Behavioral Health in Ohio

Improving Data, Moving Toward Racial & Ethnic Equity

Report 1:
An Overview of Opportunities

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About the Partners Conducting this Research

Central State University (CSU), an 1890 Land-Grant institution, prepares students with diverse backgrounds and experiences for leadership, research and service. The University fosters academic excellence within a nurturing environment and provides a strong liberal arts foundation leading to professional careers and advanced studies. Central State University aspires to be a premier institution of excellence in teaching and learning that embraces diversity and produces graduates with the knowledge, skills, and dispositions to make valuable contributions in a global society.

centralstate.edu

Multiethnic Advocates for Cultural Competence (MACC) is Ohio's leading voice for cultural competence, and we've held this distinction for nearly 20 years. Our mission is to help organizations embrace, achieve, and benefit from diversity and equity. We are the premier statewide organization offering cultural competence education and training for behavioral health and healthcare systems, non-profit organizations, educational institutions, businesses and any organizations interested in creating equity and addressing disparity. We believe discrimination in any form harms people, communities, and the economy. MACC supports organizations in getting to win-wins gaining understanding and skills in cultural competence to increase employee engagement and satisfaction, increase equity in upward mobility, improve service delivery and outcomes, increase the bottom line and impede attrition all while receiving a return on investment that is measurable.

maccinc.net

The Mental Health & Addiction Advocacy Coalition (MHAC) is comprised of over 130 member organizations statewide, including: health and human service agencies; the faith based community; Alcohol, Drug Addiction, Mental Health and Recovery Services Boards; advocacy organizations; courts; major medical institutions; the corporate arena; and behavioral health agencies serving children and adults. The MHAC's mission is to foster education and awareness of mental health and addiction issues while advocating for public policies and strategies that support effective, well-funded services, systems, and supports for those in need, resulting in stronger Ohio communities.

The MHAC would like to thank its generous philanthropic supporters including: Abington Foundation, Bruening Foundation, The Cleveland Foundation, Community West Foundation, The Char and Chuck Fowler Family Foundation, The George Gund Foundation, Interact for Health, The McGregor Foundation, Network for Good, The Nord Family Foundation, Peg's Foundation, Woodruff Foundation (and its funders who have asked to remain anonymous).

mhaadvocacy.org

Ohio University (OU) is the oldest public university in the state of Ohio, with a total enrollment of over 28,000 students across the state and online. Ohio University is also the state's leading producer of health professionals with the largest medical school in the state and among the top ten largest colleges of health professions nationally. The University holds as its central purpose the intellectual and personal development of its students. Distinguished by its rich history, diverse campus, international community, and beautiful Appalachian setting, Ohio University is known as well for its outstanding faculty of accomplished teachers whose research and creative activity advance knowledge across many disciplines.

ohio.edu

Introduction: What Do Race and Ethnicity Have to do with Health?

Race is a concept that came about in the United States (U.S.) because of the need to justify differential treatment of Black people as part of the Atlantic slave trade. Today the idea that humans can be sorted into five different racial groups based on perceived physical characteristics remains an integral part of American culture. However, research on the human genome suggests that genetic differences cannot account for racial differences. In fact, there are often more genetic differences between two people of the same racial group than between people of different racial groups. In other words, race is a social idea rather than a tangible, observable aspect of human biology.

The need to better understand how racial difference impacts behavioral health outcomes in Ohio prompted four partner organizations, Central State University (CSU), the Mental Health & Addiction Advocacy Coalition (MHAC), Multiethnic Advocates for Cultural Competence, Inc. (MACC), and Ohio University (OU) to develop the present report as well as three additional installments. In this, the first installment, an overview of the issues surrounding race, ethnicity, and behavioral health is presented. Following this first report, the additional three installments focus on racial and ethnic disparities in relation to 1) the behavioral health workforce, 2) treatment, and 3) funding. Each report contains data describing what we currently know and makes recommendations for improvements that will begin moving Ohio towards racial and ethnic equity in behavioral health.

Currently, profound health disparities exist between different racial groups, but this cannot be attributed to innate genetic or biological differences. Instead, these health disparities arise because of the ways racism impacts marginalized groups in the U.S. Talking about, studying, and characterizing the impacts of racism in the context of health outcomes is vital because racism is a force that continues to shape health in significant ways.

> **In this report we define racism as:**
> prejudice plus power; anyone of any race can have/exhibit racial prejudice, but in North America, [W]hite people have the institutional power, therefore racism is a systematized discrimination or antagonism directed against people of color based on the belief that whiteness is superior. It is insidious, systemic, devastating, and integral to understanding both the history of the United States and the everyday experiences of those of us living in this country.[1]

Understanding racism's relationship to health outcomes is essential because a person's racial or ethnic identity is a key predictor of how long they live and their likelihood to develop certain illnesses.[2] Historically, racism was an intentional and visible part of U.S. society. In present-day America, unequal treatment continues in a variety of institutions from schools, banks, hospitals, employers, and other entities. This unequal treatment leads to profound inequity in both physical and mental health outcomes.

At the outset, examining the complex relationships between race, ethnicity, and health requires an understanding that health is created from the interactions of social environments and an individual's genes. Though the interconnectedness of our health and social contexts may not be intuitive, understanding why and how we have good or bad health requires consideration of our histories, lived experiences, environments, and access to opportunities. In the U.S. and Ohio, individuals from marginalized racial and ethnic backgrounds face challenges on their path to good health because of prejudice, stereotyping,

and discrimination. This report's aim of gathering and analyzing available data around behavioral health disparities for racial and ethnic groups is a first step that will help formulate better questions, provide a baseline from which we can assess change, and enable strategic allocation of resources to have the greatest impact.

Mental health and substance use disorders, categorized together as behavioral health disorders, affect Ohioans of all racial, ethnic and socioeconomic backgrounds, but marginalized racial and ethnic groups have worse outcomes.[3] While there is currently some Ohio-specific race and ethnicity information available, often the information is incomplete or lacks detail.[4] This series of reports seeks to present data that quantify the ways marginalized racial and ethnic groups experience disparities surrounding mental health and substance use disorders.

At present, the deficits of language and words, particularly in reference to race, have no perfect or even universally palatable solutions. With this in mind, the partners involved in this report recognize these challenges and continue to engage in learning and self-reflection around issues of race and racism. Topics such as inequity, racism, and health disparities can and do bring up many feelings: memories of past experiences, for example, generational and present-day exposures to systemic racism. Readers are encouraged to engage in personal reflection about what comes up for them as they review these reports.

Throughout the report, the terms BIPOC (standing for Black, Indigenous, and people of color), communities of color, or people of color (POC) will be used. The partners supporting this research intend to honor the innumerable differences and unique identities of each individual, yet use of the term BIPOC may come across as doing the opposite. BIPOC has become a catch-all term for referring to non-White groups. Among the critiques of the term BIPOC is that it lumps the vast array of people and their differences into an undifferentiated monolith.[5] Further, reference to BIPOC, or other non-

specific terms such as POC can lead to the neglect of the specific issues, concerns, and problems faced by minoritized groups, in particular Black people.[6] As discussed, having better, more detailed and specific data is one way to combat the problematic aspects of the term BIPOC. Statistics that are currently available provide information such as "BIPOC are more likely to have lower incomes than other groups," but this statement is too broad, lacking the specificity necessary for deciding what actions to take for the greatest impact. Having data about the within-group differences of racial and ethnic categories, for example, income, education, incarceration rates, and more will help focus programs and resource allocation towards those most impacted. While this report uses terms that can be critiqued because they mask the differences within and between racial groups, the partners in this project assert the importance of reporting data on race despite the current limitations of language.

Readers may also note that much of the data presented are about Black and White people and only sometimes include other racial or ethnic groups (i.e. Hispanic).[A] One reason for having more information about Black and White populations is the population demographics of Ohio, with White people making up the largest group, and Black people the second largest. Because Black and White people make up most of the population of the state, there are more data about these groups. However, not having a large population in a particular racial or ethnic group should not exclude them from receiving the help and care they need.

Further, in this report, data about Black people are often shown in relation to White people. Presenting data in this way can potentially lead to the conclusion that Black people have "worse" or "bigger" problems than White people because there is something intrinsic to Black people that makes them more likely to suffer behavioral health problems. However, this report does not present the problems faced by Black people as personal deficits that can be blamed on individual biology or health behaviors. Instead, these reports seek

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[A] The term Hispanic is used in this research with an awareness that other terms, such as Latinx, Latino/a/e may be preferred, more appropriate, or accurate for describing individuals. Hispanic is used in this research because it aligns with the label used in national data sources (i.e. the U.S. Census). Although it is not universally-agreed upon as the best term, Hispanic is currently the standard for research.

to point out that not only are there systemic factors that contribute to inequitable outcomes, but that the lack of data about behavioral health for marginalized racial and ethnic groups makes it increasingly difficult to provide culturally relevant solutions related to these problems. In other words, with currently available data we do not have a solid basis for knowing what the problems actually are. Encouraging the collection of more complete data on racial and ethnic groups beyond Black and White people is a goal of this research.

With the caveats above in mind, this report presents high-level information on health indicators that are linked to behavioral health outcomes. The health indicators reported here are specific to marginalized racial and ethnic groups and include measures related to suicide, overdose, substance use, engagement with mental health care, rates of mental illness, and co-occurring disorders. The partner organizations worked together to define the kinds of questions that will guide this work. These include:

• What data are available to help understand issues related to behavioral health in marginalized communities?

• What data are needed and are not available?

The relevance of these questions around data can be understood by considering this statistic about Black Ohioans: "While African Americans comprise 12.6% of the overall population,[B] they account for 23% of all consumers in Ohio's public behavioral health system."[6] Statistics such as this one need to be examined and considered carefully. More detailed information, such as age, education levels, sex, and employment status would help contextualize the information and make it more relevant and useful. Even with more detail, there are additional questions to consider before the information can be appropriately used for planning or policy

decisions. It is unknown how this statistic compares with other groups' usage of services, how many people need services but are not getting them, where in Ohio the people that need and/or use the services live, whether the services are effective or beneficial, and much more. Further, even with more detailed statistics that quantify the problems, the question of *why* there are differences between racial and ethnic groups remains. These reports are a starting place that will help answer some of these questions, as well as aid in the formulation of better, more precise, and relevant questions going forward.

Existing Ohio–Specific Data on Race, Ethnicity, and Behavioral Health

Figure 1 lists some of the sources that currently have Ohio-specific data related to behavioral health, race, and ethnicity. There are also sources of Ohio-specific data that can inform work on health equity broadly (rather than specifically for behavioral health, race, and ethnicity). The Ohio Health Improvement Zones uses data based on the Social Vulnerability Index (SVI) created by the U.S. Centers for Disease Control and Prevention (CDC) to assess socioeconomic and demographic factors that affect the resilience of individuals and communities, particularly in terms of disaster preparedness.[7] Ohio's Community Wellbeing: Social Determinants of Health dashboard contains local-level data on demographics, education levels, income, and other indicators that can provide context for understanding barriers and facilitators to achieving health equity.[8]

As Figure 1 shows, many Ohio-based and national organizations are working on the issue of racial and ethnic equity in behavioral health. A few recent or forthcoming reports are important companions to this series, including the Disparities and Cultural

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[B] Population numbers used in this series of reports vary because multiple sources (i.e. ODH, SAMHSA) were used to create an overview of behavioral health and race in Ohio. Currently, there is no central, comprehensive data source on behavioral health and race in Ohio, prompting the need to use a variety of secondary data sources. Different organizations base their population estimates on a variety of sources and/or years which leads to the variation in population estimates readers may notice. Each data point used in this report has a link to its original source that readers can reference.

Competency Advisory Committee's strategic plan for 2021-2024, which is focused on improving behavioral health access, quality, and cultural and linguistic competency. Additionally, the Ohio Department of Mental Health and Addiction Services (OhioMHAS) and the Ohio Department of Health (ODH) are in the process of developing a Behavioral Risk Factor Surveillance System. What is presented here is not meant as a comprehensive list of the data available or a full accounting of who is doing work in this area. However, the data sources and organizations discussed have been helpful for informing the present report and are useful resources for anyone interested in the topic of behavioral health, race, and ethnicity. ■

FIGURE 1

Data Sources with Ohio-Specific Information Related to Mental Health and Substance Use Disorders that Include Race and/or Ethnicity

America's Health Rankings and Segregation Index

Health Policy Institute of Ohio

Health Resources Service Administration Area Health Resources Files

National Equity Atlas

Ohio Behavioral Risk Factor Surveillance System

Ohio Department of Health

Ohio Department of Health Eliminating Racial Disparities in Infant Mortality Task Force

Ohio Department of Medicaid

Ohio Department of Rehabilitation and Correction Annual Report

Ohio Healthy Youth Environments Survey

Ohio Department of Mental Health & Addiction Services: Disparities Research Advisory Committee Report

Ohio Department of Mental Health & Addiction Services Health Disparities Reports

Ohio Psychological Association

Ohio Substance Abuse Monitoring network

Ohio Youth Risk Behavior Survey

Substance Abuse and Mental Health Service Administration: Health Equity

Substance Abuse and Mental Health Service Administration: Mental Health Client-Level Data Annual Report

U.S. Department of Health and Human Services Office of Minority Health: Compendium of Data Sources on Health Disparities

Overview of Behavioral Health and Racial and Ethnic Inequity in Ohio

More than 2.3 million adults 18 and older in Ohio report having a mental illness.[9] It is important to contextualize this number because although it seems like this would be a basic data point, finding this number and ensuring clarity about what it means is not straightforward. The challenges and complexities involved in data on behavioral health can be understood by examining where the data come from and how they are collected. Prevalence data on mental illness vary because they depend on which source is consulted, how mental illness is defined, whether the data are based on self-reports or on diagnosed mental health disorders, and other considerations. In fact, The Congressional Research Service, a group that provides information to the U.S. Congress to inform federal policy explains:

> Determining how many people have a mental illness can be difficult, and prevalence estimates vary. While numerous surveys include questions related to mental illness, few provide prevalence estimates of diagnosable mental illness (e.g., major depressive disorder as opposed to feeling depressed, or generalized anxiety disorder as opposed to feeling anxious), and fewer still provide national prevalence estimates of diagnosable mental illness.[10]

The Congressional Research Service goes on to explain that there are three national surveys that report national prevalence estimates of diagnosable mental illness: the National Comorbidity Survey Replication (NCS-R), the National Comorbidity Survey Replication Adolescent Supplement (NCS-A), and the National Survey on Drug Use and Health (NSDUH). While

the NCS-R and the NCS-A identify specific mental illnesses, these surveys have not been conducted in over a decade. Hence, the data in the NCS-R and the NCS-A are not useful for understanding contemporary behavioral health issues. The NSDUH has the weakness of not identifying specific mental illnesses, but it is conducted annually and provides more up-to-date information.[10]

For this report, the determination was made that the NSDUH, conducted by SAMHSA, was the most appropriate source to include. Still there are drawbacks to consider with the NSDUH in addition to it not including questions designed to identify specific Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnoses. The NSDUH is only conducted in English and Spanish, and if a person does not speak one of these languages, they are not eligible to take the survey. Further, the NSDUH is a self-reported survey, meaning that the interpretation of the questions may vary significantly for each respondent depending on their education level, familiarity with terms and concepts related to mental health, and other factors.[11] With all of these caveats in mind, the NSDUH reports that Ohio has one of the highest percentages of adults who report experiencing any mental illness.

The map in Figure 2 from NSDUH puts Ohio in the range of 23.75-29.68 percent for *prevalence of any mental illness for people who are 18 or older* in a 12-month period between *2019 and 2020.* The NSDUH reports the exact number as 25.27% for 2019-2020.[12] Again, this is only for people ages 18 and over, which according to the 2021 U.S. census is 9,176,633 Ohioans.[B] Taking 25.27% of that number results in 2,318,935, which is the number cited at the beginning of this section. However, this number does not represent other relevant behavioral health concerns such as substance use disorders, the severity of the

Any Mental Illness in the Past Year: Among People Aged 18 or Older; by State, Average Percentages, 2019 and 2020[11]

▉	23.75 - 29.68%
▉	22.21 - 23.74%
▉	21.19 - 22.20%
▉	19.81 - 21.18%
▉	17.49 - 19.80%
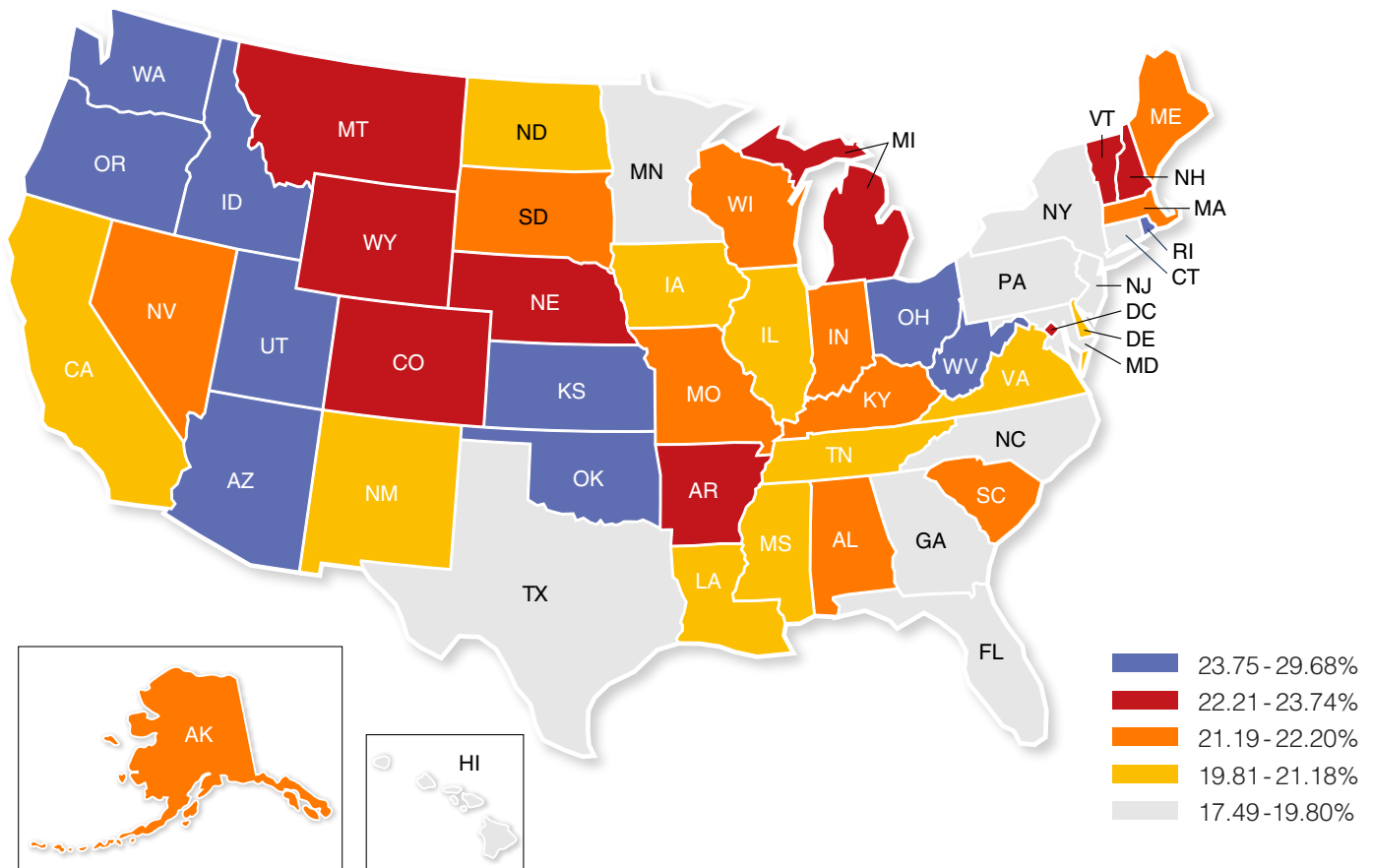
mental health issue, how long a person has experienced mental illness, how many young people have a mental illness, and most importantly for this report–what is the breakdown of this number by race and ethnicity.

To understand prevalence by race and ethnicity, research that is not Ohio-specific must be consulted. Statistical analysis shows that BIPOC have similar—or in some cases, fewer—mental disorders than White people.[13] According to the American Psychological Association, although the prevalence, in some instances, is lower for marginalized groups, the impacts of mental illness are found to be more debilitating. One factor that leads to more severe outcomes in marginalized groups is that people of color are less likely to seek care due to reasons that include but are not limited to stigma, lack of insurance, historical

experiences of misdiagnosis and mistreatment and other forms of systemic racism.[14]

For over two decades, researchers, practitioners, and others interested in the population's health have noted how marginalized racial and ethnic groups experience worse health outcomes than White people.[15,16] Behavioral health and physical health problems are interlinked and compounding, leading to poor quality of life and decreased life expectancy.[17] In particular, health indicators for Black Americans and Native Americans tend to point towards poorer outcomes for life expectancy, infant mortality, and preterm births.[18]

COVID–19: Race, Ethnicity, and Behavioral Health

COVID-19 disproportionately impacts marginalized racial and ethnic groups in Ohio and across the nation. In response to this disproportionate impact on Ohioans of color, Ohio Governor Mike DeWine formed the COVID-19 Minority Health Strike Force on April 20, 2020. The group of advisors worked with state leadership, community leaders, and medical providers to determine that the root of the disparities in COVID-19 are deep and require the elimination of racism to ensure promotion of healthy communities.[19] The Strike Force authored a Blueprint to lead Ohio's work to dismantle systemic racism and discrimination in health care and advance health equity for BIPOC Ohioans. The COVID-19 Ohio Minority Health Strike Force Blueprint's recommendations include:

- advising state and local government leaders and cross-sector partners to apply a health equity lens to evaluate and inform policy;

- developing community understanding, health literacy and trust;

- requiring cultural and linguistic competency and implicit bias trainings for state and local elected officials, government leadership and staff, and licensed professionals;

- and recruiting and retaining people of color in health professions by providing academic and financial support, mentoring opportunities, or connections to health and career preparation programs.

Implementing these and other recommendations presented in these reports is imperative if Ohio is to begin closing the gap in behavioral health outcomes between White and BIPOC groups. ■

Foundational Concepts in Behavioral Health Equity

Racial and ethnic inequity in behavioral health must be addressed for Ohio to have a healthy and thriving population. Health equity is achieved when there is an "assurance of conditions for optimal health for all people," … which "requires valuing all individuals and populations equally, recognizing and rectifying historical injustice, and providing resources according to need."[20, 21]

The following overview of issues, terms, and concepts related to behavioral health and racial and ethnic equity are provided to give readers a baseline understanding of the context of this report. In this section, ideas such as health equity, social determinants of health (SDOH), health disparities, racial equity, institutional/systemic/structural racism, implicit/unconscious bias, and intersectionality are briefly outlined. What is provided here is only an introduction to the vast and complex body of knowledge and research associated with the topic of racial equity and health, but is presented here as a way to orient readers to the ideas that inform this series of reports.

Behavioral Health Equity and Social Determinants of Health

Behavioral health equity is defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) as "the right to access quality health care for all populations... [including] access to prevention, treatment, and recovery services for mental and substance use disorders."[22] SAMHSA emphasizes that access to behavioral health care is only part of the solution and must also involve "addressing social determinants (of health), such as employment and housing stability, insurance status, proximity to services, and culturally responsive care".[22]

SAMHSA states that addressing SDOH is essential for achieving behavioral health equity.[22] Social determinants include a broad array of factors that can influence health such as income, education, air quality, crime levels, and many other facets of our daily lives. Social determinants are viewed as interconnected to, but different than the individual behavioral or genetic risk factors that also contribute to our physical and behavioral health status.

Approaching population health through the lens of the SDOH is vital because it considers the many factors that influence how long and how well we live. As Figure 3 illustrates, clinical care, i.e. going to a medical professional, only makes up 20% of what determines our health outcomes. The other 80% of what determines health outcomes is attributed to SDOH such as our physical environment, social and economic factors, and health behaviors.[23]

Racism is a strong driver of the SDOH because it impacts all facets of an individual's life by guiding choices about how money, power and resources are distributed. For example, racist zoning, banking, and housing policies have led to lower rates of home ownership for Black people.[24] Home ownership is a primary driver of the middle classes' ability to build wealth, so the policies that make buying a home more difficult for Black people are a social factor that impacts their financial security.[25] Higher household net worth is generally associated with better health outcomes. Therefore, limiting Black people's opportunities to own a home can be a risk factor for poor health outcomes.

However, SDOH cannot be analyzed as discrete factors because they are interconnected and combine in complex ways to impact health. For instance, having a higher income usually, but not always, correlates with better health outcomes. Some factors, such as racism, have an oversized negative impact on health.

FIGURE 3

County Health Rankings Model: Impact of Social Determinants of Health
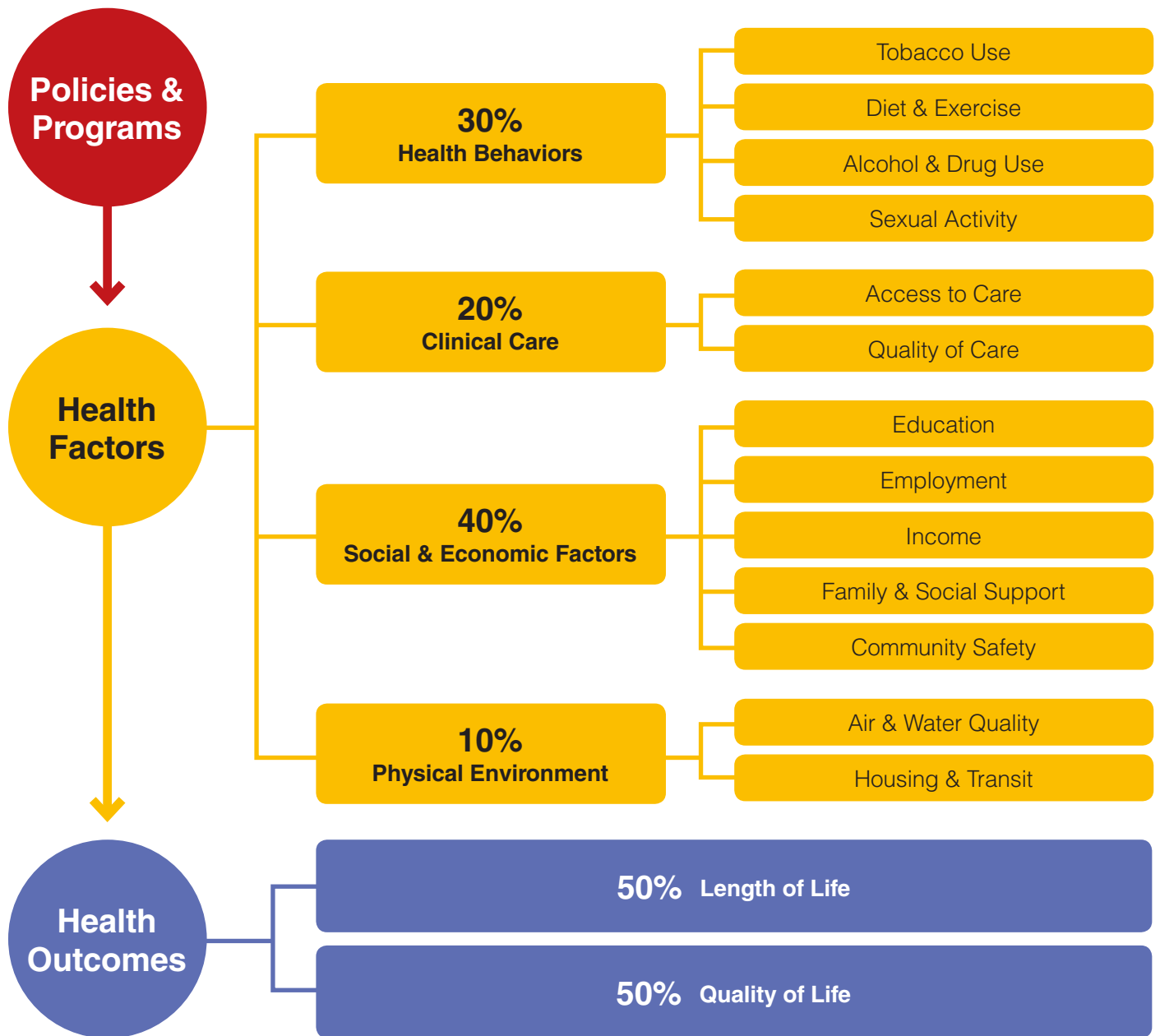
For example, studies examining individuals with the same income and education level show that Black women have worse health outcomes than White women, particularly in terms of pregnancy-related mortality.[25] Racism's tremendous negative impact on health is thought to come from the lifelong stress people of color experience from living in a society where implicit bias and structural racism are deeply ingrained in the culture. This ongoing sense of not belonging, being treated as less-than, and encountering continuous challenges related to systemic racism in daily life that White people do not face can lead to dysregulation in many body systems, impacting both physical and mental health.[26]

In addition to the examples discussed, racism drives the inequities found in employment, income, and education, all of which are SDOH. Health inequity exists and will persist until racism's effects on our social contexts are fully recognized and meaningfully addressed.

Health Disparities

Health disparities are defined as "health differences that adversely affect socially disadvantaged groups."[27] In this report, health disparities refer to "the numerical or statistical differences in health outcomes"[21] experienced by different groups. For example, there is a difference in the death rate for opioid overdoses between White and Black men in Ohio, with Black men having a higher rate than White men. The numerical difference between these groups for this health indicator is an example of a health disparity.

Implicit or Unconscious Bias

Implicit or unconscious bias are terms that denote "prejudice or unsupported judgments in favor of or against one thing, person, or group as compared to another, in a way that is usually considered unfair."[28] It is suggested that "unconscious bias occurs automatically as the brain makes quick judgments based on past experiences and background."[28] Without conscious realization, people of color are treated differently–and often unfairly, because everyone has biases from being socialized in systems that are inherently racist. For example, a Black person is five times more likely to be stopped by police without just cause than a White person.[29] Data like these point to a bias in policing practice that unfairly targets Black people, whether or not they have done anything wrong.

In health care settings it is important to increase awareness of implicit bias and how it impacts patient/provider interactions. Importantly, becoming aware of our implicit biases enables noticing when bias may be impacting our judgment. Understanding that implicit bias is influencing us provides an opportunity for reflection on our thoughts and assumptions. Over time, increased awareness of and self-reflection about how bias is influencing our beliefs and actions can lead to changes in behavior. For health care providers, working towards recognizing implicit bias is vital because research shows that implicit bias negatively impacts how patients and providers communicate, the types of treatment or tests people receive, and whether a person is labeled "noncompliant," rather than deciding to support them through their treatment.[30]

Institutional, Systemic, or Structural Racism

Institutional, systemic, or structural racism are all terms used to describe policies, laws and practices that negatively impact people based on their race. Institutional racism affects access to societal resources, goods, services and opportunities for work, housing, education, and much more. Of relevance to this report, institutional racism impacts access, affordability, and appropriateness of behavioral health services provided for marginalized racial and ethnic groups. One example is the type of mental health treatment provided to racial and ethnic minorities. Many of the treatments offered are based on research that only examined the impacts and effectiveness on majority, often White, populations.[31] Imposing interventions designed with no consideration of the needs of different racial and ethnic groups can be ineffective or even harmful.[31]

Related to the problem of not having research that includes the perspectives of BIPOC groups is the problem this series of reports seeks to address: a lack of data about behavioral health issues for marginalized racial and ethnic groups. The topics that researchers decide to study are often determined by what is agreed upon as a problem or question in need of answers. If data do not exist, or is only partially representative of the issues faced by BIPOC groups, it is difficult to make the case for doing research. The lack of data renders BIPOC communities invisible and results in a lack

of evidence to support the need for improvement or change. Institutional racism creates ways of thinking and doing that can, inadvertently or purposefully, lead to not collecting data that could help improve the health of marginalized racial and ethnic groups.

Intersectionality

Crenshaw explains that intersectionality is "a lens, a prism, for seeing the way in which various forms of inequity, like racism, classism, sexism, ableism and more, often operate together and exacerbate each other."[32] Each individual is a conglomeration of various identities, such as race, sex, gender, age, ability, and others that can, particularly in the case of people with multiple marginalized identities, compound experiences of oppression and inequity. Intersectionality is an essential aspect of achieving health equity in behavioral health care because it asks decision makers, researchers, and health care providers to think about how a policy, study, or treatment will affect different groups of people. Intersectionality requires taking not only a client's identity and culture into account but also the multiple barriers to access they may face living in a society built on institutional racism. Creating social policy that considers intersectionality involves having people with multiple marginalized identities at the decision making table so that their perspectives, knowledge, and needs are meaningfully taken into account.

In terms of data collection, the information in these reports would be more insightful if data were already being collected with intersectionality in mind. For example, rather than only presenting data about Black people as a whole, ideally the data could detail age, sex, ethnicity, socioeconomic status, gender identity, and more. The recommendations contained within this series of reports for improvements in data collection around race, ethnicity, and behavioral health will hopefully lead to more detailed analyses of within-group differences and enable the development of treatments and supports that take people's intersecting identities into account. ◼

Prevalence of Mental Illness and Substance Use Disorders

Mental illness in the U.S. and Ohio is common among all socioeconomic groups, ages, races, genders, ethnicities, and sexual orientations. According to the NSDUH, 25.27% of Ohioans 18 and older reported having any mental illness (AMI) during 2019-2020.[9] This translates to 2.3 million adults in Ohio. AMI is "a mental, behavioral, or emotional disorder (that)... can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment."[33] According to the National Institute of Mental Health (NIMH), about 52.9 million U.S. adults experienced AMI in 2020, or about one in five people.[9]

In 2021, SAMHSA researchers reported that the total of Ohioans that have been *diagnosed* with a mental health disorder increased from 355,332 in 2014 to 521,058 in 2019.[9] The numbers presented here are for people with an official diagnosis and underrepresented the full burden of mental health disorders. The counts are underrepresented because many individuals do not seek or receive treatment for mental health disorders, or may not receive an official diagnosis even if they do receive treatment. With that caveat, from 2014-2019, mental health diagnoses increased for all racial groups including American Indian or Alaska Natives (563%), Asians (476%) Black or African American (15%), Native Hawaiian or Other Pacific Islanders (559%), and White (148%). People with Hispanic ethnicity also increased (324%).[9]

Census data (2021) report that 13.2% of Ohio's population is Black, yet Black Ohioans accounted for 25.4% of individuals that had a mental health diagnosis in 2019.[34] Although the number of Black Ohioans that were reported as having a mental health diagnosis only increased by 15% from 2014 to 2019, many factors need to be considered when determining whether this number is accurate. For instance, Black people may not be formally diagnosed for a number of reasons,

including stigma, insufficient or no insurance, access to care, diversity in the behavioral health workforce, racism, and more.

Serious Mental Illness by Population

Serious mental illness (SMI) is defined as "a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities."[33] SMI includes, but is not limited to, schizophrenia, bipolar disorder, moderate/severe depression, and schizoaffective disorder. The overall prevalence of SMI in the U.S. population is 5.2%.[35] Nationwide, about 6.5% of women and 4% of men experience SMI.[35] Young people ages 18-25 are more likely to experience SMI, as are people who identify with more than one race.[36] SAMHSA reports that during 2017–2019, the annual average prevalence of past-year SMI in Ohio for young adults aged 18-25 was 9.5% (or 114,000), making Ohio's number similar to nearby states, but higher than the national average (7.9%). SAMHSA also reports that during 2017–2019, the annual average prevalence of past-year SMI in Ohio for adults aged 18 and older was 6.2% (or 556,000), which is higher than in surrounding states (5.0) and the national average (4.8).[36]

Prevalence of Substance Use Disorders

Substance use disorders (SUD) are defined by SAMHSA as the "recurrent use of alcohol and/or drugs [causing] clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home."[22] The substances most concerning for Ohio due to their negative impact on public health include tobacco,

alcohol, marijuana, opioids, and other prescription pain relievers.[37] SUD are a leading cause of preventable morbidity and mortality in the nation, and Ohio.[37] Ohio's data reveal that the "prevalence of substance use varied by gender, age, race/ethnicity, county type, education, poverty, mental health impairment, and Medicaid enrollment status."[37] The details of which substances are of most concern for which groups is an important question for allocating funding as well as providing appropriate treatment and supports. Of particular relevance to the goals of this and subsequent reports in this series are the prevalence of SUD for Ohio's racial and ethnic minorities, how it differs across age groups, income levels, geographic locations, and other defining characteristics.

Prevalence of Co-occurring Disorders

Co-occurring behavioral health disorders, or dual diagnosis, mean that a person meets diagnostic criteria for both a mental illness and SUD. In the U.S., 7.7 million people have co-occurring behavioral health disorders.[38] Nationally, about 38% of people with a SUD also have a mental illness, and just over 18% of individuals with a mental illness also have a SUD.[38] Considering that Ohio, generally, has higher prevalence of SUD and mental illness than the nation as a whole, it is likely that the co-occurrence of these behavioral health issues is a significant problem. However, Ohio-specific data about the prevalence and impact of co-occurring disorders are not readily available. Further, Ohio-specific data about co-occurring disorders for racial and ethnic groups are not available. Understanding the burden of co-occurring behavioral health disorders is an important step towards alleviating their negative impacts.

Deaths by Suicide and Unintentional Overdose for Racial and Ethnic Minorities in Ohio

Two outcomes that are used to assess the status of a population's behavioral health are suicide and unintentional overdose. Suicide and unintentional overdose are both associated with a variety of behavioral health problems, including mental illness and SUD. In contrast to data for the prevalence of mental illness or SUD, the data for suicide and unintentional overdose are based on death data collected by The Ohio Department of Health's (ODH) Bureau of Vital Statistics. Death data for suicide and unintentional overdose, as well as other causes of death, are more complete and accurate than the data quantifying things that can change over time. For example, a person may have an active SUD at one point in time, but with treatment, they may no longer be identified as a person with SUD at another point in time. Death data have an advantage over most data sources used in this report because they include complete data on racial and ethnic groups.

Suicide

For the whole population of Ohio, from 2010-2020 there was a 14.0% increase in the age-adjusted death rate for suicide.[39] For non-Hispanic Black Ohioans, there was a concerning 87.3% increase during that same interval. From 2019-2020, other racial and ethnic groups saw lowered suicide death rates: Hispanic decedents (-14.9%), non-Hispanic White decedents (-10.3%), leading to a -9.2% reduction in the overall suicide rates.[39] Despite this reduction when considering all racial and ethnic groups, the rate among non-Hispanic Black people increased by 8.4% during that time, showing a concerning upward trajectory.[39]

ODH provides statistics about suicide deaths by race and ethnicity that look at long and short-term trends. Two key takeaways from Figure 4 are that White Ohioans make up 79% of the total population, but

FIGURE 4

Number of Suicide Deaths by Race and Ethnicity, Ohio 2015-2020

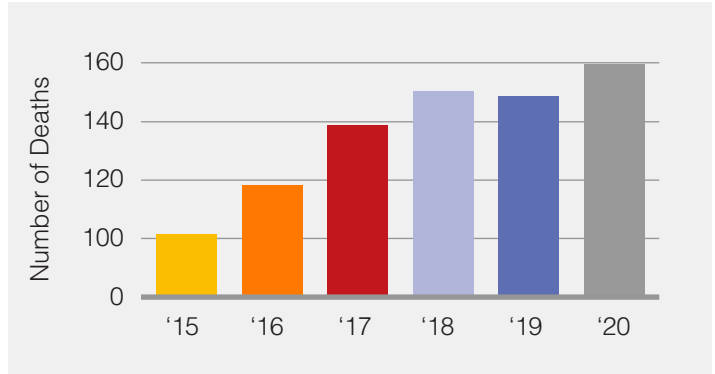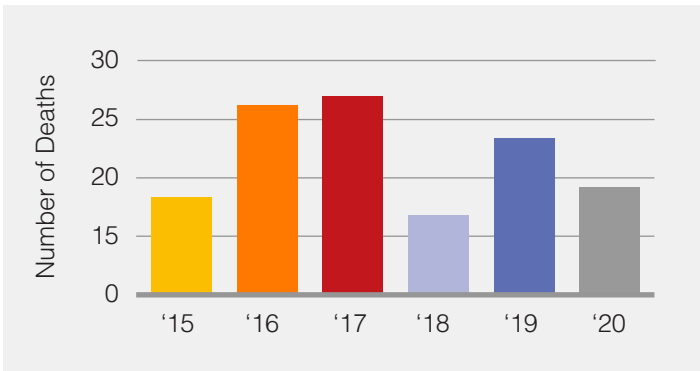### White Non-Hispanic:
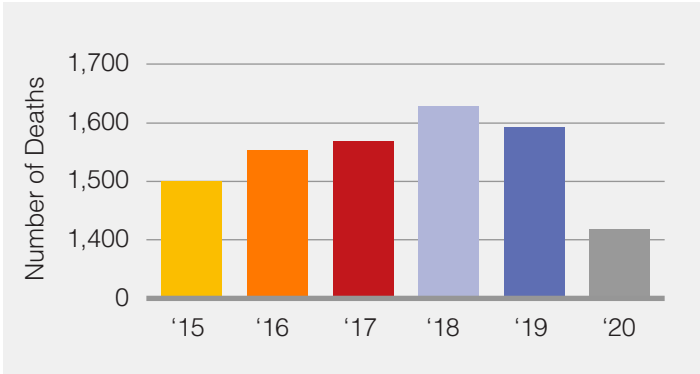
- In 2020, there were 1,421 deaths among White non-Hispanic Ohioans, which was an 11% decrease from 2019.

- White non-Hispanic individuals made up 87% of Ohio suicide deaths, compared with 79% of the total Ohio population.

- Suicide deaths among the White non-Hispanic population were highest in 2018 (1,632 deaths) and made up 89% of all Ohio suicide deaths.

Black Non-Hispanic:

- From 2019 to 2020, suicide deaths among Black non-Hispanic Ohioans increased 7% (see Footnote B).

- Suicide deaths among the Black non-Hispanic population were highest in 2020 (159 deaths). Black non-Hispanic individuals made up 10% of all Ohio suicide deaths, compared with 14% of the total Ohio population.

Asian/Pacific Islander Non-Hispanic:

- From 2019 to 2020, suicide deaths among Asian/Pacific Islander non-Hispanic Ohioans decreased 17%.

- In 2020, Asian/Pacific Islander non-Hispanic Ohioans made up 1% of all Ohio suicide deaths, compared with 3% of the total Ohio population.

- Suicide deaths among the Asian/Pacific Islander non-Hispanic population were highest in 2017 (27 deaths).

Hispanic:
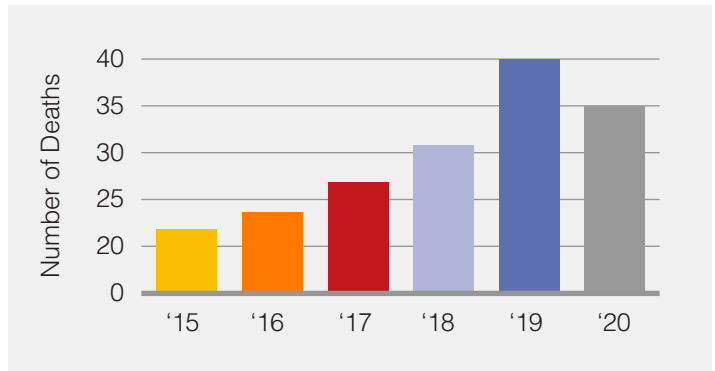
- From 2019 to 2020, suicide deaths among Hispanic Ohioans decreased 13%.

- In 2020, Hispanic individuals made up 2% of all Ohio suicide deaths, compared with 4% of the total Ohio population.

- Suicide deaths among the Hispanic population were highest in 2019 (40 deaths).

account for 87% of Ohio suicide deaths while Black Ohioans were the only group that saw an increase in suicide deaths from 2019-2020.[40]

Looking at larger overall trends, the groups experiencing the highest increases in suicide death rates over the last decade, both in Ohio and nationally, include people of color, younger people, those living in rural areas, and men.[41] Of particular concern for the present report is the increase in suicide death rates for young Black men. Organizations across Ohio are already working to implement programs directed towards young Black men, such as You are Not Alone.[39] Fortunately, the information developed through the present research will help evaluate and improve existing and future prevention, treatment, and recovery programs for mental illness and SUD. Tailoring interventions to be culturally appropriate for racial and ethnic groups is likely to reduce suicide deaths.

Overdose

Ohio consistently ranks in the top five highest states in the nation for unintentional opioid overdose deaths. The most recent year for complete data on overdose deaths in Ohio is 2020, which shows Ohio had the fourth highest death rate in the country at 47.2 per 100,000 population.[42] The data for marginalized groups (as shown in Figure 5), especially Black men in Ohio, show the gravity of the problems this population faces. For 2020, ODH reports that the overdose death rate for Black non-Hispanics (55.2 deaths per 100,000 population) surpassed the rate for White non-Hispanics (46.8 deaths per 100,000 population).[43] Black non-Hispanic males have the highest drug overdose death rate in Ohio compared with other sex and race/ethnicity groups.[43]

Overdose deaths are influenced by a complex network of factors, but as National Institute on Drug Abuse (NIDA) director Nora D. Volkow, M.D. says, "Systemic racism fuels the opioid crisis, just as it contributes mightily to other areas of health disparities and inequity, especially for Black people."[44]

Figure 5 [45] provides additional information about unintentional overdose deaths among various racial and ethnic groups in Ohio. ODH reports:

- [In] 2019, the unintentional drug overdose death rate for Ohio's Black non-Hispanic population surpassed the rate for the White non-Hispanic population.

- From 2019 to 2020, the gap continued to widen as the death rate for the Black non-Hispanic population increased 29% to 55.2 deaths per 100,000

FIGURE 5

Age-Adjusted Rate of Unintentional Drug Overdose Deaths by Race/Ethnicity, Ohio, 2015-2020.
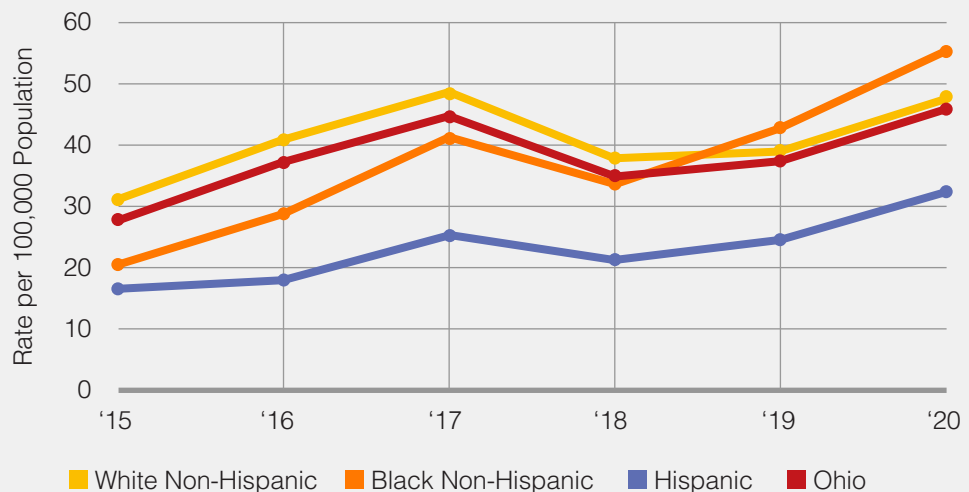
compared with a 24% increase among the White non-Hispanic population (46.8 deaths per 100,000).

- Since 2017, Black non-Hispanic males have had the highest rate of unintentional drug overdose deaths compared with other sex and race/ethnicity groups. However, while the rate for Black non-Hispanic males was higher than White non-Hispanic males in 2017, their rates were nearly the same, with only a 1% difference. By 2020, this difference had widened to 26%. In 2020, the rates for Black non-Hispanic males and White non-Hispanic males were 81.3 and 62.8 deaths per 100,000, respectively.

- In 2020, Black non-Hispanic males aged 35 to 54 had the highest opioid overdose rates.

- In 2019, the drug overdose death rate for Black non-Hispanic females was slightly lower than the rate for White non-Hispanic females. However, from 2019 to 2020, the overdose death rate for Black non-Hispanic females increased 33% and surpassed that of White non-Hispanic females (31.8 and 30.7 deaths per 100,000, respectively).

- Hispanic females have had the lowest drug overdose death rates for the years presented. However, from 2019 to 2020, they had the largest increase (56%) from 8.1 deaths to 12.6 deaths per 100,000.[45]

The HEALing Communities Study, administered in partnership by NIH's NIDA and SAMHSA investigated the effectiveness of the integration of prevention, overdose treatment, and medication-based treatment in select communities hard hit by the opioid crisis. This study, conducted in four states, including Ohio, showed that "non-Hispanic Black individuals have not benefited equally from prevention and treatment efforts."[44] For non-Black racial and ethnic groups (i.e. White and Hispanic), the study showed that rates for overdose death across all four participating states remained the same. While there was not a decrease, the study intervention successfully prevented the death rate from going up. However, the data for non-Hispanic Black people in Ohio showed a 45% increase in overdose deaths. The disparities in outcomes between Black people and other racial and ethnic groups in this study supports the claim that more and better data are needed to provide culturally-appropriate, effective interventions for Black people.

Barriers to Behavioral Health Care for Minoritized Populations

The barriers faced by minoritized groups related to engaging with the behavioral health care system for mental illness and SUD include access, utilization, and provision of care. Moreover, barriers to care are negatively impacted by provider bias, racism, and stigma, which lead to poorer quality of care and worse behavioral health outcomes.[46] Research also indicates that experiences of discrimination can prevent individuals from seeking care as well as impact adherence to medical treatment plans.[46] The information presented in this section relies primarily on national studies, as Ohio-specific data on barriers to care are lacking--underscoring the need for the type of work this research project is undertaking. Subsequent installments of these reports will focus on the racial and ethnic composition of the behavioral health care workforce as well as treatment in Ohio. Both of these reports will provide additional information that will help further understand the barriers to care for minoritized populations.

Stigma and Provider Racial Bias

Stigma involves the belief that an individual is "disqualified from full social acceptance."[47] Stigma is when a person is perceived by others or perceives themselves to be outside of what is "normal," or "good," in terms of societal expectations. For behavioral health, stigma around mental health and SUD drives people of all racial and ethnic groups away from seeking services. While self-imposed stigma can be a barrier to seeking care, marginalized groups face the added burden of dealing with the racial biases of

health care professionals.[46] Provider biases can lead to misdiagnosis because of tendencies to minimize symptoms or over pathologize people of color.[46]

Racial and ethnic biases that medical professionals hold may not be consciously understood. Unconscious bias is also known as implicit because it is automatic and unintentional. It is important for everyone to recognize that their beliefs and actions are shaped by their social context, and understand that they may be discriminating against others when it is their strong intention to not do so. All individuals in the U.S., regardless of their identity, are socialized to have racial and ethnic biases that are both overt and subtle.[46] Recognizing there are ways to change implicit bias, many of the recommendations in this series of reports work to shift the norms of social interaction that reinforce existing biases as "natural." Biases are ingrained through a lifetime of large and small experiences, and addressing them will take a similar approach: a long-term commitment to change at the individual, community, and society-wide levels.

Access, Utilization, and Provision of Care

Access, utilization, and provision of care are three interlinked issues that all play a role in whether behavioral health services will have positive outcomes. Access refers to whether behavioral health care services are available, affordable, and conveniently located. Minority racial and ethnic groups have less access to mental health care.[48] When there is no treatment available, people will suffer worse outcomes.

Utilization involves the rate at which individuals initiate and return to services. Marginalized racial and ethnic groups utilize behavioral health care services at lower rates than White populations. Black Americans and Asian Americans tend to utilize mental health services less than any other racial group.[12] Reasons cited for underutilization of mental health and/or substance use services include cost of insurance, low perceived need, stigma, structural barriers, and thinking that

behavioral health services will not work.[46] While cost of services, transportation problems, and inadequate child care resources can impact all group's utilization of care, these issues are particularly pronounced for Black communities.[48] Moreover, a 2017 meta-analysis of studies on discrimination and health service utilization reported that perceived discrimination was inversely related to positive experiences in regard to health care (e.g., satisfaction with care or perceived quality of care).[49] Further, that same study found that perceived discrimination resulted in reduced adherence to medical regimens and delaying or not seeking health care.

Provision of care refers to the interaction among providers and health care recipients. Cultural differences between provider and service user can be a barrier to effective treatment. Increasing the number of culturally competent and racially and ethnically diverse providers can result in improved behavioral health outcomes.[22] Additional barriers related to provision of care include misdiagnosis, lack of specialty and preventative care, and disempowerment while in treatment.[49]

Although the overall research shows that provision of care needs improvement regarding marginalized racial and ethnic groups, there are some Ohio-specific data that show young people of color are receiving the care they need. The 2019 Ohio Youth Risk Behavior Survey (YRBS) shows that both middle and high school students in Ohio who reported feeling sad, empty, hopeless, angry, or anxious said that they get the kind of help they need most of the time or always.[50] Figures 6 and 7 illustrate the percentages for each grade-level, as well as the differences between racial and ethnic groups. In both middle and high school, there is no statistically significant difference reported for getting needed care between different racial and ethnic groups.[50]

Ohio's YRBS is a valuable source of data in regard to the goals of this report because it adds to the understanding of whether and how marginalized groups are receiving the behavioral health care they need. These data are available because ODH participates in the national Youth Risk Behavior Surveillance System (YRBSS) administered by the U.S. Centers for Disease

Control and Prevention. The YRBSS is the largest public health surveillance system in the U.S., and it provides a reliable source of population-level, health behavior data for marginalized racial and ethnic teens in Ohio. As discussed throughout this report, this level of detail and specificity related to behavioral health and marginalized racial and ethnic groups is rare. However, the Ohio YRBS is an example of a data collection system that provides information on race and ethnicity for issues related to mental illness and SUD and could be a model for collecting data on other age groups.

The YRBSS does not align seamlessly with other national data collection sources that have Ohio-specific data, such as the NSDUH, even though they both rely on self-reports from respondents. YRBSS and NSDUH have different stated purposes, sampling procedures, and questionnaire designs that call for caution in combining or comparing results. Further, results from different sources often report different data, calling for decision makers to have an awareness of these differences as well as standardized approaches for deciding on which data to use.[51]

Looking at the provision of care for mental health challenges, it appears that there is not a disparity between the White and Black teen population in Ohio. However, it is important to note that these data cannot

FIGURE 6

Middle School Students:

Percentage who most of the time or always get the kind of help they need, among students who report having felt sad, empty, hopeless, angry or anxious, 2019
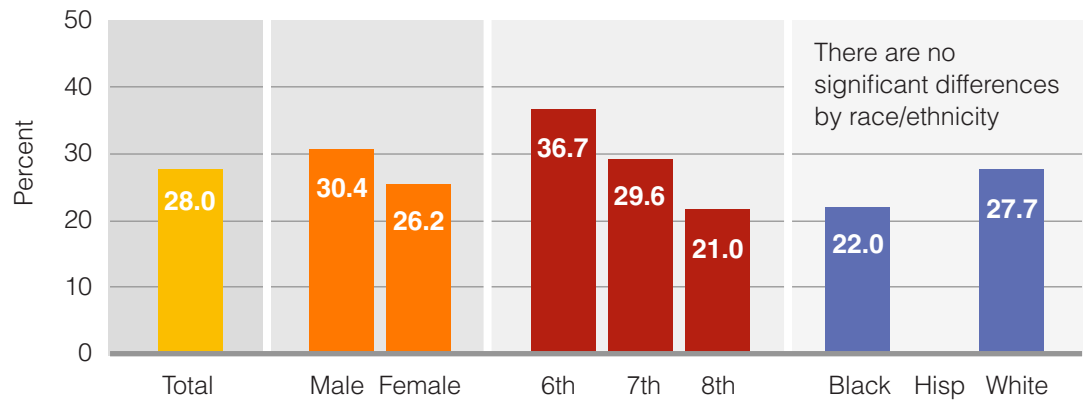
Source: Ohio YRBS, 2019

* Missing bar indicates fewer than 100 students in the subgroup.

FIGURE 7

High School Students:

Percentage who most of the time or always get the kind of help they need, among students who report having felt sad, empty, hopeless, angry or anxious, 2019
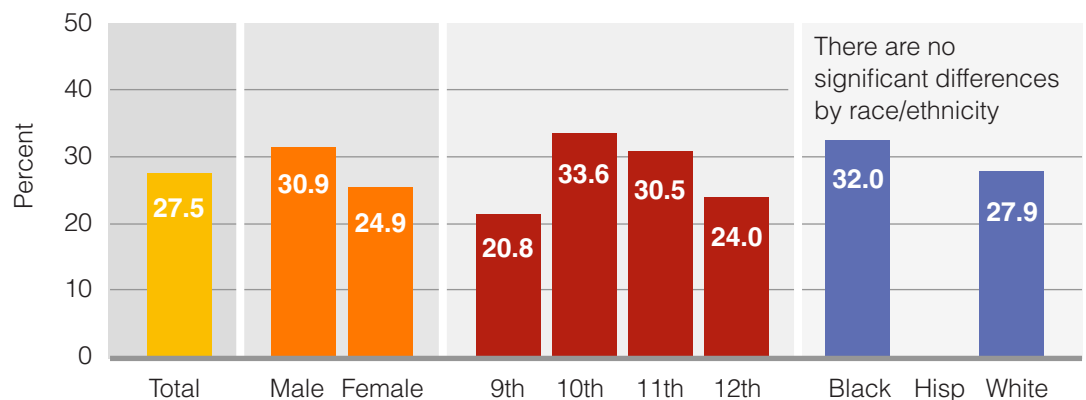
Source: Ohio YRBS, 2019

* Missing bar indicates fewer than 100 students in the subgroup.

tell us about the severity of mental health challenges teens are experiencing, their specific diagnosis, nor whether the help they receive is effective. In other words, respondents report getting the help they think they need but the impact is unknown. Still, data reporting positive perceptions regarding getting needed care are vitally important because feeling like treatment is effective makes people more likely to continue treatment and to be open to treatment in the future. ◼

Incarceration and Racial and Ethnic Inequity in Behavioral Health

Minority populations are disproportionately represented in U.S. jails and prisons.[52] In Ohio, the Black population makes up about 13% of the total population in the state, but represented 34% of people in jail in 2015 and 45% of people in prison in 2017 (see Footnote B).[52] Figure 8 shows the breakdown of race and ethnicity for people in jails and prisons in Ohio. The circles on the figure illustrate the disproportionate representation of Black people as related to their representation in the state's overall population in both jails and prisons. Further, looking at trends overtime, Figure 8 shows that Black people's incarceration in both jails (for 2015) and prisons (for 2017) has increased over time.

Race and Ethnicity of Ohio's Jail and Prison Populations

Jails 2015

<1% Asian/PI
2%*

<1% Native Am
<1%*

34%
Black
13%*

61%
White
81%*

4%
LatinX
3%*

Legend: Asian/PI, Native Am, White, LatinX, Black

Rate per 100,000 ages 15-64

15   115   177   286   620

1990   2000   2015

* % population of Ohio

Since 1990, the Black incarceration rate has increased 14%. In 2015, Black people were incarcerated at 3.5 times the rate of White people.

Prisons 2017

<1% Asian/PI
2%*

<1% Native Am
<1%*

45%
Black
13%*

51%
White
81%*

3% LatinX
3%*

* % population of Ohio

Asian/PI · Native Am · White · LatinX · Black

Rate per 100,000 ages 15-64

4000
3000
2000
1000
0

1978   2000   2017

34 403 435 501   **2,308**

Since 1978, the Black incarceration rate has increased 125%. In 2017, Black people were incarcerated at 5.3 times the rate of White people.
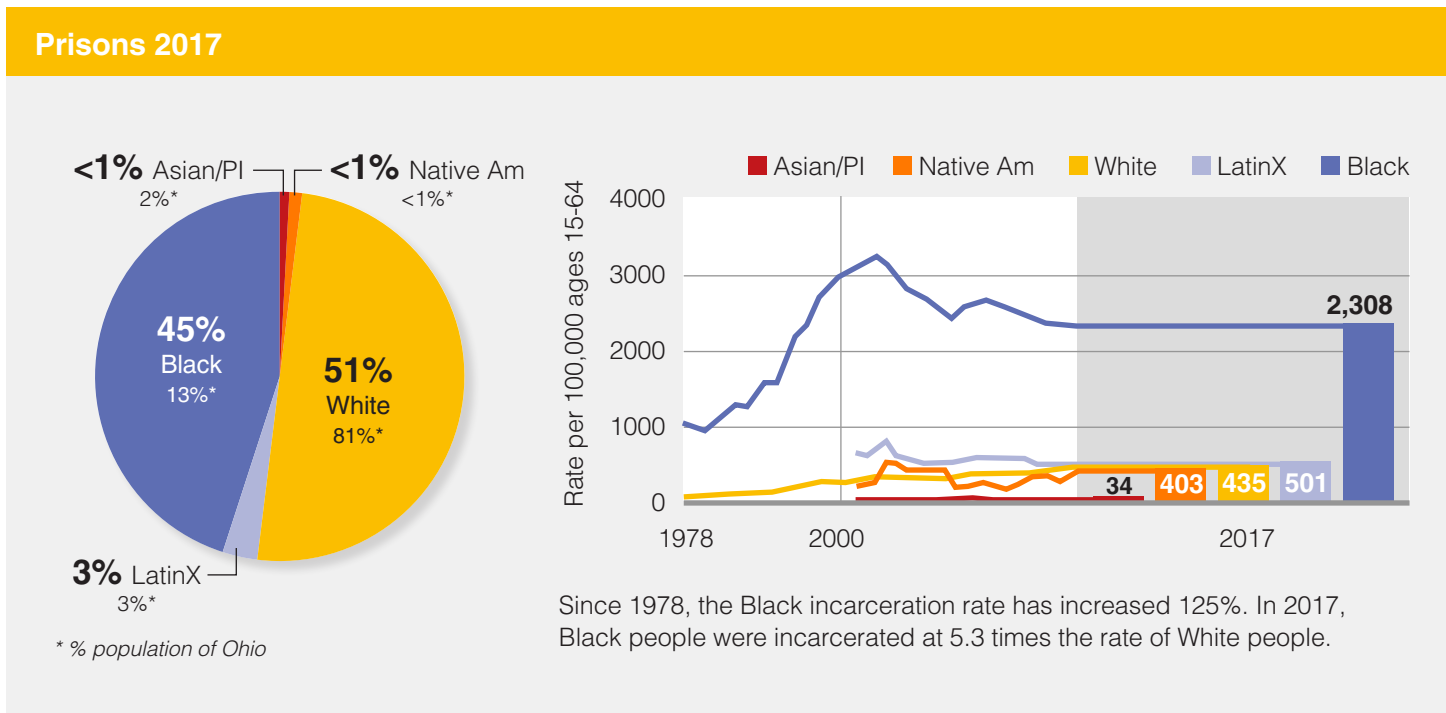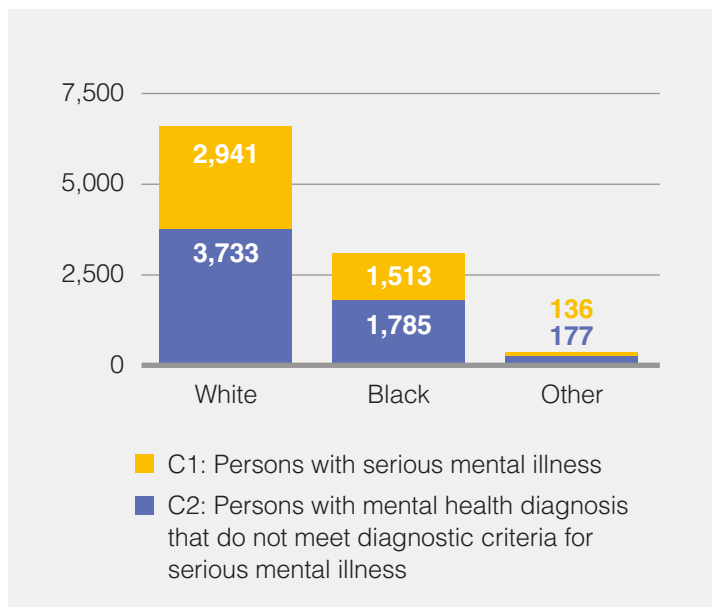
Figure 9 shows that in 2022, 3,298 Black people in Ohio's prisons received mental health services, as compared to 6,674 White people and 313 people identified as an "other" racial group.[53] Of that total, 1,513 Black people, or 46%, met the diagnostic criteria of having a serious mental illness while 2,941 White people, or 44% met the diagnostic criteria. While having these data on mental health service utilization broken down by race is a helpful start to understanding behavioral health issues for incarcerated people of color, more detailed information on race and ethnicity is needed.[53]

FIGURE 9

**Correctional Health Care:
Mental Health Caseload by Race, 2022**

7,500
5,000
2,500
0

White   Black   Other

2,941
3,733

1,513
1,785

136
177

■ C1: Persons with serious mental illness
■ C2: Persons with mental health diagnosis that do not meet diagnostic criteria for serious mental illness

* Data consist of May 2022 snapshot

Across the U.S. and in Ohio, people experiencing behavioral health emergencies often encounter law enforcement rather than behavioral health interventionists.[54, 55, 56] Research shows that incarcerating people with behavioral health emergencies does not improve their behavioral health or public safety.[54] Moreover, dealing with behavioral health issues through policing and incarceration results in over-spending on both corrections and treatment programs.[54] McCann explains that "jail actually increases the likelihood of recidivism, ensnaring people with mental health needs in a vicious cycle of incarceration without ever providing them with treatment."[54]

There is a strong partnership between the Ohio Department of Rehabilitation and Correction (ODRC) and OhioMHAS, including the provision of funding for treatment from OhioMHAS to ODRC.[53] Further, there are existing models for community-based diversion programs and wrap-around reentry and housing initiatives that are shown to reduce costs and rearrests, and improve mental health and SUD outcomes.[54] Given that jails and prisons are the largest providers of mental health care in the country and the disproportionate representation of incarcerated BIPOC groups, this research study presents this brief overview of the situation in Ohio, but recognizes it is insufficient as a basis for policy recommendations or practice change.[54] Although beyond the scope of the current research project, better collection of data on behavioral health treatment and funding for incarcerated populations is needed. ■

Recommendations

Based on the information discovered and reported in this first installment of the report series on Behavioral Health in Ohio: Improving Data, Moving Toward Racial & Ethnic Equity, the following are put forth as opportunities for improvement:

1. Improve data collection for racial and ethnic minorities and behavioral health in the following areas:

    a. Improve precision and clarity in reported data by defining terms such as mental illness and prevalence. Clearly indicate where data are coming from (i.e. via self reports or based on diagnostic codes).

    b. Assess the location of individuals with behavioral health needs in relation to the location of culturally competent and/or racially concordant service providers.

    c. Identify the barriers and facilitators to access/utilization of services.

    d. Assess the treatment needs and care provision for current or formerly incarcerated individuals.

    e. Collect detailed data to determine within-group differences in marginalized racial and ethnic groups. Within-group differences are data about gender, sexuality, ability status, income, education level, employment status, and other characteristics determined to be relevant for program and policy planning.

    f. Use existing data systems that collect high quality information about marginalized racial and ethnic groups (i.e. - Youth Risk Behavior Surveillance System) as a model for creating or revising existing systems on race and/or ethnicity in Ohio.

2. Use data contained in this series of reports as a baseline from which to measure existing interventions to determine if they are meeting the needs of marginalized groups.

3. Ensure treatment interventions are culturally appropriate for marginalized racial and ethnic groups.

4. Work with the Disparities and Cultural Competence (DACC) Advisory Committee created by The Ohio Department of Mental Health and Addiction Services to assess where improvements can be made in service equity related to the public behavioral health system.

5. Implement the COVID-19 Ohio Minority Health Strike Force Blueprint's recommendations.

6. Establish a task force and name entities responsible for implementing these recommendations and holding stakeholders accountable for improvements and positive change.

Glossary of Terms and Acronyms

AMI	Any mental illness, characterized by a range of mental, emotional, or behavioral disturbances with no, mild, moderate, or severe impact on functioning.[33]
Behavioral health equity	The right to access quality health care for all populations including access to prevention, treatment, and recovery services for mental and substance use disorders.[22]
BIPOC	Black, Indigenous, and People of Color; includes people who are of non-White ethnicity.
CDC	The United States Centers for Disease Control and Prevention.
CMS	Centers for Medicare & Medicaid Services.
CSU	Central State University.
Diversity	The various elements that contribute to human differentiations, including but not limited to background, race, color, ethnicity, creed, religion/spirituality, sex, gender, sexual orientation, gender identity, sexual identity, socio-economic status, native language, national origin, age, (dis)ability, military/veteran status, political perspective, and associational preferences.[57]
Equity	The state, quality or ideal of being just, impartial, and fair.[58]
Health disparities	Health differences that adversely affect socially disadvantaged groups.[27]
Implicit or unconscious bias	A prejudice or unsupported judgments in favor of or against one thing, person, or group as compared to another, in a way that is usually considered unfair. Many researchers suggest that unconscious bias occurs automatically as the brain makes quick judgments based on past experiences and background. As a result of unconscious biases, certain people benefit and other people are penalized.[28]
Institutional/structural/ systemic racism	The processes of racism that are embedded in laws (local, state, and federal), policies, and practices of society and its institutions that provide advantages to racial groups deemed as superior, while differentially oppressing, disadvantaging, or otherwise neglecting racial groups viewed as inferior.[28]
MACC	Multiethnic Advocates for Cultural Competence.

MHAC	Mental Health & Addiction Advocacy Coalition.
NCS-R	National Comorbidity Survey Replication.
NCS-A	National Comorbidity Survey Replication Adolescent Supplement.
NSDUH	National Survey on Drug Use and Health.
ODH	Ohio Department of Health.
OhioMHAS	Ohio Department of Mental Health & Addiction Services.
ODRC	Ohio Department of Rehabilitation & Correction.
OU	Ohio University
Ohio YRBS	Ohio Youth Risk Behavior Survey.
POC	People of color.
Race	A social category used to identify individuals based on their physical appearance or perceived cultural ancestry, and often as a way of characterizing an individual's value. Racial categories are not based on biology or genetics.[21]
Racism	Prejudice plus power; anyone of any race can have/exhibit racial prejudice, but in North America, [W]hite people have the institutional power, therefore racism is a systematized discrimination or antagonism directed against people of color based on the belief that whiteness is superior. It is insidious, systemic, devastating, and integral to understanding both the history of the United States and the everyday experiences of those of us living in this country.[1]
SAMHSA	The Substance Abuse and Mental Health Services Administration.
Social determinants of health (SDOH)	The economic and social conditions that influence individual and group differences in health status.[20]
SUD	Substance use disorder.
YRBSS	National Youth Risk Behavior Surveillance System.

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