



Behavioral Health in New Mexico

The New Mexico Race Matters Coalition works to eliminate structural racism so all New Mexico children may reach their full potential.

New Mexico is a minority/majority multicultural state where 67% of the children are racial minorities: 51% are Hispanic, 12% are Native American, 2% are African American and 2% are Asian, while only 33% are white non-Hispanic. Despite their high numbers, children of color in New Mexico tend not to fare as well as their white counterparts due to the numerous disparities they face.

Disparities are often created and maintained both intentionally and inadvertently through policies and practices that contain barriers to opportunities. We call this structural racism. Structural racism is evident in New Mexico as unequal outcomes in the health, success and wellness of children of color. Because of its negative impacts on behavioral health across generations and along the life span, structural racism should be eliminated in New Mexico.

What is Behavioral Health? Behavioral health is a blanket term that encompasses mental illness and developmental disabilities, including autism spectrum disorders, brain injury, substance abuse, and co-occurring/dual diagnosis. Everyone is affected by behavioral/mental health issues, from substance abuse (legal and illegal) to the stress of daily living, however children of color experience disproportionate levels of behavioral/mental health-related illnesses due to structural racism.

National Data:

- Minority children receive mental health services through the juvenile justice and welfare systems more often than through schools or special settings.¹
- African-American youth are more frequently referred for conduct problems to corrections facilities rather than psychiatric hospitals, even when the measures of aggressive behaviors are lower or equal to those of the youth population overall. This also impacts the quality of care.²
- Between 50% and 75% of incarcerated youth nationwide are estimated to have a diagnosable mental health disorder. Youth of color, females, and homosexual youth are most vulnerable to mistreatment and mismanagement among those suffering from mental health problems.³
- ADHD is less often treated by medications in minority groups than in white populations. There is also increased probability of misdiagnoses among minority individuals, affecting subsequent care.⁴
- Latino youth have the highest rate of suicide, yet they are less likely to be identified by their caregivers as having problems. Disparities in services may be due to different barriers such as insurance status and access to settings where mental health care is delivered.⁵
- Efforts to address racial and ethnic disparities in mental health care delivery are constrained by profound socio-environmental, institutional, and market forces. For example, managed care providers, being limited to treating only medical necessities, may be constrained in their ability to service minority children in the schools, juvenile justice settings or welfare agencies.⁶
- Income is highly related to health care access and insurance coverage. Because African-American, Latino, and Native-American families are more likely to be poor than whites and Asians, they are less likely to have adequate insurance coverage and access to quality care. Most studies show that even when income is similar across groups, racial and ethnic disparities remain. Workers of color, especially Hispanics, are more likely to be relegated to low-wage jobs and labor markets that offer minimal if any health benefits.⁷
- People who have primary care physicians are more likely to receive preventative care. Yet, 30% of Hispanics, 21% of Asian Americans, 20% of African Americans, and 19% of American Indians lack primary care doctors, in comparison to 16% of whites. Hispanic children are three times more likely than white children to lack primary care physicians.⁸

New Mexico Data:

- Mental health is essential to prosperity and well-being, and access to mental and physical health care is related to insurance status. In New Mexico, 40% of Native-American youth, 18% of African-American youth and 17% of Hispanic youth are uninsured, compared to 15% of white non-Hispanic youth.⁹
- Suicide rates in New Mexico for male youth ages 15 to 24 for 1999 to 2004 were 49.9 for Native Americans; 47.7 for Hispanics; and 23.4 for white non-Hispanics. However, more than 65% of Native American youth report that they have caring and supportive relationships with their peers, which could provide the basis for a strong peer-to-peer education project on youth suicide prevention.¹⁰
- In 2005, the Youth Risk and Resiliency Survey showed that New Mexico youth have higher rates of drug use (26.3%) than the national average (20.2%). Native Americans have one of the highest rates of marijuana use (35.5%), followed by Hispanics (28%).¹¹

- Tribal communities are impacted by a history of violence perpetrated by the dominant Euro-American culture. This has included numerous systemic influences throughout history: 1.) Dispossession, 2.) Biological warfare, 3.) Disruption of culture, 4.) Indian wars, 5.) Federal and religious boarding schools (disruption of family and language), 6.) Termination, 7.) Relocation, 8.) Modern influences (gangs & drugs). Historical trauma and continuing structural racism have current and generational impact on the behavioral health of our Native youth and communities and creates special needs.¹²

Funding is part of the problem:

Native Americans are on the front lines when it comes to racial disparities in health care. The majority of Native Americans receive their health care through Indian Health Services. Indian Health Services (IHS) is a federal agency that has always been run on a barebones budget, but times have gotten increasing harder as IHS has lost an enormous amount of its funding. On a national level, IHS is currently funded at 60% of its annual need.

The Santa Fe Service Unit has been greatly affected by the cuts in funding. This unit serves nine pueblos in Northern New Mexico but can only cover about half its caseload because of its current funding. According to Jim Lyons, CEO of the Santa Fe Indian Hospital, the Santa Fe Service Unit has roughly 300 employees who cared for some 15,000 patients and had approximately 110,000 outpatient visits at its five facilities during the 2005 fiscal year. The Santa Fe Indian Hospital has had to cut needed programs. The last program cut was labor and delivery.

These cuts have greatly affected mental health and substance abuse services. Native-American youth have had to endure the pain of watching their friends and elders suffer. According to IHS statistics, the Native American life expectancy is 2.4 years lower than the national average (which is 76.9 years), and Natives die at a significantly higher rates from tuberculosis (600% above the national average), diabetes (189%), and alcoholism (510%). The cuts to IHS funding are compounded by the reality that no group has had to suffer more from poor health than Native-American children and their families. Consequently, this form of structural racism has long been over looked and has harmed too many Native-American youth.

We Know:

We know that significant health disparities continue to exist across diverse populations¹³, and as mental health problems are defined by the dominant cultural group, ethnic populations often suffer from undiagnosed mental health disorders; the nature of racism as a mental health problem requires a perspective that differs from the conventional view.¹⁴

We know that in 2000 six of the ten leading causes of death for all age groups in this country were behaviorally based: diet, stress, sedentary lifestyle, smoking, violence, and accidents. In addition, many behavioral factors are now known to increase an individual's risk for disease, physical disability, and early death. Emotional stress, for example — the accumulation of life stress, daily hassles, racial micro-aggressions, hostility, job strain, lack of social and economic resources, expressions of anger, and mood disturbances — heightens the body's response to stress.¹⁵

We know that many jails and prisons are the community safety nets and the largest providers of mental health services, that when children and youth with severe emotional disturbances cannot get the family-based care and supports they need, they often end up in foster care or the juvenile justice system, and may be consigned to institutional settings where they are further cut off from their natural support systems.¹⁶ While New Mexico has an estimated youth population of color of 62%, in 1997, youth of color made up 81% of commitments to public facilities and 82% of detention placements.¹⁷

We know that the shortage of people of color in health care education and training settings impedes the progress of translating evidence-based or promising practices into promotion, prevention, or treatment services that are appropriate for children, families, schools, and communities in real world settings.¹⁸

Recommendations:

- Work towards providing cultural competency training for all behavioral health providers, including training on historical trauma
- Work to reduce barriers to people of color entering the medical and public health fields, so trained professionals are more representative of the communities they serve
- Advocate for health insurance coverage for all, including SCHIP reauthorization and Medicaid expansion
- The state should increase its investment in behavioral health services
- Advocate for adequate funding of IHS
- Data on youth behavioral health, disaggregated by racial group/ethnicity, should be made available
- Ensure appropriate professional behavioral health translation services for clients who are not primary English speakers

Endnotes

- ¹ (U.S. Public Health Service, Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington, DC: Department of Health and Human Services, 2000)
- ² (Ibid)
- ³ (J. Hubner and J. Wolfson. p. 126, from *Coalition for Juvenile Justice*, 2000)
- ⁴ (U.S. Public Health Service, Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Washington, DC: Department of Health and Human Services, 2000)
- ⁵ (Ibid)
- ⁶ (Ibid)
- ⁷ (Institute of Medicine (IOM), *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. National Academy of Sciences: Washington, D.C., 2002, p. 5)
- ⁸ (www.ahrq.gov/research/disparit.htm (AHRQ); www.kff.org/minorityhealth)
- ⁹ ("The Condition of African American Children in New Mexico," Feb. 2005, NM Voices for Children.)
- ¹⁰ (Hall, Janie Lee, RN, PNO and Dan Green, MPH, Corazon Halasan, MPH, *Youth Suicide Risk and Suicide Rates in New Mexico, USA*, PowerPoint presentation to New Mexico Pediatrics Society Meeting, Gallup, NM, September 9, 2006.)
- ¹¹ (NM Epidemiology: March 10, 2006: 2006 (1))
- ¹² (Northwest New Mexico SBHC Champions Behavioral Health Training Module # One: The Neurological, Psychological, and Social Impact of Post-Colonial Stress for Tribal Behavioral Health)
- ¹³ (IOM, 2002)
- ¹⁴ (Brown, 2003; Ponterotto, Casas, Suzuki, & Alexander, 1995; Fernando, 2005; Bowser, 1981; Dobbins & Skillings, 2000)
- ¹⁵ (APA, 2004)
- ¹⁶ (National Council on Disability, 2002)
- ¹⁷ (Juvenile Offenders and Victims: 1999 National Report. Office of Juvenile Justice and Delinquency Prevention (1999))
- ¹⁸ (Martin, J., 2006)

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