rates **decreased by 10%** from November 2019 to November this year in the Rural Region.

Figure 1. Suspected monthly rates for drug-related ED visits in Nevada and Rural Region (per 10,000 population)

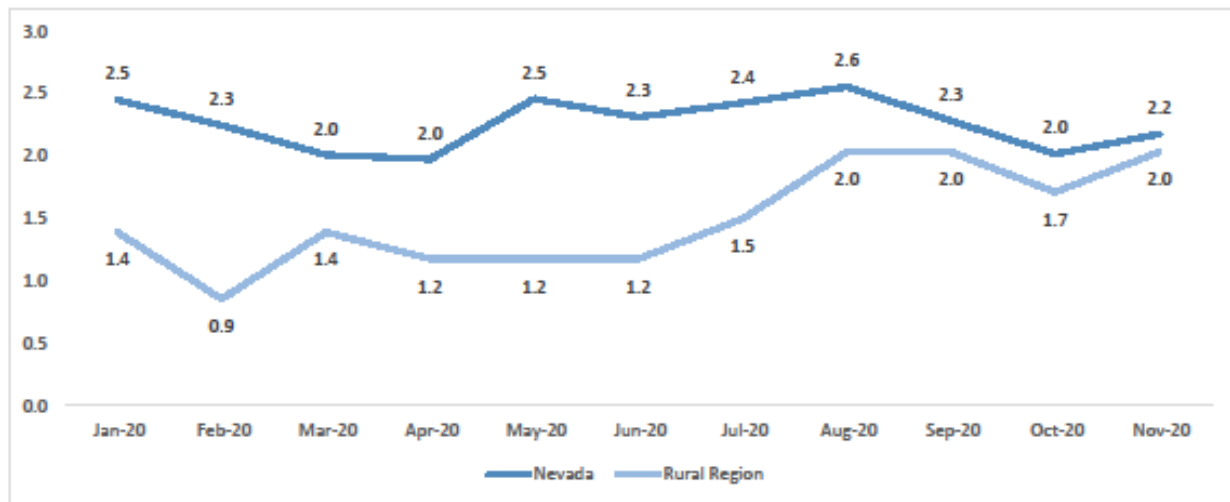
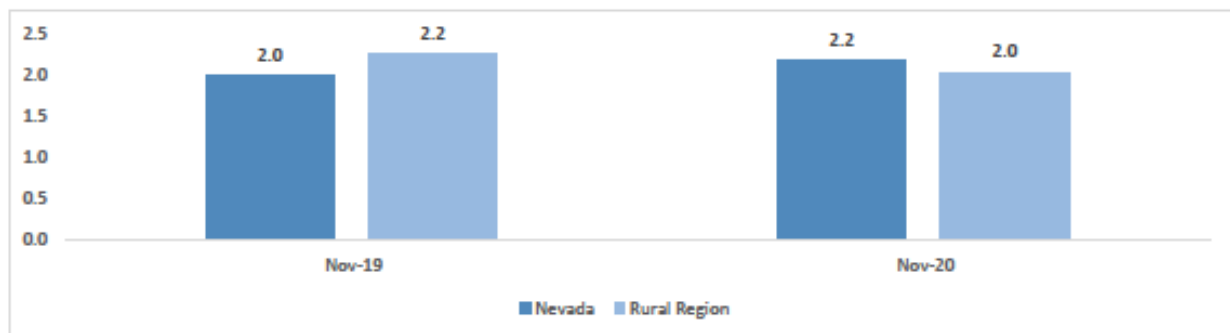


Figure 2. Suspected rates for drug-related ED visits in Nevada and Rural Region, November 2019-2020 (per 10,000 population)



Technical Notes:

Data Sources: National Syndromic Surveillance Program is a near real-time method of categorizing visits to the ED across Nevada based on a patient's chief complaint and/or discharge diagnosis.

Case definitions: Case definitions and queries for suspected all drug ED visits are created and provided by CDC and include chief complaint keywords and ICD-10-CM discharge diagnosis codes.

Analysis: ED visit rates per 10,000 population were calculated using Census Bureau estimates. ED visit counts with less than 5 counts for any month were not included.

Limitations: Statewide, the National Syndromic Surveillance Program is estimated to capture approximately 80% of Nevada emergency department visits, and thus may underestimate the occurrence of overdoses across the state. Since not everyone who overdoses is able to make it to the ED, this report may underestimate the total overdose burden in the state.

Address questions/comments to Nevada OD2A's opioid epidemiologist, Shawn Thomas, MPH, at shawnt@unr.edu.



**APPENDIX B:
2020 BEHAVIORAL
HEALTH PROFILE,
RURAL REGION**

DRAFT

Accessibility Disclosure

We understand the importance of making reports accessible to everyone and if you have any problems related to the accessibility or you need any enhanced accessibility, please email data@dhhs.nv.gov.

2020 Rural Behavioral Health Profile

*Elko, Eureka, Humboldt, Lander, Pershing, and White
Pine Counties*

February 2021

Office of Analytics on behalf of



Nevada Department of Health and Human Services

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Acknowledgements

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Behavior Survey**

Data Sources/Limitations/Terminology

Age-Adjusted Rates

A rate is a measure of the frequency of a specific event over a given period, divided by the total number of people within the population over the same period 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 states may include and pay for their own questions in the survey. While the survey’s focus is chronic disease and injury, topics covered by the survey include car safety, obesity, and exercise among many others. Since state-added questions are not asked nationwide, these questions are not comparable.

Crude Rates

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

Hospital Billing Data (Emergency Department Encounter and Inpatient Admissions)

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

Nevada Report Card

The Nevada Report Card is the accountability reporting website of the Nevada Department of Education. In compliance with federal and state law, it assists community members (parents, educators, researchers, lawmakers, etc.) in locating a wealth of detailed information pertaining to K-12 public education in Nevada. The 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](#).

United States Census Bureau

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

Web-Enabled Vital Records Registry Systems (WEVRRS)

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

Youth Risk Behavior Survey (YRBS)

The purpose of the YRBS is to provide Nevada data to assess trends in priority health-risk behaviors among high school students, measure progress toward achieving national health objectives for Healthy People 2020 and other program and policy indicators and evaluate the impact of broad school and community interventions at the national, state, and local level. The YRBS is a biennial, anonymous, and voluntary survey of students in 9th through 12th grade in traditional, public high schools that monitors the prevalence of health risk behaviors among youth. The survey asks students to self-report their behaviors in six major areas of health that directly lead to morbidity and mortality; these include: (1) Behaviors that contribute to unintentional injuries and violence; (2) Sexual behaviors that contribute to human immunodeficiency virus (HIV) infection, other sexually transmitted diseases, and unintended pregnancy; (3) Tobacco use; (4) Alcohol and other drug use; (5) Unhealthy dietary behaviors; and (6) Physical inactivity. For more information on YRBS: [UNR YRBS](#).

Purpose

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

Demographic Snapshot

Figure 1. Selected Demographics for Rural Region.

Population, 2019 estimate*	97,257
Population, 2010 estimate*	90,213
Population, percentage change*	7.4%
Male persons, 2019 estimate*	51,135 (52.7%)
Female persons, 2019 estimate*	46,122 (47.3%)
Median household income, Rural Region (2019) **	\$60,827
Persons in poverty, percent, Rural Region (2019) **	11.4%
With a disability, under the age 65 years, percent, 2015-2019, Rural Region**	7.5%
Land area (square miles), 2019**	51,389

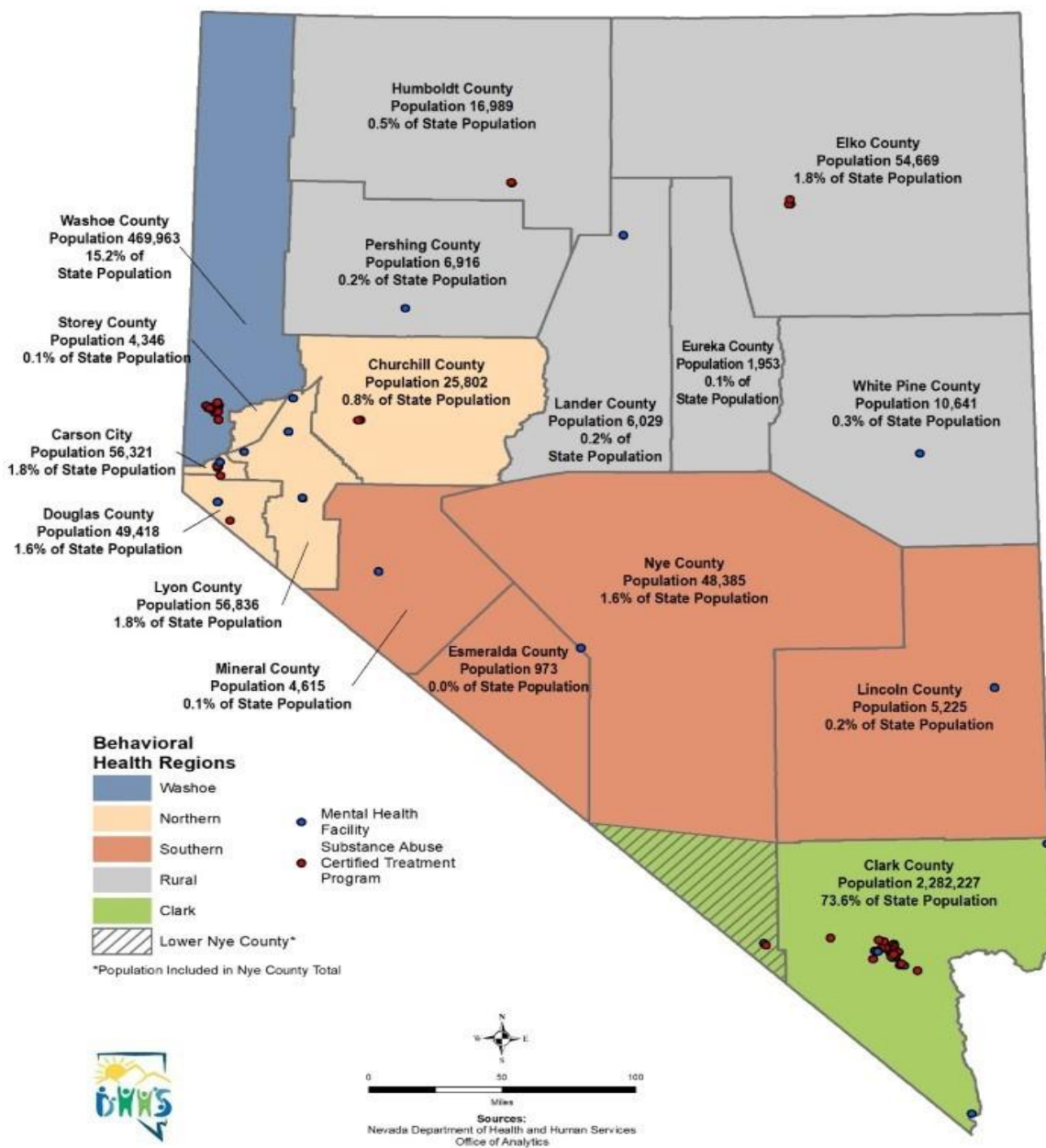
Source: *Nevada State Demographer, vintage 2019 and **US Census Bureau.



In 2019, the estimated population for the Rural Region was 97,257, a 7.4% increase from the 2010 estimated population. There are more males than females in the Rural Region. The median household income is \$60,827.

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

Figure 2. Nevada Population Distribution by County, 2019.



Source: Nevada State Demographer, vintage 2019.

Clark Region: Clark County and southern Nye County.

Northern Nevada Region: Carson City, Churchill, Douglas, Lyon, and Storey Counties.

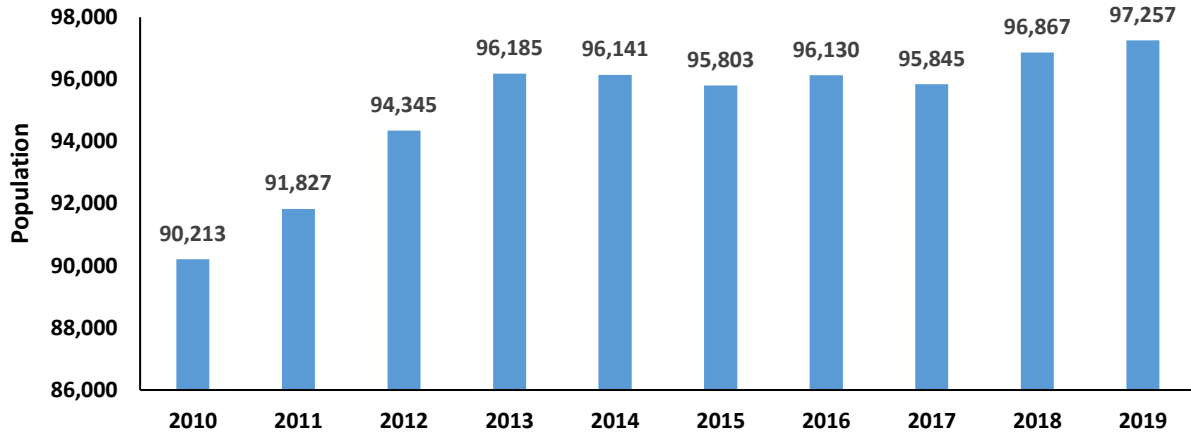
Rural Region: Elko, Eureka, Humboldt, Lander, Pershing, and White Pine Counties.

Southern Region: Esmeralda, Lincoln, Mineral, and northern Nye Counties.

Washoe Region: Washoe County.

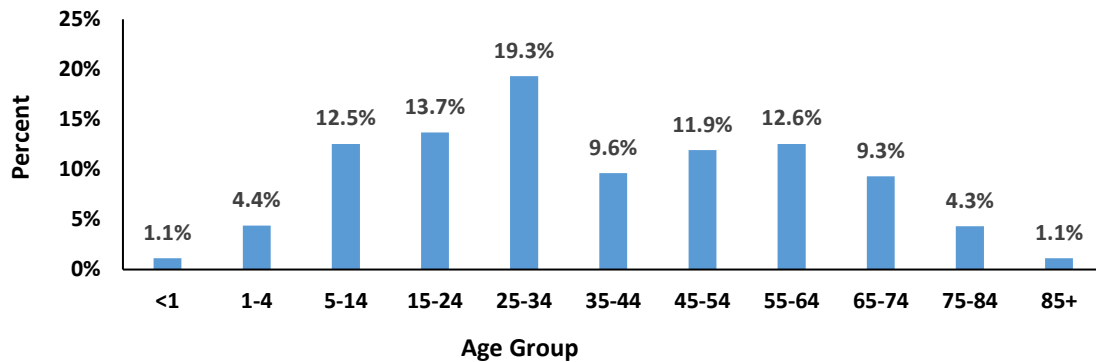
*Nye County: Northern Nye County is included in Southern Region and southern Nye County is in part of Clark County Region. For data purposes, Nye County data is included in Southern Region Report and not in the Clark County Region report.

Figure 3. Rural Region Population, 2010-2019.



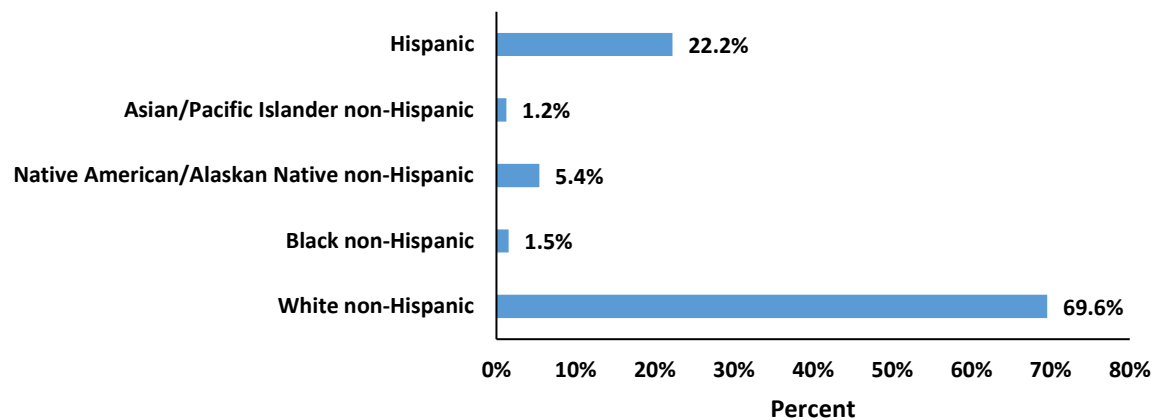
Source: Nevada State Demographer, vintage 2019.
Chart Scaled to display differences among groups.

Figure 4. Rural Region Population by Age Group, 2019.



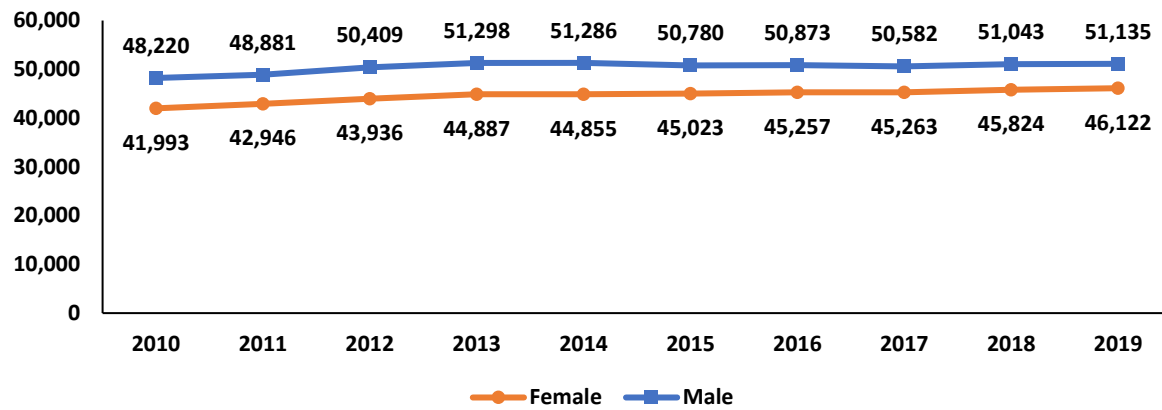
Source: Nevada State Demographer, vintage 2019.
Chart scaled to 25% to display differences among groups.

Figure 5. Rural Region Population by Race/Ethnicity, 2019.



Source: Nevada State Demographer, vintage 2019.
Chart scaled to 80% to display differences among groups.

Figure 6. Rural Region Population Distribution by Sex, 2010-2019.



Source: Nevada State Demographer, vintage 2019.

The male population in the Rural Region has been higher than the female population for the last 10 years, with 51,135 males and 46,122 females in 2019.

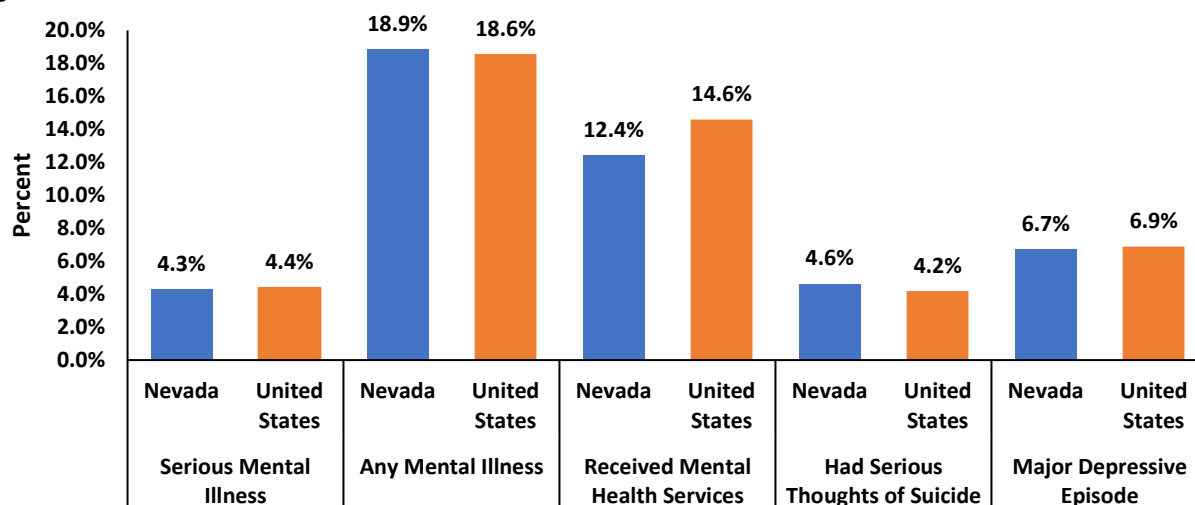
Mental Health

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

National Survey of Drug Use and Health

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

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



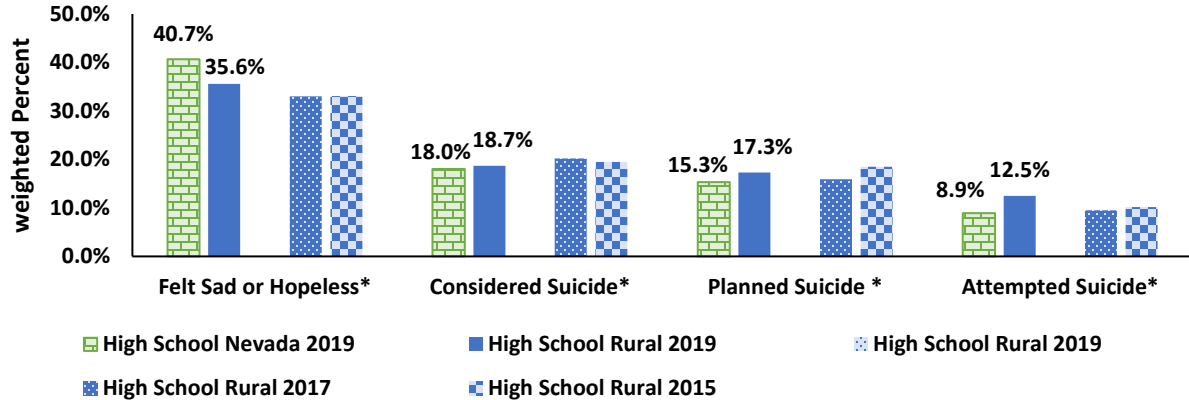
*SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2016-2017.
Chart scaled to 20% to display differences among groups.*

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

Youth Risk Behavior Survey (YRBS)

and disabilities among youth and adults. Nevada high school and middle school students are surveyed during the odd numbered years. In 2019, 585 school, and 570 middle school students participated in the YRBS in the Rural Region. The University of Nevada, Reno maintain the YRBS data and publishes data on each survey. For more information on the YRBS survey, please go to the following site: [UNR YRBS](#)

Figure 8a. Mental Health Behaviors, Rural Region High School Students 2015, 2017, and 2019, and Nevada High School Students, 2019.



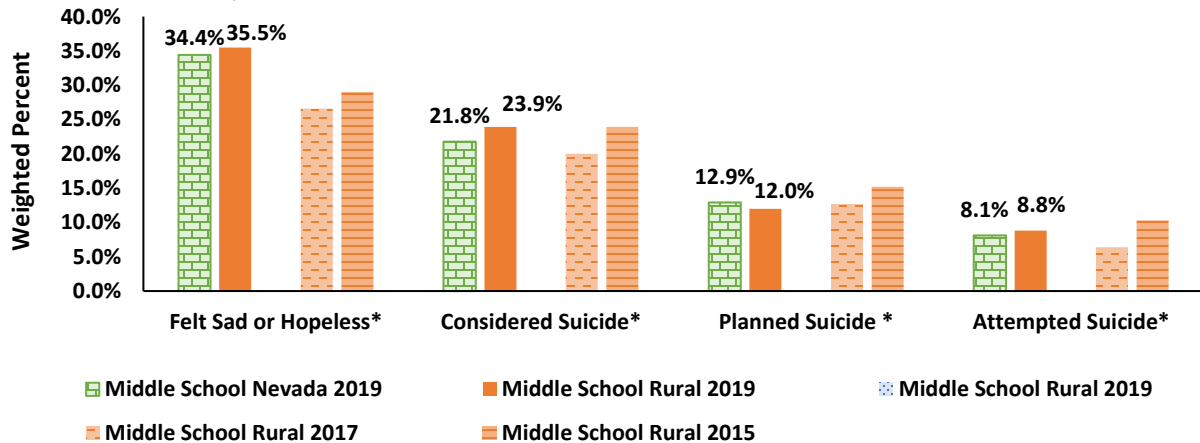
Source: Nevada Youth Risk Behavior Survey (YRBS).

Chart scaled to 50% to display differences among groups.

*Questions worded differently in 2019 and therefore not comparable to previous years.

The questions relating to suicide and feelings of sadness and hopelessness were worded differently from 2019 to past years and therefore should not be compared.

Figure 8b. Mental Health Behaviors, Rural Region Middle School Students 2015, 2017, and 2019, and Nevada Middle School Students, 2019.



Source: Nevada Youth Risk Behavior Survey (YRBS).

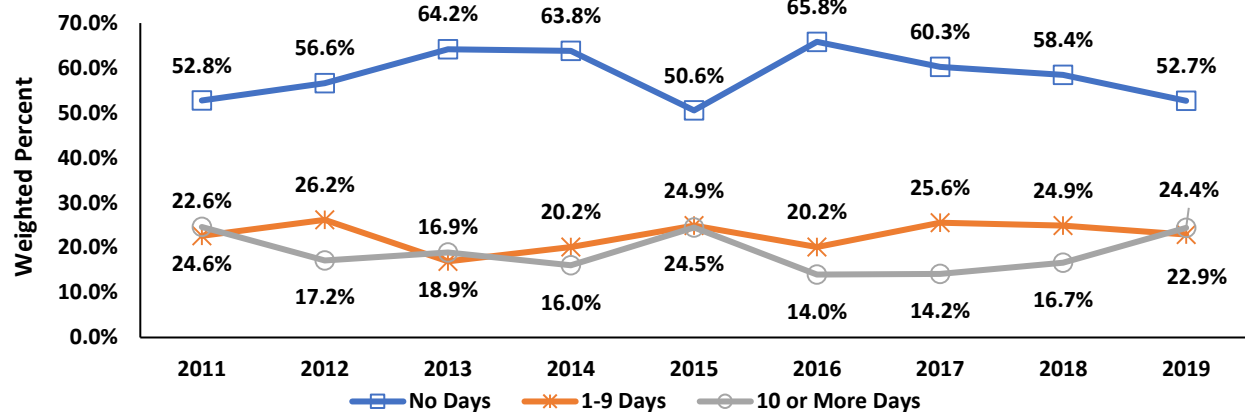
Chart scaled to 45% to display differences among groups.

*Questions worded differently in 2019 and therefore not comparable to previous years.

Behavioral Risk Factor Surveillance System (BRFSS)

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

Figure 9. Percentages of Adults Who Experienced Poor Mental or Physical Health that Prevented Them from Doing Usual Activities by Days Affected in Past Month, Rural Region, 2011-2019.



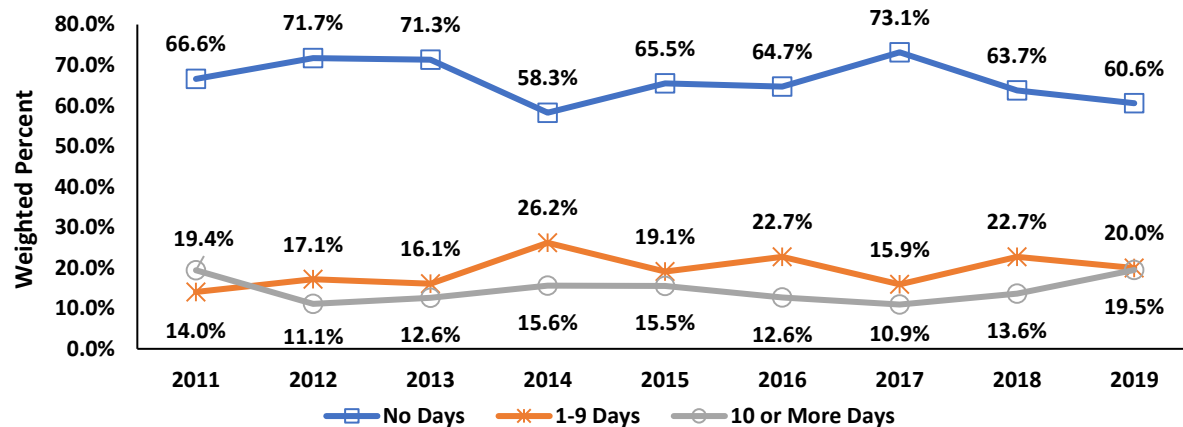
Source: Behavioral Risk Factor Surveillance System.

Chart scaled to 70% to display differences among groups.

Specific question asked in survey: "During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?"

In the Rural Region, adults who experienced no days of poor mental or physical health that prevented them from doing their usual activities decreased from 58.4% in 2018 to 52.7% in 2019. Rates for adults who experienced 10 or more days of poor mental health increased from 16.7% in 2018 to 24.4% in 2019.

Figure 10. Percentages of Adults in which Their Mental Health was Not Good by Number of Days Experienced in the Past Month, Rural Region, 2011-2019.



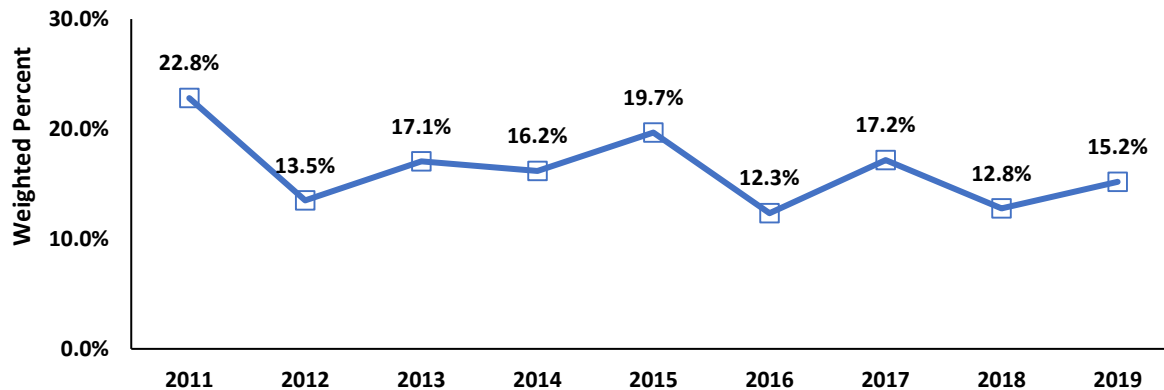
Source: Behavioral Risk Factor Surveillance System.

Chart scaled to 80% to display differences among groups.

Specific question asked in survey: "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"

In 2019, 19.5% of the Rural Region residents reported 10 or more days of poor mental health. The percent of amongst those who experienced 1-9 days in declined from 22.7% to 20.0% days.

Figure 11. Percentages of Adults Who Have Ever Been Told They have a Depressive Disorder, Including Depression, Major/Minor Depression, or Dysthymia, Rural Region, 2011-2019.



Source: Behavioral Risk Factor Surveillance System.

Chart scaled to 30% to display differences among groups.

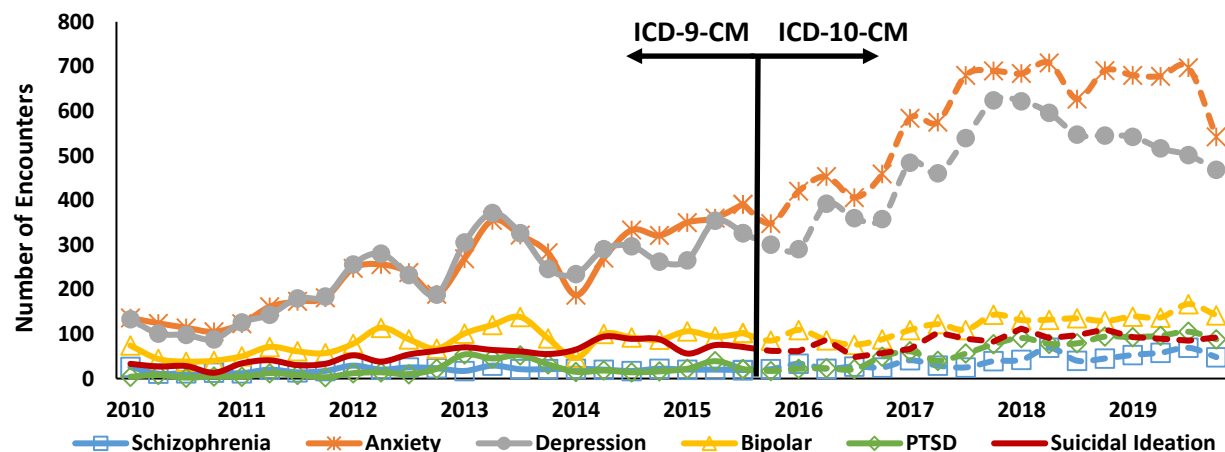
Specific question asked in survey: "(Ever told) you have a depressive disorder (including depression, major depression, dysthymia, or minor depression)?"

From 2018 to 2019, the percent of Rural Region residents who ever told they have had major/minor depression or dysthymia, increased to 15.2% from 12.8% in 2018.

Hospital Emergency Department Encounters

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

Figure 12. Mental Health-Related Emergency Department Encounters, by Quarter and Year, 2010-2019.



Source: Hospital Emergency Department Billing.

Categories are not mutually exclusive.

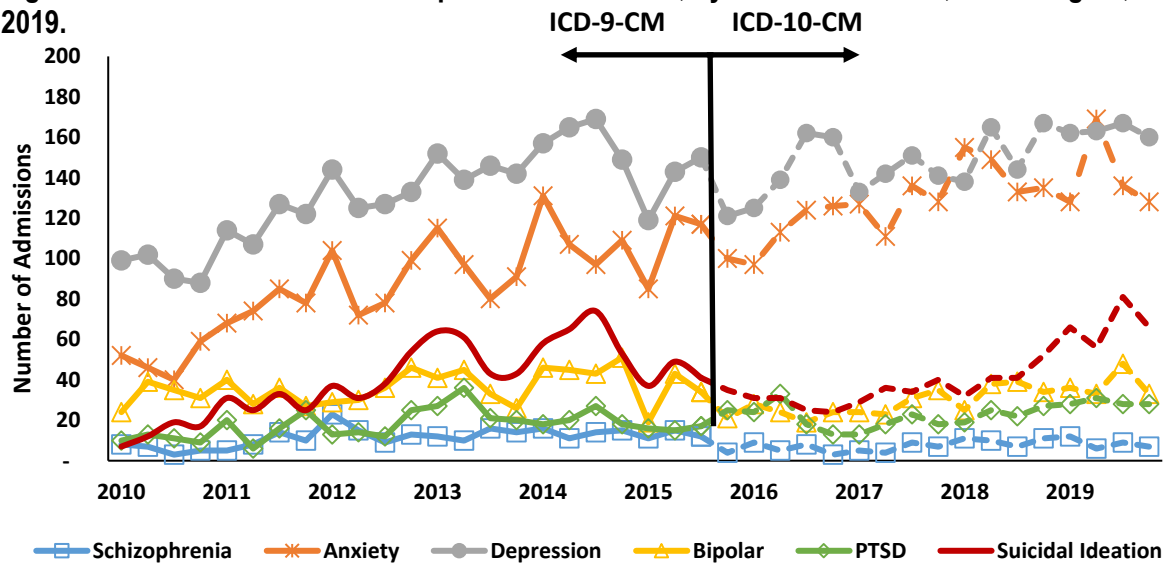
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Anxiety has been the leading mental health-related diagnosis since 2012 in emergency department encounters. Anxiety-related encounters increased significantly from 2010 to 2019 in both counts and rates in the Rural Region.

Hospital Inpatient Admissions

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

Figure 13. Mental Health-Related Inpatient Admissions, by Quarter and Year, Rural Region, 2010-2019.



Source: Hospital Inpatient Billing.

Categories are not mutually exclusive.

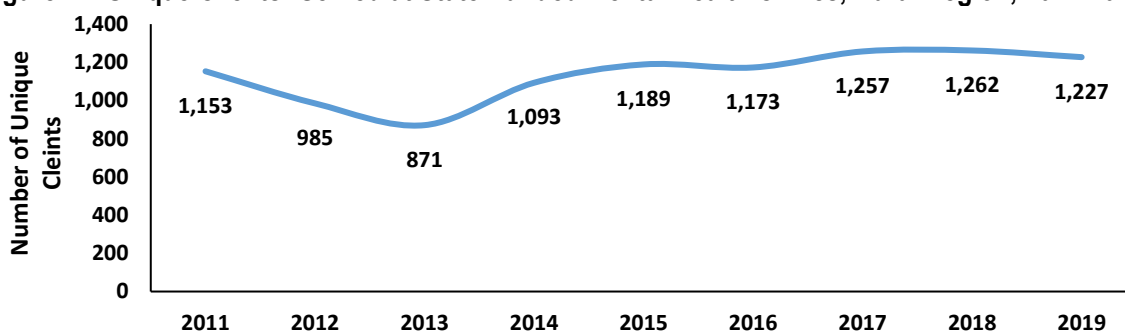
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Unlike emergency department encounters, depression is the leading diagnosis for mental health-related inpatient admissions.

State-Funded Mental Health Services

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

Figure 14. Unique Clients* Served at State-Funded Mental Health Clinics, Rural Region, 2011-2019.

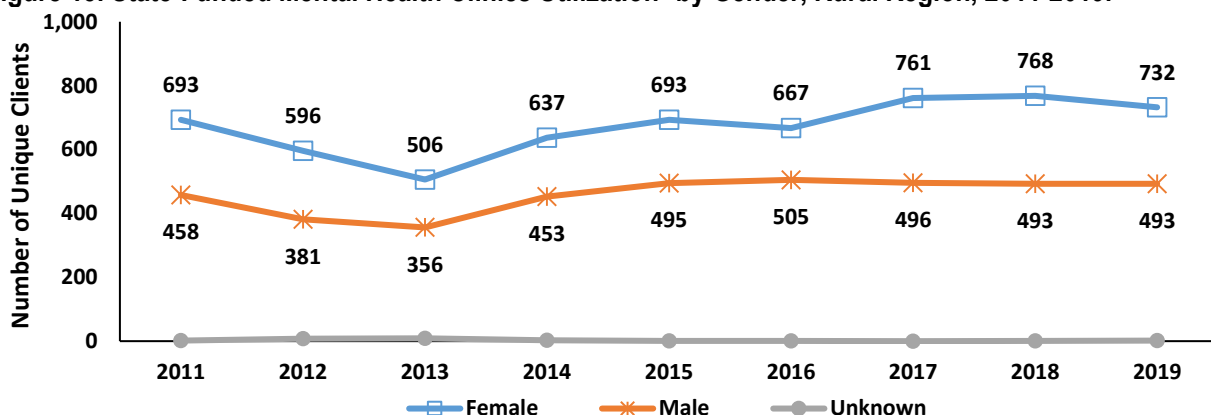


Source: State-Funded Mental Health: Avatar.

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

The number of unique clients served by state-funded mental health facilities has remained steady for the Rural Region residents. In 2019, there were 1,227 patients served by state-funded mental health facilities.

Figure 15. State-Funded Mental Health Clinics Utilization* by Gender, Rural Region, 2011-2019.



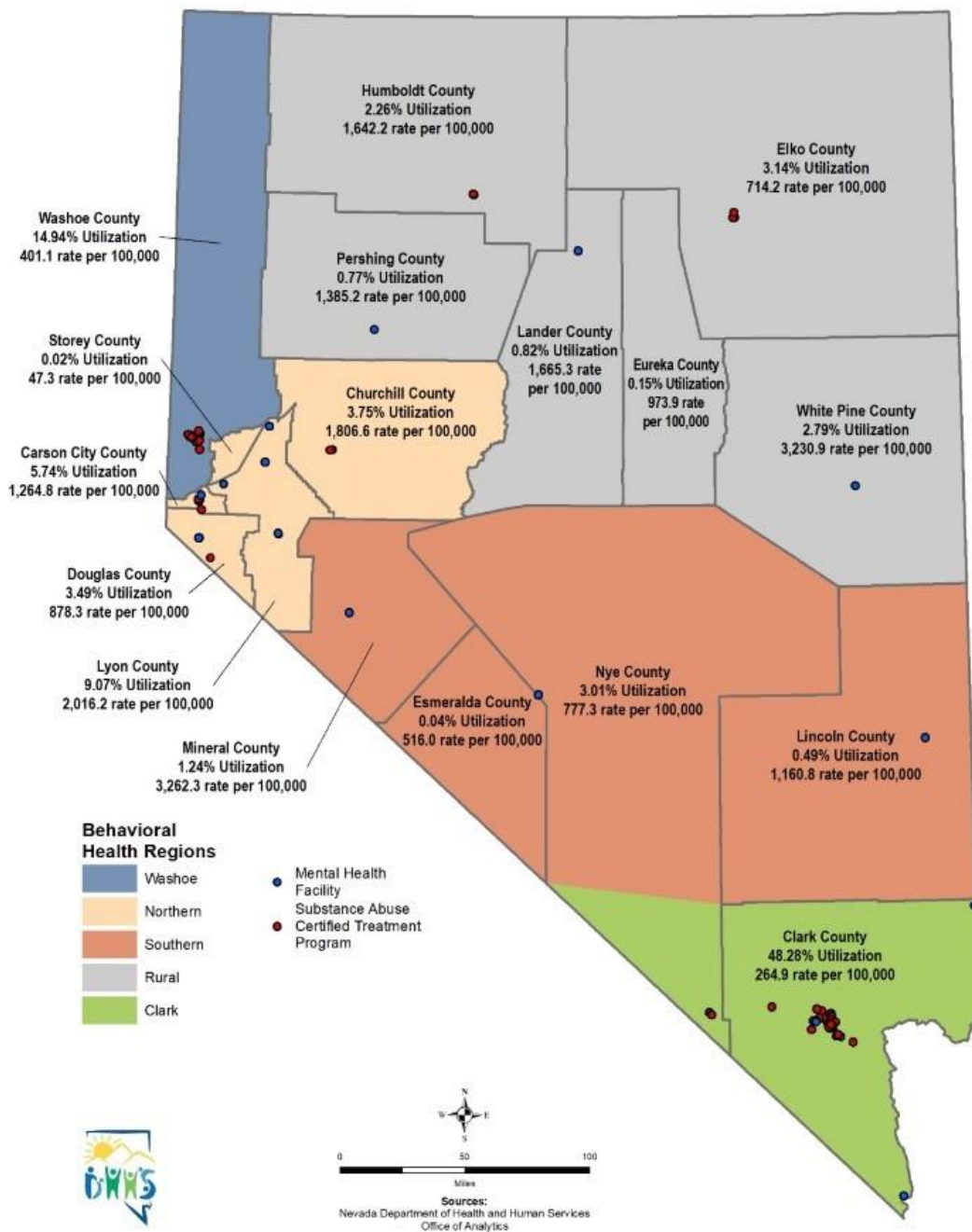
Source: State-Funded Mental Health: Avatar.

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

From 2011 to 2019 females significantly utilized the state-funded mental health clinics more than males.

Of patients that utilized state-funded mental health services, the most common age group was 25-34 years old, on average accounting for 18.1% of patients. High school graduates accounted for 33.3% of patients, followed by those with some college at 21.7% in 2019.

Figure 16. State-Funded Mental Health Clinics Utilization by County, 2019.



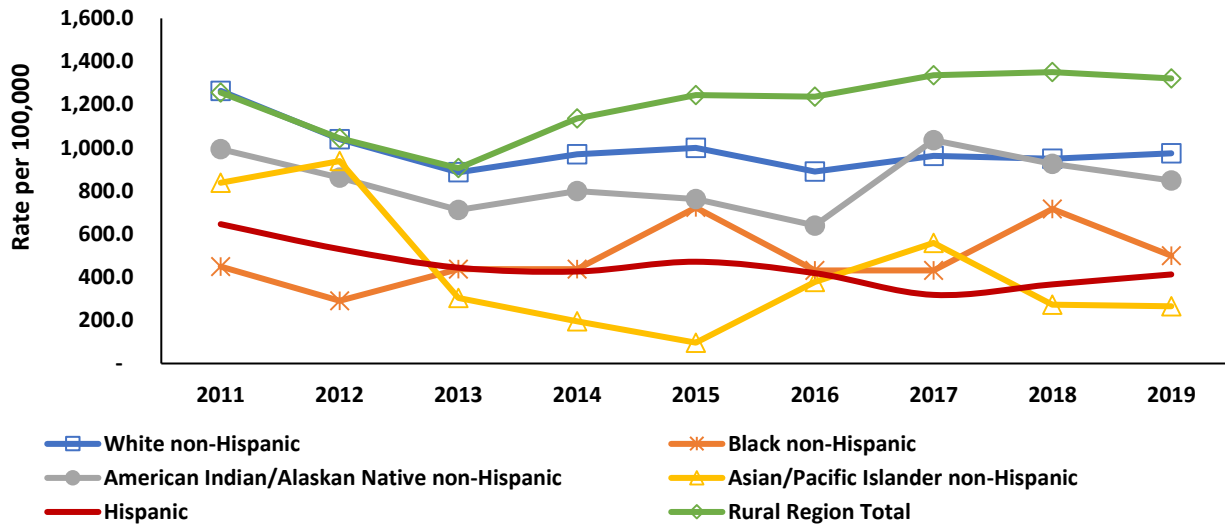
Source: State-Funded Mental Health: Avatar.

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

Percent (%): Number of clients who utilize mental health services in that county divided by total utilization.

Rate: Number of clients who utilize mental health services in that county divided by county population per 100,000 people.

Figure 17. State-Funded Mental Health Clinics Utilization* by Race/Ethnicity Crude Rates, Rural Region, 2011-2019.



Source: State-Funded Mental Health: Avatar.

Race "Unknown" not included in analysis.

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

The White non-Hispanic's in the Rural Region had the highest rate amongst the race/ethnicities at 973.8 per 100,000 population.

Figure 18. Top Mental Health Clinic Services by Number of Patients Served*, Rural Region, 2011-2019.

Program	Year								
	2011	2012	2013	2014	2015	2016	2017	2018	2019
Ely Outpatient Counseling	145	121	120	165	174	250	292	276	159
Elko Outpatient Counseling	234	222	175	153	145	152	140	141	90
Elko Medication Clinic	81	108	112	102	133	163	155	141	124
Elko Outpatient Screening	43	21	10	90	176	171	200	223	83
Winnemucca Outpatient Counseling	200	171	88	91	78	79	106	105	63
Winnemucca Medication Clinic	119	90	53	57	71	90	117	125	96
Ely Medication Clinic	63	50	49	62	82	104	110	113	99

Source: State-Funded Mental Health: Avatar.

~Program no longer active.

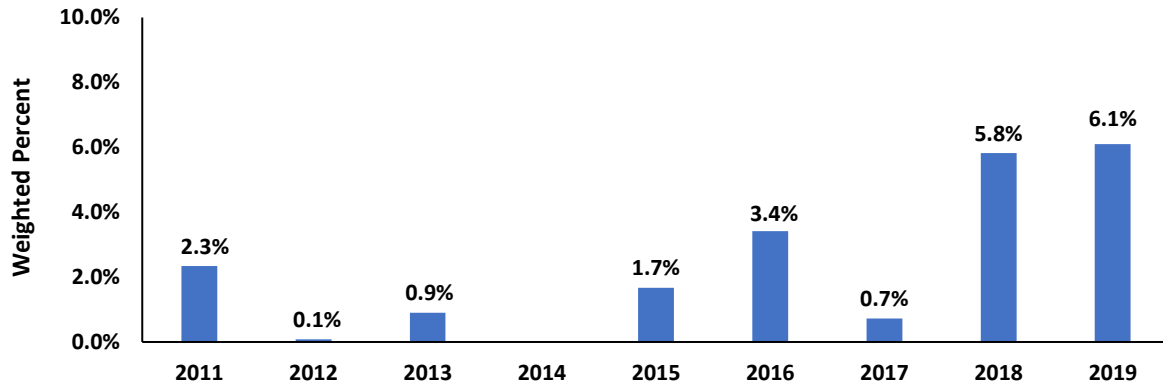
*A client is counted only once per year. Clients may be counted more than once across years.

Patients were counted only once per program per year. Since a patient can receive services in more than one program, the counts 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 19. Percentage of Adult Rural Region Residents Who Have Seriously Considered Attempting Suicide, 2011-2019.



Source: Behavioral Risk Factor Surveillance System (BRFSS).

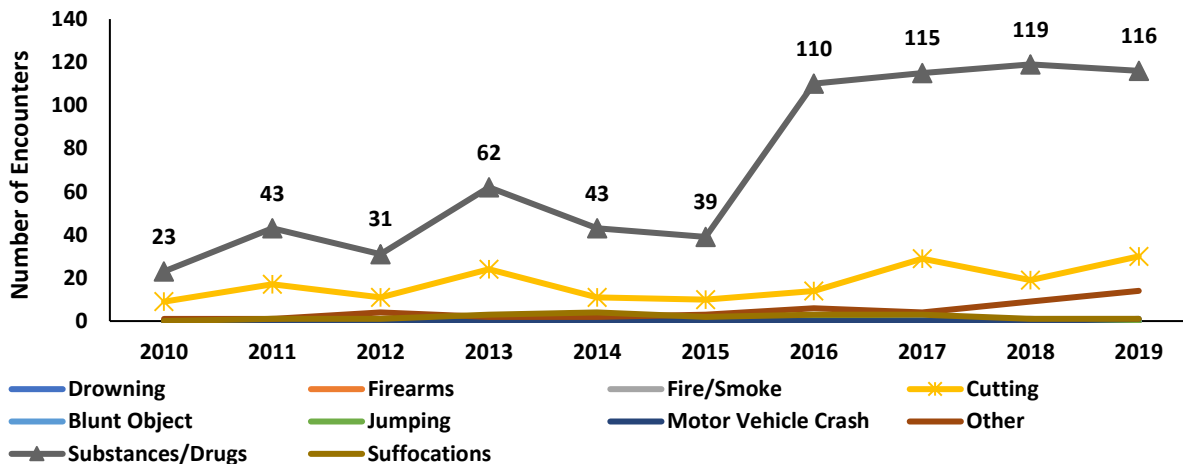
Chart scaled to 10% to display differences among groups.

Indicator was not measured in 2014.

Specific question asked in survey: "During the past 12 months have you ever seriously considered attempting suicide?"

When asked "have you seriously considered attempting suicide during the past 12 months," 6.1% of the Rural Region residents responded yes in 2019. Between 2011 and 2019, the average prevalence for suicide consideration in the rural region 2.6%.

Figure 20. Suicide Attempt Emergency Department Encounters by Method, Rural Region, 2010-2019.



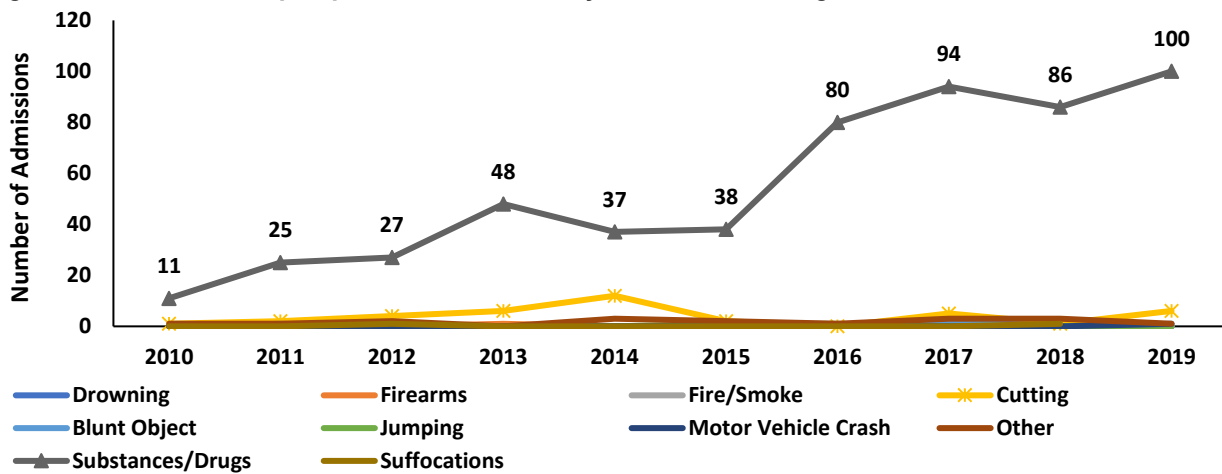
Source: Hospital Emergency Department Billing.

ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

A person can be included in more than category and therefore the counts above are not mutually exclusive.

Emergency department encounters related to suicide attempt, where the patient did not expire at the hospital, have remained steady from 2010 to 2019, except for drug-related overdoses. The most common method for attempted suicide is a substance or drug overdose attempt.

Figure 21. Suicide Attempt Inpatient Admissions by Method, Rural Region, 2011-2019.



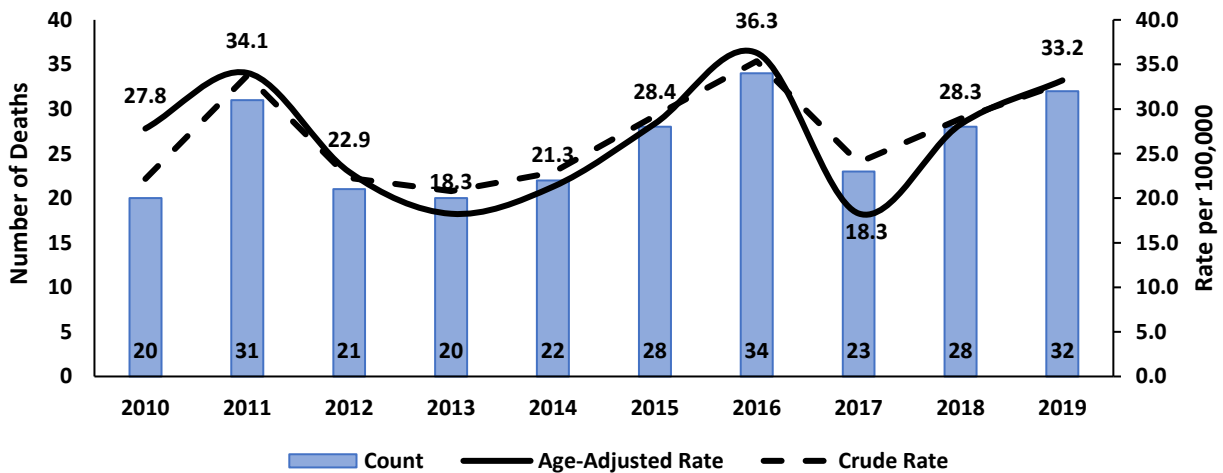
Source: Hospital Inpatient Billing.

ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

A person can be included in more than category and therefore the counts above are not mutually exclusive.

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 drug, with 100 inpatient admissions in 2019 for the Rural Region residents.

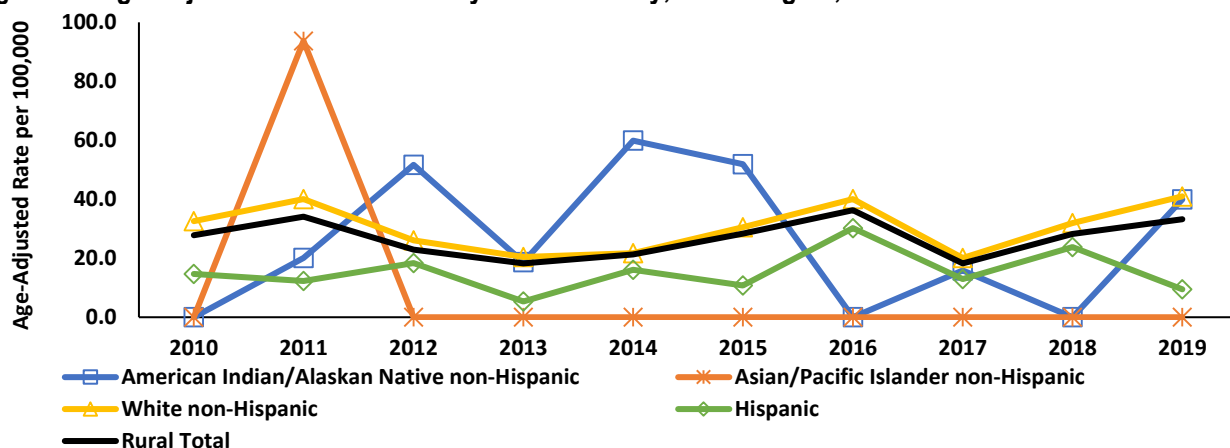
Figure 22. Number of Suicides and Rates, Rural Region, 2010-2019.



Source: Nevada Electronic Death Registry System.

The age-adjusted suicide rate for 2019 in Rural Region residents was 33.2 per 100,000 population, which is a slight increase from 2018 at 28.3 per 100,000 population.

Figure 23. Age-Adjusted Suicides Rates by Race/Ethnicity, Rural Region, 2010-2019.



Source: Nevada Electronic Death Registry System.

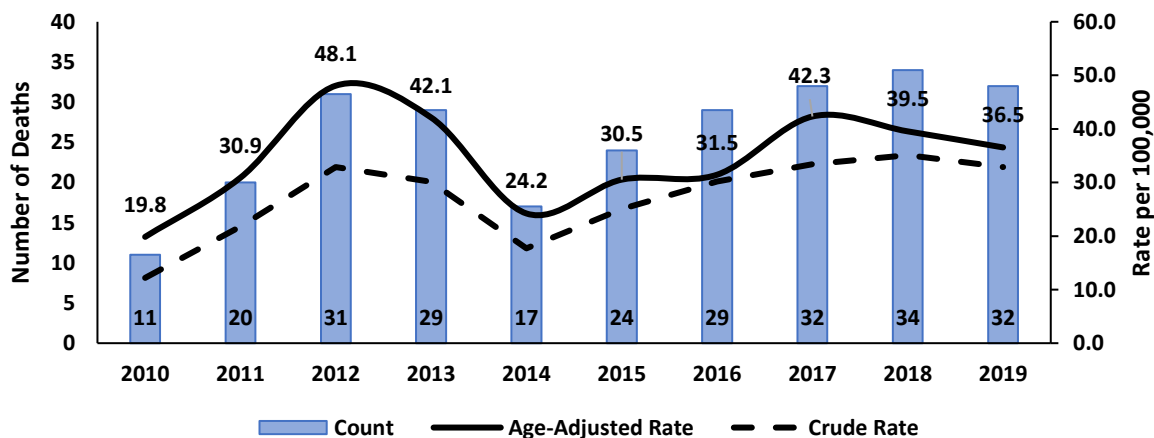
There is no significance between race/ethnicities for suicides in the Rural Region, in 2019.

Mental Health-Related Deaths

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

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

Figure 24. Mental Health-Related Deaths and Rates, Rural Region, 2010-2019.

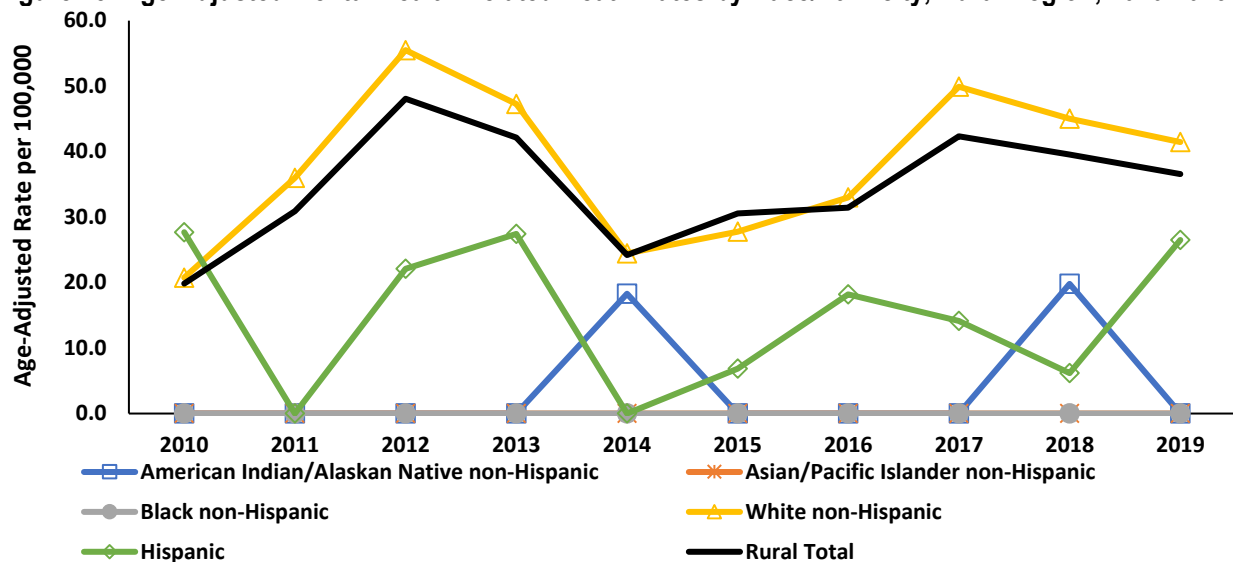


Source: Nevada Electronic Death Registry System.

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The age-adjusted rate for the Rural Region decreased slightly from 39.5 to 36.5 per 100,000 population, 2018 and 2019, respectively.

Figure 25. Age-Adjusted Mental Health-Related Death Rates by Race/Ethnicity, Rural Region, 2010-2019.



Source: Nevada Electronic Death Registry System.

There are no significant differences between the age-adjusted mental health-related death rates among races/ethnicities for 2019.

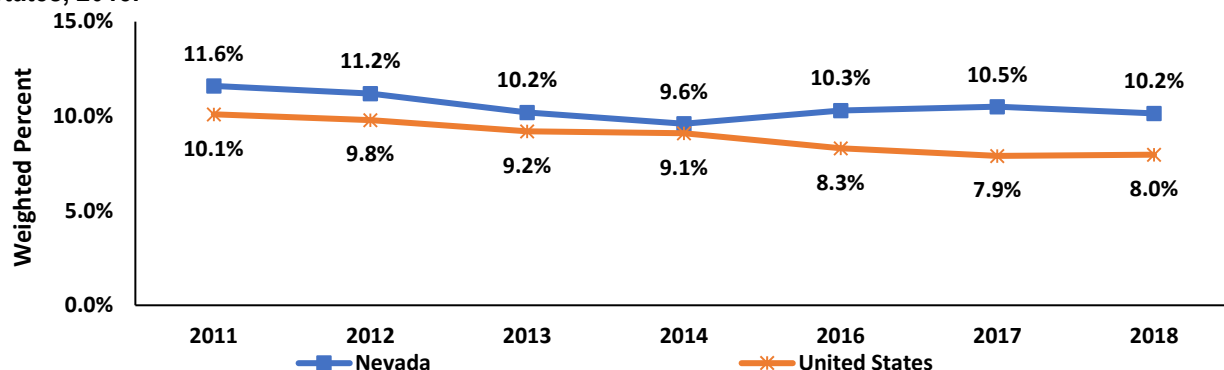
Substance Use

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

National Survey on Drug Use and Health

The Substance Abuse and Mental Health Services Administration (SAMHSA) sponsors the National Survey on Drug Use and Health (NSDUH). The survey tracks trends of illicit drug, alcohol, and tobacco use, as well as mental health issues throughout the United States. For more information about the national survey, please go to the following website: [SAMHSA NSDUH](https://www.samhsa.gov/2k17).

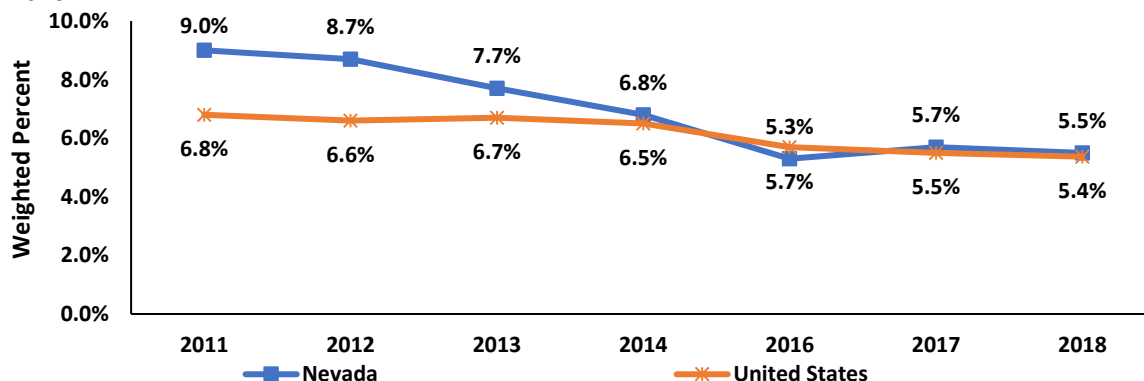
Figure 26. Illicit Drug Use Among Adolescents in the Past Month, Aged 12-17, Nevada and the United States, 2018.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2017.
Chart scaled to 14% to display differences among groups.

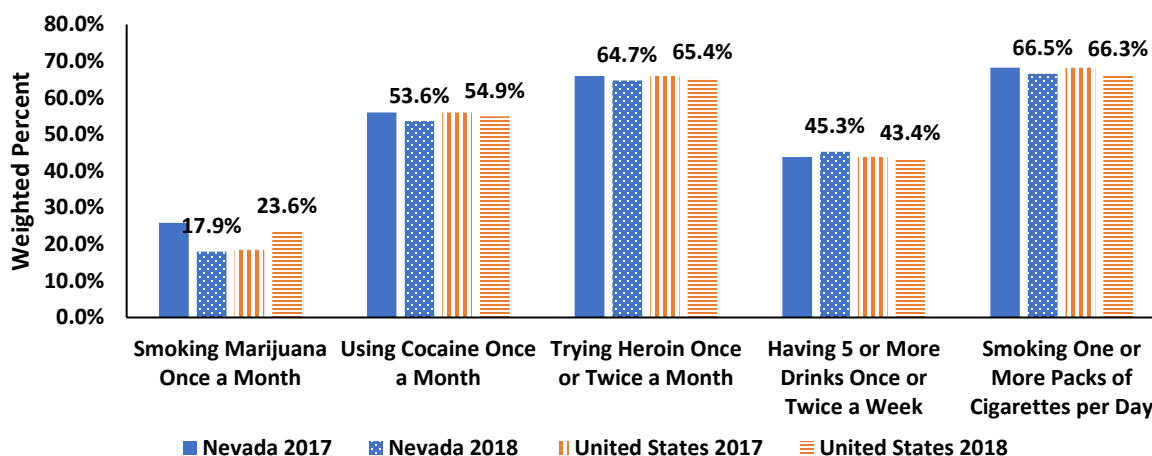
Nevada adolescents illicit drug use has remained within 2% from 2011 to 2018, 10.2% reported illicit drug use in 2018. Alcohol use disorder in the past year has decreased from 9.0% in 2011 to 5.5% in 2018.

Figure 27. Alcohol Use Disorder in the Past Year Aged 12 and Above, Nevada and the United States, 2011-2018.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health.
Chart scaled to 10% to display differences among groups.

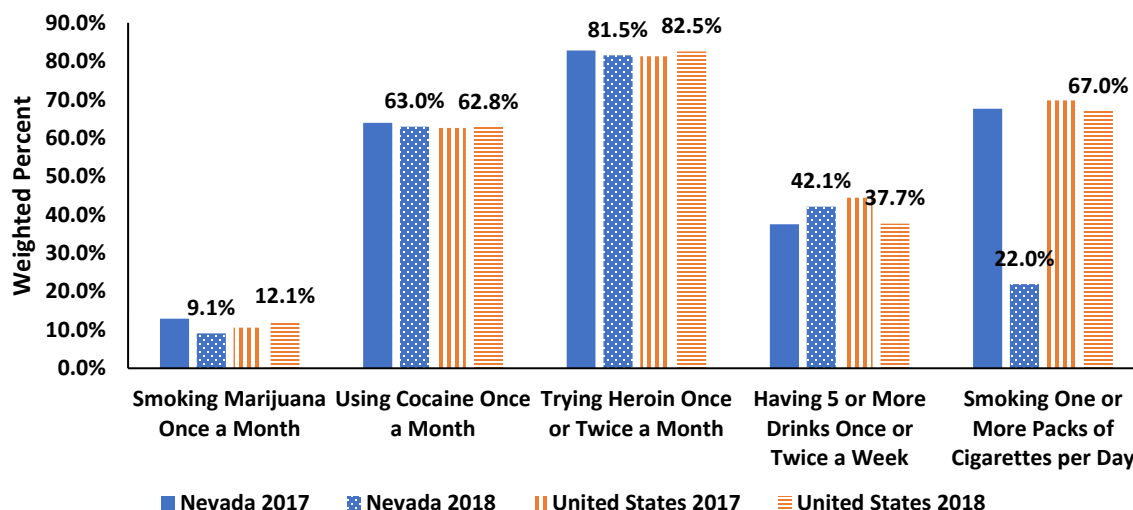
Figure 28. Perceptions of Great Risk from Alcohol or Substance, Aged 12-17, Nevada and the United States, 2018.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health.
Chart scaled to 80% to display differences among groups.

For perceived risks, the higher percent the more the person perceives there is a risk from it. Nevadans perceived risk among both teens (Figure 30 and 31) and young adults is lower than the nation for most substance uses, including smoking one or more packs of cigarettes per day in young adults, 22.0% in Nevada and nationally at 67.0%

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

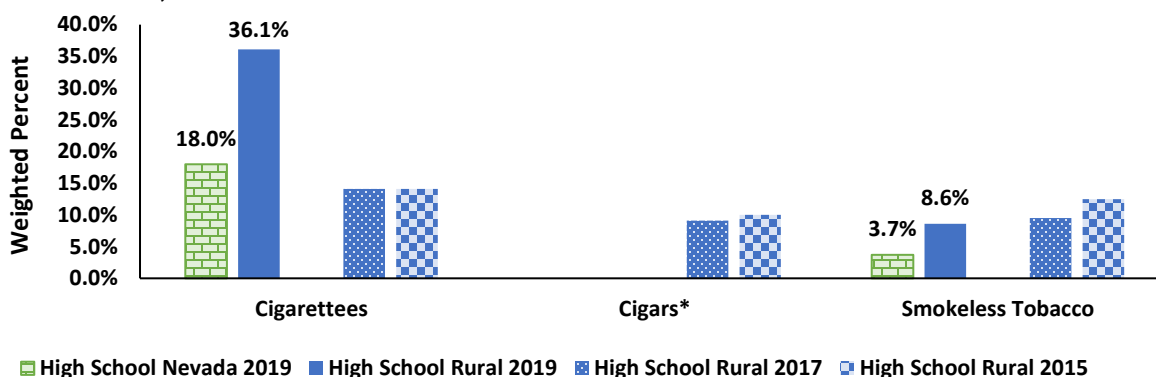


Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health.
Chart scaled to 90% to display differences among groups.
Table in the Appendix.

Youth Risk Behavior Survey (YRBS)

The YRBS monitors six categories of health-related behaviors that contribute to leading causes of death and disabilities among youth and adults. Nevada high school and middle school students are surveyed during the odd numbered years. In 2019, 4,980 high school, and 5,341 middle school students participated in the YRBS in Nevada. The University of Nevada, Reno maintains the YRBS data and publishes data on each survey. For more information on the YRBS survey, please go to the following site: [UNR YRBS](#)

Figure 30a. Tobacco Use, Rural Region High School Students, 2015, 2017 and 2019, and Nevada High School Students, 2019.



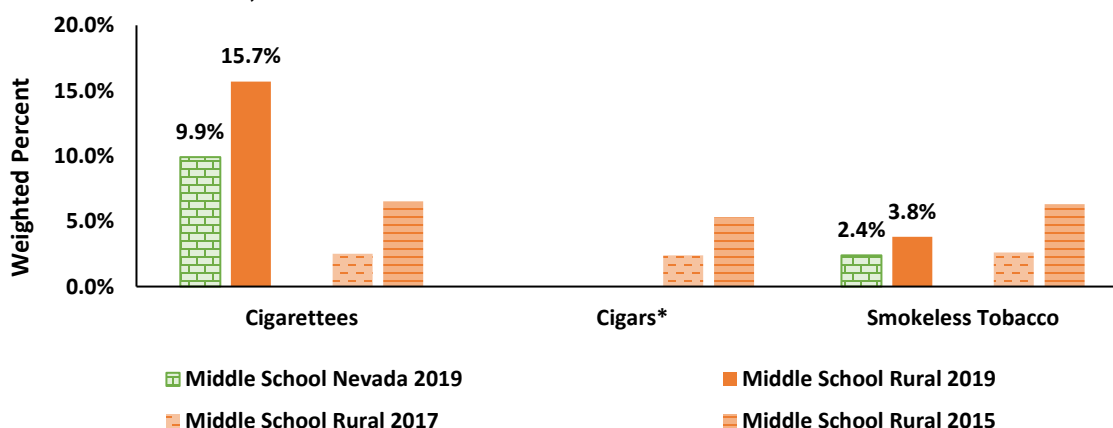
Source: Nevada Youth Risk Behavior Survey.

Chart scaled to 40% to display differences among groups.

*Questions related to cigar use are no longer asked.

High school students for the Rural Region in 2019, had a significantly higher percent for ever having smoked cigarettes than Nevada at 36.1% and 18.0% respectively. The middle school students in the Rural Region while a higher percent of cigarette use, it is not significant.

Figure 30a. Tobacco Use, Rural Region Middle School Students, 2015, 2017, and 2019, and Nevada Middle School Students, 2019.



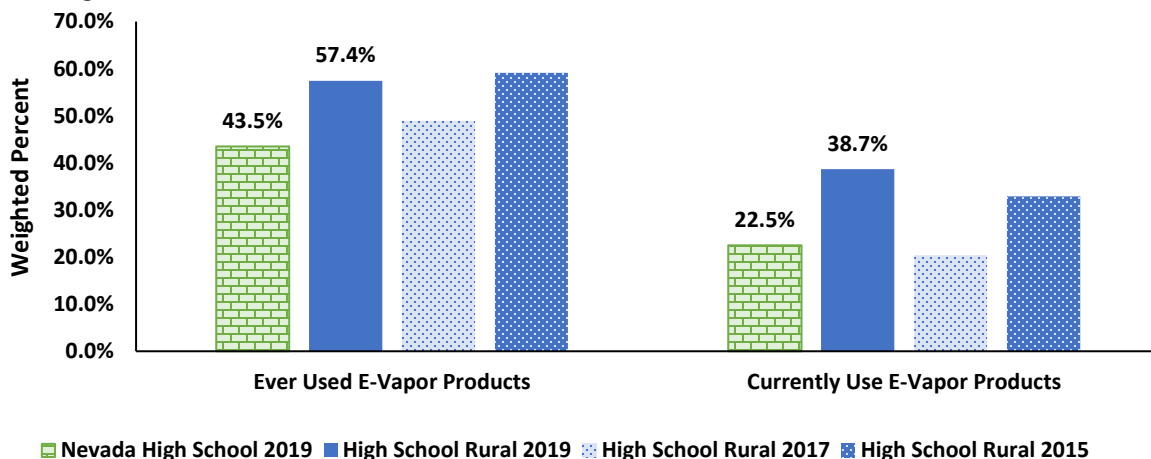
Source: Nevada Youth Risk Behavior Survey.

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Chart scaled to 20% to display differences among groups.

*Questions related to cigar use are no longer asked.

Figure 31a. Electronic Vapor Product Use, Rural Region High School Students, 2015, 2017 and 2019, and Nevada High School Students, 2019.

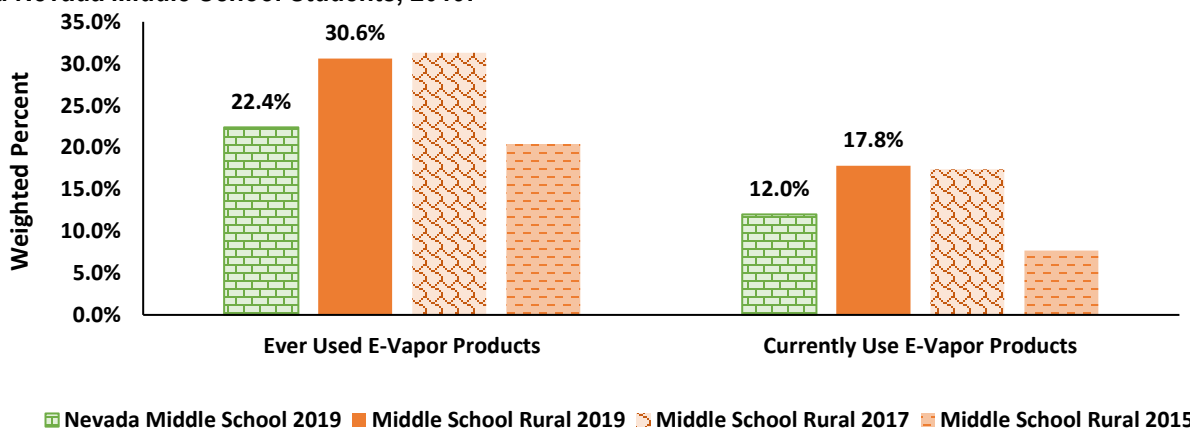


Source: Nevada Youth Risk Behavior Survey.

Chart scaled to 70% to display differences among groups.

High school students in the Rural Region in 2019 have significantly higher percent for ever having using an electronic vapor (e-vapor) product than Nevada at 57.4% and 43.5% respectively. Similarly, middle school students in the Rural Region have a significantly higher percent for ever using an e-vapor product at 30.6%, 22.4% for Nevada.

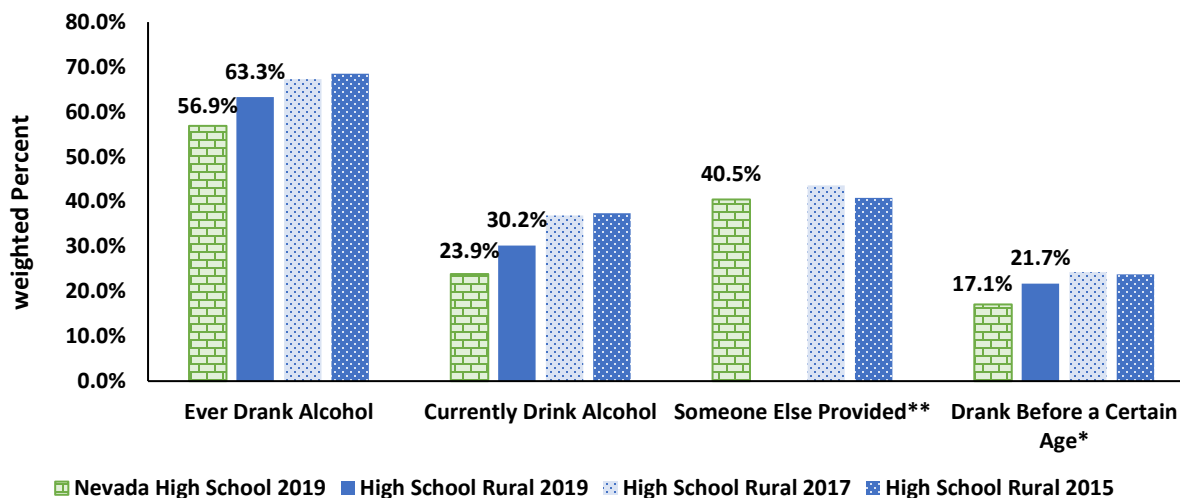
Figure 31b. Electronic Vapor Product Use, Rural Region Middle School Students, 2015, 2017, and 2019, and Nevada Middle School Students, 2019.



Source: Nevada Youth Risk Behavior Survey.

Chart scaled to 35% to display differences among groups.

Figure 32a. Alcohol Use, Rural Region High School Students, 2015, 2017 and 2019, and Nevada High School Students, 2019.



Source: Nevada Youth Risk Behavior Survey.

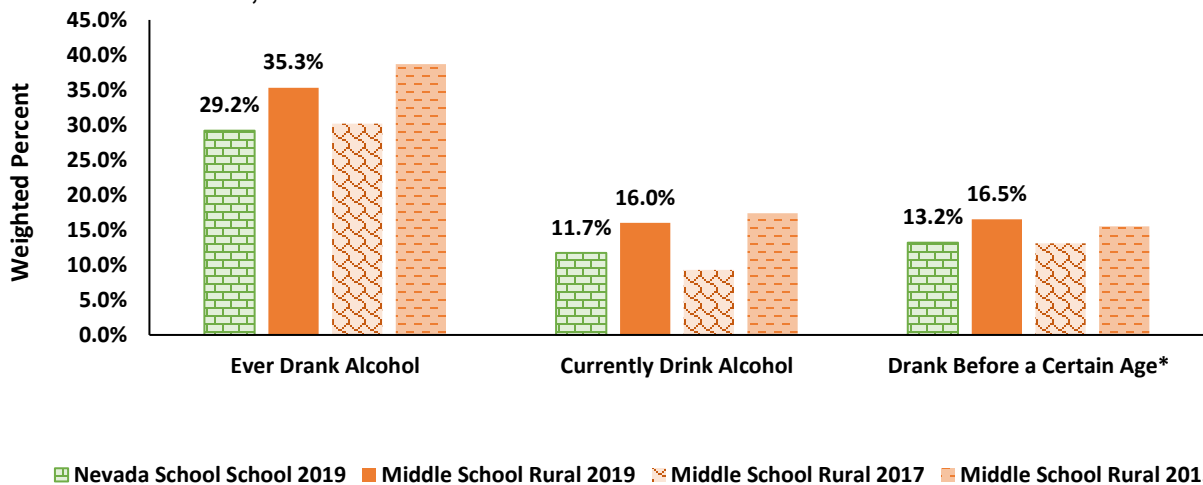
Chart scaled to 80% to display differences among groups.

*In high school students, if they ever drank before age 13.

**Question 'someone else provided' is no longer asked.

High school students in the Rural Region in 2019 have a higher percent for ever drinking alcohol than Nevada at 63.3% and 56.9%, respectively. The percent from previous years has decreased from 67.3% in 2017. Similarly, middle school students in the Rural Region have a higher percent for ever drinking alcohol at 35.3%, compared 29.2% for Nevada.

Figure 32b. Alcohol Use, Rural Region Middle School Students, 2015, 2017, and 2019, and Nevada Middle School Students, 2019.

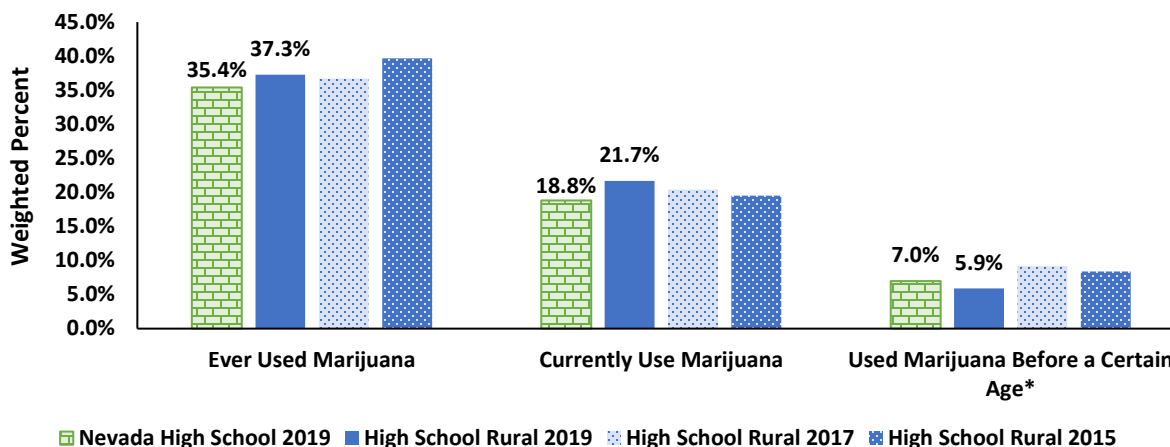


Source: Nevada Youth Risk Behavior Survey.

Chart scaled to 45% to display differences among groups.

*In high school students, if they ever drank before age 13.

Figure 33a. Marijuana Use, Rural Region High School Students, 2015, 2017 and 2019, and Nevada High School Students, 2019.



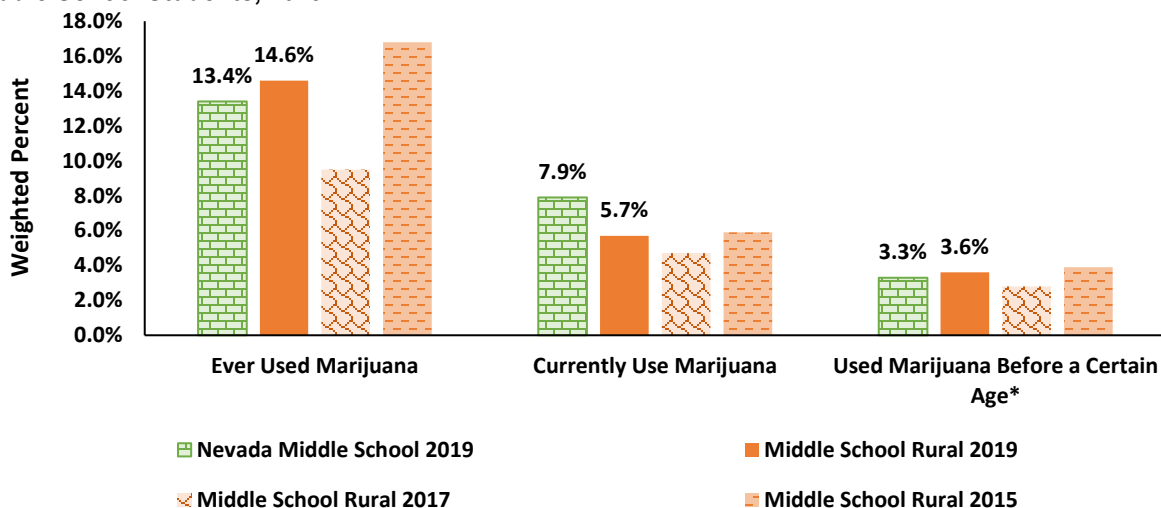
Source: Nevada Youth Risk Behavior Survey.

Chart scaled to 45% to display differences among groups.

*In high school students, if they ever used marijuana before age 13.

There is no significant change for marijuana use from 2017 to 2019 for the Rural Region high school and middle school students. In 2019, 37.3% of the Rural Region high school students said they had tried marijuana before and 14.6% of middle school students. This is up slightly from 2017 in high school students which was 36.7%.

Figure 33b. Marijuana Use, Rural Region Middle School Students, 2015, 2017, and 2019, and Nevada Middle School Students, 2019.

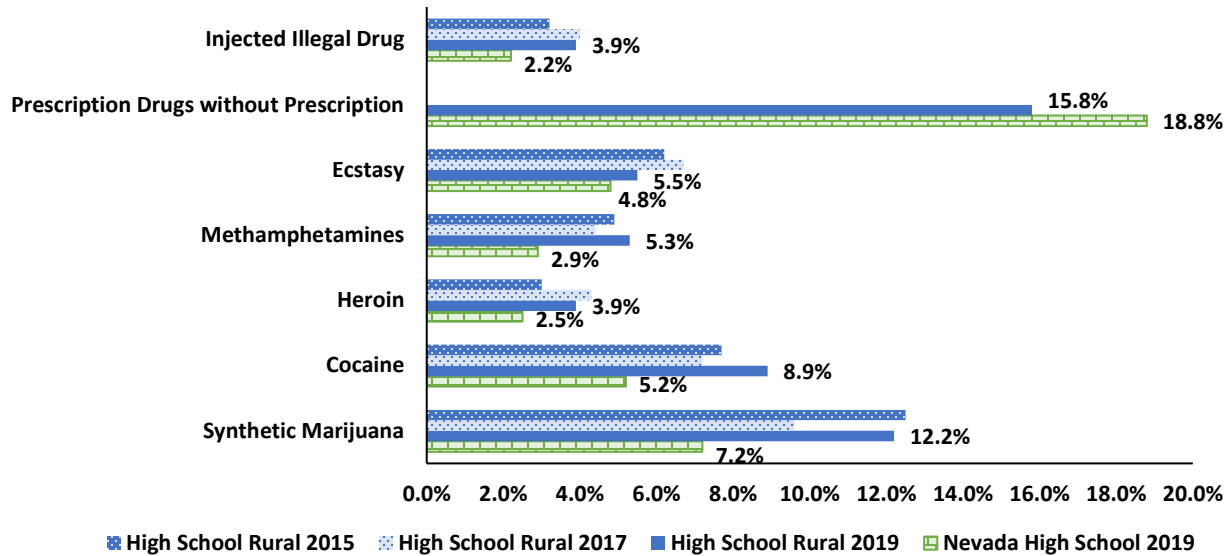


Source: Nevada Youth Risk Behavior Survey.

Chart scaled to 18% 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.

Figure 34a. Lifetime Drug Use, Rural Region High School Students, 2015, 2017 and 2019, and Nevada High School Students, 2019.

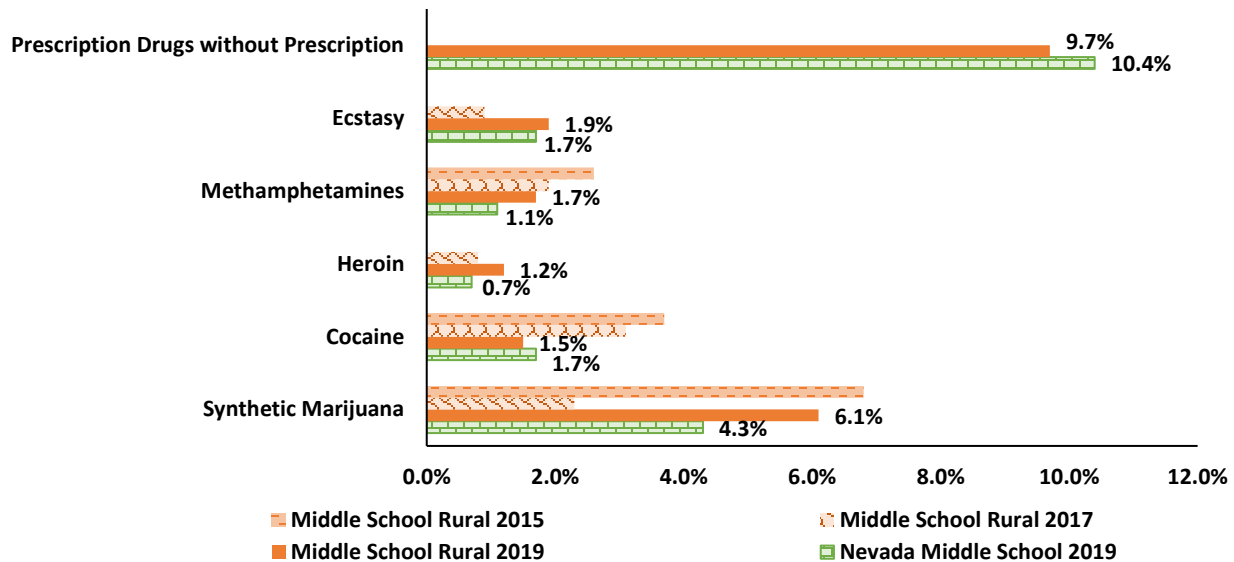


Source: Nevada Youth Risk Behavior Survey.

Chart scaled to 20% to display differences among groups.

Drug use increased from 2017 to 2019 in the Rural Region in high school students. In 2017, lifetime methamphetamine use increased from 4.4% to 5.3% in 2019. Similarly, lifetime cocaine use increased from 7.2% to 8.9% which is higher than Nevada high school students at 5.2% but decreased in the middle schools from 3.1% to 1.5% lifetime use.

Figure 34b. Lifetime Drug Use, Rural Region Middle School Students, 2015, 2017, and 2019, and Nevada Middle School Students, 2019.



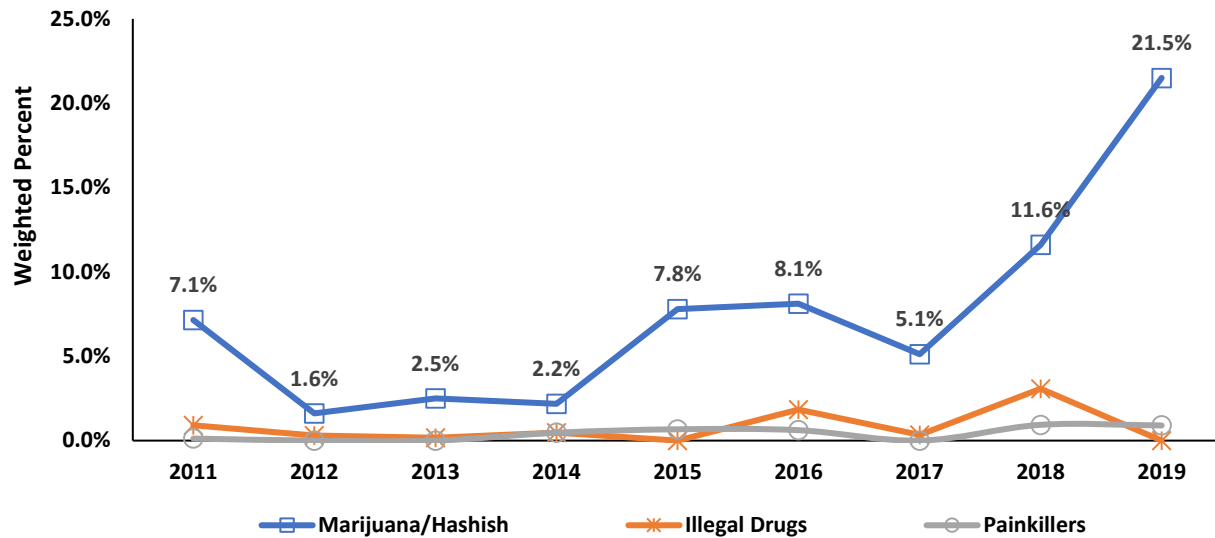
Source: Nevada Youth Risk Behavior Survey.

Chart scaled to 12% to display differences among groups.

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 35. Adult Nevada Residents Who Used Marijuana/Hashish, Illegal Substances, or Painkillers to Get High in the Last 30 Days, Rural Region, 2011-2019.



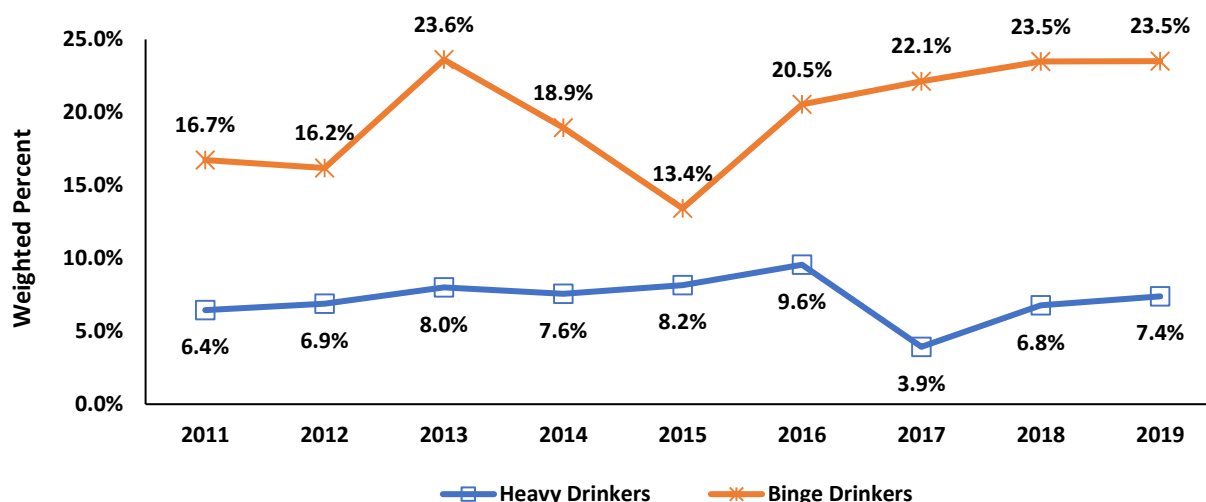
Source: Behavioral Risk Factor Surveillance System.

Chart scaled to 25% to display differences among groups.

Specific question asked in survey: "During the past 30 days, on how many days did you use marijuana or hashish/any other illegal drug/prescription drugs without a doctor's order, just to "feel good," or to "get high"?"

Marijuana use has more than doubled since 2011. In 2019, 21.5% have used marijuana in the past 30 days from 7.1% in 2011. Marijuana use is expected to increase as marijuana was legalized in Nevada in 2017. Of those surveyed in the Rural Region, 0.7% (on average) used painkillers to get high in the last 30 days which is a slight decrease from 2018 at 0.9%.

Figure 36. Percentage of Adults Who are Considered Binge Drinkers or Heavy Drinkers, Rural Region, 2011-2019.



Source: Behavioral Risk Factor Surveillance System.

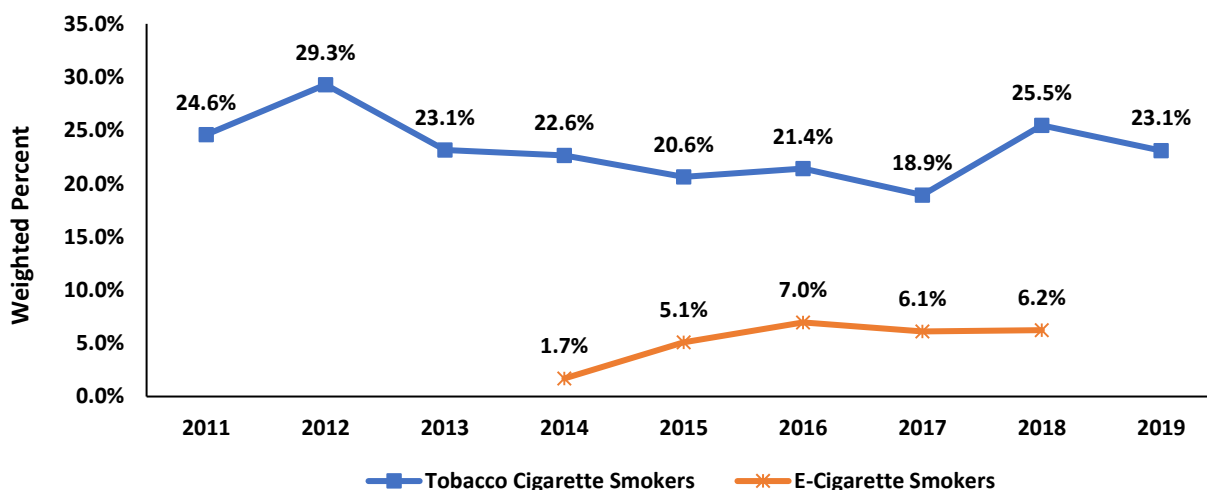
Chart scaled to 25% to display differences among groups.

Heavy drinkers (adult men having more than 14 drinks per week and adult women having more than seven drinks per week).

Binge drinkers (adult men having five or more drinks on one occasion, adult women having four or more drinks on one occasion).

Binge drinking is defined in men as having five or more alcoholic beverages and 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 decreased to 13.4% in 2015 then increased steadily until 2018. Heavy drinking decreased to a low of 3.9% in 2017 then increased in 2018 and 2019.

Figure 37. Percentage of Adults Who are Current Tobacco Cigarette or E-Cigarette Smokers, Rural Region, 2011-2019.



Source: Behavioral Risk Factor Surveillance System.

Chart scaled to 35% to display differences among groups.

E-cigarette use was not collected until 2014.

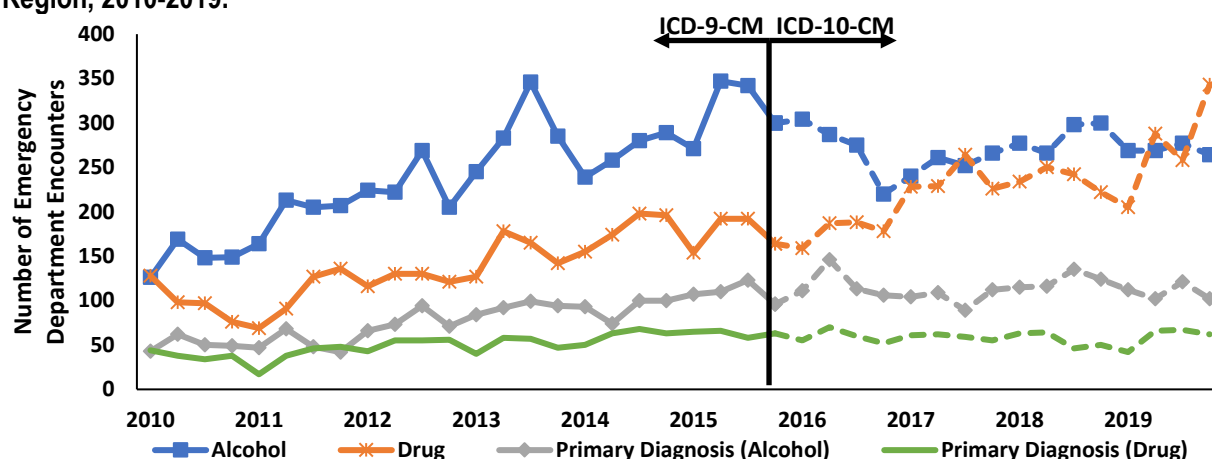
Current cigarette smokers are defined as individuals who have smoked at least 100 cigarettes in their lifetime and currently smoke. Current e-cigarette smokers are defined as individuals who currently have smoked on at least one day in the past 30 days or who currently report using e-cigarettes or other electronic "vaping" products every day or some days.

In 2019, 23.1% of adults in the Rural Region were current cigarette smokers, which has decreased from a high of 29.3% in 2012. E-cigarette use has increased among adults in the Rural Region from 1.7% in 2014 (the first year this data was collected) to 6.2% in 2019.

Hospital Emergency Department Encounters

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

Figure 38. Alcohol and Drug-Related Emergency Department Encounters by Quarter and Year, Rural Region, 2010-2019.



Source: Hospital Emergency Department Billing.

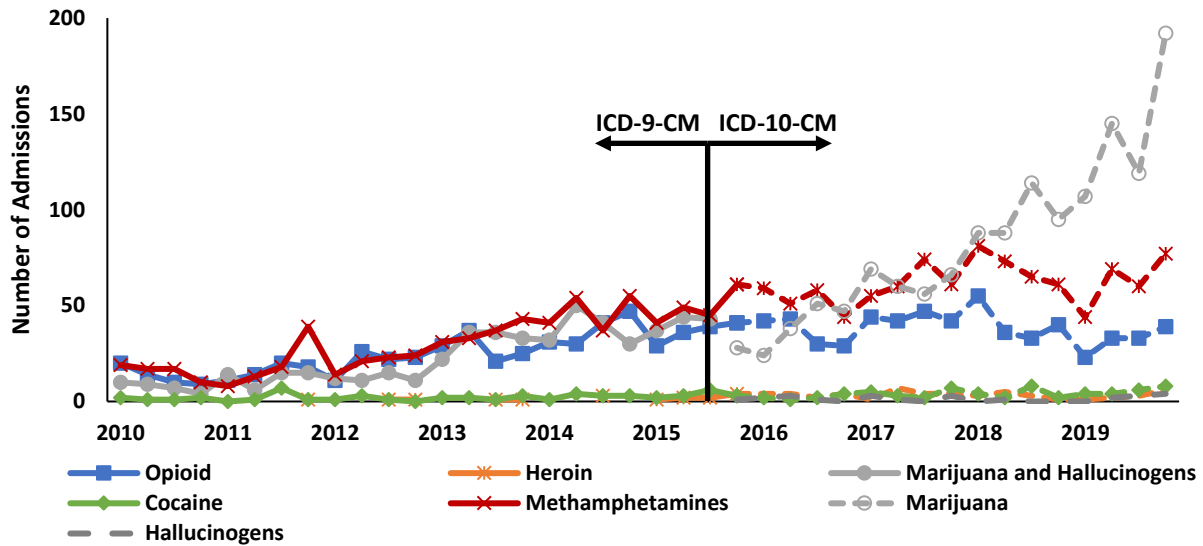
Categories are not mutually exclusive.

ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

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

Alcohol-related visits for Rural Region residents were more common than drug-related visits until 2017 when drug-related visits to the emergency department closely equaled the number of alcohol-related visits and surpassed the number of alcohol-related visits in 2019.

Figure 39. Drug-Related Emergency Department Encounters by Drug and Quarter and Year, Rural Region, 2010-2019.



Source: Hospital Emergency Department Billing.

Categories are not mutually exclusive.

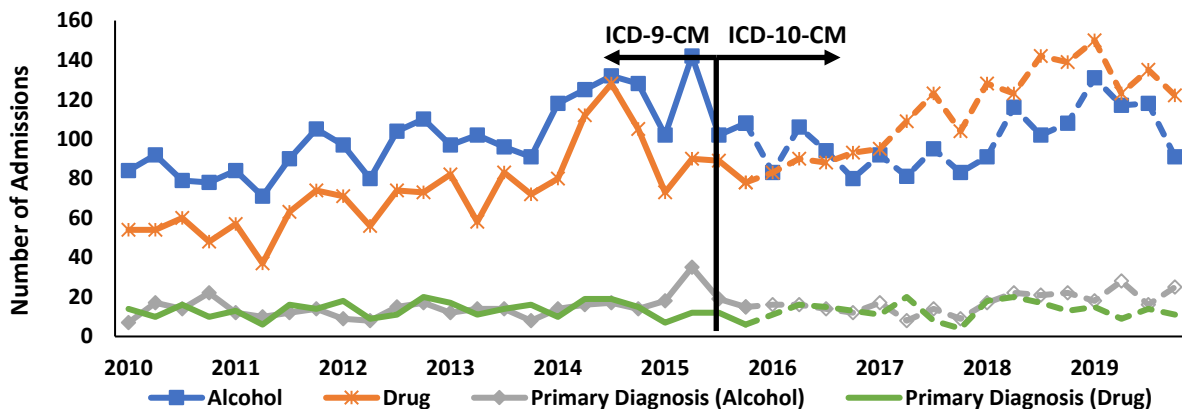
ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Hallucinogens and marijuana were grouped together for ICD-9-CM, but in 2015 were separated into different groups in the ICD-10-CM codes. Marijuana drug use rates in the Rural Region were higher in 2018 and 2019 than previous years.

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 2019, more people were admitted into Nevada hospitals for drug-related issues than for alcohol-related issues.

Figure 40. Alcohol and/or Drug-Related Inpatient Admissions by Quarter and Year, Rural Region, 2010-2019.



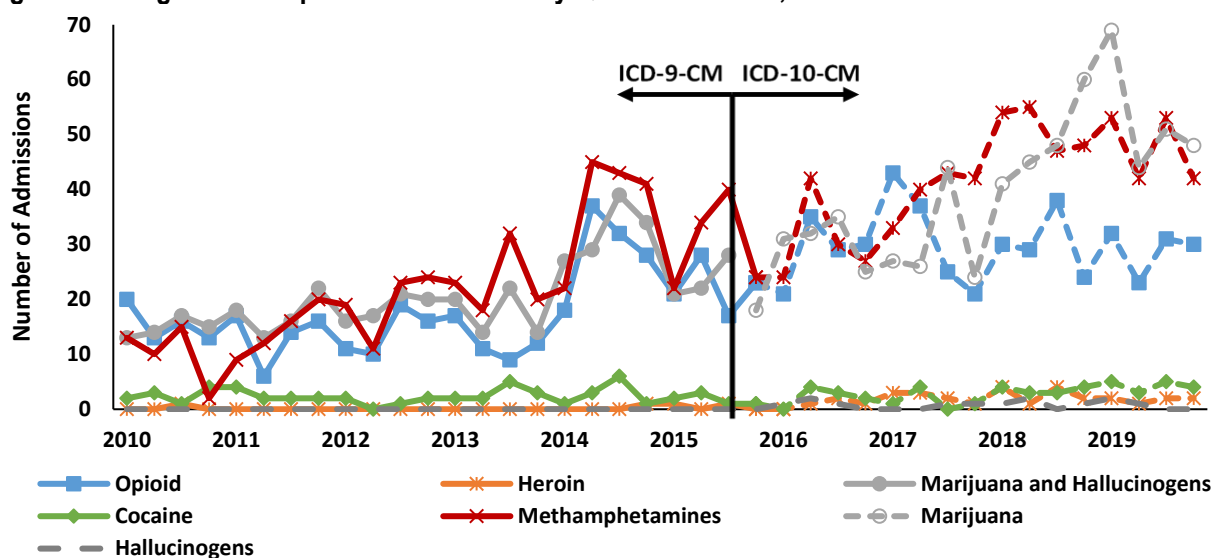
Source: Hospital Inpatient Billing.

Categories are not mutually exclusive.

ICD-9-CM codes were replaced by ICD-10-CM codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Alcohol-related admissions were more common than drug-related admissions until 2018 where drug-related admissions surpassed alcohol-related admissions and have remained higher through 2019.

Figure 41. Drug-Related Inpatient Admissions by Quarter and Year, 2010-2019.



Source: Hospital Inpatient Billing.

Categories are not mutually exclusive.

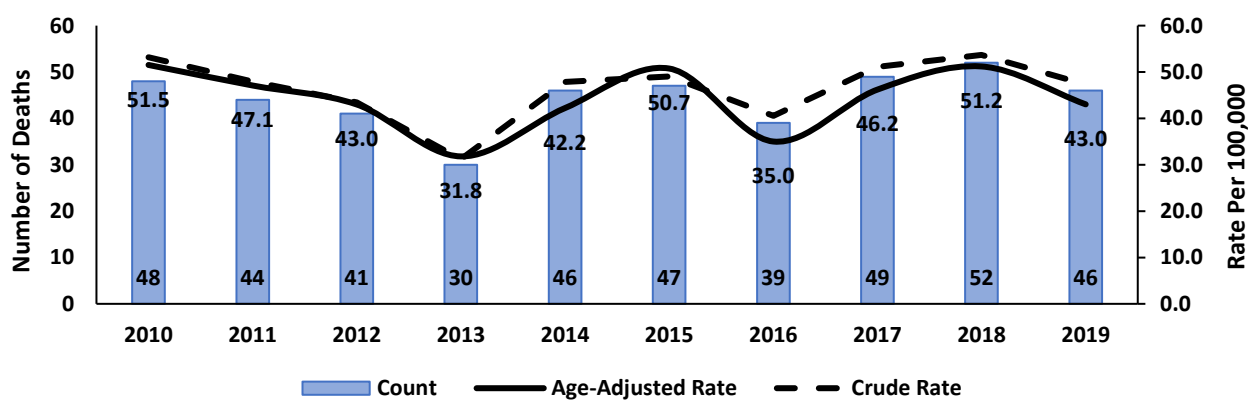
ICD-9 codes were replaced by ICD-10 codes in last quarter of 2015, therefore data prior to that may not be directly comparable.

Hallucinogens and marijuana were grouped together for ICD-9-CM, but in 2015 were separated into different groups in the ICD-10-CM codes. Marijuana and methamphetamine Rural Region admissions have increased steadily since 2010.

Alcohol-Related and/or Drug-Related Deaths

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

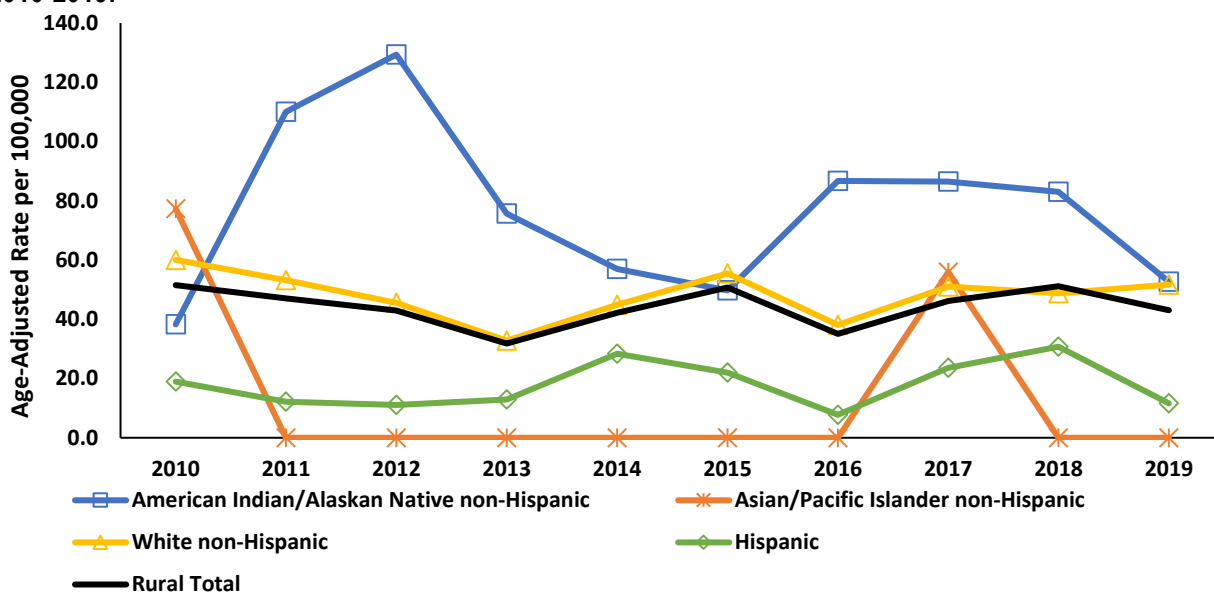
Figure 42. Alcohol-Related and/or Drug-Related Deaths and Rates, Rural Region, 2010-2019.



Source: Electronic Death Registry System.

Alcohol-related/or drug-related age-adjusted rate decreased in 2019 from the previous two years, with 43.0 alcohol-related and/or drug related deaths per 100,000 in the Rural Region.

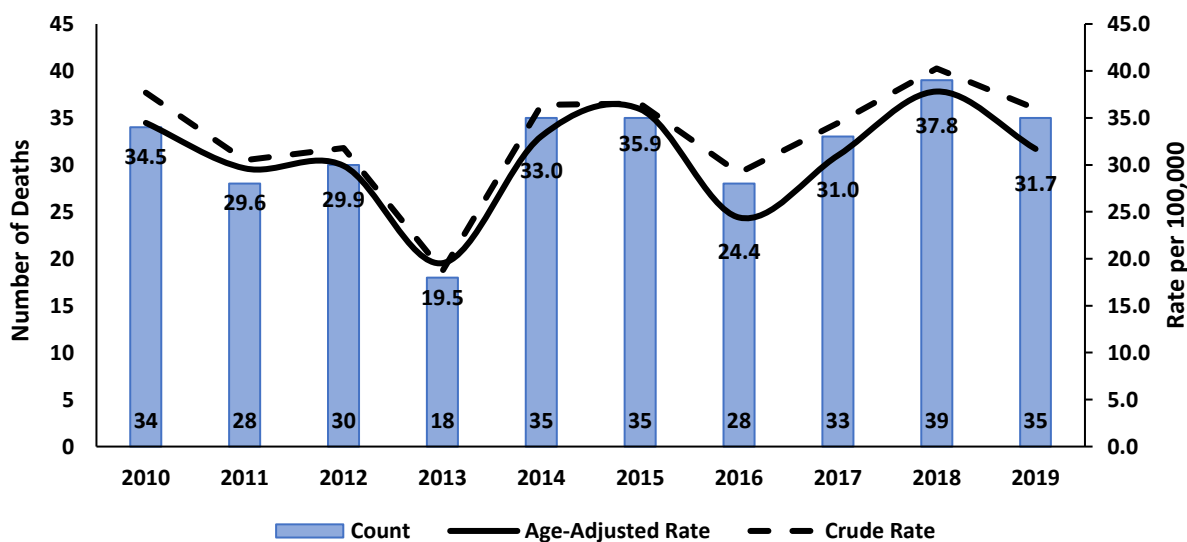
Figure 43. Age-Adjusted Rate for Alcohol-Related and/or Drug-Related Deaths by Race, Rural Region, 2010-2019.



Source: Electronic Death Registry System.

Although it appears that the American Indian/Alaskan Native non-Hispanic population had higher rates of alcohol-related and/or drug-related deaths in all years from 2011 to 2018, these deaths are not statistically significant (95% confidence interval) due to the relatively small population size. Black non-Hispanic race was not included in this graph due to small counts.

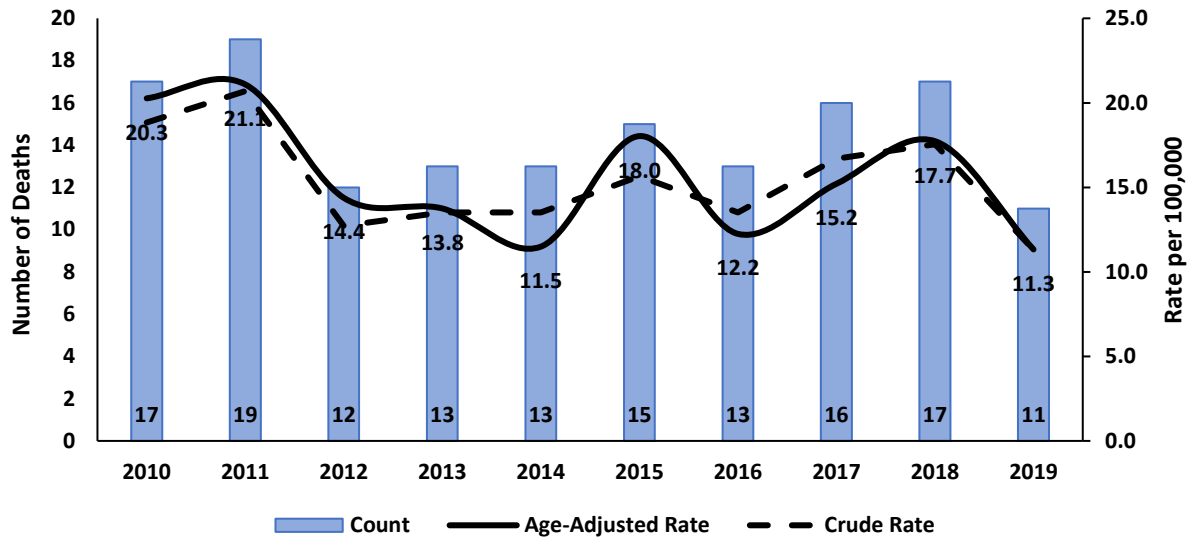
Figure 44. Alcohol-Related Deaths and Rates, Rural Region, 2010-2019.



Source: Electronic Death Registry System.

Alcohol-related deaths in the Rural Region have neither increased nor decreased significantly between 2010 to 2019.

Figure 45. Drug-Related Deaths and Rates, Rural Region, 2010-2019.



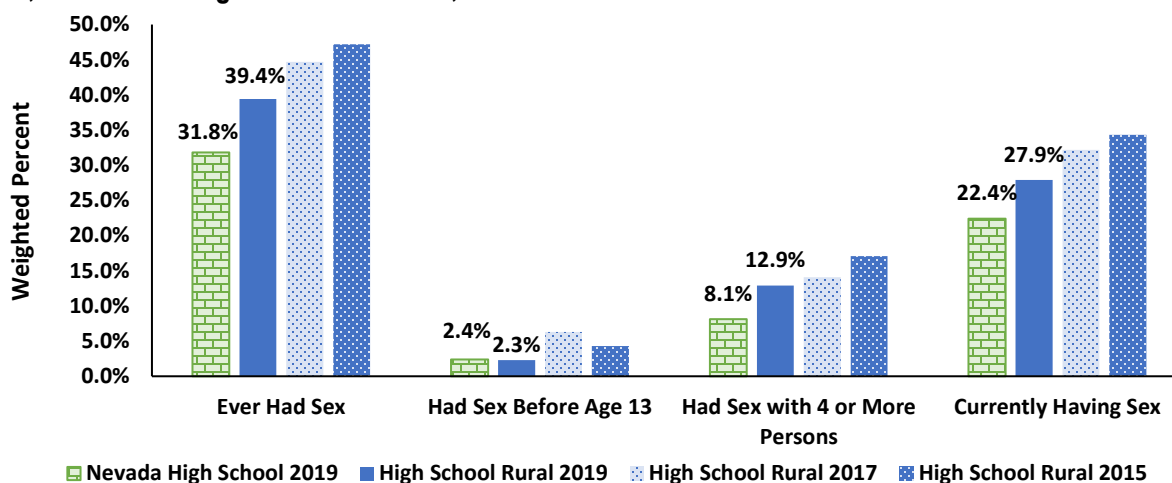
Source: Electronic Death Registry System.

In 2019, 11.3 deaths per 100,000 in the Rural Region were drug-related. This rate is the lowest in the 10-year period, with a high of 21.1 per 100,000 in 2011.

Youth (Adverse Effects from Youth)

Youth Risk Behavior Survey (YRBS)

Figure 46. Sexual Behaviors Among Students, Rural Region High School Students, 2015, 2017, and 2019, and Nevada High School Students, 2019.

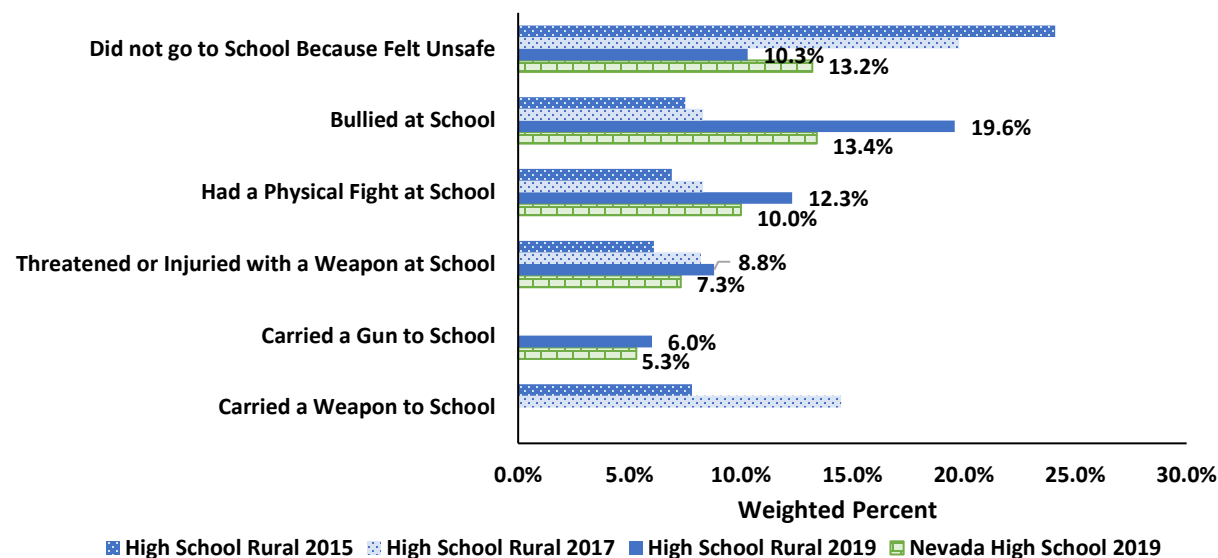


Source: Nevada Youth Risk Behavior Survey.

Chart scaled to 50% to display differences among groups.

There was a decrease in rates across sexual behaviors among high school students in the Rural Region in 2019.

Figure 47. Violence Among Students, Rural Region High School Students, 2015, 2017, and 2019, and Nevada High School Students, 2019.



Source: Nevada Youth Risk Behavior Survey.

Chart scaled to 30% to display differences among groups.

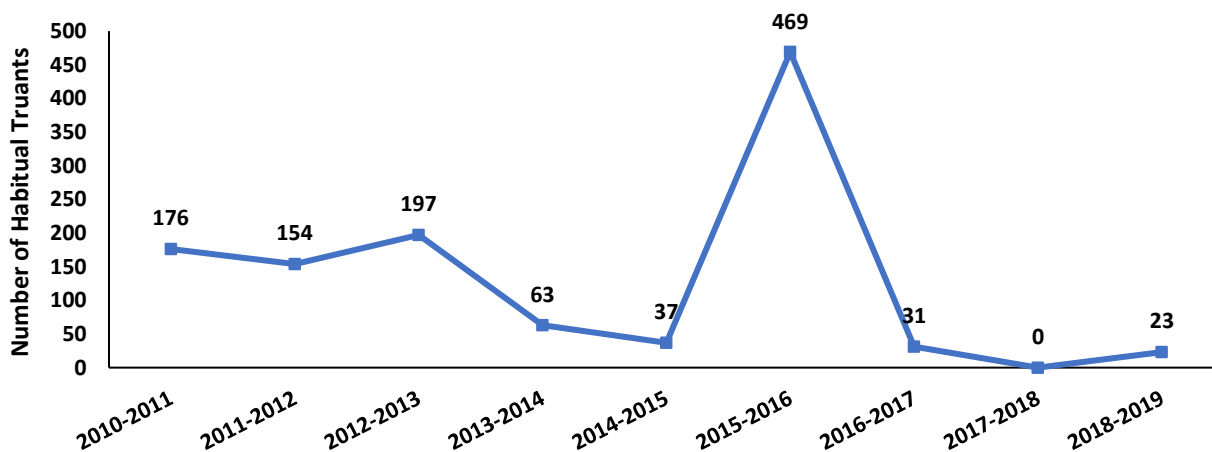
High school students in the Elko, White Pine and Eureka Counties; and Churchill, Humboldt, Pershing, and Lander Counties, at a significant higher percent's for carrying a weapon on school property. The high school students in Lyon, Mineral and Storey Counties had significantly high percent for being bullied at school. The middle school students in Nye, Lincoln, and Esmeralda County have significantly higher percent's for being bullied at school.

Nevada Report Card

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

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

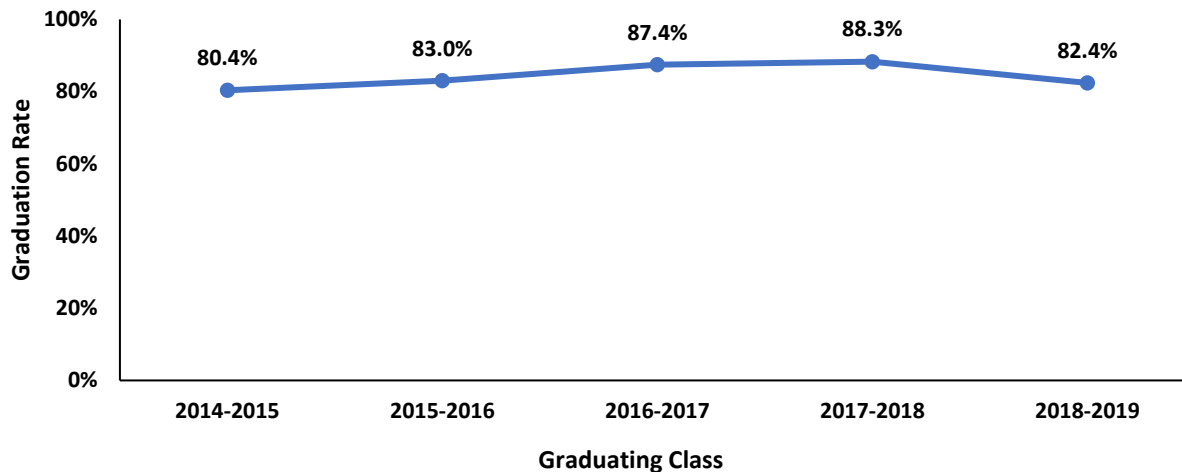
Figure 48. Number of Habitual Truants, Rural Region, Class Cohorts 2010–2019.



Source: Nevada Department of Education, Report Card.

The Rural Region's number of habitually truant students has decreased overall since 2010-2011 except for a spike in the 2015-2016 school year. The Rural Region recorded the lowest number of 0 truant students during the 2017-2018 school year. In 2018-2019, there were 23 habitually truant students.

Figure 49. High School Graduation Rate, Rural Region, Class Cohorts 2014–2019.



Source: Nevada Department of Education, Report Card.

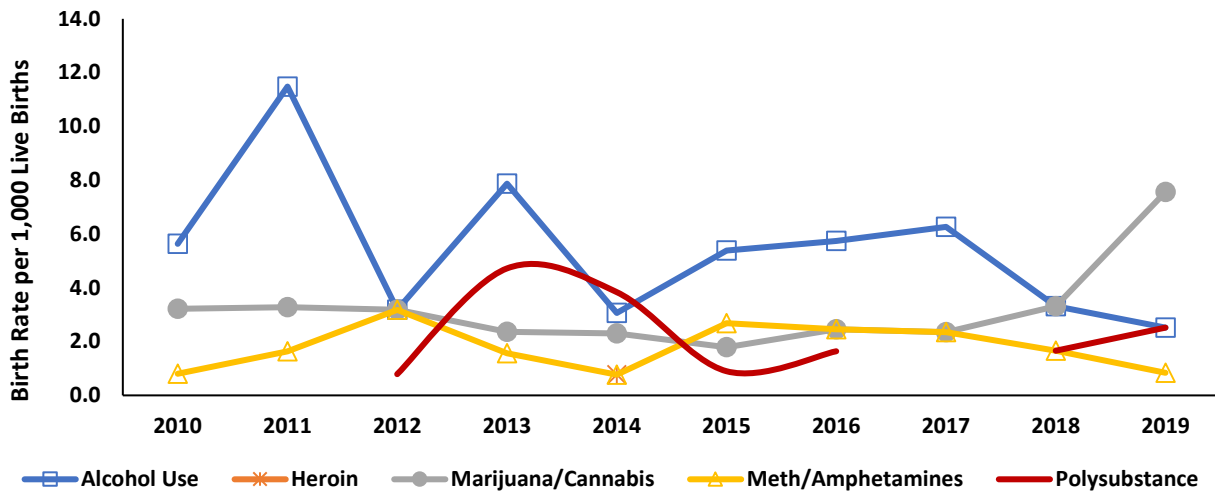
Graduation rate is defined as the rate at which 9th graders graduate by the end of the 12th grade (number of students who graduate in four years with a regular high school diploma divided by the number of students from the adjusted cohort for the graduation class). The Rural Region high schools' graduation rates decreased from 2017-2018 to 2018-2019 by approximately 6%.

Maternal and Child Health

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. In 2019, there were 1,190 births to mothers who reside in the Rural Region.

Figure 50. Prenatal Substance Use Birth Rates (Self-Reported) for Select Substances, Rural Region, 2010-2019.



Source: Nevada Electronic Birth Registry System.

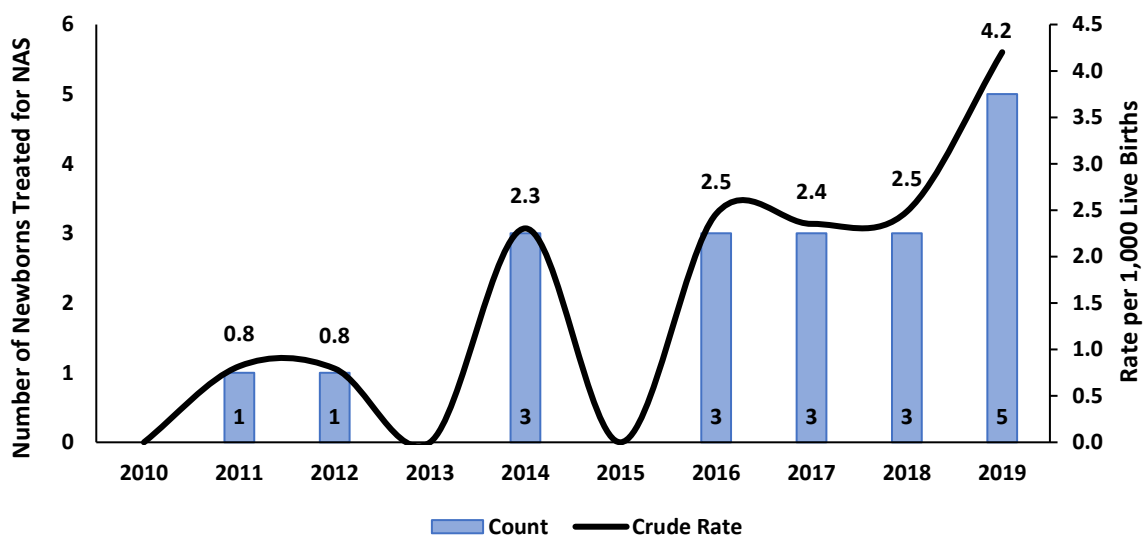
Of the self-reported substance use during pregnancy among Rural Region mothers who gave birth between 2010 and 2019, the highest rate was with alcohol use in 2011, at approximately 11.5 per 1,000 live births. Marijuana use increased from a rate of 3.3 per 1,000 live births in 2018 to 7.6 per 1,000 live births in 2019.

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

Neonatal Abstinence Syndrome

Neonatal abstinence syndrome (NAS) is a group of 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. The NAS rate in the Rural Region increased from 2.5 in 2018 to 4.2 in 2019.

Figure 51. Neonatal Abstinence Syndrome, Rural Region, 2010-2019.



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

Appendix

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

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

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

All Diagnosis:

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

Primary and All Diagnosis:

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

*Alcohol and Drug Use encounters are both Primary Diagnosis and All diagnosis were analyzed:

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

Suicide-related deaths: X60-X84, Y87.0 (Initial cause of death is suicide).
 Mental and Behavioral-related deaths: F00-F09, and F20-F99 (Initial or contributing cause of death).
 Alcohol-related deaths: K70, Y90, Y91, X45, X65, Y15, T51, K73, K74, G31.2, G62.1, I42.6, K29.2, K86.0, K85.0, R78.0, E24.4, O35.4, Q86.0, and Z72.1 (Initial cause of death).
 Drug-related Deaths: X40-X44, X60-S64, X85, Y10-Y14 (Initial cause of death).

*The 2019 Epidemiologic Profile utilized contributing cause of death for drug and alcohol related deaths, this methodology is changed to only the initial cause of death in this report, numbers will have decreased due to this change.

2020 Rural Behavioral Health Profile

Data Tables

Table 1. Population Distribution, Rural Region, 2010-2019.

	2010	2011	2012	2013	2014	2015	2016	2017	2017	2019
Rural	90,213	91,827	94,345	96,185	96,141	95,803	96,130	95,845	95,919	97,257
Sex										
Female	41,993	42,946	43,936	44,887	44,855	45,023	45,257	45,263	45,383	46,122
Male	48,220	48,881	50,409	51,298	51,286	50,780	50,873	50,582	50,536	51,135
Age										
<1	1,409	1,207	1,241	1,153	1,237	991	1,124	1,117	1,097	1,111
1-4	5,158	5,239	4,948	5,141	4,986	4,771	4,429	4,355	4,365	4,274
5-14	12,158	11,597	11,264	11,142	11,331	11,314	11,484	11,875	12,030	12,203
15-24	16,955	18,094	19,235	19,749	18,910	17,303	16,636	14,349	13,260	13,331
25-34	7,920	9,128	10,531	11,544	12,433	14,464	15,560	17,358	18,119	18,797
35-44	12,358	11,898	11,540	10,970	10,334	9,850	9,460	9,215	9,363	9,381
45-54	14,212	13,986	13,852	13,380	13,251	12,945	12,681	12,663	12,284	11,595
55-64	10,920	11,153	11,502	12,045	11,849	11,431	11,658	11,654	11,565	12,210
65-74	6,042	6,084	6,683	7,463	8,138	8,548	8,622	8,436	8,686	9,052
75-84	2,195	2,479	2,543	2,577	2,703	3,125	3,432	3,809	4,086	4,192
85+	885	961	1,007	1,019	968	1,060	1,044	1,012	1,065	1,110
Race/Ethnicity										
White non-Hispanic	65,181	66,532	68,624	70,069	69,648	67,899	67,887	67,110	66,940	67,664
Black non-Hispanic	1,133	1,334	1,375	1,370	1,373	1,423	1,449	1,481	1,491	1,498
Native American/Alaskan Native non-Hispanic	4,347	4,430	4,529	4,633	4,632	4,997	5,005	5,140	5,156	5,267
Asian/Pacific Islander non-Hispanic	904	954	959	985	1,026	1,153	1,151	1,182	1,191	1,205
Hispanic	18,648	18,577	18,857	19,128	19,461	20,332	20,638	20,933	21,141	21,622

Source: Nevada State Demographer, vintage 2019.

2020 Rural Behavioral Health Profile

Table 2: Prevalence Estimates of Health Risk Behaviors by Region, Nevada Adults, 2019.

Indicator	Clark	Northern	Rural	Southern	Washoe	Nevada
Ever seriously considered attempting suicide during the past 12 months	4.9% (3.2 - 6.6)	5.4% (2.7-8.1)	6.1% (1.6-10.6)	5.2% (0.0-11.9)	4.1% (2.6-5.5)	4.8% (3.6-6)
Heavy Drinkers	6.2% (4.6 - 7.8)	7.9% (4.9-10.9)	7.4% (3.1-11.6)	2.2% (0.0 - 6.6)	6.8% (4.8-8.8)	6.4% (5.1-7.7)
Binge Drinkers	16.4% (13.8 - 19.0)	15.9% (11.7-20.1)	22.0% (15-29)	11.3% (0.2 - 22.5)	18.3% (15.2-21.4)	15.0% (13.2-16.9)
General Health Poor or Fair	21.4% (18.7 - 24.4)	18.7% (14.4-23.1)	16.1% (10.2-22)	22.4% (5.3 - 36.5)	19.6% (16.3-22.8)	20.9% (18.7-23.1)
Depressive Disorder Diagnosis	18.0% (15.5 - 20.7)	21.9% (18-25.8)	15.2% (9.5-20.9)	16.9% (1.2 - 32.9)	16.8% (13.8-19.9)	17.7% (15.7-19.7)
Ten or more days of poor mental health	17.4% (15.0 - 20.3)	22.4% (17.4-27.2)	19.5% (12.9-26)	17.3% (1.3 - 25.5)	17.3% (14.4-20.2)	17.6% (15.5-19.6)
Ten or more days of poor mental or physical health kept from usual activities	23.3% (19.7 - 27.6)	20.5% (14.8-26.2)	24.4% (14-34.9)	29.1% (12.8 - 45.3)	20.3% (16.1-24.5)	22.9% (19.8-25.9)
Used marijuana/hashish in the last 30 days	16.4% (13.8 - 19.3)	20.3% (15.6-25.1)	21.5% (14-29)	11.0% (1.9 - 11.5)	18.7% (15.4-21.9)	17.4% (15.3-19.4)
Used other illegal drugs in the last 30 days	1.7% (0.8 - 2.6)	1.6% (0.1-3.1)	0.0% 0	2.3% (0.0 - 4.5)	3.1% (1.6-4.6)	1.9% (1.2-2.6)
Used prescription drugs/pain killer to get high in last 30 days	0.6% (0.5 - 1.1)	1.0% (0-2.2)	0.9% (0-2.2)	0.0% (~ - 2.9)	0.9% (0.4-1.5)	1.0% (0.2-1.1)
Current tobacco cigarette smokers	14.9% (12.7 - 17.5)	17.4% (13-21.8)	23.1% (15.7-30.4)	17.0% (3.9 - 26.5)	15.7% (12.7-18.8)	15.7% (13.8-17.5)
Difficulty doing errands alone because of physical, mental, or emotional condition	8.7% (6.8 - 10.9)	10.6% (6.9-14.3)	7.2% (3.3-11.1)	10.8% (0.0 - 25.2)	7.5% (5.5-9.5)	8.6% (7.1-10.2)
Serious difficulty concentrating, remembering, or making decisions because of physical, mental, or emotional condition	13.0% (10.8 - 15.4)	13.9% (9.8-18)	14.4% (8.2-20.7)	9.4% (1.5 - 16.9)	11.1% (8.5-13.7)	12.8% (11-14.6)

Source: Behavioral Risk Factor Surveillance System (BRFSS).

2020 Rural Behavioral Health Profile

Table 3a. Age-Adjusted Rates per 100,000 of Mental Health-Related Emergency Department Encounters by Region, Nevada Residents, 2019.

Region	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicidal Ideation
Clark	508.7 (499.4-517.9)	1,983.1 (1,964.9-2,001.2)	1,254.6 (1,240.2-1,269.0)	763.0 (751.8-774.3)	245.3 (238.9-251.7)	577.9 (568.1-587.8)
Northern	158.3 (139.9-176.7)	1,391.1 (1,338.9-1,443.2)	584.0 (551.0-617.0)	466.6 (435.1-498.1)	131.7 (114.9-148.5)	223.1 (200.4-245.8)
Rural	245.6 (213.7-277.4)	2,741.4 (2,636.0-2,846.9)	2,160.2 (2,066.2-2,254.3)	623.5 (573.0-674.1)	464.2 (417.7-510.8)	383.1 (343.4-422.7)
Southern	206.9 (166.6-247.3)	1,530.6 (1,430.9-1,630.4)	827.2 (753.3-901.1)	477.9 (418.5-537.4)	216.4 (177.9-255.0)	585.9 (519.5-652.3)
Washoe	309.6 (293.5-325.8)	1,876.0 (1,837.0-1,915.0)	1,142.6 (1,112.3-1,172.8)	565.8 (544.4-587.2)	238.6 (224.5-252.7)	415.0 (396.5-433.5)
Nevada	445.4 (438.0-452.9)	1,945.8 (1,930.4-1,961.3)	1,212.8 (1,200.7-1,224.9)	707.6 (698.3-717.0)	242.9 (237.4-248.5)	527.8 (519.7-535.9)

Source: Hospital Emergency Department Billing.

Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2019.

Categories are not mutually exclusive.

Table 3b. Crude Rates per 100,000 of Mental Health-Related Emergency Department Encounters by Region, Nevada Residents, 2019.

Region	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicidal Ideation
Clark	510.6 (501.3-519.8)	2,008.1 (1,989.7-2,026.5)	1,281.0 (1,266.4-1,295.7)	769.4 (758.0-780.8)	244.8 (238.3-251.2)	575.4 (565.5-585.2)
Northern	147.4 (130.2-164.5)	1,416.5 (1,363.4-1,469.7)	622.7 (587.4-657.9)	437.4 (407.9-466.9)	122.5 (106.8-138.1)	192.5 (172.9-212.1)
Rural	234.4 (204.0-264.9)	2,670.2 (2,567.5-2,772.9)	2,084.2 (1,993.4-2,174.9)	601.5 (552.8-650.2)	392.8 (353.4-432.2)	369.1 (330.9-407.3)
Southern	170.6 (137.3-203.9)	1,528.8 (1,429.2-1,628.4)	812.5 (739.9-885.1)	418.9 (366.8-471.1)	204.4 (168.0-240.8)	505.1 (447.8-562.3)
Washoe	300.5 (284.8-316.1)	1,889.3 (1,850.0-1,928.6)	1,168.6 (1,137.7-1,199.5)	570.9 (549.3-592.5)	234.5 (220.6-248.3)	411.1 (392.8-429.4)
Nevada	441.9 (434.5-449.3)	1,970.3 (1,954.7-1,985.9)	1,241.4 (1,229.0-1,253.8)	708.0 (698.6-717.4)	239.8 (234.4-245.3)	520.2 (512.2-528.2)

Source: Hospital Emergency Department Billing.

Rates are per 100,000 population, provided by the state demographer, vintage 2019.

Categories are not mutually exclusive.

2020 Rural Behavioral Health Profile

Table 4a. Age-Adjusted Rates per 100,000 of Mental Health-Related Inpatient Admissions by Region, Nevada Residents, 2019.

Region	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicidal Ideation
Clark	245.6 (239.2-251.9)	1,135.3 (1,121.7-1,148.8)	1,066.8 (1,053.6-1,079.9)	473.5 (464.7-482.2)	187.4 (181.8-192.9)	559.8 (550.1-569.4)
Northern	89.1 (76.3-102.0)	1,276.0 (1,228.3-1,323.7)	1,250.4 (1,202.8-1,297.9)	400.3 (372.2-428.4)	342.5 (315.6-369.3)	651.4 (613.2-689.5)
Rural	31.7 (21.0-42.4)	572.2 (524.9-619.6)	669.4 (618.0-720.8)	160.7 (135.0-186.4)	122.5 (100.1-144.9)	289.8 (255.1-324.4)
Southern	91.9 (67.4-116.4)	1,324.1 (1,244.0-1,404.2)	915.4 (845.9-985.0)	526.8 (466.8-586.8)	229.5 (192.0-267.0)	394.1 (342.3-446.0)
Washoe	132.9 (122.7-143.2)	988.0 (960.2-1,015.7)	1,077.1 (1,048.1-1,106.2)	402.8 (384.9-420.7)	281.9 (266.6-297.1)	713.4 (689.0-737.7)
Nevada	445.4 (438.0-452.9)	1,945.8 (1,930.3-1,961.2)	1,212.8 (1,200.7-1,224.9)	707.6 (698.2-717.0)	242.9 (237.4-248.5)	527.8 (519.6-535.9)

Source: Hospital Inpatient Billing.

Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2019.

Categories are not mutually exclusive.

Table 4b. Crude Rates per 100,000 of Mental Health-Related Inpatient Admissions by Region, Nevada Residents, 2019.

Region	Schizophrenia	Anxiety	Depression	Bipolar	PTSD	Suicidal Ideation
Clark	251.6 (245.1-258.1)	1,183.2 (1,169.1-1,197.3)	1,107.4 (1,093.7-1,121.0)	490.0 (480.9-499.1)	192.1 (186.4-197.7)	564.3 (554.6-574.1)
Northern	96.0 (82.2-109.8)	1,427.4 (1,374.1-1,480.8)	1,379.2 (1,326.8-1,431.6)	405.2 (376.8-433.7)	323.8 (298.4-349.2)	580.6 (546.6-614.7)
Rural	35.0 (23.2-46.7)	576.8 (529.1-624.6)	670.4 (618.9-721.9)	154.2 (129.6-178.9)	118.2 (96.6-139.9)	276.6 (243.5-309.6)
Southern	91.2 (66.9-115.6)	1,773.7 (1,666.4-1,881.0)	1,125.0 (1,039.6-1,210.5)	500.0 (443.1-557.0)	243.3 (203.5-283.0)	375.0 (325.7-424.3)
Washoe	136.8 (126.2-147.4)	1,034.6 (1,005.5-1,063.6)	1,125.4 (1,095.1-1,155.7)	413.0 (394.6-431.4)	277.9 (262.8-293.0)	702.8 (678.9-726.8)
Nevada	441.9 (434.5-449.3)	1,970.2 (1,954.6-1,985.8)	1,241.4 (1,229.0-1,253.8)	708.0 (698.6-717.3)	239.8 (234.3-245.2)	520.2 (512.1-528.2)

Source: Hospital Inpatient Billing.

Rates are per 100,000 population, provided by the state demographer, vintage 2019.

Categories are not mutually exclusive.

Table 5. Mental Health-Related Deaths Age-Adjusted Rates and Region, Nevada Residents, 2019.

Region	White non-Hispanic	Black non-Hispanic	Native American/ Alaskan Native	Asian/Pacific Islander	Hispanic	Total
Clark	45.5 (41.9-49.1)	51.1 (40.1-62.1)	15.3 (0.0-45.3)	27.1 (20.0-34.3)	26.1 (19.3-32.8)	42.0 (39.1-44.9)
Northern	83.1 (72.4-93.9)	0.0 (0.0-00.0)	70.8 (8.7-132.9)	42.7 (0.0-101.8)	12.9 (0.0-30.7)	79.2 (69.1-89.2)
Rural	41.5 (26.4-56.6)	0.0 (0.0-00.0)	0.0 (0.0-00.0)	0.0 (0.0-00.0)	26.5 (0.0-56.5)	36.5 (23.9-49.2)
Southern	36.0 (24.5-47.4)	115.9 (0.0-276.5)	0.0 (0.0-00.0)	90.5 (0.0-215.8)	32.4 (0.0-77.4)	39.5 (28.0-51.1)
Washoe	77.1 (68.0-86.1)	55.6 (0.0-118.6)	60.8 (1.2-120.3)	42.0 (16.0-68.1)	35.1 (15.2-54.9)	71.7 (63.7-79.7)
Nevada	55.1 (51.9-58.2)	52.3 (41.4-63.1)	33.1 (12.6-53.6)	29.5 (22.5-36.4)	26.5 (20.6-32.5)	50.1 (47.5-52.7)

Source: Electronic Death Registry System.

Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2019.

Table 6. Suicide Attempts and Suicides by Leading Method and Region, Nevada Residents, 2019.

Region	Suicide Attempts				Suicides		
	Emergency Department Encounters		Inpatient Admissions		Substance	Hanging/ Suffocation	Firearms/ Explosives
	Substance	Cutting	Substance	Cutting			
Clark	49.8 (46.9-52.7)	8.2 (7.1-9.4)	54.4 (51.4-57.4)	27.0 (24.9-29.1)	3.2 (2.4-03.9)	3.9 (3.1-04.7)	9.6 (8.4-10.9)
Northern	83.5 (70.6-96.4)	18.7 (12.6-24.8)	42.0 (32.9-51.2)	22.8 (16.1-29.6)	3.1 (0.6-05.6)	9.9 (5.4-14.3)	17.1 (11.3-23.0)
Rural	78.1 (60.6-95.7)	46.3 (32.8-59.8)	35.0 (23.2-46.7)	9.3 (3.2-15.3)	0.0 -	4.1 (0.1-08.1)	25.7 (15.6-35.8)
Southern	79.4 (56.7-102.1)	62.5 (42.4-82.6)	49.0 (31.2-66.8)	11.8 (3.1-20.6)	5.1 (0.0-10.8)	5.1 (0.0-10.8)	23.6 (11.3-36.0)
Washoe	51.7 (45.2-58.2)	11.3 (8.2-14.3)	87.9 (79.4-96.4)	12.1 (9.0-15.3)	3.8 (2.1-05.6)	6.4 (4.1-08.7)	13.0 (9.7-16.2)
Nevada	54.4 (51.8-57.0)	25.6 (23.9-27.4)	56.7 (54.0-59.3)	9.5 (8.5-10.6)	3.2 (2.6-03.8)	4.7 (3.9-05.4)	11.4 (10.2-12.6)

Source: Hospital Emergency Department Billing, Inpatient Billing, and the Electronic Death Registry System.

Rates are per 100,000 population, provided by the state demographer, vintage 2019.

Table 7. Suicides (Crude) Rates by Age, Race/Ethnicity and Region, Nevada Residents, 2019.

	Clark	Northern	Rural	Southern	Washoe	Nevada
Age Group						
Less than 15	0.6 (0.0-01.5)	4.6 (0.0-13.6)	0.0 -	0.0 -	3.3 (0.0-07.9)	1.2 (0.2-02.3)
15-24	13.0 (9.0-17.1)	18.1 (0.4-35.8)	52.5 (13.6-91.4)	0.0 -	19.9 (9.1-30.7)	15.4 (11.7-19.2)
25-34	24.2 (18.8-29.6)	32.0 (9.8-54.1)	31.9 (6.4-57.5)	42.8 (0.0-91.3)	28.8 (15.8-41.7)	26.0 (21.2-30.7)
35-44	17.1 (12.6-21.6)	51.7 (19.6-83.7)	42.6 (0.9-84.4)	70.8 (1.4-140.2)	23.3 (11.1-35.5)	20.9 (16.5-25.3)
45-54	23.2 (17.7-28.6)	43.9 (18.0-69.9)	34.5 (0.7-68.3)	44.8 (0.0-95.6)	30.4 (16.0-44.9)	26.4 (21.4-31.4)
55-64	27.2 (20.9-33.5)	26.1 (6.8-45.5)	16.4 (0.0-39.1)	32.7 (0.0-69.8)	36.4 (21.2-51.7)	28.4 (23.0-33.8)
65-74	29.2 (21.5-37.0)	28.1 (7.3-48.8)	44.2 (0.9-87.5)	47.2 (0.9-93.5)	23.9 (9.8-38.0)	29.3 (22.9-35.7)
75-84	35.6 (23.5-47.8)	44.3 (8.9-79.8)	95.4 (1.9-188.9)	17.7 (0.0-52.3)	67.7 (32.2-103.1)	42.4 (31.5-53.3)
85+	44.0 (19.1-68.9)	108.6 (13.4-203.8)	90.1 (0.0-266.6)	120.7 (0.0-288.1)	16.1 (0.0-47.5)	51.4 (29.4-73.4)
Race/Ethnicity						
White non-Hispanic	29.1 (25.7-32.4)	38.5 (28.5-48.4)	39.9 (24.9-55.0)	39.3 (21.1-57.4)	34.2 (27.5-40.8)	31.8 (29.0-34.6)
Black non-Hispanic	13.2 (8.8-17.7)	0.0 -	0.0 -	0.0 -	8.2 (0.0-24.4)	12.8 (8.5-17.0)
Native American/Alaskan Native non-Hispanic	19.8 (0.0-42.1)	0.0 -	38.0 (0.0-90.6)	0.0 -	13.5 (0.0-40.1)	16.9 (3.4-30.4)
Asian/Pacific Islander non- Hispanic	10.6 (6.7-14.6)	0.0 -	0.0 -	0.0 -	12.0 (0.2-23.7)	10.5 (6.9-14.2)
Hispanic	7.5 (5.6-09.5)	6.3 (0.0-15.0)	13.9 (0.0-29.6)	23.5 (0.0-56.0)	4.1 (0.5-07.7)	7.3 (5.6-09.1)
Total	18.3 (16.5-20.0)	30.6 (22.8-38.4)	32.9 (21.5-44.3)	33.8 (19.0-48.6)	24.0 (19.6-28.5)	20.7 (19.1-22.3)

Source: Electronic Death Registry System.

Rates are per 100,000 population, provided by the state demographer, vintage 2019.

Table 8a. Drug-Related Emergency Department Encounters Age-Adjusted Rates by Drug Type and Region, Nevada Residents, 2019.

Region	Opioids	Heroin	Cocaine	Methamphetamines	Marijuana	Hallucinogens
Clark	188.7 (183.1-194.3)	8.6 (7.4-9.8)	83.6 (79.9-87.3)	507.7 (498.4-517.0)	390.3 (382.2-398.4)	24.0 (21.9-26.0)
North	165.7 (147.7-183.6)	8.4 (4.5-12.3)	30.9 (22.5-39.4)	280.3 (255.3-305.2)	594.4 (558.4-630.4)	3.4 (.7-6.2)
Rural	128.1 (105.9-150.3)	9.4 (4.1-14.8)	24.6 (14.3-34.8)	262.9 (230.3-295.5)	594.3 (545.2-643.4)	10.3 (3.6-17.0)
Southern	211.2 (173.8-248.7)	19.1 (9.1-29.1)	18.0 (6.8-29.2)	377.6 (324.4-430.7)	232.4 (191.0-273.9)	8.5 (.2-16.8)
Washoe	220.5 (207.1-233.9)	18.3 (14.4-22.2)	38.5 (32.9-44.1)	525.1 (503.9-546.2)	240.5 (226.4-254.6)	7.7 (5.1-10.2)
Nevada	200.1 (195.1-205.0)	10.4 (9.3-11.5)	70.7 (67.7-73.6)	489.1 (481.2-496.9)	382.7 (375.8-389.6)	19.9 (18.3-21.5)

Source: Hospital Emergency Department Billing.

Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2019.

Categories are not mutually exclusive.

Table 8b. Drug-Related Emergency Department Encounters Crude Rates by Drug Type Region, Nevada Residents, 2019.

Region	Opioids	Heroin	Cocaine	Methamphetamines	Marijuana	Hallucinogens
Clark	192.9 (187.2-198.6)	8.9 (7.6-10.1)	85.9 (82.1-89.7)	501.8 (492.6-511.0)	389.3 (381.2-397.4)	23.6 (21.6-25.6)
North	169.7 (151.3-188.1)	9.3 (5.0-13.7)	26.5 (19.2-33.7)	251.7 (229.3-274.1)	543.8 (510.9-576.7)	3.1 (.6-5.6)
Rural	131.6 (108.8-154.4)	12.3 (5.4-19.3)	22.6 (13.2-32.1)	257.1 (225.2-288.9)	578.9 (531.1-626.7)	9.3 (3.2-15.3)
Southern	206.1 (169.5-242.7)	23.6 (11.3-36.0)	16.9 (6.4-27.4)	327.7 (281.6-373.8)	204.4 (168.0-240.8)	6.8 (.1-13.4)
Washoe	220.9 (207.4-234.3)	18.3 (14.4-22.2)	38.5 (32.9-44.1)	504.7 (484.4-525.0)	237.5 (223.5-251.4)	7.4 (5.0-9.9)
Nevada	204.0 (199.0-209.1)	10.7 (9.6-11.9)	71.8 (68.9-74.8)	477.4 (469.7-485.1)	378.9 (372.1-385.8)	19.2 (17.7-20.8)

Source: Hospital Emergency Department Billing.

Rates are per 100,000 population, provided by the state demographer, vintage 2019.

Categories are not mutually exclusive.

2020 Rural Behavioral Health Profile

Table 9a. Drug-Related Inpatient Admissions Age-Adjusted Rates by Drug Type and Region, Nevada Residents, 2019.

Region	Opioids	Heroin	Cocaine	Methamphetamines	Marijuana	Hallucinogens
Clark	269.0 (262.5-275.6)	9.6 (8.3-10.8)	89.5 (85.8-93.3)	393.8 (385.7-401.9)	486.3 (477.4-495.2)	7.9 (6.8-9.1)
North	401.5 (374.6-428.3)	8.6 (4.9-12.2)	28.1 (20.1-36.0)	405.6 (375.5-435.8)	528.2 (494.6-561.7)	7.3 (3.0-11.6)
Rural	118.2 (96.7-139.7)	6.5 (1.7-11.3)	19.9 (10.4-29.3)	197.6 (169.5-225.7)	216.9 (187.7-246.1)	3.2 (-.4-6.9)
Southern	147.3 (119.1-175.5)	7.9 (1.0-14.9)	19.7 (9.0-30.4)	263.0 (220.0-305.9)	382.9 (334.1-431.8)	3.3 (-1.3-8.0)
Washoe	375.7 (358.5-393.0)	16.6 (13.0-20.2)	50.3 (43.8-56.8)	502.3 (481.8-522.9)	438.6 (419.8-457.4)	5.1 (3.0-7.2)
Nevada	293.9 (288.0-299.7)	10.3 (9.3-11.4)	76.0 (73.0-79.0)	401.7 (394.7-408.8)	470.6 (463.1-478.2)	7.3 (6.3-8.2)

Source: Hospital Inpatient Billing.

Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2019.

Categories are not mutually exclusive.

Table 9b. Drug-Related Inpatient Admissions Crude Rates by Drug Type and Region, Nevada Residents, 2019.

Region	Opioids	Heroin	Cocaine	Methamphetamines	Marijuana	Hallucinogens
Clark	282.2 (275.3-289.1)	10.4 (9.1-11.7)	95.7 (91.7-99.7)	398.9 (390.7-407.1)	497.8 (488.7-507.0)	8.0 (6.8-9.1)
North	445.2 (415.4-475.0)	10.9 (6.2-15.6)	24.9 (17.9-32.0)	361.1 (334.3-388.0)	494.5 (463.1-525.9)	5.7 (2.3-9.1)
Rural	119.3 (97.6-141.0)	7.2 (1.9-12.5)	17.5 (9.2-25.8)	195.4 (167.6-223.1)	218.0 (188.6-247.3)	3.1 (-.4-6.6)
Southern	177.4 (143.4-211.3)	8.4 (1.0-15.9)	22.0 (10.0-33.9)	243.3 (203.5-283.0)	398.7 (347.8-449.5)	3.4 (-1.3-8.1)
Washoe	390.0 (372.2-407.9)	17.4 (13.7-21.2)	49.4 (43.0-55.7)	488.5 (468.6-508.5)	446.2 (427.1-465.3)	4.9 (2.9-6.9)
Nevada	310.1 (303.9-316.3)	11.4 (10.2-12.6)	80.6 (77.4-83.7)	401.8 (394.7-408.8)	479.9 (472.2-487.7)	7.2 (6.2-8.1)

Source: Hospital Inpatient Billing.

Rates are per 100,000 population, provided by the state demographer, vintage 2019.

Categories are not mutually exclusive.

Table 10. Drug- and Alcohol-Related Age-Adjusted Death Rates by Race/Ethnicity and Region, Nevada Residents, 2019.

Region	White non-Hispanic	Black non-Hispanic	Native American/ Alaskan Native	Asian/ Pacific Islander	Hispanic	Total
Clark	57.4 (53.3-61.6)	48.5 (39.9-57.0)	60.2 (22.9-97.5)	16.0 (11.2-20.7)	29.6 (25.2-34.0)	44.5 (41.8-47.1)
Northern	67.8 (56.5-79.1)	81.7 (0.0-195.0)	202.9 (92.6-313.2)	21.9 (0.0-64.8)	26.8 (8.2-45.3)	67.7 (57.3-78.1)
Rural	51.7 (35.7-67.7)	0.0 (0.0-00.0)	52.7 (0.0-112.3)	0.0 (0.0-00.0)	11.6 (0.0-24.7)	43.0 (30.6-55.5)
Southern	56.0 (38.9-73.2)	0.0 (0.0-00.0)	112.5 (0.0-268.4)	0.0 (0.0-00.0)	45.7 (0.0-97.3)	54.1 (38.5-69.8)
Washoe	78.9 (69.7-88.1)	131.9 (65.1-198.6)	90.3 (23.4-157.2)	14.0 (1.7-26.2)	37.6 (24.8-50.5)	67.0 (59.9-74.0)
Nevada	62.7 (59.2-66.2)	52.2 (43.7-60.8)	89.8 (60.1-119.6)	15.8 (11.4-20.2)	30.3 (26.3-34.3)	49.9 (47.5-52.3)

Source: Electronic Death Registry System.

Rates are per 100,000 age-specific population, provided by the state demographer, vintage 2019.