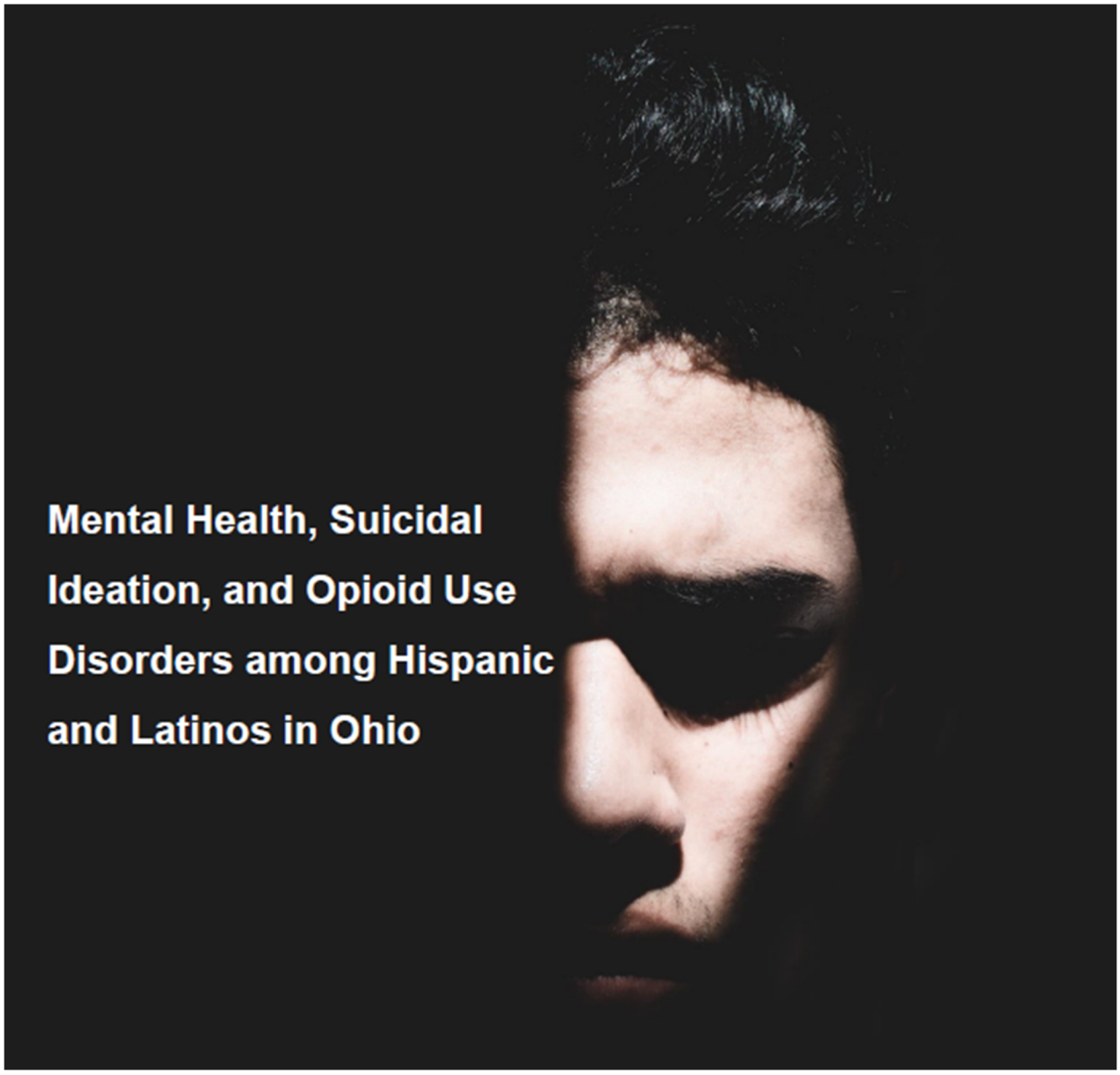
Latino Community Report 2018



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Ohio MHAS Promoting wellness and recovery

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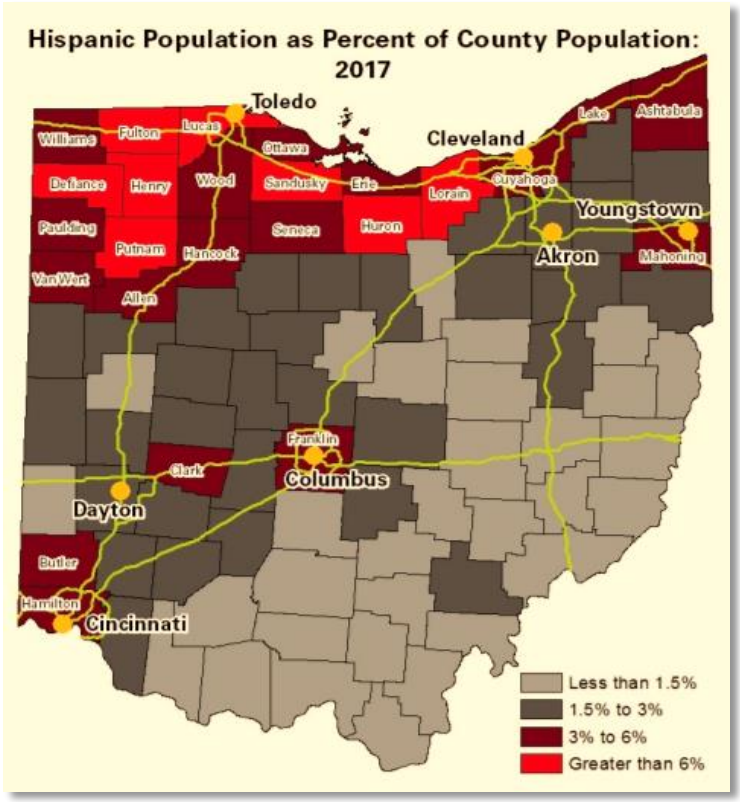
INTRODUCTION

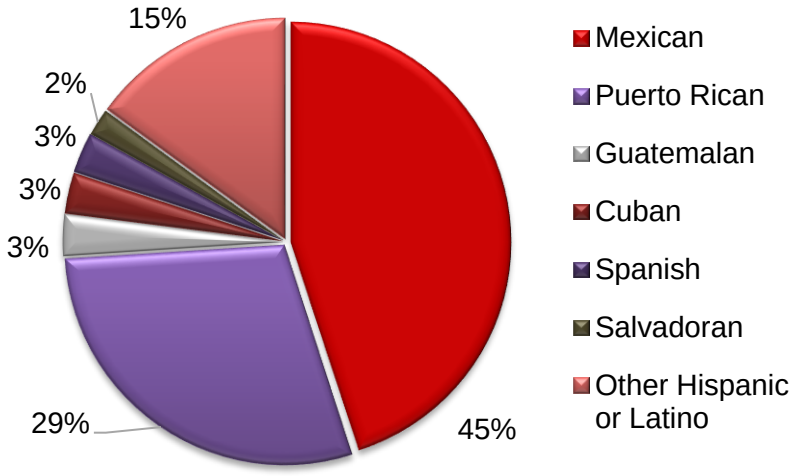
Ohio's resident population has experienced rapid diversification in recent decades. One group that has grown exponentially is the Hispanic/Latino (HL) community. According to the 2017 American Community Survey by the U.S. Census Bureau, Ohio's Hispanic population doubled since 2000 to 437,000, which accounts for 3.7% of the state's total population. The Hispanic/Latino community is well-represented throughout the state; the majority resides in metropolitan areas with one-third concentrated in just four cities (map). Columbus is currently home to over 50,000 HL residents, followed by 42,000, 25,000 and 19,000 in Cleveland, Toledo and Lorain respectively.[1]



"According to the 2017 American Community Survey by the U.S. Census Bureau, Ohio's Hispanic population doubled since 2000 to 437,000, which accounts for 3.7% of the state's total population."

[1] Ohio Hispanic Americans. *Ohio Development Services Agency*. 2017. Accessed on October 25, 2018 at: https://development.ohio.gov/files/research/P7002.pdf

Figure 1: Ancestry of Ohio HLs



Significant diversity of heritage exists within Ohio's Hispanic/Latino community, with nearly half possessing an ancestral link to Mexico. The number of Hispanic Ohioans with an ancestral link to Mexico is more than 195,000; three-quarters of these residents were born in the United States (figure 1).[2] Individuals with Puerto Rican heritage also comprise a fair portion of Ohio's HL community at 29%; Ohio is predicted to receive about 30,000 by 2020 due to displacement that occurred in the wake of Hurricane Maria.[3] In recent years, Central America has become a common point of origin for HL Ohioans with nearly 33,000 individuals reporting Guatemalan, El Salvadoran, or other Central American ancestry; only one-fifth of Ohio's total HL population, or 84,000 residents, are foreign born[4]. An estimated 98,000 undocumented immigrants reside in Ohio, a number which equates to less than 1.0% of the state's population.[5] Governor Kasich and Ohio Latino Affairs Commission signed Resolution 2017-01[6] "On Urging Congress to Act on Matters Regarding DACA" (Deferred Action for Childhood Arrivals) —which was an immigration policy introduced in 2012 during Obama administration that allows people who were brought into the United States as children to identify themselves to the U.S. government as a person without legal status and in return, to obtain renewable, two-year periods of work authorization. There are 4,000 DACA recipients in Ohio.[7]

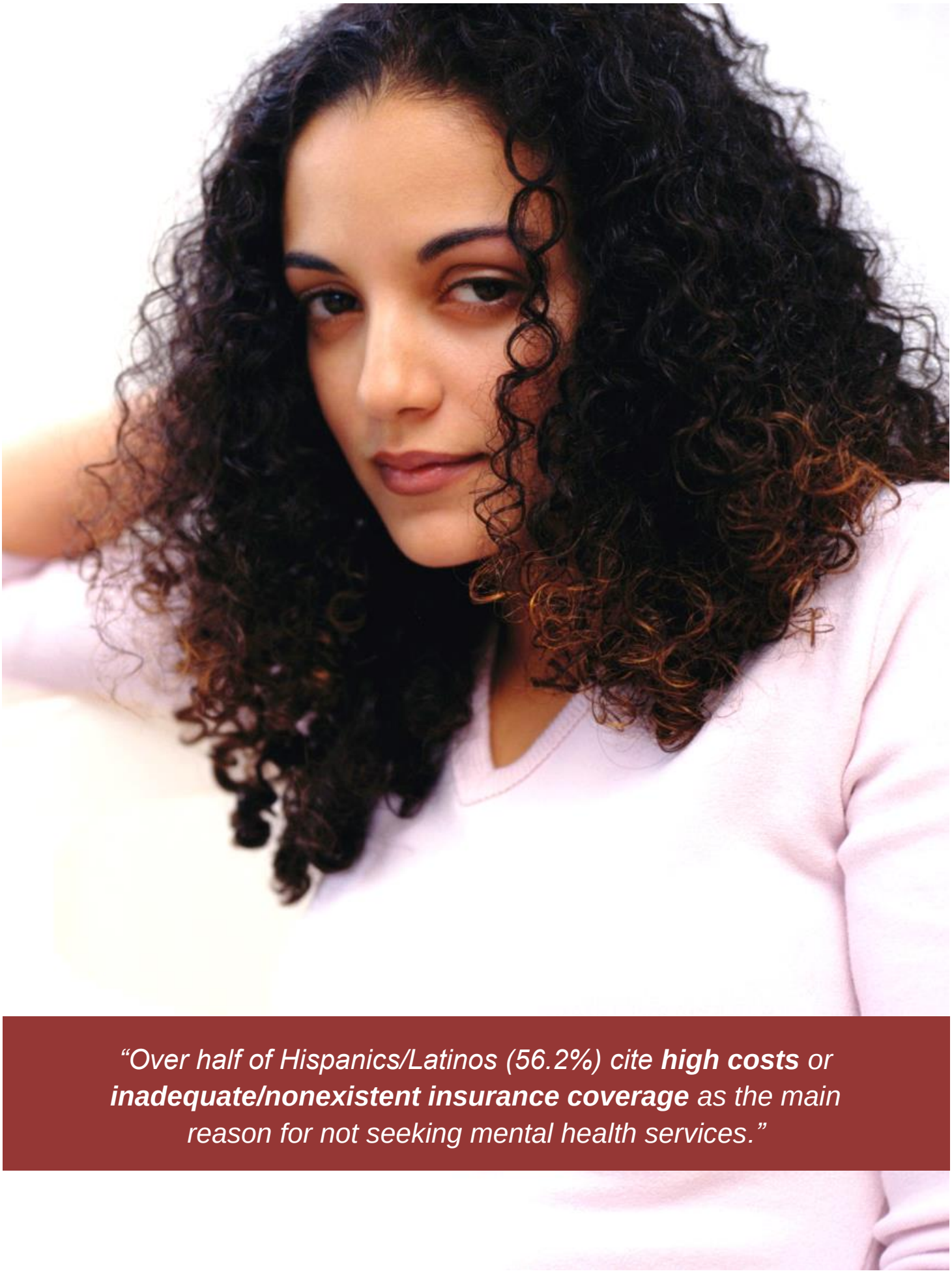
[2] Ibid. Footnote 1.
[3] https://www.dispatch.com/news/20180618/central-ohio-schools-absorbing-puerto-rican-students-in-wake-of-hurricane/1
[4] Ibid. Footnote 1.
[5] The Contributions of New Americans in Ohio. *New American Economy*. 2016.
[6] http://ochla.ohio.gov/Portals/0/rhjh/DOC101917-10192017095925.pdf. Accessed on October 25, 2018.
[7] https://www.olaf.org/wp-content/uploads/2018/03/Ohio-Immigrants-Report-FINAL-1.pdf. Accessed on October 25, 2018.

STATEMENT OF THE PROBLEM AND STUDY OBJECTIVES

Hispanic/Latino adults are at a high-risk for mental illness, such as serious psychological distress.[8] Many HL immigrants and refugees endure years of trauma prior to their arrival in the United States. Others experience negative mental health outcomes during their integration into American culture. U.S.-born children in Hispanic/Latino families are often expected to navigate multiple cultures and adopt new social norms, and the associated pressure can adversely affect mental health. For individuals living in mixed immigration status families, the constant fear of deportation and the trauma of real or anticipated familial separation can be particularly damaging. Undocumented immigrants face a climate of mistrust that often leaves them fearful of deportation and unsure of eligibility. One research succinctly states how many undocumented individuals in the U.S. economy remain excluded from many public benefits, rights, and resources that could promote their health and the health of their families.[9]

A myriad of structural barriers places Hispanic/Latinos at disparate burden of behavioral health issues and related morbidity and mortality. Low healthcare utilization is an important contributing factor. Only 7.3% of Hispanics in the U.S. utilized mental health services from 2008-2012, compared to 16.6% of Caucasians and 8.6% of African Americans; and a meagre 5.7% of Hispanics/Latinos used prescription medicine against the backdrop of 27% reporting high levels of depression.[10] Unaffordability or lack of insurance is another critical barrier; over half of Hispanics/Latinos (56.2%) cite high costs or inadequate/nonexistent insurance coverage as the main reason for not seeking mental health services (figure 2)[11]; 18.0% HL Ohioans do not have health insurance, a rate significantly higher than Caucasian (8.0%) or African-American (13.0%)

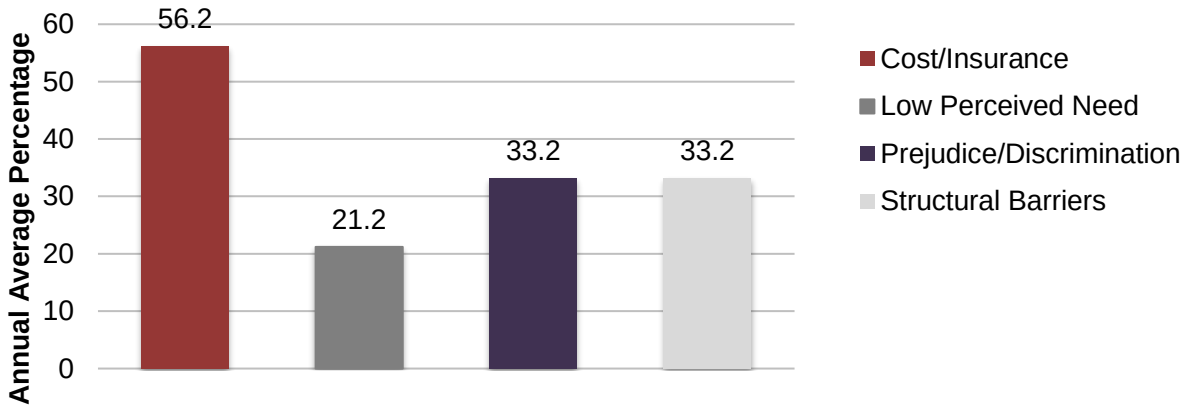
[8] CDC, 2016. Health United States, 2015. Table 46. http://www.cdc.gov/nchs/data/hus/hus15.pdf. Accessed October 25, 2018.
[9] Rodriguez, Michael; Young, Maria-Elena; Wallace, Steven. Creating conditions to support healthy people: State policies that affect the health of immigrants and their families. University of California Global Health Institute. 2015.
[10] Substance Abuse and Mental Health Services Administration, Racial/ Ethnic Differences in Mental Health Service Use among Adults. HHS Publication No. SMA-15-4906. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. Accessed on October 25, 2018 at: https://www.integration.samhsa.gov/MHServicesUseAmongAdults.pdf
[11] An Overview of Healthcare Access in Ohio's Hispanic Community. *Ohio Latino Affairs Commission*. 2017.



*"Over half of Hispanics/Latinos (56.2%) cite **high costs** or **inadequate/nonexistent insurance coverage** as the main reason for not seeking mental health services."*

Ohioans; foreign-born HLs are even more likely to be uninsured at 46.0%.[12] These stressors and traumatic experiences, cumulatively, contribute to disparate and adverse behavioral health. One important barrier to accessing mental healthcare is the underlying problem with identifying psychiatric symptoms when chief complaint is somatic symptom.[13] Twenty-seven percent of Hispanics/Latinos report high levels of depression and anxiety, and suicide is the third leading cause of death for Hispanics aged 10-34; females are twice as likely as men to experience such symptoms; and Latina adolescents have the highest suicide attempt rate of all female adolescents at 15.0%.[14]

Figure 2: Reasons for Not Using Mental Health Services among Hispanic Adults with Adults with Any Mental Illness Who Had an Unmet Need for Services in the Past Year, 2008-12



Source: Hispanic data isolated and chart recreated from figure 4.7 (Chapter 4) of SAMHSA Report (2015).[15]

"One important barrier to accessing mental healthcare is the underlying problem with identifying psychiatric symptoms when chief complaint is somatic symptom."

[12] Demographic Profile of Hispanics in Ohio. *Pew Research Center*. 2014.
[13] American Psychiatric Association. 2017. *Mental Health Disparities: Hispanic and Latinos*. Psychiatry.org
[14] Ibid. An Overview of Healthcare Access in Ohio's Hispanic Community.
[15] Ibid, footnote 7.

Also, at play are other social determinants of health issues. In Ohio**, one third of Latinos cite lack of transportation or inability to miss work** as the reason for their low rates of service utilization; another third cites **prejudice and/or discrimination**.[16] Linguistic barriers are another critical factor contributing to poor access to care among Hispanic/Latinos in Ohio; 233,819 Ohioans speak Spanish in their homes, and 22% of these individuals speak English "not well" or "not at all".[17] **Interpretation services are often unavailable or inaccurate**, unavailable or inaccurate interpretation services can prevent non-English speakers from accessing care. **Cultural norms and stigmas may lower perceived need for services** and, in turn, deter many Latinos from seeking mental health treatment.[18]

The objective of this study is to analyze mental health, suicidal ideation, and opioid use disorders among Hispanic and Latinos in Ohio.

[16] Ibid. An Overview of Healthcare Access in Ohio's Hispanic Community.
[17] Medical and Legal Language Access in Ohio. *Ohio Latino Affairs Commission*. 2014.
[18] Ibid. An Overview of Healthcare Access in Ohio's Hispanic Community.

METHODS

This Health Disparities White Paper, prepared in collaboration with the Ohio Commission on Hispanic/Latino Affairs, is part of the public health informatics effort from the Ohio Department of Mental Health and Addiction Services (OhioMHAS), which analyzes Ohio's statewide substance abuse treatment episode data to investigate behavioral health disparities among clients in the public behavioral health system. Analyses may range from age, gender, race/ethnicity disparities to drugs of choice and clients with reported mental health history.

The White Paper is patterned after SAMHSA's Treatment Episode Data Set (TEDS) reports, but it presents in-depth analyses on trends and disparities unique to HL communities in Ohio. It also expands upon traditional TEDS reports by incorporating information exclusive to OhioMHAS' Ohio Behavioral Health (OHBH) data system. OHBH data are collected at admission, transfer and discharge, and contain a variety of socio-demographic items and fields used to report federally mandated treatment outcomes.

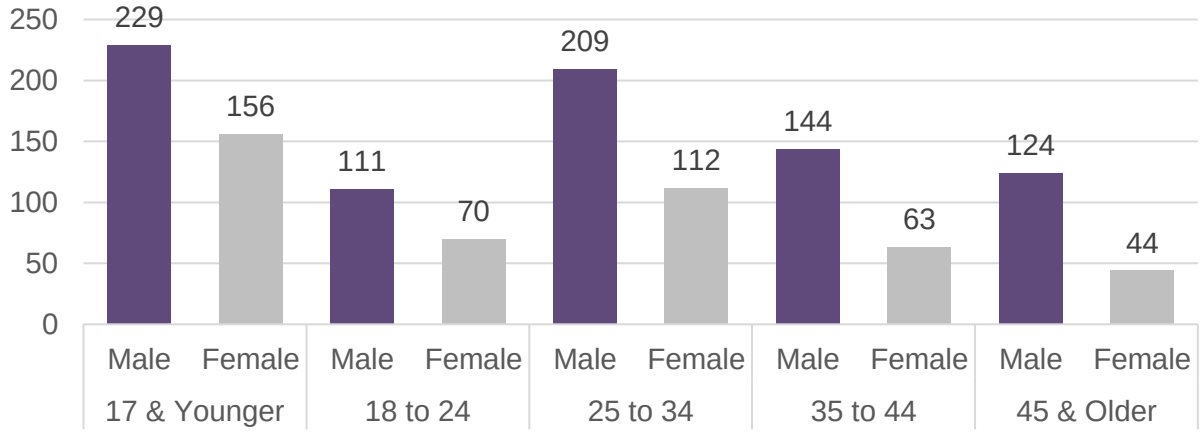
This paper analyzes admissions data on drug use, mental health and suicidal ideation among Hispanic-Latinos in substance abuse treatment during state fiscal year (SFY) 2015. Data was isolated to select those with Hispanic/Latino (HL) ethnicity (n=1,277), yielding a sample of 1,277. We also present select findings on select socio-demographic characteristics, such as, gender disparities; primary drugs of choice; opioid abuse; and exposures to physical/sexual abuse and domestic violence. SPSS version 21.0 was used for the univariate and bivariate analyses.

RESULTS

TREATMENT ADMISSIONS

In 2015, 1,277 HLs were admitted for treatment, mostly male (64.7%); of Cuban or Other Hispanic descent (46.5%); single or never married (78.2%); and with some high school education (55.4%) (Appendix A). The average age of HL clients was 27.7 years, with males at 28.6 years and female, 25.9 years. Most HL clients in treatment fell in 17 and younger age (30.2%) and 25 to 34 years (35.5%) age categories (figure 3). In 2015, most HL clients came in as mental health client (41.9%), followed by non-intensive outpatient care (24.4%), intensive outpatient care (14.3%), detoxification services (6.6%), pre-treatment services (5.4%), and non-medical community residential services (4.3%), and other services (3.1%). The average duration of treatment for HL clients was 3.3 months with females (3.6 months) staying in treatment longer than males (3.2 months). HL clients of Mexican descent stayed for a longer period (4.1 months), followed by Cuban and & Other Hispanic ethnicities (3.2 months), and Puerto Rican clients had stayed in treatment for the shortest amount of time (2.9 months). Ethnicity-wise, gender disparities across HL ethnicity was interesting with male clients dominating and with female clients fairly represented, Mexicans (38%), Cuban and Other Hispanic (37.0%), and Puerto Ricans (27.0%).

Figure 3: Admission Rates of Hispanic/Latino by Gender and Age Group, SFY 2015



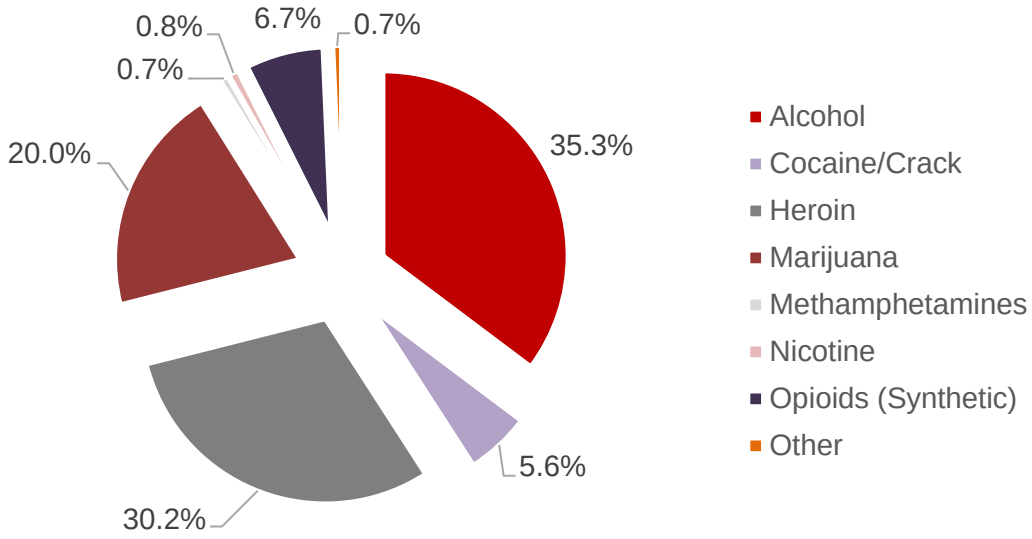
Source: OhioMHAS Behavioral Health Data

PRIMARY DRUG OF CHOICE

Close to three-fifths (57.1%) of all Hispanic/Latino clients in treatment reported having abused at least one drug of choice. Using a second or third drug was only infrequently reported (26.6% and 11.5% respectively). Usage of four or more drugs (poly drug use) among HL clients was rare (0.6%). When asked about their primary drug of choice, most drug-using clients said that alcohol was their primary choice (35.3%), followed by heroin-opiates (30.2%), then marijuana (20.0%) (Figure 4). Clients of Mexican descent chose alcohol as their primary drug of choice

(47.1%) whereas clients of Puerto Rican and Cuban and other Hispanic descent preferred heroin/opiates (35.8% and 32.7% respectively).

Figure 4: Primary Drug of Choice among Hispanic/Latinos, SFY 2015

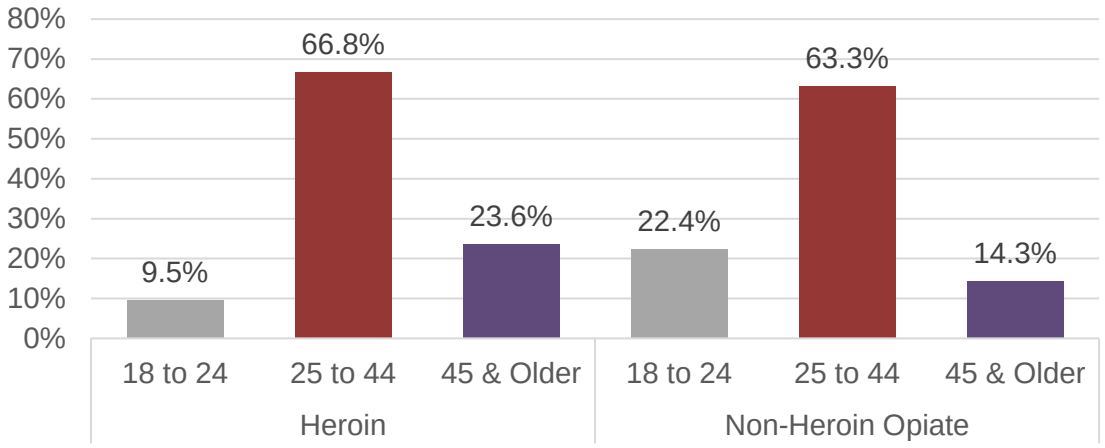


Source: OhioMHAS Behavioral Health Data

OPIOID ABUSE

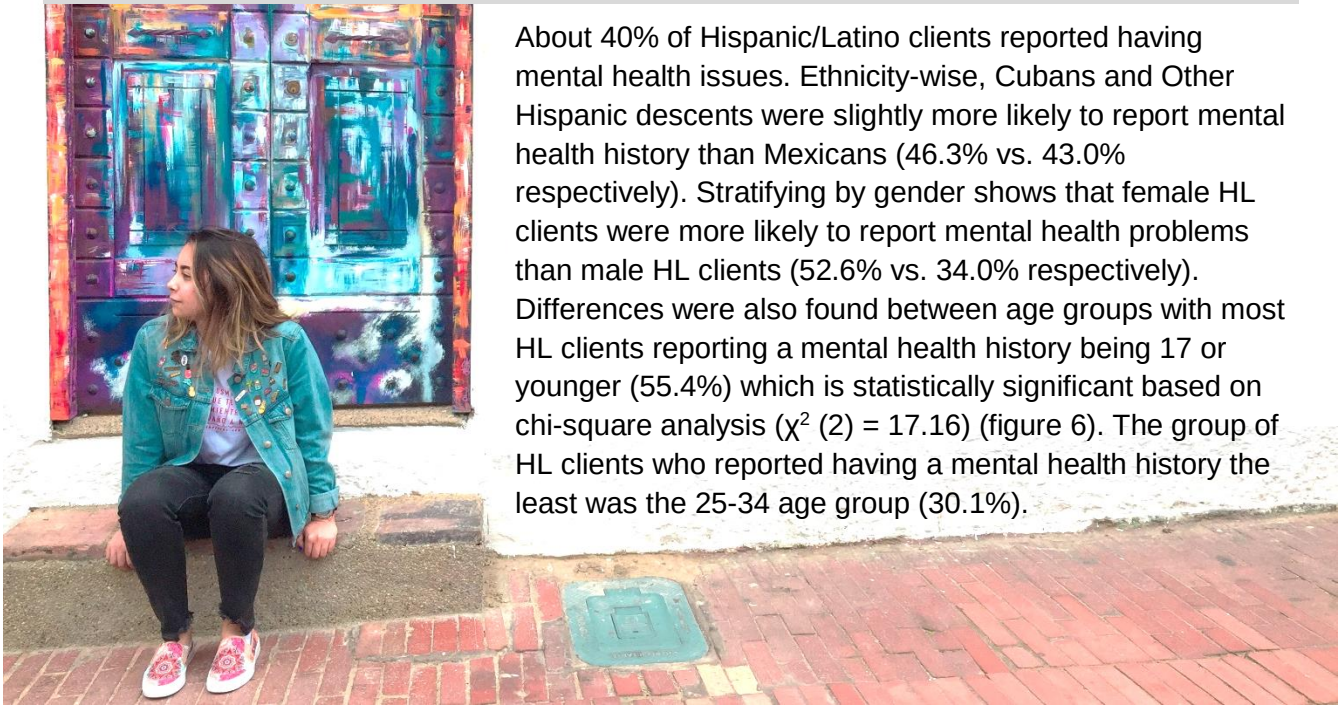
Close to 37.0% (36.9%) of admitted HL clients had abused opioids as their primary drug of choice (Figure 4). Within the opiates use, 30.2% preferred heroin and 6.7% chose opiates. There were no opiate users in the 17 years and younger age category. Comparatively, non-Hispanic clients in this age category reporting opiates use is small, with (15 reporting heroin use and 25 reporting non-heroin opiates). In terms of secondary drug of choice, only 4.1% of reported taking heroin. Findings related to co-occurring disorders are insightful. One-fifth of HL clients who reported taking opioids also reported having a mental health history (20.1%). There are also gender disparities in HL clients and opioid use with more male clients using opioids than female clients (68.8% vs. 31.2% respectively). Most of the reported heroin and non-opiate users were HL clients aged between 25 and 44 (66.8% and 63.3% respectively) (Figure 5).

Figure 5: Prevalence of Opioid Use among Hispanic/Latino Clients by Age Group, SFY 2015



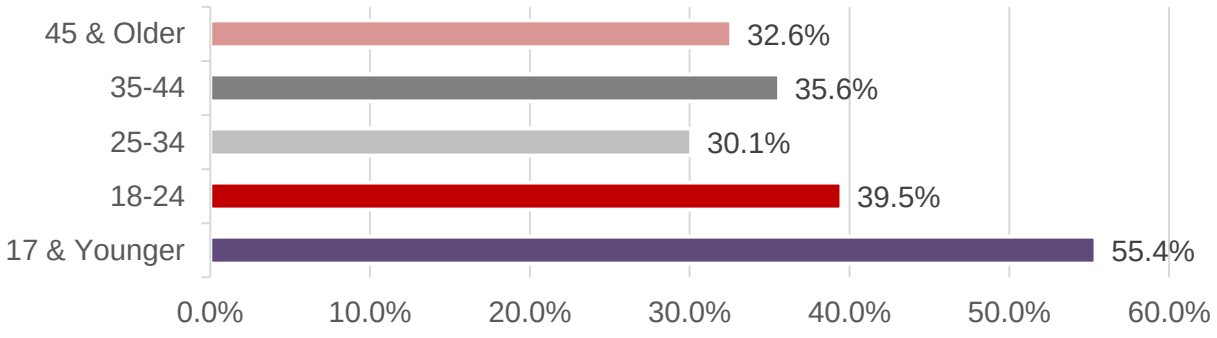
Source: OhioMHAS Behavioral Health Data

MENTAL HEALTH HISTORY



About 40% of Hispanic/Latino clients reported having mental health issues. Ethnicity-wise, Cubans and Other Hispanic descents were slightly more likely to report mental health history than Mexicans (46.3% vs. 43.0% respectively). Stratifying by gender shows that female HL clients were more likely to report mental health problems than male HL clients (52.6% vs. 34.0% respectively). Differences were also found between age groups with most HL clients reporting a mental health history being 17 or younger (55.4%) which is statistically significant based on chi-square analysis (χ^2 (2) = 17.16) (figure 6). The group of HL clients who reported having a mental health history the least was the 25-34 age group (30.1%).

Figure 6: Prevalence of Mental Health History among Hispanic/Latinos by Age, SFY 2015



Source: OhioMHAS Behavioral Health Data

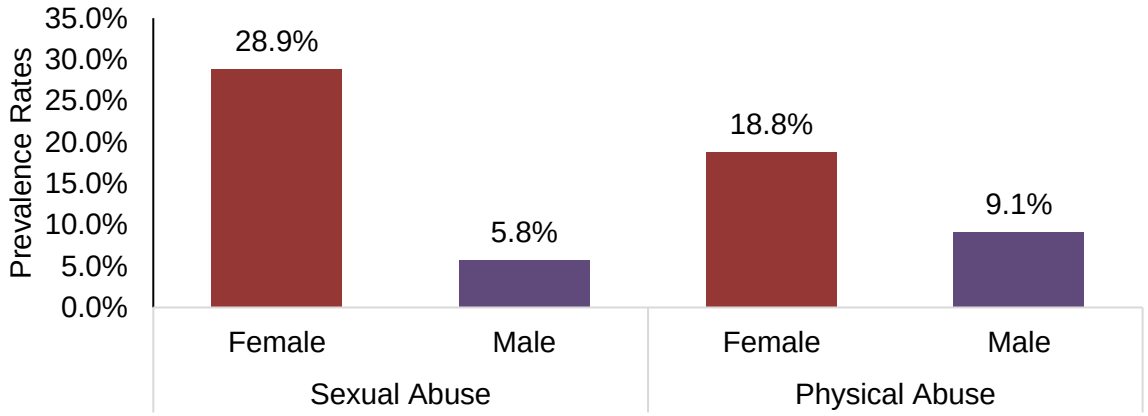
SUICIDAL IDEATION

Only a small number of HL clients reported experiencing suicidal ideation (3.7%). HL clients of Puerto Rican descent were more likely to report experiencing suicidal ideation than Mexicans and Cubans and Other Hispanics (4.1% vs. 3.3% and 3.7% respectively). Gender and age disparities were also found in HL clients reporting suicidal thoughts. Female HL clients were almost twice as likely to report experiencing suicidal ideation than male HL clients (5.3% vs. 2.7% respectively). HL clients aged 17 & younger were more likely to report experiencing suicidal ideation than other age groups (5.8%).

EXPOSURE TO VIOLENCE AND TRAUMA

About 17.3% of Hispanic/Latino clients reported being either victims of domestic violence or a witness to a domestic violence incident. Cuban and Other Hispanics were more likely to be a victim or a witness to domestic violence compared to other Hispanic/Latino ethnicities (19.3% vs 16.6% (Mexican) and 14.4% (Puerto Rican)). HL female clients were almost three times as likely to reporting being either victims or a witness of domestic violence than male HL clients (28.9% vs. 11.1% respectively), which was found to be statistically significant based on Chi-square analysis (($\chi^2(1) = 52.71$, $p < 0.001$)). HL clients who are 17 and under were the most likely to be a victim or witness of domestic violence (49.7%) and followed by those in the 25-44 age group (15.3%). Of those HL clients who have experienced abuse, 13.7% experienced past sexual abuse, 12.4% of HL clients reported experiencing physical abuse, and [experienced both]. Cuban & Other Hispanic clients were more likely to report sexual abuse (18.1%) and physical abuse (14.8%) than Mexican and Puerto Rican clients. Female HL clients were almost five times as likely to report experiencing previous sexual abuse than male HL clients (28.9% vs. 5.8% respectively), which was found to be significant ((χ^2 (1) = 107.37, $p < 0.001$)). They were also twice as likely to report being a victim of physical abuse than male clients (18.8 vs. 9.1 respectively), which was also found to be significant ((χ^2 (1) = 20.59, $p < 0.001$)). HL clients in the 45 and older age group were the most likely to report experiencing physical abuse (16.0%) whereas HL clients that were 35-44 were more likely to report experiencing sexual abuse (15.8%).

Figure 7: Prevalence of Abuse among Hispanic/Latinos by Gender, SFY 2015



Source: OhioMHAS Behavioral Health Data

DISCUSSION – MAJOR FINDINGS

This brief utilizes triangulation research method to provide a glimpse into the mental health history, substance abuse, and exposure to trauma among Hispanic/Latinos in Ohio. On the quantitative domain, the brief analyzed HL treatment admission in public behavioral health system during SFY 2015. As concerns the qualitative methods, the brief draws some insights from behavioral health conversations held in various regions of Ohio.[19]

Quantitative. The demographics of this sample (n=1,277) give us insight into potential implications on policy, some recapitulated here. Much of this HL sample were male (64.7%), were of Cuban or Other Hispanic descent (46.5%), were single or never married (78.7%), and had only completed some high school education (55.4%). Most HL clients admitted for service were a mental health client only (41.9%), followed by non-intensive outpatient care (24.4%). HL females tended to stay in treatment longer than HL males (3.6 vs. 3.2 months respectively). Alcohol and heroin were the most preferred drugs of choice in this sample. 55.4% of HL clients reporting a mental health history were aged 17 and younger and more female HL clients reported having a mental health history than male HL clients (52.6% vs. 34.0% respectively). Female HL clients were almost three times as likely to report being a victim or witness to a domestic violence incident and almost five times as likely to report experiencing previous sexual abuse compared to male HL clients.

These results on HL treatment admissions call for stepped up effort towards substance use prevention targeting younger Hispanic/Latinos and those of Cuban or Other Hispanic descent. For HL clients seeking substance abuse treatment, most preventative screening and counseling of HL clientele should be allocated to levels of care associated with non-intensive outpatient care. This brief's findings on mental health history were very insightful from a policy implication standpoint and warrant further discussion. The data show that there is a high need for screening for mental health issues and referral to appropriate therapeutic interventions among female HL clients and HL clients who are 17 years old or younger.

Data analysis on suicidal Ideation among Ohio Hispanic/Latinos revealed some interesting gender and age-related disparities. Stigma surrounds mental illness within the HL community and a subsequent unwillingness to seek

[19] National Hispanic & Latino Addiction Technology Transfer Center Network (NHLATTC) and Ohio Commission on Hispanic/Latino Affairs (OCHLA). Conversations with Latino Behavioral Health Practitioners and Community Advocates in Ohio. Dayton (Jul 12), Lorain (July 14).

mental health services.[20] HL female clients and HL clients aged 17 and under had higher rates of experiencing suicidal thoughts, indicating a high need for language and age appropriate screening and proper therapeutic interventions for this population. However, this screening and intervention must also align with Hispanic/Latino cultural understandings. Cultural stigmas for example in the Latino community may deter individuals from seeking mental health treatment.[21] Exposure to violence and trauma shows wide ranging disparities in terms of gender and age. HL females should be consistently screened for trauma since they were three times as likely to report being a witness or victim of domestic violence and five times as likely to report being a victim of sexual abuse as their male counterparts. Screenings also need to be done among HL clients aged 45 and older since there were high reports of physical and sexual abuse among this age range.

Qualitative. From a qualitative assessment standpoint, roundtable discussions (n=50; July 12-14, 2018)[22] organized by the National Hispanic Latino Addiction Technology Transfer Center Network in conjunction with the Ohio Commission on Hispanic/Latino Affairs highlight a few key barriers affecting Ohio Hispanic/Latino communities.[23]

A few snippets (*ad verbatim*) from the discussion are insightful. One female participant referred to a phone conversation where she is sharing with her mother "…I'm really at a low place, and I don't know what to do..." and her mother replies back: "…you're not really in a place to feel that way. Where you're going… 'You have so much going for you." The participant felt like her mom was dismissing her feeling and the conversation made her feel that "...she couldn't turn to her own family for support and made her realize that "…as children we're taught to seek help on our own or self-cope…" This snippet illustrates lack of familial support.

…she couldn't turn to her own family for support and made her realize that "…as children we're taught to seek help on our own or self-cope…"

[20]Maura, Jessica; Weisman de Mamani, Amy (2017, December). Mental Health Disparities, Treatment Engagement and Attrition Among Racial/Ethnic Minorities with Severe Mental Illness: A Review. *Journal of Clinical Psychology in Medical Settings* 24: 187-210.

[21] Ibid footnote 16.

[22] Ibid footnote 12.

[23] Roundtable Discussion Questions included: Q1. Based on your experience, what are the major issues/situations service providers face while working with HL populations? Q2. What are the training needs faced by service providers to deliver culturally appropriate service and treatment for HL? Q3. What strengths can you mention from providers of your organization to deliver specific services to HL? Q4. Has Health Care Reform affected or influenced the way you are currently delivering treatment services? and Q.5: What does the recovery culture look like for HL in your area?

The roundtable discussion also pointed to other barriers, one importantly being incomprehension among some providers regarding behavioral health symptoms and red flags. For example, one of the roundtable participants mentioned how most non-Hispanic providers cannot differentiate between a term of expression (for example: “Oh my God, it would kill me now”) and a real threat of suicide. A study found providers lacking consideration for Hispanic/Latino culture and an unwillingness among the Hispanic/Latino community to trust providers[24]. In terms of barriers, the roundtable also recorded references to geographic disparities in access to treatment and/or lack of substance abuse and mental health services in Northeast and Northwest regions of Ohio, especially the cities of Toledo, Cleveland, and Lorain.

Limitations. The results from this study may not be fully generalizable to the general population since the HL admissions are exclusively from the publicly funded behavioral health system and do not represent the total state demand for substance abuse and mental health treatment. The study findings to some extent are vulnerable to some degree of sample bias since a few service providers and community boards do not contribute information to the OHBH database. Lastly, social desirability bias may have potentially led to the underestimation of the prevalence rates in self-reported substance abuse and mental health history. Specific to the HL communities, this is critical and relevant to highlight given the: (a) prevalent stigma surrounding mental illness; and (b) under or inaccurate self-reports of drug abuse history for fears of getting in trouble for any substances they admitted to taking, especially if they were an undocumented immigrant.

[24]Ibid footnote 12.

IMPLICATIONS FOR MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT

It is critical to provide specialized culturally and linguistically competent prevention and treatment services to address the behavioral health issues, opioid use disorders, and co-occurring disorders among Hispanic/Latinos.[25] We draw the following policy implications for consideration:

- There is a high unmet need among HL population for behavioral health screening and proper therapeutic interventions, especially those aligned well with Hispanic/Latino cultural understandings.
- There should be specialized programs to provide improved or accessible culturally and linguistically competent mental health services for the growing Hispanic/Latino community.
- Willingness of providers to understand and integrate Hispanic/Latino culture into their practice will encourage better outcomes among Hispanic/Latino clients seeking mental health services.
- Ethnicity-wise, treatment and counseling for alcohol and opiate use disorders need to be specially tailored given the high alcohol use (47.1%) by clients of Mexican descent; and heroin/opiates abuse among Puerto Rican (35.8% and Cuban & Other Hispanic descent (32.7%).

[25] Ohio has a Hispanic UMADAOP (Urban Minority Alcoholism and Drug Abuse Outreach Program) that serves Hispanic/Latino community by providing culturally sensitive, holistic prevention, education, intervention, treatment, and re-entry programs. Visit: http://hispanicumadaop.org

- Higher rates of suicidal ideation experienced by HL female clients and HL clients aged 17 and younger reflects a high need for culturally, linguistically and age appropriate screening and proper therapeutic interventions for this population.[26]
- HL females should be consistently screened for trauma since they were three times as likely to report being a witness or victim of domestic violence and five times as likely to report being a victim of sexual abuse as their male counterparts.
- Screenings also need to be strongly encouraged among HL clients aged 45 and older since there were high reports of physical and sexual abuse among this age range.
- Future policy for substance abuse treatment in Ohio needs to consider the treatment gap faced by the HL population in the Northeast and Northwest regions of Ohio, especially the cities of Toledo, Cleveland, and Lorain.
- To address the gender-based health disparities in domestic violence, special programs need to be developed and implemented especially towards the female HL clients who are at aggravated risks of physical/sexual abuse.
- There is a need to promote health and well-being among HL communities by instituting policies that grant access to higher education, health care and driver's licenses; and to implement programs that promote immigrant integration such as ESL (English as a Second Language) classes and instituting more universal labor and employment protections for all workers.[27]

[26] American Academy of Pediatrics. Addressing Mental Health Concerns in Primary Care: A Clinician's Toolkit. Accessed on October 25, 2018 at: https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf

[27] Rodríguez, Michael, A., Young, Maria-Elena, Wallace, Steven P. Creating conditions to support healthy people: State policies that affect the health of undocumented immigrants and their families. Los Angeles, California. University of California Global Health Institute. (2015)

Appendix A: Demographics

Table 1: Select Demographics of Hispanic-Latinos by Unduplicated Counts: SFY 2015

Demographics	N	Percent*
Gender [Hispanic/Latino]	1262	
Male	817	64.7%
Female	445	35.3%
Ethnicity	1277	
Mexican	384	30.1%
Puerto Rican	299	23.4%
Cuban & Other Hispanic	594	46.5%
Marital Status	1255	
Single/Never Married	982	78.2%
Married	135	10.8%
Divorced/Separated/Widowed	138	11.0%
Age at Admission	1277	
17 & Younger	386	30.2%
18-24	185	14.5%
25-34	326	25.5%
35-44	208	16.3%
45 & Older	172	13.5%
Education	1234	
Less than High School	684	55.4%
High School Graduate	352	28.5%
Some College/Tech/Trade	181	14.7%
College Graduate/Postgraduate	17	1.4%

*Totals for each variable may not total to 100% due to rounding.

Source: OhioMHAS Behavioral Health Data

Appendix B: Glossary of Select Key Terms

Drug of choice – A client's preferred dug of choice. A client may identify up to four drugs of choice, which fall into the following categories: primary, secondary, tertiary or quaternary.

Health disparity – "A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion."[28]

Heroin – A traditional and non-pharmaceutical form of opiate drug. It is made from morphine, a natural substance taken from the seed pod of the various opium poppy plants grown in Southeast and Southwest Asia, Mexico, and Colombia. Heroin can be a white or brown powder, or a black sticky substance known as black tar heroin.[29]

Mental health history – A client self-identifies whether they have a mental health history.

Opioids – Opioids reduce the perception of pain but can also produce drowsiness, mental confusion, euphoria, nausea, constipation, and, depending upon the amount of drug taken, can depress respiration. Illegal opioid drugs, such as heroin and legally available pain relievers such as oxycodone and hydrocodone can cause serious health effects in those who misuse them.[30] Prescription medications used to treat pain include morphine, codeine, methadone, oxycodone, hydrocodone, fentanyl, hydromorphone, and buprenorphine, as well as illegal drugs such as heroin and illicit potent opioids such as fentanyl analogs (e.g., carfentanil).[31]

Opioid Use Disorders (OUD)[32] – Symptoms of opioid use disorders include strong desire for opioids, inability to control or reduce use, continued use despite interference with major obligations or social functioning, use of larger amounts over time, development of tolerance, spending a great deal of time to obtain and use opioids, and withdrawal symptoms that occur after stopping or reducing use, such as negative mood, nausea or vomiting, muscle aches, diarrhea, fever, and insomnia.[33]

Suicidal Ideation – This is one of the four types of suicide-related concepts. According to SAMSHA, "Suicidal ideation which is much more common than suicidal behavior, lies on a continuum of severity from fleeting and vague thoughts of death to those are persistent and highly specific; and serious suicidal ideation is frequent, intense and perceived as uncontrollable."[34]

Trauma –The American Psychological Association defines trauma as "…an emotional response to a terrible event like an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms like headaches or nausea."[35]

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[28] U.S. Department of Health and Human Services. The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Phase I report: Recommendations for the framework and format of Healthy People 2020 [Internet]. Section IV: Advisory Committee findings and recommendations [cited 2010 January 6]. Available from: http://www.healthypeople.gov/sites/default/files/PhaseI_0.pdf. Accessed on October 23, 2018.

[29] https://www.drugabuse.gov/publications/drugfacts/heroin. Accessed on October 16, 2018.

[30] https://www.samhsa.gov/disorders/substance-use. Accessed on October 23, 2018.

[31] More information at (accessed on October 16, 2018): https://store.samhsa.gov/shin/content/SMA18-4742/opioid-use-disorder-facts.pdf

[32] Detailed discussion of DSM-5 Criteria for Diagnosis of Opioid Use Disorder available at: https://www.asam.org/docs/default-source/education-docs/dsm-5-dx-oud-8-28-2017.pdf?sfvrsn=70540c2_2

[33] Ibid footnote 20.

[34] Center for Substance Abuse Treatment. (2009). *Addressing suicidal thoughts and behaviors in substance abuse treatment. Treatment Improvement Protocol (TIP) Series 50*. HHS Publication No. (SMA) 09-4381. Rockville, MD: Substance Abuse and Mental Health Services Administration. Accessed on October 23, 2018 at: http://store. samhsa.gov/shin/content//SMA09-4381/TIP50.pdf.

[35] American Psychological Association. (2013). *Trauma*. Available at (accessed October 23, 2018): https://www.apa.org/topics/trauma/index.aspx

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