New Mexico
Latino Behavioral Health
Policy Summit Report

“Uno Es El Arquitecto
De Su Propio Destino”
“One is the architect of their own destiny”.

September 2007
A brief history of New Mexico – Nuestras Raíces (Our Roots)

New Mexico is home to the prehistoric and anthropological sites of Folsom Man, Clovis Man and Sandia Man. These ancient sites in New Mexico are one of many examples throughout the Western Hemisphere of man’s presence prior to 7,000 B.C. Over thousands of years indigenous inhabitants could be found throughout North America in Pre-Columbian times. The ubiquitous presence of established Native American communities and tribes throughout the Americas is important to understanding the relationship between those cultures and societies who came in contact with the first wave of Europeans in present day New Mexico, the Spaniards. In New Mexico there were Anasazi communities and nomadic tribes who had inhabited the region for centuries prior to the arrival of the Spanish explorers and colonists.

Early Spanish explorations and colonization during the 1500’s into New Mexico speaks to the beginning of periodic migration from New Spain. The Spanish colonial families settled along the northern reaches of New Mexico and especially along the Rio Grande River and its tributaries. There were instances of interracial ties between indigenous communities and Spanish families that are documented by the work of Spanish historians and clergy. There is also evidence to show that interracial marriage and “mestization” did occur throughout the New World with the arrival of the early Spaniards. The mestization of indigenous communities with Spaniards begot offspring referred to as “mestizos.” The Spanish exploration into New Mexico started in 1539 by Fray Marco de Niza followed by Francisco Vasquez de Coronado in 1540. Subsequently, the Juan de Oñate expedition was charged with the Spanish colonization of New Mexico in 1598. These early Spanish colonial families have remained in New Mexico except for those who returned to New Spain due to challenges to survival, were expelled or that returned to Mexico after the signing of the Guadalupe Hidalgo Treaty ending the Mexican-American War. Mexico lost almost two thirds of its land to the United States in 1848 as a result of having lost the war. The heirs and descendants of Spanish and Mexican land grants who remained in New Mexico were guaranteed that their rights, property and ownership would be honored and protected under the treaty. However, there was a persistent loss of communal and individual land under American occupation and that has significantly contributed to economic, social and cultural erosion of New Mexican’s original Spanish agrarian communities and familial self-sufficiency.

The Spanish colonial ancestors of New Mexico have a long and enduring culture of healing, spirituality and wellness that is embedded in the beliefs, traditions and customs of today’s New Mexico’s Spanish families. The cuentos, dichos, alabados, remedios, danzas, oraciónes, and canciones (tales, proverbs, religious songs, remedies, dances, prayers and songs) document and disseminate the practices and interventions passed on from generation to generation to demonstrate the methods and approaches to wellness, healing and traditional forms of treatment, prevention and recovery. The practitioners - curanderas, sobadoras and yerbalistas (folk healers, massage therapists and herbalists) are, in fact, the tradition.
To understand the history, depth and breadth of Latino\(^1\) behavioral health practices, one must know what constitutes these traditional practices or have experienced them first hand to begin to grasp the effectiveness of culturally defined approaches. This also helps to shape what modern-day behavioral health prevention, treatment and recovery that are relevant, accepted and appropriate to Latino communities. It is important to understand how to engage, involve, and make behavioral health services relevant to Latinos. All in all, it requires creating a therapeutic environment that establishes a nexus between body, mind and soul. In contemporary terms this would be seen as an integrative and holistic system of care.

To understand the uniqueness of New Mexico’s Latinos it is also vital to understand the context of man’s earliest ancestors in Pre-Columbian times; the mestization of Europeans, in particular the Spaniards, with indigenous societies of Pueblo Indians and nomadic tribes; the isolation of New Mexico’s Spanish colonial communities; post Mexican-American War and Mexican Revolution migration; and the modern day intra-continental movement of immigrants between Latin America and the United States.

**Present-day Latino Behavioral Health in United States and New Mexico**

According to the 2004 U.S. Census Bureau there were 41.3 million Latinos who constituted 14% of the United States population. By 2030, there will be 73 million Latinos, 20.1% of the United States population and by 2050, 102.6 million or 24%. By 2050, 1/3 of all youth under 19 will be Latinos according to the 2004. Several keys issues to consider is that Latinos are now the largest ethnic group in 19 states, the Latino population continues to grow rapidly and they will become the majority of population in some states.

With this projected population growth comes the demand for health and behavioral health care and health coverage. It is reported that the rate of uninsured Hispanics is 33.5% in the U.S. and in New Mexico that figure is 27.6%.\(^2\) According to the Robert Wood Johnson Foundation 2010 Institute for the Future report\(^3\), the erosion of health insurance as an employee benefit has been particularly severe for employees with no more than a high school education. In New Mexico, Latinos experience a disproportionately high drop out rate and combined with high uninsured rates poses a significant challenge to policy makers, providers, healthcare consumers, and ultimately the health and behavioral health status of Latinos. Mental health care in the United States lags behind physical health care; in New Mexico that also holds true. In 1999, the Surgeon General released a significant report that addressed mental health care, culture, race and ethnicity called “Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General, Department of Health and Human Services, U.S. Public Health Service.”\(^4\) This report documents the existence of several disparities affecting mental health care of racial and ethnic minorities compared to whites:

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1. Latino is used in this report because of its common usage. It does not infer a preference over other terms used such as Hispanic, Hispano, Spanish American, Mexican American, Chicano or other related terms.
Minorities have less access to, and availability of, mental health services.
Minorities are less likely to receive needed mental health services.
Minorities in treatment often receive a poorer quality of mental health care.
Minorities are underrepresented in mental health research.

This important public acknowledgment of the presence of disparities has helped raise awareness amongst behavioral health delivery systems, policy makers, funders, providers and communities as a whole about the disparities affecting ethnic/racial groups in the United States. As the report cites, more is known about the disparities than the reasons behind them. A constellation of barriers deters ethnic/racial groups from reaching treatment. Many of these barriers operate for all Americans: cost, fragmentation of services, lack of availability of services, and societal stigma toward mental illness (DHHS, 1999). But additional barriers deter racial and ethnic groups; mistrust and fear of treatment, racism and discrimination, and differences in language and communication. The ability for consumers and providers to communicate with one another is essential for all aspects of health care, yet it carries special significance in the area of mental health because mental disorders affect thoughts, moods and the highest integrative aspects of behavior. The diagnosis and treatment of mental disorders greatly depends on verbal communication and trust between client and clinician. More broadly, mental health care disparities may also stem from the historical and present day struggles of ethnic/racial groups with racism and discrimination, which affect their mental health and contribute to their lower economic, social, and political status. The cumulative weight and interplay of all barriers to care, not any single one alone, is likely responsible for mental health disparities.

In the Surgeon General’s 1999 report there is a call to ensure that “culturally competent services incorporate understanding of racial and ethnic groups, their histories, traditions, beliefs, and value systems. With appropriate training and a fundamental respect for clients, any mental health professional can provide culturally competent services that reflect sensitivity to individual differences and, at the same time, assign validity to an individual’s group identity. Nonetheless, the preference of many members of ethnic and racial minority groups to be treated by mental health professionals of similar background underscores the need to redress the current insufficient supply of mental health professionals who are members of racial and ethnic minority groups.”5 This call for action has had very little traction by public policy leaders in New Mexico when addressing the specific behavioral health needs of Latinos as evidenced by poor behavioral health indicators for Latinos.

In 2001, the Surgeon General issued a series of conclusions regarding Latino mental health in the United States by stating that the system of mental health care services currently in place fails to provide for the vast majority of Latinos in need of care. This failure is especially pronounced for immigrant Latinos who make the least use of mental health services. The report also cites two particularly vulnerable populations including incarcerated Latinos due to excessive use of alcohol and drugs and Latino youth who are at a significantly higher risk for poor mental health outcomes and suggests that they are more likely to drop out of school. The report also concludes that Latinos are more likely to seek mental health services in primary care settings, thus

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5 Mental Health: Culture, Race, and Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General, U.S. Department of Health and Human Services, 1999
improving detection and care within those settings as being vital to effectively serving Latinos.\(^6\) This is an important point when considering appropriate and accessible venues for Latinos to seek and receive behavioral health services; and given the traditional receptiveness of Latinos to treating and healing the body and mind as a whole.

**National Alliance on Mental Illness (NAMI) “Grading the States Report”**

The National Alliance on Mental Illness, the nation’s leading mental health advocacy organization, cites in its national report, “Grading the States - A Report on America’s Health Care System for Serious Mental Illness, 2006”\(^7\) that New Mexico was below average in its mental health care delivery system and was issued a “C-” grade. The State mental health division received an “F” for information access and in a State where there are limited behavioral health services the inability of the State to make information accessible to consumers and families compounds the difficulties of navigating a resource poor system. Information is more restricted when linguistic access is unavailable to residents where languages other than English are spoken regularly. In New Mexico, the number of languages and dialects is extraordinarily high when referencing racial and ethnic groups whose first language or primary language at home is not English. The state’s total mental health spending is 47\(^{th}\) in the nation and only recently as there been any effort to increase State funding for additional services. The State has the fifth highest suicide rate in the United States.\(^8\)

**Con Alma Health Foundation “Closing the Gap Report”\(^9\)**

The state’s leading health foundation, the Con Alma Health Foundation recently studied the issues affecting New Mexico’s population and cites several significant findings that impact the behavioral health of Latinos in New Mexico. According to this important report, the economic, educational, and health conditions for Hispanic/Latinos in New Mexico has reached a crisis point despite the fact that they comprise a large proportion of the population and contribute to the rich culture, language, history and traditions of New Mexico.

In New Mexico, of all persons with disabilities requiring assistance, Hispanic/Latinos have the highest need at 7.3 percent. From 1997-1999, 34 percent of Hispanic/Latinos were living in poverty (persons who make less than 100 percent of the Federal Poverty Level which was $13,290 for a family of three in 1999) as compared to 16 percent for whites. New Mexico’s Hispanic/ Latinos had a median family income of $21,457 as compared to $32,687 for whites from 1997-1999.

In 2000-2001, Hispanic/Latinos (6.7 %) had the highest dropout rate of all ethnic groups in grades nine through twelve. In grades seven and eight, Hispanic/Latinos had the third highest

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\(^6\) Mental Health: Culture, Race, and Ethnicity – A Supplement to Mental Health: A Report of the Surgeon General, U.S. Department of Health and Human Services, 2001

\(^7\) National Alliance on Mental Illness, “Grading the States – A Report on America’s Health Care System for Serious Mental Illness”, 2006

\(^8\) National Alliance on Mental Illness, “Grading the States – A Report on America’s Health Care System for Serious Mental Illness”, 2006

\(^9\) Con Alma Health Foundation, Closing the Gap Report, 2007
dropout rates (0.9 %). New Mexico’s Health Status Disparities report found that “white Hispanics had the poorest perception of health and the highest rates of teen birth, drug-related death, firearm injury death, chlamydia, and binge drinking. They experienced the greatest disparity increases for teen births and hepatitis B, and the greatest disparity decrease for smoking”.

New Mexico Behavioral Health Purchasing Collaborative

New Mexico is distinctly unique from any other state in the country. Latinos make up 42% of the State’s population. They are in fact the majority population in the State, not a minority. While Latinos enjoy a significant role as the largest ethnic population in the State, they experience disproportionate and disparate behavioral health indicators. The New Mexico Behavioral Health Collaborative (the Collaborative) identified that Hispanics have a suicide rate of 25.2 per 100,000 which is almost double than the 13.8 nationally and that Hispanics have a far higher percentage of non-English speaking residents than is the case nationally. Nearly 30% of the households in the State list Spanish as a primary language (national mean is 10%).

The Collaborative has identified three goals to address disparities in behavioral health services: 1) Identify community strengths, ensure cultural competency, family and consumer driven services at all levels; 2) Promote use of culturally appropriate and traditional healing services for Native Americans; and 3) Assure appropriate number of practitioners in rural service systems. Communities across the State have identified in 2002 the following key issues: need for bilingual professionals, increase in Spanish and native speaking service providers and increased cultural sensitivity. In 2006, similar focus groups identified the lack of services in border communities; language barriers, need for bilingual professional, cultural stereotypes and related discrimination in service delivery; need for culturally appropriate services; need for acceptance for traditional healing practices; professional who understand the culture; and access to services by undocumented individuals.

2007 New Mexico Latino Behavioral Health Policy Summit

The quantitative data about the Latino behavioral health status expresses the need to improve the behavioral health of Latinos in New Mexico. Due to these serious behavioral health indicators and issues affecting Latinos as described in the previous sections, the New Mexico Behavioral Health Policy Summit in September 2007 was convened by several community organizations to provide leadership in addressing the behavioral health needs of Latinos in New Mexico.

In New Mexico, there are critical differences across the state between Latino communities along the border and colonias (colonies), in rural areas (such as farming and ranching communities), in urban settings (such as barrios, traditional Latino neighborhoods, and other community neighborhoods), in historical Spanish land grant communities and in immigrant neighborhoods. Other key variables are linguistic and cultural differences amongst ancestral groups; length of residency; country of origin; immigrant status; assimilation and acculturation spanning generations from early colonial settlers to recent immigrants.

10 New Mexico Behavioral Health Collaborative Transformation Grant, page 13, October 2006
11 New Mexico Behavioral Health Collaborative, Transformation Grant, page 42, October 2006
The historical and cultural context of New Mexico calls for the real and active voice of Latinos in the behavioral health system. The New Mexico proverb, “Uno es el arquitecto de su propio destino (One is the Architect of their own destiny)”, can only hold true when one is involved in the design, planning and one’s engagement in behavioral health services.

The New Mexico Latino Behavioral Health Policy Summit was convened both as a “Call to Action” and to provide a grassroots venue to express the voice of Latinos by and for Latinos to fellow New Mexicans. The recommendations presented in this summit report will be shared with the broader community of policy makers, legislators, foundations, other funders, providers, researchers, community based agencies, consumers, families, advocates and users of the behavioral health system. The recommendations are a starting point for dialogue and call to improve and change the behavioral health delivery system to benefit the Latino community across the State so that the behavioral health disparities affecting Latinos in New Mexico are publicly acknowledged, addressed and reduced.

The National Latino Behavioral Health Association (NLBHA) joined in partnership with the Con Alma Health Foundation, the American Legacy Foundation, the Albuquerque Partnership, Eli Lilly, Sangre de Cristo Community Health Partnership and the Albuquerque Hispano Chamber of Commerce to sponsor the New Mexico Behavioral Health Policy Summit in the traditional Latino custom of working together for the benefit of the Latino community. The proverb, “Una mano lava la otra y las dos llavan la cara (One hand washes the other and both hands wash the face)” is appropriate to the spirit and actual workings of the Summit in September 2007.

NLBHA’s mission is to influence national behavioral health policy, eliminate disparities in funding and access to services, and improve the quality of services and treatment outcomes for Latino populations. NLBHA’s vision is “El Bienestar de Nuestra Gente.” This national organization was formed in March 2000 resulting from the Substance Abuse and Mental Health Services Administration (SAMHSA) and its Center for Mental Health Services (CMHS) acknowledgement of the growing mental health service needs of a rapidly growing Hispanic/Latino community by sponsoring the National Congress for Hispanic Mental Health. SAMHSA determined that services must be more accessible, appropriate, and responsive to the needs of the Latino Community; and developed a plan to serve as a blueprint for the next generation. The aim of the Hispanic Congress was to create a vision for Latino mental health for the new century.

Several of NLBHA’s goals directly relate to purpose of the New Mexico Behavioral Health Policy Summit. NLBHA’s goals are:

- Develop local exposure for NLBHA
- Build network and partnerships with state and local individuals and groups
- Build local knowledge of Latino issues
- Use knowledge from Roundtables for national advocacy and policy development
- Build a coalition with local and state policy makers for future support of the Latino Congress Agenda state by state and/or region
- Identify key leaders for support of the future NLBHA policy agenda
- Identify local Latino consumer advocates to increase the membership of Tenemos Voz
- (Assist in Developing) Policy/Advocacy efforts in other states
- (Identify) Evidence Based Practices and Outcomes
The objective of NLBHA is to provide national leadership on mental health and substance abuse concerns of the Latino community in five major areas of focus: Policy issues in mental health, substance abuse, education and workforce; service delivery of mental health and substance abuse; Latino focused behavioral health research and interventions. NLBHA works with its partners by convening state Latino Behavioral Health Policy Roundtables; providing cultural competency training; providing consultation to policy makers, community agencies and others on Latino behavioral health issues; identifying characteristics of community based programs and services that are successful and effective in delivering culturally appropriate services to Latino families; serving as a clearinghouse for Latino related behavioral health information, studies and reports; educating the public on Latino disparities; providing conferences, workshops, task forces and interviews on Latino behavioral health related issues; training of mental health interpreters; and collaborating with other national racial/ethnic behavioral health organizations on issues of mutual concern.

The New Mexico Behavioral Health Policy Summit is one of several venues to give voice to the behavioral health needs of New Mexico’s Latino community in developing a statewide official response to the underlying mental health and substance abuse needs of the Latino community.

The summit fulfilled its goals to:

- Convene local Latino and non-Latino policy makers to dialogue and develop a plan to address the mental health and substance abuse prevention and treatments needs of Latinos in terms of traditional approaches and contemporary models.
- Gather local Latino professionals, consumers, and community leaders to sit together, dialogue, and plan with elected officials.
- Bring together local/state providers of mental health and substance abuse organizations serving Latinos to build coalitions and develop an Action Plan.
- Facilitate development of, and local ownership of, a state mental health and substance abuse services agenda.

Policy Summit Participation

NLBHA along with local Latino leaders collaborated and identified possible participants that included consumers, family members, providers, advocates, government agencies, legislators, and political leaders. Participants were solicited from all parts of the state to ensure solicitation from urban, rural, frontier and border communities. Participants were contacted through email, telephone, word of mouth, and mailings. A “Save the Date” flyer was sent in advance and followed up with email and telephone contacts prior to the planned event. Scholarships were available and provided to consumers and family members to ensure their attendance and participation. CEU’s were provided for licensed professionals to further benefit from their participation. Language interpreters were made available to assist mono-lingual speakers and to ensure that English to Spanish or Spanish to English translation would be accommodated for bilingual speakers. Attendance was recorded through a registration and sign in process. A total of 92 participants registered at the summit.
Participant Profile

The recruitment process took into consideration the diverse characteristics of the participants and the regions they represented. The following will describe the participant representation:

1. Seven NLBHA Board of Directors members representative of national geographic regions, professional backgrounds, age and gender were in attendance.
2. Consumers consisted of adults who have been diagnosed with mental health, substance abuse or co-occurring disorders. The consumers who had criminal justice involvement represented those issues as well as the behavioral health and daily living needs of that population. Consumers represented the diverse regions of the state: urban, semi-urban, rural, frontier, and border area.
3. Family members whose lives have been touched by an adult or child with behavioral health needs within their own family participated in the summit. Their participation was critical as they are often the caregivers of their family member who aren’t typically involved in the treatment process.
4. Government: police chaplain, courts, state agencies were represented. This gave the group an opportunity to listen to the experiences of these individuals and the impact behavioral health issues have on the Latino community.
5. Providers: Early intervention, prevention, treatment, psycho-social rehabilitation and residential service providers were present to address the continuum of services needed to address behavioral health conditions. Also in attendance was a curandera.
6. Advocates: National and local advocacy groups were in attendance representing family and consumers accounting for 25% of individuals in attendance. This lived experience perspective helped inform the entire summit discussion.
7. Legislators and political leaders: Two state legislators attended the summit; one as a panel speaker; and one as a participant.

Keeping to Latino Customs of Social and Community Engagement

The summit was organized using traditional Latino cultural customs when engaging in community dialogue and business gatherings to include: comida (food), plática (discussion), música (music) and enseñamientos (teachings). In addition, there were information tables on treatment and advocacy services and programs serving Latinos. A networking period was also incorporated between the small group work and the evening enseñamientos presentation on curanderismo (folk healing).

Comida - The comida aspect of the summit included lunch and dinner with traditional New Mexican dishes. Meals are served to ease tension and promote a sense of community, belonging, and well-being.

Música - A traditional rendition of Las Mañanitas by local musicians was performed to welcome participants and set the tone of camaraderie and community for the summit. During the networking session, traditional Mexican and New Mexican music was provided so that participants could sing, dance or interact with other participants.
**Plática** - Honoring our attendees, speakers, guests and opening the event with a *bendición* (blessing) by Chaplin Jose Villegas. The first part of the *plática* (discussion) phase of the Summit began with opening remarks by Diane Rivera, Program Officer, from the Con Alma Health Foundation. Dr. Ken Martinez presented “The State of Latino Behavioral Health in the United States.” A Latino Thought Leaders Panel represented by Senator Bernadette Sanchez, New Mexico State Senator; Gilberto Romero, a national community leader in consumer issues and affairs; Dr. Moises Venegas, community advocate; Dr. Arturo Gonzales, Executive Director, Sangre de Cristo Community Health Partnership; and Secretary Alfredo Vigil, New Mexico Department of Health. The panel set the stage for the participants by presenting keys issues regarding Latino behavioral health in New Mexico.

The second part of the *plática* phase was the group facilitation of Summit participants by local Latino professionals experienced in group facilitation, policy analysis and development. The results of this portion of the summit are included below. The process for dialogue and discussion focused on engaging all participants to ensure that the voice of each individual was heard, respected, recorded, and incorporated into the summit recommendations.

**Enseñamientos** - The evening program was presented by Dr. Eliseo Rodriguez, a University of New Mexico professor, on *Curanderismo*. This presentation focused on the history and practice of *curanderismo* and how the mind is integral to healing the body. The three levels discussed were the materials (candles, oils and herbs), the mind and spiritual. This also included an overview of various rituals and practices applied by different *curanderos/as*.

**Advocacy and Policy Issues and Needs**

The group at large was asked for input regarding Latino behavioral health concerns. The following were the key issues discussed and formed the basis for creating the advocacy and policy priorities:

1. Early mental health and substance abuse prevention for Latinos.
2. Educating providers and policy makers on the issues of stigma and access to substance abuse and mental health treatment affecting Latinos.
3. Statement of current gaps in behavioral health services for Latinos (including mental health; substance abuse and co-occurring services).
4. Cultural and language barriers to accessing and utilizing mental health and substance abuse services by Latinos.
5. Capacity building among Latino family and community members to ensure their voice is sought, engaged, supported, understood and taken into account.
6. Incorporating non-traditional methods of treatment and reimbursement of this service to non-traditional service providers.
7. How to recruit and retain more Latino health providers and other professionals to work in the behavioral health field.
8. Lack of or limited healthcare coverage particularly with Latino communities and within other racial/ethnic populations.
9. Limited access to behavioral health services by immigrant Latino families.
10. Ineffective collaboration and coordination of services between the statewide and local behavioral health systems to effectively serve more Latinos.
11. There is a disproportionate large number of Latinos arrested and incarcerated for substance abuse related charges. This has consequences for the family, re-entry into society and limited family services.

12. Training/Curriculum for doctors, lawyers, and professionals related to substance abuse, mental health and co-occurring disorders is needed so that the issues specific to Latinos is shared.

13. Re-examine current behavioral health policy that has been developed without specific Latino consumer/provider/family input.

14. Identification of processes and practices that promote cultural appropriateness and relevance including science based and best practices that serve the Latino community. Look at strengths of Latino programs and Latino communities to inform best practices.

Some summit participants indicated that the transformation of New Mexico’s behavioral health delivery system has not included a proactive and recognized strategy that explicitly involves Latino consumers and families or Latino serving organizations in the redesign of the state’s behavioral health system nor is there a organized presence of Latino-specific or Latino-focused advisory groups, commissions or committees convened or involved in decision making to address the specific behavioral health issues affecting the Latino communities across the State.

**Small Group Work**

The group was divided into small working groups. The facilitators gave the following instructions to begin the process of identifying specific policy issues:

1. Select recorder, reporter, and time keeper.
2. Introduce yourself! Name and agency.
3. Generate conversation around “issue of concern”.
5. Prioritize 1-3 policy issues.
6. List individuals, agencies, and corporations who need to be included in process.

**Logic Model for Action Planning**

A logic model was used to solicit, document, organize and prioritize the concerns and problem issues identified by summit participants and to develop a clear relationship to strategies, resources needed and project outcomes. This helped to frame the picture of ideas, issues, needs, gaps and solutions and to produce recommendations from this action planning process. The facilitators worked closely with work group members in identifying key issues, discussing the significance and relevance of concerns specific to Latino communities and developed consensus around priorities and outcomes.

Below is the framework used in developing the advocacy and policy priorities generated by summit participants.
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<thead>
<tr>
<th>Specific Problem</th>
<th>Strategies</th>
<th>Resources</th>
<th>Projected Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>-How resulted</td>
<td>-How are you going to address problems?</td>
<td>-What exists</td>
<td>-What will happen as a result of policy implementation?</td>
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<td>-How affect/impact Latinos</td>
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<td>-What do we need but don’t have?</td>
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<td>-Intervening variables</td>
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<td>-Funds</td>
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<td>-Contributing factors</td>
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<td>-People</td>
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<td>-How to leverage resources</td>
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The summit participants were fully committed to developing five advocacy and policy priorities. The participants focused their energy on these particular areas though there were many issues identified and discussed. The recommendations identified below will help inform interested and committed parties to understand the urgency and concerns of the Latino community who participated in the policy summit. These recommendations are a starting point, not an end point. The participants who helped shaped these recommendations are commended for their honesty, candor, and willingness to improve the behavioral health of Latinos throughout New Mexico.
Advocacy and Policy Priority #1:

Problem:

The Latino culture (language, family, faith, work ethic, traditions, patriotism and national loyalty) have been under attack by dominant culture contributing to addiction, deterioration of family and mental illness experienced by Latinos.

Strategies/Recommendations:

1. Evidence Based Practices (EBPs) need to fit the community and be defined and normed (come from) by the community it serves.
2. New “measuring sticks” (ways to measure evidence) need to be discovered, community validated, funded and used.
3. Require “documentation” of community practices that work and fund it (and train on it).
4. Use/engage entities (universities, research centers) that adopt community “participatory action research”. (Equity of “power”).

Resources Needed:

1. Proportional Latino representation in academia, program, policy, and decision-making arenas regarding diversification of the behavioral health workforce, culturally and linguistically appropriate research.
2. Funding for Latino community driven research and mentoring opportunities.
3. Commitment and collaboration (“el compromiso”) between Latino communities and service providers to make a paradigm shift from competition to cooperation.

Anticipated Outcomes:

1. Improve knowledge base of what works in Latino communities.
2. Increase the social capital of Latino communities.
3. Increase self empowerment of Latino communities through their involvement in research.
4. Increase pride in culture to mentor others (give back in the Latino tradition of reciprocity).
5. An environment of mutuality that values Latino involvement and participation.
6. Shift from “hard power” to “soft power” in decision-making environments.
Advocacy and Policy Priority # 2:

Problem:

1. Limited behavioral health workforce programs that recruit, train and retain Latinos.
2. Limited loan forgiveness/reduction program for Latino college students.
3. Hidden information about college opportunities at the high school and undergraduate level.
4. Limited commitment to mentoring Latino students by the broader community.

Strategies/Solutions:

1. Collaboration with stakeholders invested in effective recruitment and retention with a focus at high school and college level for Latinos.
2. Ensure behavioral health training is among loan forgiveness disciplines at state level.
3. Ensure that a statewide website identifies schools and colleges with behavioral health programs available to serve Latinos.

Resources Needed:

1. University, community college and high schools focused on the Latino pipeline of students being trained to enter the behavioral health workforce.
2. Tuition assistance, stipends, work-study programs, exchange, scholarship and mentorship programs that focus on Latino students pursuing a behavioral health career.
3. Leadership at the state behavioral health and high education levels committed to graduating Latino students into the behavioral health profession.
4. Funding to reduce the number of Latino students dropping out of high school and college to ensure a Latino workforce entering the behavioral health field.

Anticipated Outcome:

1. Increased numbers and retention of Latino professionals in urban, frontier, border and rural areas.
2. Reduce the number of Latino students dropping out of high school and college.
3. Increase the number of Latino students graduating from high school and college who enter the behavioral health workforce.
**Advocacy and Policy Priority #3:**

**Problem:**
1. Lack of non-traditional methods of treatment serving Latinos.
2. Lack of access and support for non-traditional methods of treatment unique to Latinos.
3. Lack of awareness or education about non-traditional treatments for Latinos.

**Strategies/Recommendations:**
1. Develop awareness and research around community defined evidence on what treatment methods are effective for Latino populations receiving behavioral health services.
2. Research to promote market for remedios/herbs and other methods (resulting in agricultural and economic development).
3. Establish new collaborative partnerships with universities and other institutions to develop education/training.
4. Advocate and seek funding for non-traditional methodologies.
5. Establish an institute that specializes in teaching on non-traditional methods.
6. Organize and fund Latino consumers/community groups around each issue.
7. Develop advisory bodies and workgroups of Latinos to advise, guide, inform and instruct the State’s policy makers, Collaborative, Statewide Entity, Behavioral Health Planning Council and Local Collaboratives.
8. Increase funding for behavioral health services to ensure that an epidemiological approach to reaching and serving Latinos is achieved.

**Resources Needed:**
1. Public demand and interest can be used to leverage resources.
2. State and federal foundation funding sources must collaborate with the Latino community to address these needs.
3. Use community centers.
4. Engage churches, healing practitioners and faith communities as partners.

**Projected Outcomes:**
1. Revitalize community health systems serving Latino populations.
2. Increase economic development by stimulating economy (new jobs).
3. Create a community defined research base specific to Latino communities.
4. Improve quality of life indicators for Latino individuals, families, and community.
5. Reduce covert and overt discrimination and anti-Latino sentiments.
6. Reduce stigma for Latinos seeking behavioral health services.
7. Increase participation of Latinos in behavioral health prevention, treatment and recovery.
**Advocacy and Policy Priority #4:**

**Problem:**

Lack of resources and funds for early mental health and substance abuse prevention programs serving Latinos that include: community outreach and mobilization, funding at the community level, and services that are culturally competent.

**Strategies/Recommendations:**

1. Go to state and government officials to solicit support for early mental health and substance abuse prevention that serves Latinos.
2. Ask state and federal officials to come into communities where Latinos reside.
3. Establish mentor and sponsorship coalitions within the community to serve Latinos.

**Resources Needed:**

1. Access to community centers.
2. Recruit, support and retain Latino volunteers.
3. Organize and develop new Latino behavioral health associations or use existing community based organizations to serve more Latinos. Optimize the expertise of existing resources (e.g., the Albuquerque Partnership).
4. Work closely with the faith communities and churches.
5. Mobilize Latino leaders and Latino networks in communities throughout the state to collaboratively address behavioral health disparities affecting Latinos.

**Anticipated Outcomes:**

1. Increased community involvement by Latinos in designing and evaluating prevention, treatment and recovery services serving Latinos.
2. Decrease in substance abuse amongst Latinos.
3. Reduce the number of Latinos who are involved with the juvenile and criminal justice systems.
4. Increase the number of cultural relevant behavioral health prevention programs serving Latinos.
Advocacy and Policy Priority #5:

Problem:

Cultural and language barriers to accessing and utilizing mental health and substance abuse services.

Strategies/Recommendations:

1. Collect and document evidence where these barriers exist; support research that identifies these barriers and develop strategies to eliminate or reduce these barriers.
2. Investigate and develop policies that address covert and overt discrimination and racism that prevent Latinos from accessing, receiving and benefiting from behavioral health services.
3. Ensure that Latino populations who speak in Spanish and request behavioral health services by state funded agencies can receive them.
4. Provide home based visiting services in Spanish.
5. Provide interpreter training to providers and agencies in Spanish and English.
6. Provide incentives to providers with value added compensation for Spanish speaking staff.
7. Ensure that all service providers have Spanish speaking staff at all levels of the organization.
8. Ensure that non-profit boards and state agencies adopt and enforce policies to ensure Spanish language services are available to Latino consumers and families.
9. Provide funding for agencies to translate materials into Spanish.
10. Establish a peer review of state funded programs to determine that linguistic barriers are being fully addressed.
11. Record and document linguistic complaints against service providers; report findings to the state’s Civil Rights enforcement agency, Statewide Entity and the Collaborative.
12. Provide linguistic training to service providers to ensure that consumers and families can access services by competent organizations.

Resources Needed:

1. Submit funding requests to the Statewide Entity to fund linguistically appropriate services as outlined above.
2. Solicit funding for services that ensure linguistic access to behavioral health services from the legislature, Statewide Entity and the state behavioral health authority.
3. Work with community resources to match up culturally and linguistically competent Latino focused interpreters, trainers, consultants and contractors with Latino serving organizations.
4. Secure community reinvestment funds to pay for training, consultation and technical assistance in Latino focused approaches, treatments and services.
5. Create partnerships with Latino serving organizations.
6. Provide and increase funding for Latino consumer and family support groups across the state.
Anticipated Outcomes

1. Increase the number of culturally and linguistically competent service providers serving Latinos.
2. Increase the number of Latinos receiving behavioral health services in New Mexico.
3. Create a Latino behavioral health association that ensures linguistic access to behavioral health services by Latinos.
4. Protection of Latino civil rights to receive behavioral health services in Spanish.
5. Database of Latino consultants, trainers, interpreters, translators and providers with qualifications and expertise in Spanish language.
6. Increased funding by the Statewide Entity, legislature, Executive, Collaborative, foundations and other financing streams that explicitly serve Latino families.
Conclusion

New Mexico represents a unique state in the country; its inhabitants date back many centuries pre-dating European occupation of the New World. New Mexico itself has the oldest colonial capital in the United States and the original Spanish settlement of San Gabriel precedes the British colonization of the Atlantic eastern seaboard of current day United States. Throughout the centuries, New Mexico’s diverse racial and ethnic groups have preserved ancient cultural traditions, customs, beliefs, and values that make New Mexico unlike any other state. Taken as a whole, racial and ethnic groups in New Mexico constitute a majority of the state’s population and all the while their numbers continue to grow faster than their white counterparts.

Latinos take enormous pride in their heritage and ancestry despite the challenges that face them in the contemporary world. The social and economic benefits to the state by strengthening the emotional, physical and spiritual core of New Mexico’s Latinos can not be understated. No doubt there is a great appreciation for the state’s Latino art, museums, monuments, and natural landscapes, yet there is not a widespread and full understanding of the Latino community, its families, its social structures, and its capacity to help, heal and promote wellness for its members. The societies of this ancient land are alive, but not as well as they can be.

Despite the overwhelming need for culturally and linguistically appropriate intervention and prevention services for Latinos in New Mexico, there is limited evidence of how Latinos have been fully engaged in the behavioral health system or in its current redesign. While it goes without saying that providers, advocates, planners, funders, evaluators and administrators can improve the state’s ability to reduce behavioral health disparities affecting Latinos by implementing the recommendations from this summit report, it is action that speaks louder than words.

To reduce the disparity of behavioral health indicators facing Latinos, in the one State in the nation with the highest percentage of Latino residents, there must be a deliberate and organized effort to involve the Latino community throughout the State in a planned, independent and organized fashion. Decisions that impact Latino consumers, families and communities merits at the most fundamental level of planning and decision making that includes and represents Latinos proportionately. Omission of their active voice and engagement illustrates a practice that violates the principles of full participation and engagement in a consumer and family driven system.

Latinos, on the other hand, must take up a leadership role to be involved in the planning, design, implementation and evaluation of the behavioral health system. Latinos are part of the solution to the behavioral health conditions affecting Latino communities and thus their unique and distinct voice is essential to those solutions. Those solutions must consider both traditional approaches and new models that demonstrate effective prevention, treatment, recovery, and wellness specific to Latino populations. The therapeutic venue shall consider home-based sites, alternative sites and settings closer to the Latino families, students and consumers; and should optimize the well-received community health center locations where Latinos already receive health care services by increasing the use and adaptation of the integrated service sites and model. As advocates, Latino can call for cross agency planning and delivery to make greater use of existing resources.
A new chapter in the wellness of New Mexico’s Latino community must not only start with its own residents, but it must be fully supported by the broader community around it. The behavioral health of Latinos is equally as important as that of any racial and ethnic groups in New Mexico and across the United States for that matter. The time for action is now. Mañana is too late. The future of New Mexico rests in the wisdom and deeds of its leaders to serve all of its residents and in particular those who are disproportionately affected by poor behavioral health indicators.

Latinos are a proud people; however, their health, welfare and safety must be valued and respected with both vigor and vitality. The grito “Que Viva La Raza” should not be relegated to empty words with no action. Implementing these recommendations will message to the Latino community a commitment to their well being and future. The summit participants expressed that by doing so that it imparts the importance and value of Latino involvement in the delivery and the transformation of the behavioral health system for all of New Mexico’s people.

Si se puede!

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