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The Social Health of Nevada

Leading Indicators and Quality of Life in the Silver State

Injury-Related Mortality in Nevada

Elizabeth Lawrence, *University of Nevada, Las Vegas*
Izuchukwu Chikeluba, *University of Nevada, Las Vegas*
Jay Parikh, *University of Nevada, Las Vegas*

Introduction

Too many lives are lost to injury in the United States and Nevada. In 2023, over 300,000 people in the United States died from an injury (NCHS 2024). Each of these deaths not only extinguishes a life but also affects the friends, family, and community of the deceased. And deaths from injury are costly: the most recent estimates indicate that annual costs from fatal injuries are around $3 trillion (CDC 2025a).

Injury refers to damage to the body from some external force, such as from a car crash or a fall, including kinetic, chemical, electrical, thermal, or other forces. There are multiple types of death from injury. Health researchers and policymakers classify injuries as unintentional or intentional, and if intentional, injury deaths are then classified as either suicide or homicide. Researchers and policymakers further categorize injuries by the mechanism or circumstances of the injury (such as motor vehicle crash, poisoning, or firearm).

Since the previous report on this topic indicating a potentially worrisome rise in injury mortality (Lawrence and Pace 2018), the death rate from injuries has dramatically increased for both Nevada and the United States. The social and economic impacts of the COVID-19 pandemic (2020-2023) likely were an important contributor to the increases in injury mortality, although researchers are still working to disentangle the complex and overlapping factors shaping changes over time.

Highlights

- Injury mortality has risen over the last decade in Nevada and the United States, exceeding 300,000 deaths in 2023.
- In 2023, suicides were 41% higher for Nevadan, compared to American men, and 64% higher for Nevadan women.
- Drug overdose deaths increased from 2020; U.S. rates peaked in 2022, but Nevadan rates continued to rise in 2023.
- Women in Nevada are 65% more likely to be killed by an intimate partner compared the U.S. average.
- Nearly half (44%) of motor vehicle fatalities in 2022 were linked to impairment in Nevada.

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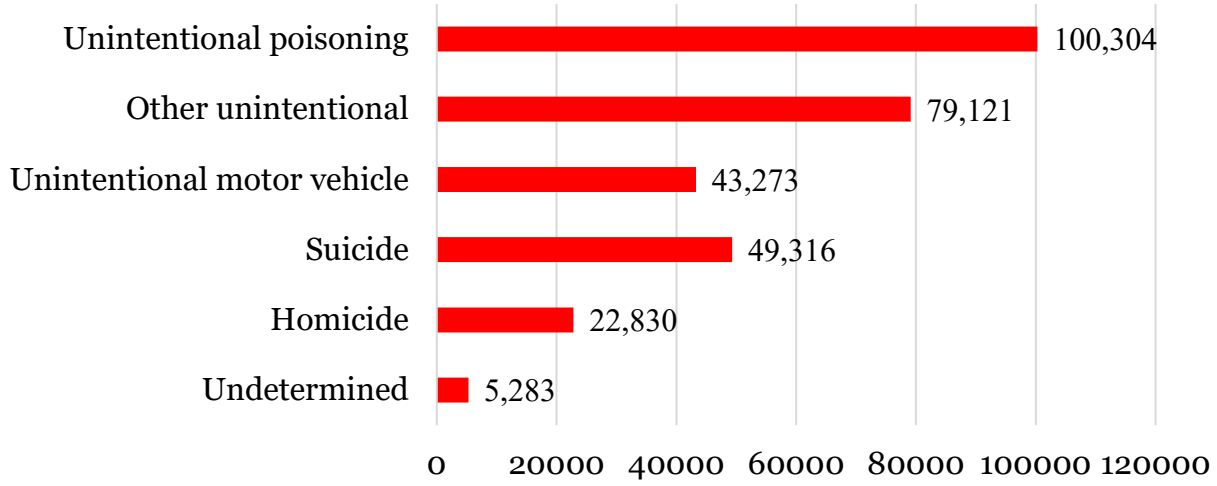
Current rates of death from injury in the United States are high, with over 300,000 lives lost in 2023. As depicted in Figure 1, nearly three-quarters of injury deaths in the U.S. were unintentional, which includes over 100,000 individuals dying from poisoning (drug overdose), over 40,000 from motor vehicle crashes, and nearly 80,000 deaths from other unintentional causes. Public health researchers use the term unintentional rather than accidental, to indicate that deaths are not random or inevitable: drug overdoses, car crashes, falls, and other such deaths are preventable. For intentional deaths, there were more than twice as many suicides (49,316) as homicides (22,830). A small proportion of deaths (5,283, or 2% of injury mortality) had intentions that were unable to be determined. Comparing injury rates in the United States to other countries (displayed in Appendix B) further emphasizes the relatively high rates of injury mortality, and also demonstrates the increasing U.S. disadvantage compared to its peers.

Figure 1. Number of deaths from injury in the United States, 2023



Source: CDC (2025b)

Injuries are a key area for public health because they are mostly preventable. Indeed, death from injury is much less common today compared to a century ago, as a result of preventive measures such as seatbelts as well as improved treatment and care. Yet, injury mortality is still quite high. Table 1 presents the leading causes of death in the state of Nevada and nationally, with injury causes in bold. Unintentional injuries, both nationally and within Nevada, were the third leading cause of death in 2023, trailing behind only heart disease and cancer (CDC 2025b). Suicide and homicide claim many lives each year, and more so within Nevada compared to other states. Suicide ranks eleventh in the leading cause of death for the United States, and eighth within Nevada. Homicide is not within the top 15 for the country, but ranks at number 15 within Nevada.

Table 1. Leading causes of death in the United States and Nevada, 2023

	United States	*Nevada*
1	Diseases of heart	Diseases of heart
2	Malignant neoplasms	Malignant neoplasms
3	**Unintentional injuries**	**Unintentional injuries**
4	Cerebrovascular diseases	Chronic lower respiratory diseases
5	Chronic lower respiratory diseases	Cerebrovascular diseases
6	Alzheimer disease	Diabetes mellitus
7	Diabetes mellitus	Alzheimer disease

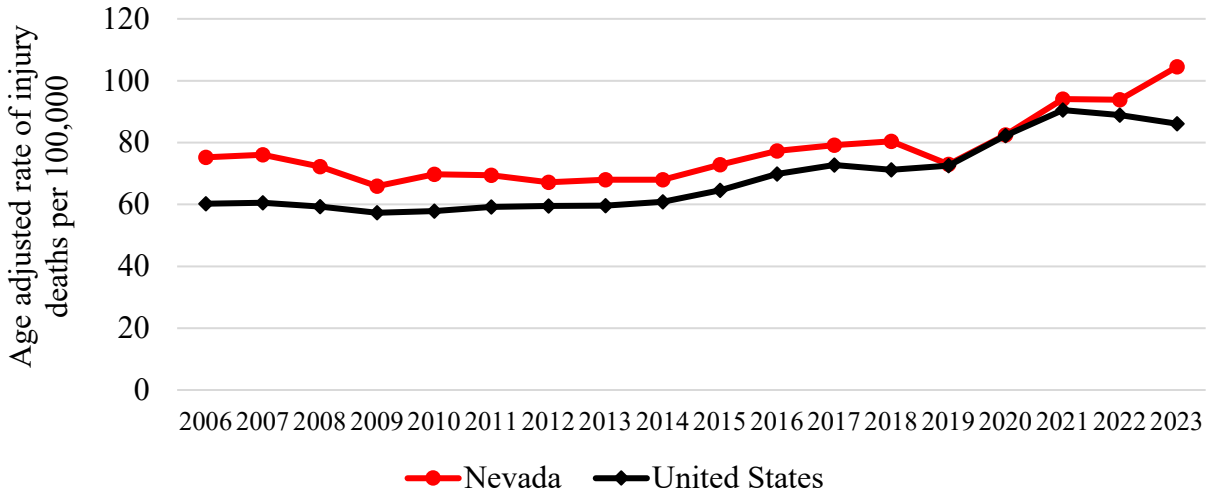
8	Nephritis, nephrotic syndrome and nephrosis	**Suicide**
9	Chronic liver disease and cirrhosis	Chronic liver disease and cirrhosis
10	COVID-19	Influenza and pneumonia
11	**Suicide**	Essential hypertension and hypertensive renal disease
12	Influenza and pneumonia	COVID-19
13	Essential hypertension and hypertensive renal disease	Parkinson disease
14	Septicimia	Nephritis, nephrotic syndrome and nephrosis
15	Parkinson disease	**Homicide**

Source: CDC (2025b)

Injuries are particularly dangerous for those in the first half of life since injury is the leading cause of death for all age groups 1- 45 (CDC 2025a). Because injuries affect those of all ages, the deaths of young people from injuries take many more years of life compared to other causes of death, which mostly affect older people.

Injury mortality is a key public health issue in Nevada and nationwide. Figure 2 shows injury mortality rates for Nevada compared to the U.S. average from 2006 to 2023. These rates have been adjusted so that the age composition for Nevada and the United States do not affect the comparison. Nevada had consistently higher rates of injury mortality from 2006-2018, but converged with the United States in 2019-2020. Nevada had a higher injury mortality rate in 2021-2022, which grew in 2023. (Appendix C depicts comparisons between Nevada and 10 states with the highest and lowest injury mortality.) How Nevada fares compared to the rest of the country currently and in the future is yet unknown.

Figure 2. Age-adjusted rates of injury death in Nevada and United States, 2006-2023



Source: CDC (2025b)

This report describes injury mortality in Nevada and compares it to the United States average. It focuses on the most prevalent deaths from injury: suicide, homicide, poisoning, and motor vehicle crashes. We use data provided by the Centers for Disease Control and Prevention (CDC) in a web application known as Wide-ranging Online Data

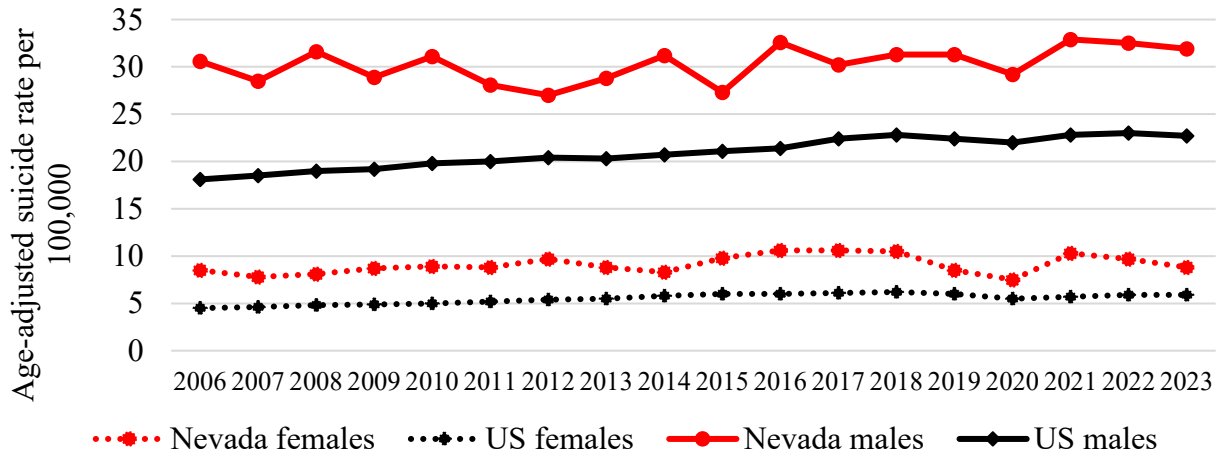
for Epidemiologic Research (CDC 2025b; see the website for details on this publicly accessible resource, https://wonder.cdc.gov/). In the previous chapter published on the same topic (Lawrence and Pace 2018), we presented data from 2006-2016, to which we now add 2017-2023 figures and analyze the 2006-2023 dataset. Within Nevada, deaths within specific groups can be a small number, but we describe rates within sex, race/ethnicity, and ten-year age groups when possible and relevant. With regard to age-specific values, we use age-adjusted rates to account for the differing age structure in the United States and Nevada. Our report concludes with policy implications, suggestions about prevention programs, and recommendations for future research.

Suicide

Suicide is more common in Nevada than the United States. Nevada lies in what has been termed the "suicide belt," a geographic distinction that encompasses 10 western mountain states (Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, and Wyoming) (Wray et al. 2012). Suicide rates are often higher in rural, compared to urban areas, but the city of Las Vegas, home to nearly two-thirds of Nevada's residents, displays a high suicide rate, leading to the moniker of "suicide capital" (Wray et al. 2008).

Figure 3 shows the age-adjusted suicide rates for men and women in Nevada and the United States from 2006 to 2023. Because the population is smaller in Nevada, there is considerable year-to-year fluctuation, so examining broader trends is more useful than specific years. Several important findings stand out in this chart. First, for both men and women, suicide rates are rising across the time period. The rate for US men rises from 18.1 deaths per 100,000 in 2006 to 23 in 2024. Similarly, US women register an increase from 4.5 to 5.9 from 2006 to 2023. Second, men and women in Nevada have consistently higher suicide rates across this period compared to the United States average. Although the magnitude of the differences fluctuates, Nevada maintains a sizable disadvantage. In 2023, the suicide rate is 41% higher for Nevadan compared to American men and 64% higher for Nevadan women over their counterparts. Lastly, the figure illustrates the higher rate of suicide among men compared to women. Research consistently finds that males take their lives at a much higher rate than females, although females attempt suicide more often.

Figure 3. Age-adjusted rates of death from suicide in Nevada and United States, 2006-2022



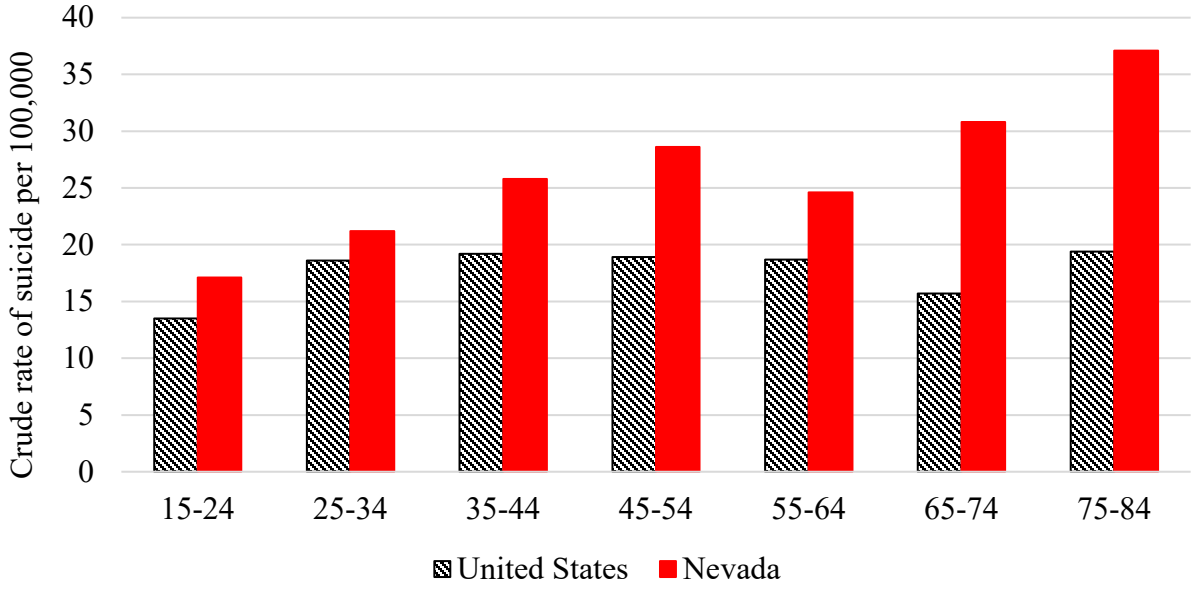
Source: CDC (2025b)

Why are suicide rates higher in Nevada than in other states? Researchers look at mental disorders, substance use, rural location, and gun ownership to explain suicide rates (Smith & Kawachi 2014). Yet, these factors may not fully account for the increased suicide risk among Nevadans compared to the rest of the United States. The reason is that the Silver State does not have disproportionate substance use, rurality, or gun ownership compared to other states. Social support and social isolation are also important factors, as social connections are key protective factors. In Las Vegas, the culture and anonymity that the city offers may also promote individualism and isolation. Interestingly, the risk for suicide in Las Vegas is not limited to its residents; visitors to Las Vegas also demonstrate much greater risk of suicide compared to individuals who stay in their home county or who travel elsewhere (Wray et al. 2008). Problem gambling in particular has been related to elevated suicide risk (Seguin, Lesage, and McGirr 2010).

There are a number of factors to consider beyond state of residence and sex. In the United States, suicide is also more common among non-Hispanic White, compared to Non-Hispanic Black or Hispanic individuals, and similar patterns emerge in Nevada. Native Americans also demonstrate high rates of suicide in the United States (Olson and Wahab 2006), but examining this relatively small population in Nevada prevents specific estimates and comparisons in this study. Veteran status is another important distinction (Fernquist 2001), as suicide is more common among veterans (Zivin et al. 2007).

Age is another important consideration: suicide is more common among middle- and older-aged adults, which may be contrary to some popular media portrayals. Figure 4 illustrates suicide rates by age group for the United States and Nevada. Suicide is most common among older adults in Nevada. Among adolescents and young adults, rates in Nevada are slightly higher than national patterns but diverge in middle age, with the Nevada disadvantage most evident at older ages. Prior research has found similar results (Wray et al. 2012).

Figure 4. Crude rate of deaths from suicide by 10-year age group in the United States and Nevada, 2023



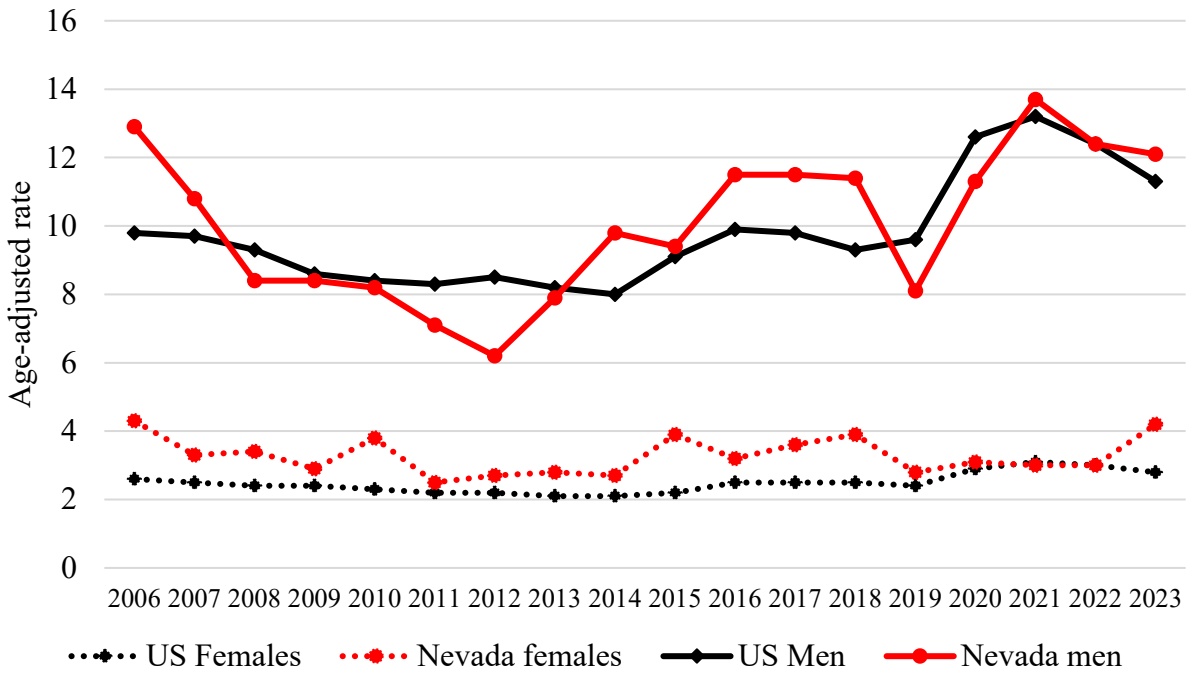
Source: CDC (2025b)

To address the problem of suicide, there are a number of national, state, and local organizations and programs. Wray and colleagues (2012) describe a number of these in a report on suicide trends and prevention in Nevada. Notably, the Nevada Office of Suicide Prevention, established in 2005, implements a variety of programs as indicated on their website (http://suicideprevention.nv.gov/; DPBH 2021). Yet, much work remains to be done, as high rates of suicide persist in Nevada, particularly among older adults.

Homicide

Figure 5 depicts the age-adjusted rates of homicide for men and women in Nevada and the United States from 2006 to 2023. For the most part, Nevada tracks alongside national trends, although Nevadan women have higher rates every year except in 2021 and 2022. For men, there is more volatility. There is year-to-year variation, but the rates generally decline in the early part of the time period examined, with the lowest rates in 2012 for Nevada and 2014 for the United States. Since then, the rates generally increased in early 2010 and 2020-2021, with national rates currently higher in 2023 than in 2006 and only slightly lower in Nevada. Whether the decreases shown for 2022 and 2023 continue is not yet known. These high rates are particularly striking when compared to other wealthy countries. For example, the age-adjusted homicide rate per 100,000 for the United States is 7.1 (CDC 2025b) compared to 2.10 for Europe in 2023 (UNODC 2025).

Figure 5. Homicide rates among men and women in the U.S. and Nevada, 2006-2023



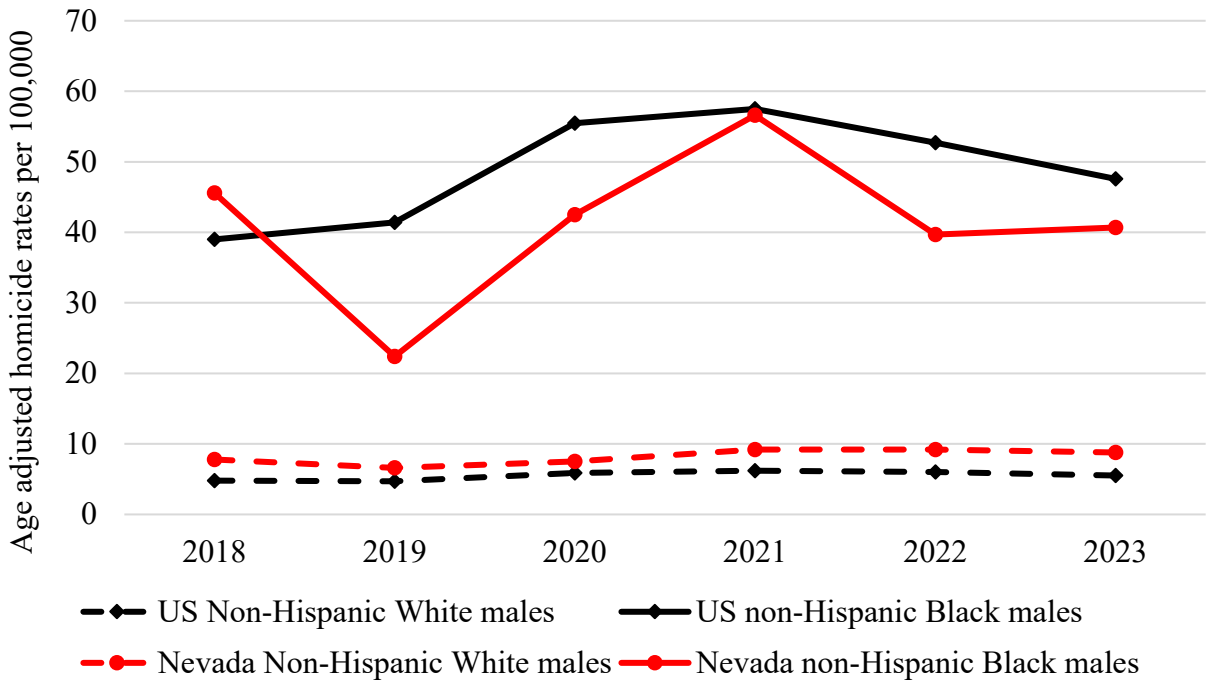
Source: CDC (2025b)

An area of concern is the higher homicide rates among women in Nevada, likely driven by intimate partner violence. Women in Nevada are 65% more likely to be shot to death by an "intimate partner" compared to women throughout the rest of the United States (Everytown for Gun Safety 2024). For those experiencing domestic violence, there are a number of resources, many of which are listed on the Nevada Attorney General website

(https://ag.nv.gov/Hot_Topics/Victims/Domestic_Violence/; State of Nevada 2025). Local organizations such as SafeNest offer a range of prevention and response services (SafeNest 2025). There is also a National Domestic Violence hotline available at thehotline.org or 1-800-700-SAFE (National Domestic Violence Hotline 2025). At the state level, the organization Nevada Coalition to End Domestic and Sexual Violence (NCEDSV) offers a number of efforts to advocate, educate, and support those experiencing domestic and sexual violence (NCEDSV 2025).

The risk of homicide also differs across race/ethnicity, with Black men displaying the highest rates both nationally and within Nevada. Figure 6 shows the age-adjusted homicide rates among non-Hispanic White and non-Hispanic Black men nationally and within Nevada for 2018-2023. The high rate of homicide among Black men is striking; in 2023, the rate is over 40, indicating nearly 40 homicides for every 100,000 Black men in that one year. Indeed, homicide is the leading cause of death among non-Hispanic Black males aged 15-24 nationally and the second leading cause of death among Black males ages 1-4, 5=9, and 25-34, behind unintentional injury (CDC 2025a). Figure 6 indicates that non-Hispanic White males have higher rates in Nevada compared to the rest of the country, but non-Hispanic Black males in Nevada fare a little better for most of the years shown.

Figure 6. Homicide rates among non-Hispanic Black and White men in the U.S. and Nevada, 2018-2023



Source: CDC (2025b)

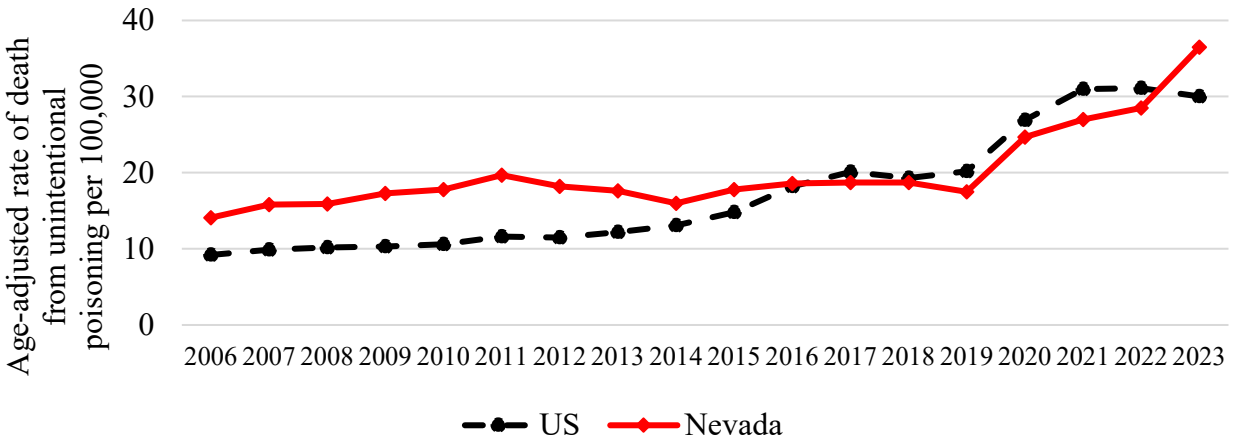
Unintentional Poisonings

Unintentional poisonings, or drug overdoses, have shown dramatic patterns in the United States and Nevada over the last two decades, dominated by the "opioid overdose crisis". Opioids reduce pain by interacting with opioid receptors on nerve cells, which can also produce euphoria. Researchers usually classify opioids into three groups: 1) prescription (natural or semi-synthetic) such as oxycodone, hydrocodone, morphine, or methadone;

2) heroin; and 3) synthetic, which includes fentanyl, a pain reliever many times more powerful than other opioids (CDC 2024b). The first phase of the opioid overdose crisis began around the turn of the century, driven by deaths from prescription opioids. Throughout the 2000s, pharmaceutical companies marketed opioid prescriptions, and patients with chronic pain were using these medications for long-term relief (Quinones 2015). As a result, prescription opioids skyrocketed nationwide, and overdoses steadily increased during this first phase before remaining somewhat similar during subsequent phases. Around 2010, heroin deaths began increasing, marking the second phase of the opioid crisis (CDC 2024b). Heroin deaths peaked around 2017-2018 and began declining around 2020. The third phase of the crisis is characterized by the emergence of fentanyl around 2013 (CDC 2024b). Deaths from fentanyl have increased since then, showing abatement in 2023 compared to the prior year. Some researchers have identified a fourth phase of the opioid overdose crisis, which is the sharp rise in deaths that show both fentanyl and stimulants such as methamphetamine, starting around 2015 (Friedman, Tiako, and Hansen 2024).

For the most part, trends in Nevada have mirrored these national patterns. Figure 7 displays the overall age-adjusted unintentional poisoning mortality rates in the United States and Nevada from 2006-2023. These deaths include overdoses from prescription opioids such as oxycodone, illegal opioids such as heroin and fentanyl, as well as other prescription, over-the-counter, and illegal drugs including cocaine, alcohol, or acetaminophen. These deaths do not encompass all drug and alcohol-related mortality, but only those deaths that are the result of poisoning. For example, drug use may contribute to chronic disease or injuries related to falling that are not captured with unintentional poisonings. Further, these include only unintentional poisonings and not suicide or homicide using drugs. As shown in the figure, rates of unintentional poisoning mortality have risen steeply. In 2023, the age-adjusted rate was 30.0 per 100,000 people for the United States as a whole, over three times the rate in 2006 of 9.2. Nevada has also increased over the last two decades. Nevada had higher rates than the United States from 2006-2016 and lower rates from 2017-2022. What has been somewhat of a surprise to health researchers is that the United States exhibited a decrease in the overdose death rate in 2023 compared to the year prior. However, Nevada displayed a further increase, surpassing the U.S. rate of death from drug overdoses.

Figure 7. Age-adjusted death rate from unintentional poisonings in the United States and Nevada, 2006-2023

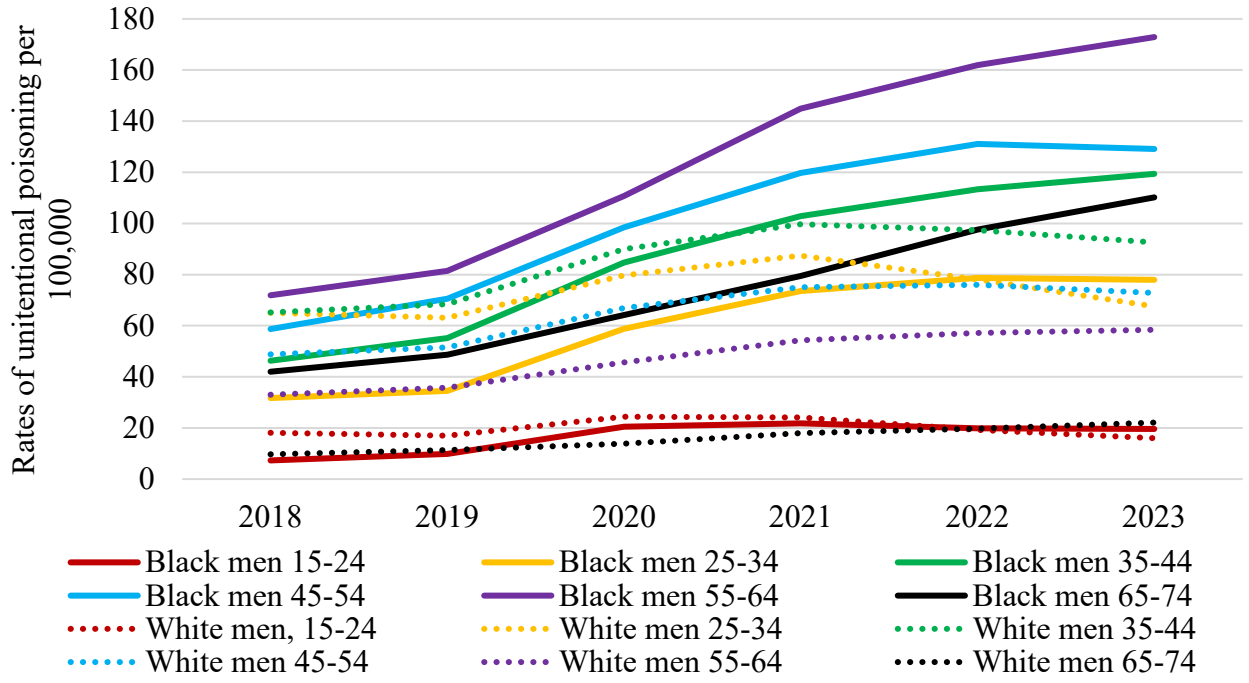


Source: CDC (2025b)

A number of measures have shaped the opioid overdose crisis in the United States and Nevada. There have been several initiatives that have reduced overdose deaths, including better data monitoring, reduced prescription drug availability, and harm reduction efforts, such as increased access to test strips that can detect fentanyl in pills, powders, or injectables, and naloxone, a life-saving medication that can rapidly reverse the harmful effects of an opioid overdose. Yet, overdoses remain high.

Examining the age, sex, and race/ethnicity of those dying of drug overdoses can shed light on the current phase of the opioid overdose crisis. Figure 8 depicts 2018-2023 death rates by age for non-Hispanic Black and White men in the United States, the groups with the highest drug overdose mortality. The small sizes of specific ages within these groups prevent examination within Nevada, although the data indicate that high rates of deaths among Black men in the last few years are driving the increases since 2020. The figure demonstrates increases in overdoses within each age group of Black men, with shockingly large magnitude. For White men, most age groups registered increases over this time span, although not uniformly and of smaller magnitude. Of particular concern are the high rates among Black men in middle and older adulthood who came of age during a time of wide economic and racial inequality (1950s-1970s) and have been exposed to heroin and other drug epidemics over their life span (Katz, Sanger-Katz, and Thieme 2024). Public health authorities highlight the intensity and risk of fentanyl, particularly used in combination with other substances, known as polysubstance use. The United States Drug Enforcement Agency describes its approach to fentanyl as "one pill can kill" to emphasize the risk of taking any illicit drug and the small amount of fentanyl necessary for a fatal overdose (DEA 2025).

Figure 8. Crude death rates by 10-year age groups for non-Hispanic Black men and non-Hispanic White men in the United States, 2018-2023

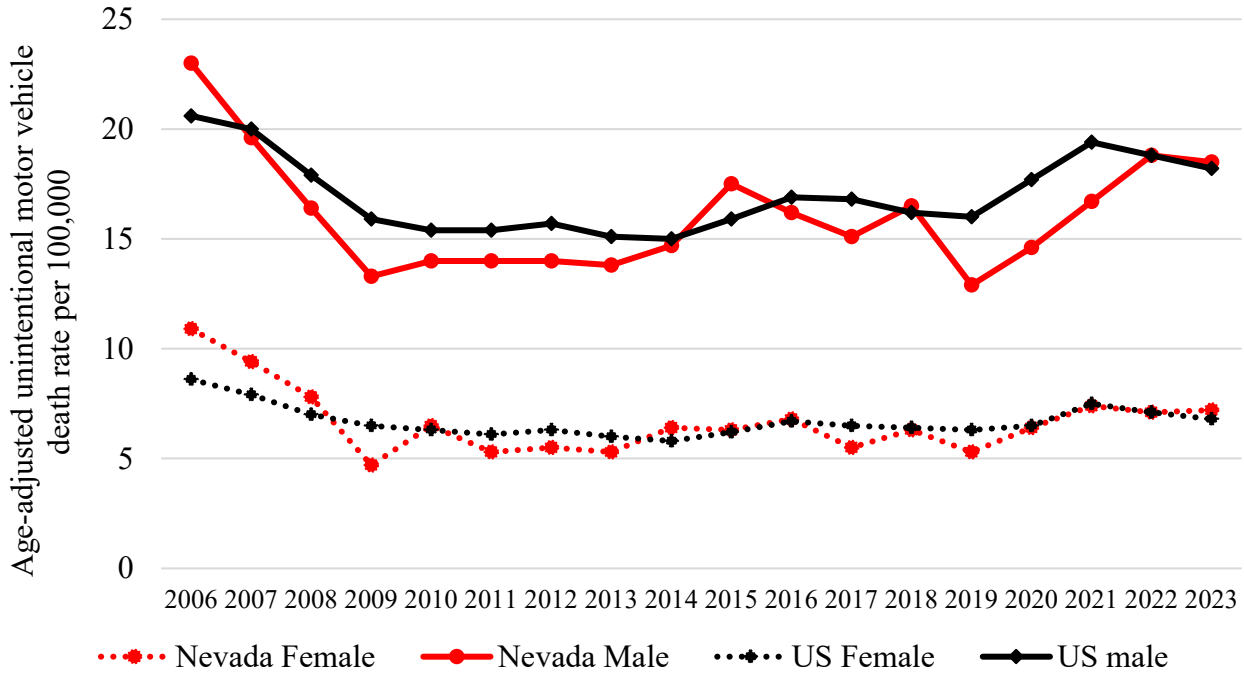


Source: CDC (2025b)

Motor Vehicle Crashes

Deaths from motor vehicle crashes have declined over the last century thanks to improved automobile safety, reduced rates of impaired driving, and better transportation infrastructure. However, roughly 100 Americans die each day from car crashes, the highest rate among 29 high-income countries (Yellman et al. 2022). Further, motor vehicle deaths have been on the rise in recent years in the United States, while other countries are showing decreases (Yellman et al. 2022). Figure 9 displays the age-adjusted death rates from motor vehicle crashes among men and women in the United States and Nevada. This figure demonstrates that Nevada has similar rates of mortality as the nation and that rates have not declined since 2009. The figure also illustrates the higher mortality among men, with motor vehicle death rates more than twice that of women. Men drive more miles than women, drive more aggressively than women, and drive under the influence more often, contributing to this disparity (Chang 2012).

Figure 9. Age-adjusted unintentional motor vehicle death rates per 100,000 for males and females in Nevada and the United States, 2006-2023



Source: CDC (2025b)

There are several factors that contribute to motor vehicle fatalities that also provide a point of intervention for reducing death. Among these factors are proper seat belt usage, impaired driving, and car size. Seatbelts are the single most effective measure to avoid serious injury or death in a car crash. In Nevada, about 20% of fatalities in 2022 were unrestrained (Nevada DPST 2025). Among unrestrained Nevadans who died or were seriously injured in a crash, half were totally or partially ejected from the car during the collision (NDOT 2016). Impaired driving is also an important contributor across the country, particularly in Nevada. In 2022, alcohol-impaired driving fatalities accounted for 13,524 deaths, or 32% of overall driving fatalities, in the United States (NIAAA 2024), but 44% of 2022 motor vehicle fatalities were linked to impairment in Nevada (Zero Fatalities 2025). Lastly, there has been recent attention to the increasing size of trucks and SUVs as a contributor to traffic fatalities. While bigger, heavier cars are safer for their occupants, there is an increased risk of fatal injuries to others; the fatality rate is about

seven times higher for someone in a crash with a heavy pickup truck compared to compact car (The Economist 2024). Americans are driving more and more SUVs, and these vehicles are getting bigger and heavier, as well as taller (The Economist 2024; IIHS 2023). Taller vehicles have less visibility, greatly increasing risk to pedestrians (IIHS 2023).

Most of the deaths in motor vehicles are car drivers and passengers, but motorcyclists, pedestrians, and cyclists also lose their lives in crashes. In Nevada, more than one in five traffic deaths was a motorcyclist (Nevada DPST 2025); the National Highway Traffic Safety Administration reports that motorcyclists were about 22 times as likely to die in crashes compared to car occupants in 2022 (NCSA 2024).

There are a number of efforts seeking to reduce deaths and injuries from motor vehicle traffic, including Zero Fatalities, which brings together statewide, coordinated efforts involving multiple task forces and committees. The Zero Fatalities website (Nevada DPST 2025) offers information useful for monitoring trends and specific issues with a publicly available data dashboard of specific information on the number and type of fatal crashes since 2018. There is a Nevada Strategic Highway Safety Plan, led by the Nevada Department of Transportation and Nevada Department of Public Safety, is focused on four categories, each with subareas: safer roads (safe speed, lane departures, intersections, work zones), vulnerable road users (pedestrians, motorcyclists, bicyclists, micromobility), safe drivers and passengers (occupant protection, older drivers, young drivers, distracted driving), and impaired driving prevention (Nevada DPST 2024).

COVID-19 Pandemic Impacts

The COVID-19 pandemic and related impacts, including stay-at-home orders, social distancing, economic and employment changes, and increased stressors may have contributed to the rise in injury mortality beginning in 2020. As mentioned in the introduction, researchers are still analyzing data and working to disentangle the many circumstances and changes in 2020 and subsequent years to understand the effects of COVID-19 on excess mortality (the deaths beyond that which we would expect in "normal" circumstances) other than those attributed directly to COVID-19. For injury deaths, we may expect increases in suicide, homicide, and drug overdoses due to increased distress and stress from the pandemic, as well as reduced access to mental health and substance use treatment. On the other hand, we might expect car crashes to decrease due to fewer people on the roads during stay-at-home measures.

The observed patterns and existing research confirm some but not all of these expectations. For suicide, there was a decrease in 2020 across the United States and in Nevada (see Figure 3), which was also observed in other countries (Polizzi et al. 2025). Unfortunately, this small dip rebounded in 2021. The 35% national increase in homicides from 2019 to 2020 is the largest in over 100 years (Degli Esposti, Schell, and Smart, 2025; Light and Vachuska 2024). Homicide again increased in 2021, but the rate retreated in 2022 and 2023 (see Figures 5 and 6). The increase appears to be entirely attributable to firearms, as non-firearm homicide did not show an increase. The observed increase is likely to be the result of many factors including greater numbers of firearm purchases (Degli Esposti et al., 2025). The COVID-19 pandemic appears to be one of multiple important factors shaping homicide rate trends. The role of the COVID-19 pandemic is similarly difficult to isolate in its impact on the staggering increase in fatal drug overdoses (see Figure 7). One difficult issue is the temporal overlap between the opioid epidemic, and in particular the rise of fentanyl, and the COVID-19 pandemic. One study using a quasi-experimental method to isolate the effects of the pandemic reports a clear and large

positive effect of the COVID-19 pandemic on opioid mortality (Laing and Donnelly, 2024). Lastly, fatal car crashes increased in 2020 and 2021, peaking in 2021 nationally and 2022 in Nevada (see Figure 9), despite a sizable reduction in miles traveled during those years. Extant research suggests that risky driving, including speeding, accounts for some or most of the increase (Marshall, Shirazi, and Ivan 2024). According to one study examining Michigan traffic, drivers appear to have been taking more risks, unimpeded by congestion, but the study also highlights that the reduced miles driven was disproportionately low risk mileage (Peterson et al. 2024). Further research and examination of more recent data will uncover whether risky driving is abating.

Implications for Policies and Programs

Deaths from injuries are preventable. Rather than view such deaths as "accidents" that cannot be avoided, a public health approach aims to identify and control the factors that lead to injuries. Injury prevention researchers focus on the three E's: 1) education, 2) engineering, and 3) enforcement (Christoffel 2012). For example, to reduce drunk driving, public health officials may work to educate the public on the dangers of driving while under the influence, the use of ignition mechanisms preventing cars from starting when the driver is drunk, and the role of legal consequences for those who have been caught drunk driving. Approaches that span the three E's require coordination of multiple agencies, but they are also more effective in addressing multiple risks. Nevadans are already working together to reduce deaths from injuries. Appendix A lists local, state, and national resources reflecting these efforts.

Three overarching considerations for reducing injury mortality in Nevada should be mentioned here. First, we highlight the pernicious consequences of drug abuse and misuse. Unintentional poisonings only trail heart disease and cancer as a cause of death, and the largest group within this category is drug overdose. However, drugs and alcohol play a role in each of the other injuries as well, fueling suicides, homicides, and motor vehicle crashes, and also to non-injury mortality. There are many efforts to educate individuals on the dangers of drugs and alcohol and also to enforce drug and alcohol laws, but perhaps fewer endeavors focus on "engineering." How can we engineer the environment where people are less prone to misuse drugs and alcohol?

Many of the treatment approaches in the United States view alcohol and drug misuse and abuse as a moral rather than medical issue. Medications, such as naltrexone, have proven their effectiveness in treatment of heavy drinking (Rösner et al. 2010), yet few adults have access to such medications (Jonas et al. 2014). Addiction treatment counselors are largely unaware of effective pharmacotherapies (Abraham et al. 2009). A recent development that may be a helpful tool for substance misuse is the newly developed GLP-1 receptor agonists (and similar medications), which show promising effects on many problem behaviors, including substance misuse. This class of drugs is best known by the medication with brand Ozempic. They have shown successful results in improving diabetes and other conditions associated with body weight, and more recent trials have demonstrated its usefulness in containing alcohol and opioids abuse (Subhani et al. 2024; Qeadan, McCunn, & Tingey 2025).

Better design and implementation protocols are also likely to improve treatment programs. Researchers argue that the most commonly recommended treatment by clinicians, twelve-step programs, are among the least effective for recovery from alcohol or drug addiction, with only 5-10% succeeding in recovery (McGovern et al. 2004). Other countries have found greater success using "harm reduction" approaches that aim to

reduce the impact that alcohol or drugs have on individual opportunities or livelihood. Such an approach involves individuals in their recovery and focuses on improving multiple areas, including: 1) the ability to make money, 2) access to good meals, 3) access to housing/combating homelessness, 4) relating to families, 5) obtaining needed social services or benefits, 6) handling health problems, 7) handling negative emotions 8) handling legal issues 9) improving oneself, and 10) managing drug-related problems (Ruefli and Rogers 2004).

Second, we need to focus attention on gun violence. Firearms are central to both suicide and homicide. In 2022, over half of suicides involved firearms (CDC 2024a). Accessibility to means is a key issue for suicide, and research continually shows that removing immediate access to fatal means reduces suicide rates (Yip et al. 2014). The idea that individuals wanting to kill themselves will "find a way" has been disproven. And research further shows that gun availability is related to suicide rates (Kposowa, Hamilton, and Wang 2016). Thus, reducing access to guns may have multiple benefits, including reduced suicide and homicide rates.

Third, we emphasize the upstream determinants of safety and well-being. Upstream determinants include those factors that shape more proximate risks and protections, such as race/ethnicity, socioeconomic status, gender, age, sexual orientation, and immigrant status. The troubling rates of unintentional poisonings, unintentional motor vehicle deaths, suicide, and homicide, in Nevada and the United States compared to other countries, suggest that well-being is withering in our state and our country. Social policies that improve the economic and social lives of Nevadans and Americans can have broad, manifold benefits, including population-level health advantages.

Recommendations for Future Research

Injury mortality is a key public health issue for the Silver State. We described here the Nevadan injury mortality patterns across the four largest types: homicide, suicide, unintentional poisoning, and motor vehicle crashes. Future research should consider other types, including falls, drownings, or fires. Injury mortality by socioeconomic status (SES) is an important topic that fell beyond the scope of this chapter, but current research points out that injury mortality is strongly patterned by SES (Karb et al. 2016; Powell 2023). Future work identifying the risk of death from injury by SES within Nevada will be important to targeting prevention efforts.

Identifying geographic heterogeneity within Nevada can also shed light on risk and protective factors leading to injury mortality. Table 2 displays the injury mortality rates for 2018-2023 for the six largest counties in Nevada. Small numbers of deaths prevent us from examining smaller counties. As shown in the chart, Clark County, which comprises more than two-thirds of Nevada's population and includes Las Vegas, has the lowest rate, whereas Nye County, a rural area known as the home for the nuclear waste site at Yucca Mountain, has the highest rate. Although rural areas have higher rates, it should be noted that urban areas have greater numbers of deaths since there are more people. The extent to which intervention efforts could or should focus on population centers will be crucial to program efficacy.

Table 2. Injury mortality rates per 100,000 by county, Nevada 2018-2023

County	Crude rate of injury mortality per 100,000
Clark	84.9
Douglas	97.1
Elko	107.6
Lyon	121.1
Nye	155.3
Washoe	107.9
Carson City	111.8

Source: CDC (2025b)

Nevada's racial and ethnic diversity makes our state a fruitful area to study multiple subgroups. The unique environment that includes a desert landscape, throngs of tourists, casinos, and gold mining provides several points of comparison that can be leveraged in research. We encourage researchers to study injury and public health in Nevada.

Conclusion

Although the long history of declining injury mortality is encouraging, recent trends are concerning. By focusing on mortality, we have only discussed the tip of the injury iceberg. There are a greater number of injuries that do not result in death but nonetheless-have serious medical, health, financial, and social consequences. In 2021, there were over 40 million visits to emergency departments related to injuries (Cairns and Kang 2023). However, deaths are the worst consequence because deaths from injury are mostly premature and disproportionately contribute to years of life lost. Because injuries are preventable, the public health community in the Silver State should spare no effort in reducing mortality in our state.

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Appendix A: Community Resources

Suicide:

National Suicide and Prevention Lifeline. Phone Number: 1-800-273-8255. Website Address: https://suicidepreventionlifeline.org

Reno Crisis Call Center. 24-hour Phone Number: 1-800-992-575. Local Phone Number: 775-784-8090. Website Address: http://crisiscallcenter.org.

Suicide Prevention Hotline of Nevada. 24-hour Phone Number: 1-877-885-4673. Website Address. crisiscallcenter.org.

Suicide Prevention, Awareness, and Support. Website Address: http://www.suicide.org/hotlines/nevada-suicide-hotlines.html

Suicide Prevention Resource Center. Nevada Division of Public and Behavioral Health, Office of Suicide Prevention, 3811 W Charleston Blvd Las Vegas, NV 89102. Phone Number: 702-486-8225. Website Address: https://www.sprc.org/states/nevada

Nevada Division of Public and Behavioral Health. Office of Suicide Prevention. Contact DPBH: Northern Offices: 4150 Technology Way, Suite 101 Carson City, NV 89706. Phone number: 775-684-2240. Fax: 775-684-8048. Southern Offices: 3811 Charleston Blvd. Suite 210 Las Vegas, NV 89201. Phone Number: 702-486-8225. Fax: 702-486-5250. Website Address: http://suicideprevention.nv.gov/Contact/Contact/

Nevada Coalition for Suicide Prevention. Phone Number: 1-800-273-8255. Website Address: https://nvsuicideprevention.org/contact/.

Substance use/misuse:

Desert Hope Treatment Center. Drug Treatment Center. Address: 2426 E Twain Ave, Las Vegas, NV 89121. Phone Number: 702-848-6223. Website Address: https://deserthopetreatment.com.

Las Vegas Recovery Center. Addiction Treatment Center. Address: 3321 N Buffalo Dr. #150, Las Vegas, NV 89129. Phone Number: 702-515-1373. Website Address: https://lasvegasrecovery.com.

Solutions Recovery. Addiction Treatment Center. Address: 2975 S Rainbow Blvd. Las Vegas, NV 89146. Phone Number: 702-228-8520. Website Address: https://www.solutions-recovery.com.

Mission Treatment. Address: 4120, 1536 N Boulder Hwy, Henderson, NV 89011. Phone Number: 702-558-8600. Website Address: http://missiontreatment.com/wordpress1/.

Adult Children of Alcoholics or Dysfunctional Families. Website Address: http://www.meetings.adultchildren.org/find-a-meeting1.

Alcoholics Anonymous. Address: 1431 E Charlston Blvd #15, Las Vegas, NV 89104. Website Address: https://www.lvcentraloffice.org/.

Narcotics Anonymous. Address: Henderson, NV 89014. Phone Number: 702-898-8111. Website Address: https://region51na.org/meetings/meeting-list/.

Destinations to Recovery. Address: 9089 S Pecos Rd #3500, Henderson, NV 89074. Phone Number: 877-466-0620. Website Address: https://www.destinationsforteens.com.

Nevada Enforcing Underage Drinking Laws. Address: 1711 Roop St. Carson City, NV 89706. Phone Number: 775-841-4733. Website Address: http://www.nveudl.com/index.htm.

Motor Vehicle Accidents:

Mothers Against Drunk Driving (MADD). Southern Nevada Affiliate. Address: Las Vegas, NV 89173. National Phone Number: 877-MADD-HELP. Local Phone Number: 775-910-3494. Website Address: www.MADD.org.

Nevada Department of Public Safety, Office of Traffic Safety. Zero Fatalities, Drive Safe Nevada. Website Address: https://zerofatalitiesnv.com.

Violence:

Emergency Services. Phone Number: 911.

The Department of Administration, Victims of Crime. Victim Advocacy. Program Manager Phone Number: 702-486-2740. Website Address: http://voc.nv.gov/Advocates/Victim_Advocates/.

Victim Assistance Academy of Nevada. Contact Priscilla Colegrove. Phone Number: 775-684-7953. Website Address: www.vann.nv.gov.

Trauma Intervention Program (tip) of Southern Nevada INC. Address: PO BOX 93203 Las Vegas, NV 89193. Phone Number: 702-229-0426. Website Address: https://www.tipoflasvegas.org/help.

Safe Nest. Address: Las Vegas, NV. Local Phone Number: 702-433-2889. 24-hour hotline: 702-646-4981. Website Address: https://safenest.org.

Safe House Inc. Address: 921 American Pacific Dr. Suite 300, Henderson, NV. 24-hour Hotline: 702-564-3227. Local Phone Number: 702-451-4203. Website Address: http://safehousenv.org.

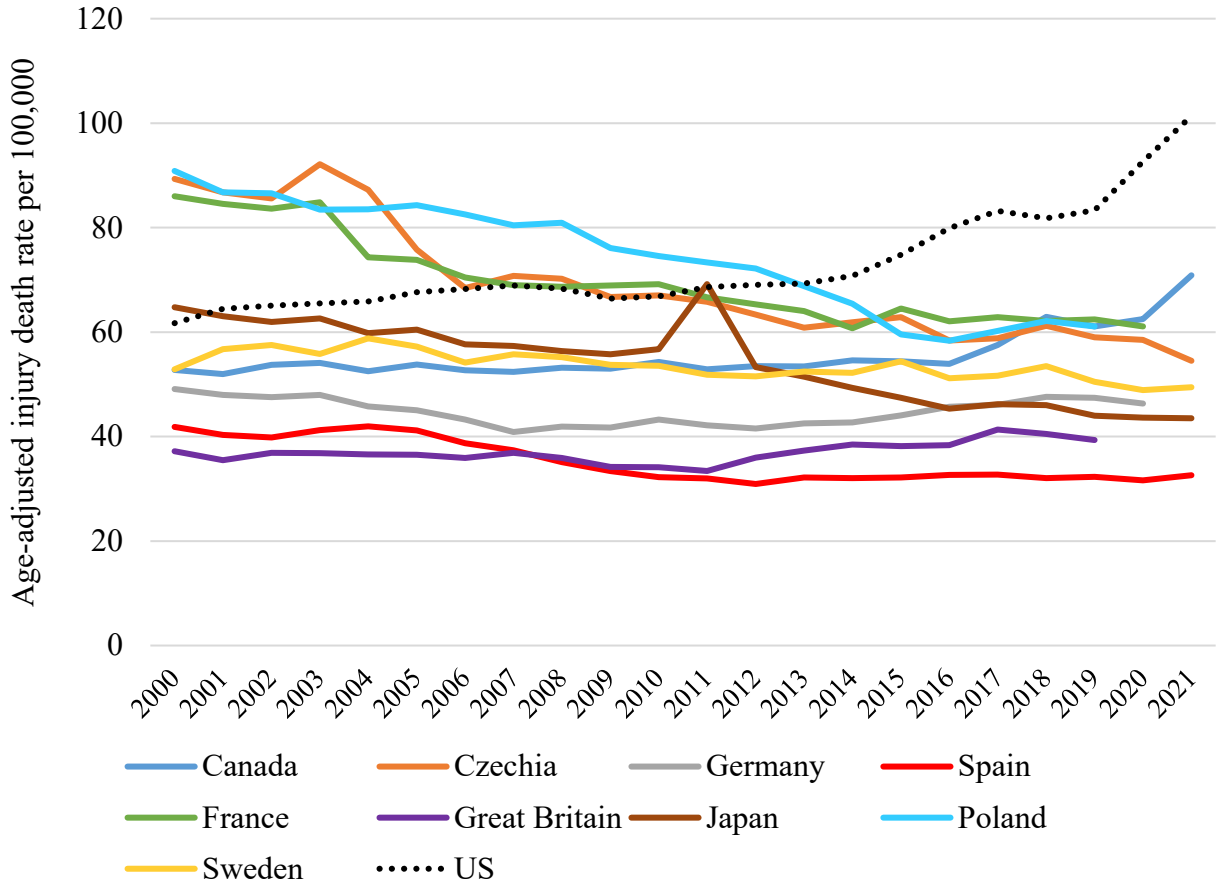
The Shade Tree. Address: 1 W Owens Ave, North Las Vegas, NV 89030. Local Phone Number: 702-385-0072. Website Address: www.theshadetree.org.

The Women's Development Center. Address: 4020 Pecos-McLeod Interconnect, Las Vegas, NV 89121. Local Phone Number: 702-796-7770. Website Address: http://www.wdclv.org.

Everytown, for Gun Safety. Phone Number: 646-324-8250. Website Address: www.nevada.everytown.org.

Appendix B: International Comparison of Injury Mortality

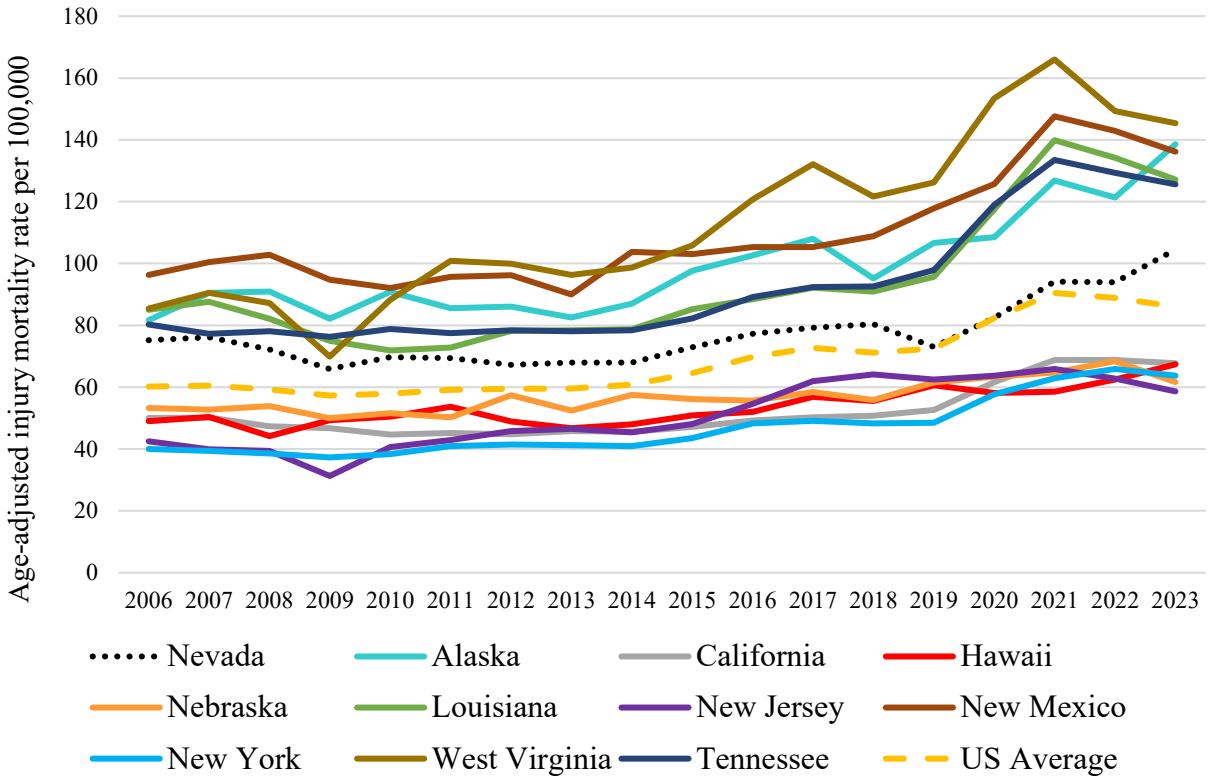
Figure. Age-adjusted injury mortality rate, selected countries 2000-2021



Source: Data obtained from HMD (2025).

Appendix C: Interstate Comparison of Injury Mortality

Figure. Age-adjusted death rates from injury per 100,000 for Nevada, the United States, and selected states (2006-2023)



Source: CDC Wonder (2025)
Notes: Alaska, Louisiana, New Mexico, Tennessee, and West Virginia have the highest combined injury mortality rates for 2018-2023; California, Hawaii, Nebraska, New Jersey, and New York have the lowest.