African American Health In New Mexico: Social and Economic Factors

New Mexico

State Office of African American Affairs

October 2006

DEDICATED TO DIVERSITY AND INCLUSION OF AFRICAN AMERICANS

Identify, study and provide solutions to issues of concern relevant to African Americans

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FOREWORD

The New Mexico Office of African American Affairs is genuinely concerned about the health status of African Americans.

This booklet will give the reader a more vivid insight into the social and economic factors that adversely affect the overall quality of life of the African American family. Poor health and poverty are factors that create an environment that is destructive not only to the African American community but other minority group communities as well. Although this booklet is presented from an African American perspective, Hispanics, Native Americans and Asians are faced with similar challenges. This is why I personally believe that it is imperative that effective coalitions and partnerships be established between minorities to address these conditions. A collective strategy is needed to combat these ills of New Mexico.

Since African Americans have some of the highest rates of heart disease, all the cancers, hypertension, stroke, diabetes, obesity and new infections of HIV-AIDS, we as a people must be pro-active and concentrate on education and prevention, as well as treatment. We must teach our children to develop healthy attitudes and habits, and to not engage in questionable behavior that leads to disease and destruction of the African American family unit.

As Executive Director, I will continue to advocate for workforce diversity in the medical and health related fields; gather support for African American based cultural competencies and bio-ethics education for physicians and medical personnel; seek additional financial support for the Center of Excellence on African American Health; and work to improve mental and behavioral health care for African Americans in New Mexico.

Hopefully, the information contained herein will influence African Americans in New Mexico to play a greater role in ones health. I respectfully submit that if we have a better understanding of health disparities, exercise on a regular basis, have a proper diet and schedule regular appointments with a physician; we can become healthier and reach our full potential in life.

New Mexicans have the opportunity to address these health disparities and put in place a comprehensive strategy. New Mexico's Secretary of the Department of Health, Michelle Lujan-Grisham, is pro active and has a vision for positive and effective change. Additionally, the Honorable Governor Bill Richardson has a record of implementing policy and legislation that puts children, youth and families high on his priority list. New Mexico must become healthier and we all should make a commitment to do our part.

Respectfully,

Dr. Harold Bailey
Executive Director
New Mexico Office of African American Affairs

Acknowledgements

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INTRODUCTION and PURPOSE

Racial and ethnic disparities in health care services are a critical problem for New Mexico and the entire nation. In many cases, non-whites have poorer health status than Anglos (whites). Non-whites receive fewer health care services, lower quality and less delivery of services later in the chain of illness. Differences in wages, employment, insurance status and medical need explain some disparities. However, the culture and historical structure of racism and education, individual stress response, risk/benefit behaviors, break up of families; hostile work environments also play a large role. Health disparities are a serious menace to the state and nation and they shout out the need for more social justice in public policy.

Nationally, Dr. David Satcher, Interim President, Morehouse School of Medicine, and 16th Surgeon General of the United States, has called for goals and action steps to eliminate racial and ethnic disparities in health. This call includes action steps on all levels and sectors of society, national organizations, and state and federal government agencies and for individual action within communities.

Following the summer 2005 forum, *Bringing Together Minority Communities*, the New Mexico Office of African American Affairs (OAAA) has championed the cause of health disparities within the African American community. We advocate the creation of a state minority health 'report card' that deals with the African American experience in New Mexico.

This guide serves as a summary of findings from numerous reviews published in various reports, journals and government databases. This filtered data reflects shared community characteristics (e.g., economic, social and physical environmental influences) connected with protective and risk factors. We hope that readers will take the opportunity to join with the OAAA in data collection about the causes and solutions for eliminating racial and ethnic health disparities; as well as "structured racism." This includes developing strategies to influence access to quality of care, the use of culturally appropriate healthcare services, outreach and education for prevention and primary care, and moves towards the process of community health improvement.

Dr. Jamal Martin

Nationwide Status of African Americans

The Black Family

- Blacks are less likely to be married than non-Hispanic whites (43 percent compared with 25 percent).
- Fewer Black families are married-couple families (43 percent of Black families were maintained by women with no spouse present, and 9 percent were maintained by Black men with no spouse present).
- Black families are larger than non-Hispanic White families

Educational Attainment

- More Black women than Black men aged 25 and over earned at least a bachelor's degree (18 percent compared with 16 percent).

Labor Force Participation and Unemployment

- Blacks participate in the labor force at a lower rate than non-Hispanic whites (12 percent compared with 72 percent).
- Unemployment is higher among Blacks than non-Hispanic whites (11 percent and 5 percent respectively).

Occupation

- Similar proportions of Black and non-Hispanic White men were employed in technical, sales, and administrative support jobs (about 20 percent);
- The proportion of non-Hispanic White men employed in managerial and professional specialty occupations (33 percent) was higher than that of Black men (18 percent).
- Black men were more than twice as likely as non-Hispanic White men to work in service occupations (19 percent and 8 percent respectively)
- Black men are nearly twice as likely as non-Hispanic White men to be operators, fabricators, and laborers (28 percent compared with 16 percent).
- Non-Hispanic White women were more likely than Black women to be in managerial and professional specialty jobs (37 percent compared with 26 percent)
- Non-Hispanic White women were more likely than Black women to be in technical, sales, and administrative support jobs (40 percent and 36 percent, respectively).
- Black women were more likely than non-Hispanic White women to be employed in service occupations (27 percent compared with 15 percent), or as operators, fabricators, and laborers (9 percent compared with 5 percent).

Family Income

- Over one-half (52 percent) of all Black married-couple families had incomes of $50,000 or more.
- The percent of non-Hispanic White families making $75,000 or more was over twice that of Blacks: 35 percent compared with 16 percent.

Poverty Status

- Blacks accounted for about one quarter of the population in poverty in 2001 (23 percent compared with 8 percent for non-Hispanic Whites).
- The poverty rate is three times as high for Black children than for non-Hispanic white children (30 percent and 10 percent, respectively).
- Families maintained by women with no spouse present have higher poverty rates overall; 35 percent for Black families with 19 percent for non-Hispanic White families; Black families maintained by men with no spouse present were more likely to live in poverty (19 percent than comparable non-Hispanic White families 10 percent).
- A greater percentage of Black families than of non-Hispanic White families were poor (21 percent compared with 6 percent).

General Population

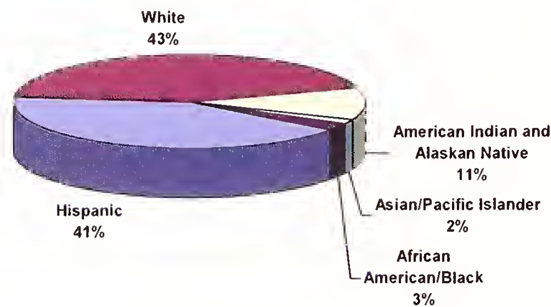
Blacks In New Mexico, Who And Where Are They?

Blacks or African Americans in New Mexico are part of a multi-cultural, not tri-cultural state. The 2000 U.S. Census lists Blacks or African Americans as having nineteen (19) distinct ethnic classifications. This increasing cultural diversity includes greater numbers of immigrants from Africa and the Caribbean. Six percent of all blacks in the United States today are foreign born. New Mexico statewide census (2000) data follows:

U.S. Census Report on African Americans in New Mexico

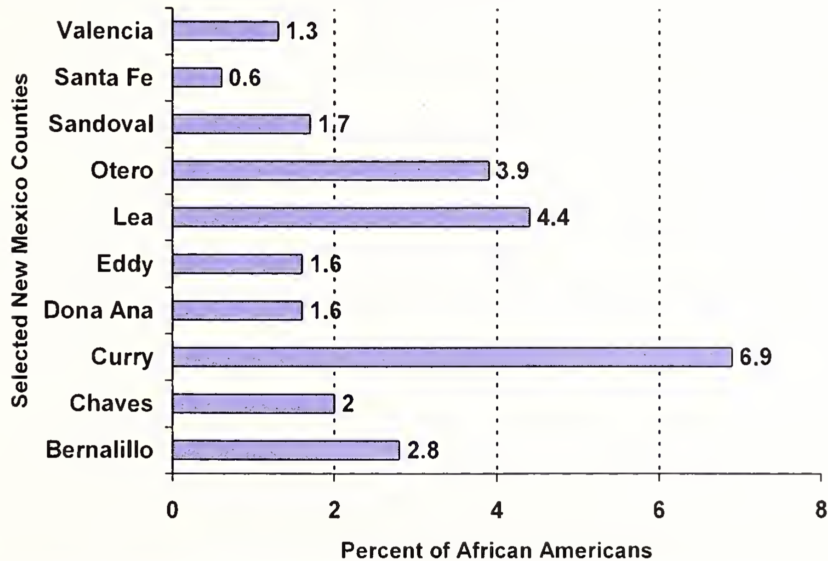
Self-Identity	State Population	% of State Population
Black or African American Alone	34,343	1.9%
Race Alone or in combination with one more Black or African American	42,412	2.3%

New Mexico Population Distribution by Race/Ethnicity, 2004*



*These figures are rounded to add to 100.

Most Blacks or African Americans in New Mexico live in the following counties: Bernalillo, Chaves, Curry, Dona Ana, Eddy, Lea, Otero, Sandoval, Santa Fe, and Valencia (New Mexico counties with less than 800 Blacks were not included in this guide. A future review will feature these population groups). In looking at the percent of Blacks or African Americans by age and sex, data shows that 35.3 percent are males under age 19 and 36.9 percent are female, respectively; and 6.3 percent are males age 65 and older and 9 percent female age 65 and older.



Population Distribution and County Economic Base of African Americans

County	Population Non-Hispanic Blacks	County Type
Bernalillo	15,401	Fed & State Government Dependent
Chaves	1,209	Farming Dependent
Curry	3,090	Fed & State Government Dependent
Dona Ana	2,723	Fed & State Government Dependent
Eddy	805	Mining Dependent
Lea	2,426	Mining Dependent
Otero	2,440	Fed & State Government Dependent
Santa Fe	826	Fed & State Government Dependent
Valencia	837	Non-specialized

Impact of Criminal Justice Disparities and U.S. Penal System

Humanitarian Efforts and Hurricane Katrina

The Office of African American Affairs along with faith based groups and nineteen (19) community partners organized a *New Mexico Response and Relief Partnership* that met the needs of hundreds of Hurricane Katrina and Rita survivors, refugees and immigrants.

African Refugees and Immigrants

Special Populations

Adult (All Race/Ethnicity and Age/Sex) Prison Population by County, 2002

Selected County	Population	Percent of NM Population	Inmate Population	Percent of NM Inmate Population
Bernalillo	556,678	30.6	1,930	32.9
Chaves	61,382	3.4	266	4.4
Curry	45,044	2.5	40	0.67
Dona Ana	174,682	9.6	654	10.9
Eddy	51,658	2.8	238	3.9
Lea	55,511	3.0	184	3.0
Otero	62,298	3.4	248	4.1
Sandoval	89,908	4.9	65	1.0
Valencia	66,152	3.6	223	3.7

Percent Adult Male Prison Population by Race/Ethnicity, Bernalillo County*

Blacks or African Americans are 2% of the state population, yet make up about 9 -10% (n = 620) of the adult male and female prison population. Lea County Correctional Facility has the highest proportion (21%) of Black prisoners. Due to rounding, percents may not add to 100.

Comparative Prison & Jail Incarceration Rates per 100,000 population, 2001

Region	White	Black	Ratio
District of Columbia	52	1,504	28.92
National	366	2,209	6.04
New Mexico	344	2,666	7.75

Juvenile Detention

Research shows that the odds of social control significantly increase for African Americans at each stage of the criminal justice process from arrest to incarceration (Chiricos & Crawford, 1995; Humphrey & Fogarty, 1987; and Steffenmeier & Demuth, 2000). Disproportionate minority contact (over or under-representation at key decision points) in the New Mexico Juvenile Justice System (NMJJS) shows that the total juvenile risk population represents almost 55% or 128,854 persons of all youth at-risk (ages 10 –17 years) in New Mexico (i.e., 235,265 persons). The racial and ethnic make up varies across five selected counties but includes all of New Mexico's minority population groups: Hispanic, African American, Native American and Asian American. Statewide trends are as follows:

Statewide Trends for Minority Youth At-Risk in Five New Mexico Counties

Counties Studied	# Children 10 –17 years of age	% Statewide Total
Bernalillo	64,930	27.6%
Dona Ana	23,640	10.0%
San Juan	17,937	7.6%
Santa Fe	14,929	6.3%
Lea	7,418	3.2%
Subtotal	128,854	54.8%

Key Facts

Minority youth comprise 65.8% of New Mexico's juvenile population at-risk and over 66% of minority youth are Hispanic/Latino.

- Over a four-year period, African American and Hispanic/Latino juvenile offenders were consistently overrepresented at arrest as compared to white juvenile offenders.
- Overrepresentation amplifies to a higher rate in comparison to their white counterparts for cases referred to juvenile court.
- African American, Hispanic/Latino, American Indian or Native Alaskan offenders, were overrepresented in secure confinement, both juvenile detention and correctional settings, and transfers to adult court.
- African American and Hispanic/Latino offenders were consistently underrepresented in cases diverted from the juvenile court process while American Indian offenders were overrepresented in diversion decisions.
- Asian youth were consistently underrepresented at the arrest stage and referrals to juvenile court and experience significant fluctuations at other decision points with the exception of cases appealed (applications for a court order or judicial action).

Comparison of Juvenile White Offenders to African American Offenders:

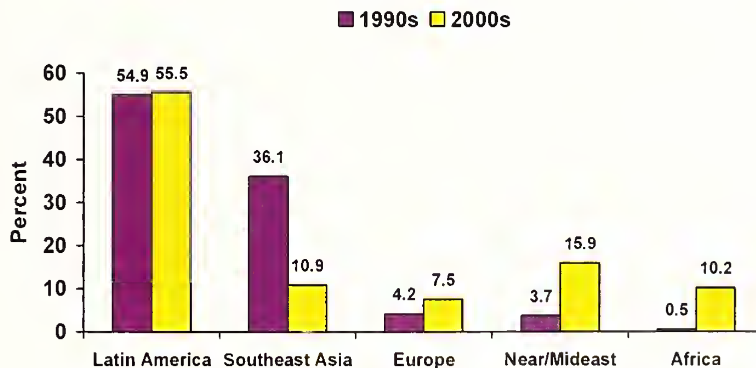
African American youth comprise roughly 2.2% of New Mexico's juvenile population at-risk and are often overrepresented in the juvenile justice system at several decision points:

- African American offenders were consistently arrested at over twice the rate of white offenders indicating significant differential handling of African American offenders.
- This initial overrepresentation trend increased to three times the rate of their white counterparts in referrals to juvenile court over a three year period
- During the above period, African American offenders were significantly underrepresented in cases diverted from the juvenile court process (minorities are considered more dangerous).
- African American offenders are underrepresented in secure detention, as well as petitioned cases (minority youth less protection and fewer hearings).
- African American youth offenders are significantly overrepresented in confinement in secure correctional facilities.

Displaced Populations, Survivors and Refugees (Non-Incarcerated)

The aftermath of hurricane Katrina and the influx of survivors highlight the issue of natural and human generated disasters such as violence and war. According to Catholic Charities of Central New Mexico, African refugees are an increasingly important refugee group in New Mexico. Their status has moved from less than one percent of refugee arrivals in the 1990's to over ten percent in 2000 and close to 50% of the arrivals in the first quarter of 2001.

Percent of Total Refugee Arrivals by Geographical Region



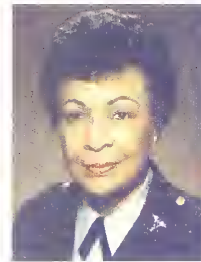
African American Veterans

Buffalo Soldiers Guarding Stagecoach

Tuskegee Airman

Colin L. Powell, First African American, National Security Advisor, First African American Chairman, Joint Chief of Staff and First African American Secretary of State.

Benjamin O. Davis, Jr.
First African American
General, USAF



Hazel W. Johnson-Brown
First African American Female
General, U.S. Army

Armed Forces Veteran Status

There are 190,718 veterans (15%) among New Mexico's total statewide population of 1,300,288. Albuquerque's Metropolitan Statistical Area (MSA), population of 521,537 reports 80,487 civilian veterans age 18 and over (15%).

Civilian Veterans as % of Civilian Veterans 18 and older

New Mexico Congressional District	Civilian Population 18 >	Civilian Veterans	Percentage
1	437,353	67,312	15%
2	420, 824	63,770	15%
3	442,111	59,636	13%

The total number of Blacks or African Americans (both male and female) holding armed forces veteran status is 23,332. Fifty-three percent (n=12,441) are males and 47% are female (n= 10,891); and 87.2 percent are between 18 and 64 and 12.7% are 65 and older.

Bernalillo County has the largest number (n = 2,164) of Black or African American veterans by sex and age followed by Otero County (n = 436).

Black or African American Armed Forces by Sex and Age for Population 18>

County	Total Veterans	Male 18- 64 Vet	Male 65 +	Female 18 - 64	Female 65 +
Bernalillo	2,164	1,557	301	290	16
Chaves	114	77	37	0	0
Curry	384	224	77	77	0
Dona Ana	286	194	91	21	0
Eddy	91	73	18	0	0
Lea	181	125	46	10	0
Otero	436	306	35	95	0
Sandoval	245	140	63	42	0
Valencia	145	115	22	8	0

Plessy v. Ferguson, 163, U.S. 537 (1896),
"Separate but Equal" accommodations for Blacks and Whites

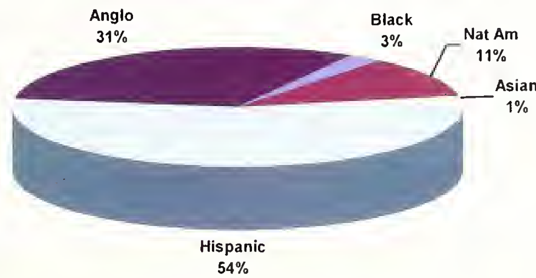
Jim Crow Segregation

Brown v Board of Education of Topeka, 347 U.S. 483 (1954)
End of legal segregation in schools

Education* in New Mexico 2005 -2006

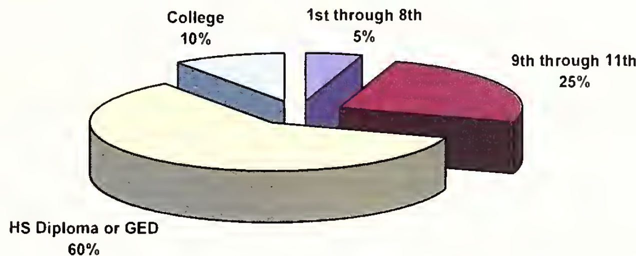
Blacks or African Americans represented 1.8 percent of the public high school graduates, 2.1 percent of the non-public high school graduates and 3.5 percent of the state-supported schools. At least 55% of Black or African American public high school graduates took developmental (remedial) courses in numeracy and/or literacy in college.

Percent Public School Enrollment by Race/Ethnicity



The chart below shows correlations between workforce training, development and education level of New Mexico Temporary Assistance or Needy Families (TANF) recipients (n= 11,021) in 2006.

Level of Education for TANF Recipients



**See Accelerating African American Student Achievement in New Mexico Public Schools Grades 9 – 12, 2006 for details on fostering high academic achievement.*

Black Economic Development in New Mexico, 2000

Major Black Owned Businesses in New Mexico

Major Industry Group	Number	%
Agricultural services, forestry and fishing	0	0
Mineral Industry	0	0
Construction industries, & subdividers and developers	91	8
Manufacturing	32	2.8
Transportation, communications & utilities	22	1.9
Wholesale trade	43	3.8
Retail trade	154	13.6
Finance, insurance & real estate (exc sub & dev)	57	5.0
Service industries (exc membership org & pvt households)	417	36.8
Unclassified non specific	316	27.9
TOTAL	1,132	100

Service Type Industries Owned by Blacks in New Mexico

Service Industries	Number	%
Personal services	56	13.4
Business services	78	18.7
Auto repair, services, parking	29	6.9
Miscellaneous repair services	12	2.8
Motion pictures	1	.23
Amusement and recreation services	66	15.8
Health services	38	9.1
Legal services	4	0.96
Educational services	4	0.96
Social services	59	14.1
Engineering, accounting, research, management & related svc	63	15.1
Services, (n.e.c)	7	1.6
TOTAL	417	100

Total Industries, Sales, Receipts, Employees and Payroll of Black Owned Businesses in New Mexico

	All Firms		Firms with Paid Employees		
	Firm #	Sales Receipts ($1,000)	Sales & Receipts ($1,000)	Employees	Payroll ($1,000)
TOTAL INDUSTRIES	1,132	142,847	130,131	1,121	20,051

Influence of Income and Poverty on Health Status

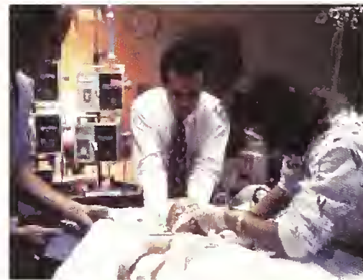
Although Blacks or African Americans are 1.9 percent of the population, 27.8 percent live in poverty. **Fifty-nine percent of African American children live under 200% of poverty, as compared to thirty-three percent of white children in New Mexico.** The following shows income and poverty estimates for the New Mexico counties where most Blacks live.

Percent Poverty by Age in Selected New Mexican Counties

County	1999 Median Household Income, in dollars	All Ages in Poverty and (%)	Age 0-17 in Poverty and (%)	Age 5- 17 in Poverty and (%)	Under Age 5 in Poverty and (%)
New Mexico	$34,827	327,444 (17.7)	126,361 (25.2)	82,281 (23.1)	40,213 (30.4)
Bernalillo	$39,465	80,234 (14%)	28,453 (19.7)	16,962 (16.9)	NA
Chaves	$28,620	12,920 (21.7)	5,111 (30.8)	3,408 (28.8)	NA
Curry	$29,698	8,242 (18.6)	3,562 (26.4)	2,420 (25.9)	NA
Dona Ana	$28,977	44,400 (25.0)	18,134 (34.9)	12,025 (33.0)	NA
Eddy	$32,941	9,158 (18.0)	3,586 (25.5)	2,370 (23.6)	NA
Lea	$32,268	9,944 (18.5)	3,898 (24.4)	2,556 (22.8)	NA
Otero	$30,623	10,684 (17.4)	4,190 (23.8)	2,994 (23.5)	NA
Sandoval	$45,213	10,934 (11.1)	4,091 (14.9)	2,589 (12.8)	NA
Santa Fe	$42,247	16,547 (12.3)	5,070 (16.3)	3,271 (14.5)	NA
Valencia	$34,672	10,745 (16.1)	4,515 (23.4)	2,777 (19.9)	NA

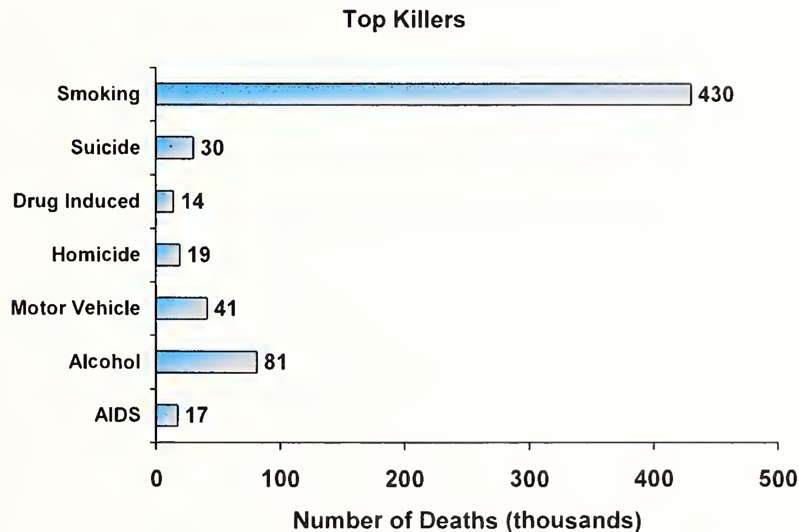
Hunger and food insecurity remains a problem in New Mexico. Many have to make difficult choices between paying for food and paying for heat or fuel; food or mortgage; and/or food or medicine or medical care. At least 6.1% of adult Black or African Americans have taken part in emergency food programs in New Mexico. Few people are aware of the link between body weight and income. This link involves uneven patterns between spending and eating healthy diets. For example, low-income groups often consume greater amounts of inexpensive high calorie foods. Excessive dietary intake of high calorie foods is a risk factor for obesity. Starting with early fetal life through old age, poor nutrition is a critical risk factor for infection and illness. Both poverty and hunger place people at risk of illness.

Snapshots of New Mexico's Healthcare System



The Office of African American Affairs supports efforts to improve insurance coverage, access to care, quality of care, and improvements in delivery of care for all New Mexicans.

Actual Causes of Death in the United States



Sickness and Death among Blacks in New Mexico

Sickness and death related to the above measures places a public health burden on New Mexico and the nation. For example, tobacco use contributes to 13% of potential life lost before 65 years of age. Tobacco use also contributes 11% to 30% of cancer deaths, 17% of cardiovascular deaths, 30% of lung cancer deaths, 24% of pneumonia and influenza deaths, 10% of infant deaths, and 20% to 30% of low-birth weight infants. Approximately 3,000 lung cancer deaths occur annually among nonsmokers because of exposure to second-hand or environmental tobacco smoke.

All of these factors are rooted in behavioral choices. Knowledge alone will not motivate change. It requires supportive environments and availability of services and policies that take into account reasons for disparities in health care, like income differentials and rates for the uninsured (African Americans 21.6%; Hispanics 34.1%; and Whites 12.5%, respectively) for those under age 65; different medical needs; and differences in delivery of health care.

Hospital Utilization and Discharges in New Mexico

Blacks or African Americans make up 3,261 of 193,375 patients of all ethnicities and ages discharged from non-federal hospitals in New Mexico; 38.5% were males 15-54 (n=1257); 16.4 were females between 35-64 (n=538); and 12% were under age one (1).

Definition of Health Disparities and Selected Health Indicators

Disparities – differences between groups of people in the type or entry to health care services, these gaps show up in new and old cases of disease, or sickness and death rates when put side by side.

Inequities – deal with the idea of unfairness, injustice or being morally wrong.

Lifestyle and behavior also play a role in the development of sickness and death. Preventable chronic diseases include heart disease and stroke, cancer, unintentional and motor vehicle injuries, chronic obstructive pulmonary diseases (lungs), pneumonia and influenza, diabetes, liver disease, suicide, homicide, and HIV infection.

Selected health statistics* on death and health risks in New Mexico, 2001

Ethnicity	Native American	Hispanic	African American	White	All Races NM	National
% NM Population	9.5	42.1	**1.9**	44.7		——
% Poverty	46.0	27.8	**27.8**	16.1	20.6	
Teen Mothers	69.8	47.8	**53.9**	25.6	44.0	
% Low Birth Wt.	6.5	7.5	**9.0**	7.7	7.5	
Infant Mortality	6.8	6.0	**8.6**	7.4	6.4	
Heart Disease Mortality	15.4	22.0	**21.0**	26.0	24.0	
Cancer Mortality	16.8	18.7	**22.0**	22.0	20.8	
Accidents – All	12.6	9.8	**7.1**	4.7	6.8	4.0
MV Accidents	8.2	4.3	**2.7**	1.6	2.9	
Diabetes Mortality	7.4	5.5	**5.9**	2.7	3.9	2.9
Suicide	3.5	2.7	**2.3**	2.4	2.6	1.2
Chronic Liver Cirrhosis Mortality	6.5	3.2	**2.7**	1.4	2.3	
Chronic Lower Respiratory	2.1	3.7	**5.1**	7.2	5.8	

* Death rates per 100,000; Teen Mother Birth rates per 1,000; and Infant Mortality rates per 1,000

NOTE: African Americans across the nation have the highest death rate for 50% of the twenty-six disease categories represented per hundred thousand people.

In New Mexico, African Americans are first in low birth weight babies and infant deaths; tied for first in cancer deaths; second in deaths from diabetes and chronic lower respiratory deaths; and third in deaths due to heart disease.

Years of Productive Life Lost (YPLL) per 100,000 before Age 75, 1996-1998

State	Hispanic	American Indian/Alaskan Native	African American	Asian/Pacific Islander	White	All Races
United States	6,224	9,195	13,338	3,869	6,708	7,455
New Mexico	8,540	11,777	8,553	2,918	7,628	7,931

Due to sickness including disability and early death, Blacks or African Americans in New Mexico when compared to whites have many years of productive life lost and therefore cannot fully participate in or receive the benefits of a democratic society. Overall, Blacks in New Mexico are doing better than Blacks in the U.S.

Homicide Rates* by Race/Ethnicity, 1996-1998

Blacks make up 1.9% of New Mexico's total population, yet their homicide rate rivals the national rate.

State	Hispanic	American Indian/Alaskan Native	African American	Asian/Pacific Islander	White	All Races
United States	11.0	10.0	27.6	4.1	4.5	7.8
New Mexico	14.4	15.4	21.7	*	9.6	10.3

*Age-adjusted death rates per 100,000 population

HIV/AIDS

Black Non Hispanics represent 2% of the population in NM and 6% of the total HIV/AIDS cases; Blacks have the highest percentage (18%) of people living with AIDS due to injection drug use (IDU); 45% of the cases are men having sex with men (MSM), 11% are MSM/IDU and 12% are Heterosexual).

Under the direction of Governor Bill Richardson, a major emphasis has been placed on DWI Enforcement.

One drink is defined as:

- 12 oz. of beer
- 5 oz. of wine
- 1.5 oz. of liquor

Mental and Behavioral Health have become a priority in New Mexico

Behavioral Health and Substance Abuse Trends in New Mexico, 1999 - 2003

- All Causes of Death
    - Nine of the 10 leading causes of death in New Mexico are partially caused by the abuse of alcohol, tobacco, or other drugs.
- Alcohol-Related Death and Injury
    - After Alaska, New Mexico consistently had the second highest alcohol-related death rate in the U.S.
    - Death rates from alcohol-related causes increase with age
    - New Mexico's rate of death due to alcohol-related chronic disease (chronic liver disease) is more than 2.5 times the national rate
    - The two most common causes of alcohol-related injury death are motor vehicle crashes and suicide. Males are more at risk than females for alcohol-related injury deaths
    - New Mexico has the sixth highest alcohol-related motor vehicle crash death rate in the country and the rate has not improved over the last ten years.
- Suicide is closely associated with alcohol and drug abuse.
    - New Mexico's suicide rate has consistently been one of the highest in the U.S.
    - Suicide rates are higher among males than among females for all ethnicities and age groups
- Smoking-Related Deaths
    - New Mexico has had one of the lowest smoking related death rates in the nation; yet the burden of death associated with smoking is considerably greater than the burden associated with alcohol and other drugs
    - Among all race/ethnic groups, males have higher smoking related death rates than females
    - **Among males, Non-Hispanic Blacks have the highest rates followed by Non-Hispanic Whites**
    - **Among females, White Non-Hispanics have the highest rates, followed by Non-Hispanic Blacks**
- Drug-Related Deaths
    - New Mexico has had the highest drug-related death rate in the nation.
    - Drug overdoses account for more than 80% of drug-related deaths
    - The most common drugs causing death reported by the Department of Health include: morphine/heroin (44%), cocaine (40%), alcohol (28%), methadone (12%), and oxycodone (9%).
    - 65% of unintentional drug overdose deaths were caused primarily by illicit drugs and 35% by prescription drugs
    - Drug-related death rates are higher for males than females, however, the percentage of females dying from drug overdose is increasing.

When looking at all causes of deaths for African Americans in New Mexico by selected counties we find:

- **Valencia County has the highest rates of death for African Americans at 2,205 deaths per 100,000 people.**
- **Otero County has the lowest rate of death for African Americans at 883 per 100,000 people.**

Alcohol and Black Non-Hispanics

- **Concerning alcohol-related deaths, Bernalillo County has a rate of 54.6 alcohol-related deaths per 100,000 for African Americans. Numbers from other counties are excluded because of the small number of deaths.**
- The alcohol-related chronic liver disease rate for all race/ethnicity and genders is 14.4 per 100,000
- **The statewide alcohol-related chronic disease death rate for Blacks or African Americans is 33.9 per 100,000 (Bernalillo County's rate is 34.8 per 100,000).**
- Alcohol-related injury death rate for African Americans is 19.6 per 100,000.
- Alcohol-related motor vehicle crash death rate for African Americans is 6.8 per 100,000.

Smoking-Related Deaths and Non-Hispanic Blacks

- **The statewide smoking-related death rate for Blacks or African Americans is 136.4 per 100,000.**
- Lea County has the largest smoking-related death rate at 197.9 per 100,000 and Bernalillo County has the lowest rate at 129.1 per 100,000.

Drug-Related Deaths and Rates for Non-Hispanic Blacks

- The statewide rate is 25.4 per 100,000 and Bernalillo County's rate is 31.7 per 100,000

Non-Hispanic Black Drug-related death rates per 100,000 by Age and Sex

Age	Male	Female
0 – 24	4.8	0.0
25 – 64	**59.9**	19.8
65 +	**31.9**	13.1

Suicide Death Rates by Age, and Sex

- The statewide suicide death rate for Non-Hispanic Blacks is 13.9 per 100,000

Non-Hispanic Black Suicide death rate per 100,000 by Age and Sex

Age	Male	Female
0 – 24	9.5	2.6
25 – 64	**28.8**	5.7
65 +	**31.9**	13.1

Adult Binge Drinking (5 or more drinks on a single occasion)

New Mexico has some of the highest death rates for causes of death associated with binge drinking (e.g., motor vehicle crash death and suicide). Binge drinking is considered responsible for the majority of alcohol-related injuries and deaths. It is also associated with a wide range of other social problems, including domestic and sexual violence, crime, and risk for sexually transmitted diseases. Recent findings show that:

- **80.0% of male Non-Hispanic Blacks between the ages of 18-24 binge drink**
- 16.3% of male Non-Hispanic Blacks between the ages of 25-64 binge drink
- 0.0% of male Non-Hispanic Blacks age 65+ binge drink
- 10.8 percent of Statewide Non-Hispanic Blacks of all ages binge drink
- **88.1% of adult Non-Hispanic Blacks in Roosevelt County binge drink**
- 67.2% of adult Non-Hispanic Blacks in Santa Fe County binge drink
- 33.4% of adult Non-Hispanic Blacks in Lea County binge drink

Youth Binge Drinking (High School)

Survey responses show that a total of 24.3% Non-Hispanic Black youth in 9th grade binge drink; 41.5% in 10th grade; 35.9% in 11th grade; and 50.4% in 12th grade.

Adult Mental Health and African Americans in the United States

The 2001 Surgeon General's Report, Mental Health, Culture, Race and Ethnicity says that African Americans and other communities of color in the U.S, face significant barriers to quality mental health care. Nationwide, African Americans receive **WORSE** medical care than their white counterparts do. The largest gap appears in the delivery of quality of care found in the mental health area. Blacks released from inpatient mental health care receive follow up care 33 percent of the time compared with 54 percent of the time for whites.

- African Americans are only 12% of the U.S. population, yet they make up 40% of the homeless population in the U.S.
- Incarcerated African Americans are nearly 50% of the adult prisoners in state and federal jurisdictions and almost 40% of juveniles in legal custody.
- African American children and youth represent 15% of all children in the U.S., and make up about 45% of children in public foster care and more than half of all children waiting for adoption.
- African Americans of all ages are more likely to be victims of serious violent crimes than non-Hispanic whites; over 25% of African American youth exposed to violence meet diagnostic criteria for post-traumatic stress disorder (PTSD); and more African American Vietnam war veterans suffer from PTSD, because of greater exposure to war-zone trauma (21% of non-Hispanic Blacks versus 14% of non-Hispanic whites).

<u>Foster Care in New Mexico</u>

African American children are overrepresented in foster care both nationally and in New Mexico. African American children are 2% of all children in the state of New Mexico, yet 6% of them are placed in foster care.

The New Mexico Office of African American Affairs in partnership with New Mexico's Secretary of Children, Youth and Family Department, Dorian Dodson intend to offset this trend through the development, implementation, and evaluation of culturally appropriate programs for African American children and families.

CONCLUSIONS AND RECOMMENDATIONS

The information in this bulletin suggests how societal conditions and inequalities have an impact on patterns of individual, family and community health, disease, and well-being. Society and community problems like poverty, hunger, unemployment, lower educational achievements and racism lead to higher sickness and death rates. Throughout the American healthcare system, minority groups, blacks, women, and poor whites receive unequal care and treatment. The consequences of discrimination and deprivation violate the principles of American justice. It's time to take a broader approach to prevention and health promotion to decrease health disparities.

The history of racial and ethnic disparities remains connected with political action, scientific research, and government policy. Thus, the State Office of African American Affairs asks the readers to support the following:

1. Recognize that health and other social policies (housing, child development, education, employment, social security/pension, wage, tax, and budget policies and criminal justice) go hand-in-hand.
2. Focus on 'people issues,' when making a common cause for coalition building, improving data collection and strengthening support at the community level.
3. Invest in young children and maternal child health.
4. Push for living wage jobs with health benefits, safe workplaces, savings and homeownership and improvement in neighborhood economic conditions.
5. Build and sustain healthy cultural norms/qualities, common value systems and a sense of community.
6. Using adult role models and peer networks to influence young people.
7. Identify community champions to help with neighborhood problem solving and development of community leadership.
8. Practice and maintain clean and healthy environments (shared air, water and land use).
9. Support development of and access to affordable, high-quality housing, recreation and safe workplaces within distance of homes and job centers.
10. Look for ways to influence safety, including reducing new crimes, violence and traffic and pedestrian accidents.
11. More use of healthcare provider advice for healthy lifestyle changes particularly for those who choose to ignore or do not meet health behavior recommendations.
12. Advocate for necessary culturally appropriate health care services delivered by well-trained practitioners.
13. Sponsor and promote community and public leadership development and quality support services within neighborhood institutions.

Appendix 1

REVIEW OF HEALTH DEFINITIONS

Community health – "The health status of a defined group of people and the actions and conditions to protect and improve the health of the community." (Green & McKenzie, in press)

Coordinated school health program – "An organized set of policies, procedures, and activities designed to protect, promote, and improve the health and well being of students and staff, thus improving a student's ability to learn. It includes, but is not limited to, comprehensive school health education; school health services; a healthy school environment; school counseling; psychological and social services; physical education; school nutrition services; family and community involvement in school health; and school health site promotion for staff" (Joint Committee, 2001, p.99) (Note: In 1998, the term coordinated school health program replaced comprehensive school health program to distinguish it from comprehensive health education)

Disease prevention – "The process of reducing risks and alleviating disease to promote, preserve, and restore health and minimize suffering and distress." (Joint Committee, 2001, p.99)

Health – Is a state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity. (Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948; Amended in 1998).

Health education – "Any combination of planned learning experiences based on sound theories that provide individuals, groups, and communities the opportunities to acquire information and the skills needed to make quality health decisions." (Joint Committee, 2001, p.99)

Health promotion – " Any planned combination of educational, political, environmental, regulatory, or organizational mechanisms that support actions and conditions of living conducive to the health of individuals, groups, and communities." (Joint Committee, 2001, p.101)

Mental health – (Termed psychological health by Goodstadt, Simpson, & Loranger, 1987) – may include emotional health; may make explicit references to intellectual capabilities; the subjective sense of well being.

Physical health – The absence of disease and disability; functioning adequately from the perspective of physical and physiological abilities; the biological integrity of the individual. (Goodstadt, Simpson, & Loranger, 1987)

Public health – "The sum of all official (governmental) efforts to promote, protect, and preserve the people's health." (McKenzie, Pinger, & Kotecki, 1999, p. 4)

Social health – The ability to interact effectively with other people and the social environment; satisfying interpersonal relationships; role fulfillment (Goodstadt, Simpson, & Loranger, 1987).

Spiritual health - (Sometimes labeled personal health) – Associated with the concept of self-actualization; It sometimes reflects a concern for issues related to one's value system; alternatively, it may be concerned with a belief in a transcending unifying force (whether its basis is in nature, scientific law, or a godlike source). (Goodstadt, Simpson, & Loranger, 1987, p.59)

Wellness – "An approach to health that focuses on balancing the many aspects, or dimensions, of a person's life through increasing the adoption of health-enhancing conditions and behaviors rather than attempting to minimize conditions of illness." (Joint Committee, 2001, p.103)

Appendix 2

RACE - The Power of an Illusion

Ten Things Everyone Should Know About Race

Our eyes tell us that people look different No one has trouble distinguishing a Czech from a Chinese, but what do those differences mean? Are they biological? Has race always been with us? How does race affect people today? There's less – and more – to race than meets the eye:

1. **Race is a modern idea.** Ancient societies, like the Greeks, did not divide people according to physical distinctions, but according to religion, status, class, even language. The English language didn't even have the word 'race' until it turns up in 1508 in a poem by William Dunbar referring to a line of kings.

2. **Race has no genetic basis.** Not one characteristic, trait or even one gene distinguishes all the members of one so-called race from all the members of another so-called race.

3. **Human subspecies don't exist.** Unlike many animals, modern humans simply haven't been around long enough or isolated enough to evolve into separate subspecies or races. Despite surface appearances, we are one of the most similar of all species.

4. **Skin color really is only skin deep.** Most traits are inherited independently from one another. The genes influencing skin color have nothing to do with the genes influencing hair form, eye shape, blood type, musical talent, athletic ability or forms of intelligence. Knowing someone's skin color doesn't necessarily tell you anything else about him or her.

5. **Most variation is within, not between, "races."** Of the small amount of total human variation, 85% exists within any local population, be they Italians, Kurds, Koreans or Cherokees. About 94% can be found within any continent. That means two random Koreans may be as genetically different as a Korean and an Italian.

6. **Slavery predates race.** Throughout much of human history, societies have enslaved others, often as a result of conquest or war, even debt, but not because of physical characteristics or a belief in natural inferiority. Due to a unique set of historical circumstances, ours was the first slave system where all the slaves shared similar physical characteristics.

7. **Race and freedom evolved together.** The U S. was founded on the radical new principle that "All men are created equal." But our early economy was based largely on slavery. How could this anomaly be rationalized? The new idea of race helped explain why some people could be denied the rights and freedoms that others took for granted.

8. **Race justified social inequalities as natural.** As the race idea evolved, white superiority became "common sense" in America. It justified not only slavery but also the extermination of Indians, exclusion of Asian immigrants, and the taking of Mexican lands by a nation that professed a belief in democracy Racial practices were institutionalized within American government, laws, and society.

9. **Race isn't biological, but racism is still real.** Race is a powerful social idea that gives people different access to opportunities and resources. Our government and social institutions have created advantages that disproportionately channel wealth, power, and resources to white people. This affects everyone, whether we are aware of it or not.

10. **Colorblindness will not end racism**. Pretending race doesn't exist is not the same as creating equality. Race is more than stereotypes and individual prejudice. To combat racism, we need to identify and remedy social policies and institutional practices that advantage some groups at the expense of others.

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