



Results from the 2012 New Mexico Community Survey

Evaluation of the Strategic Prevention Enhancement Grant

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At PIRE we'd also like to thank Shannon Fleuder and student intern Will Powell for their help in data collection and entry.

Executive Summary

With the support of the Strategic Prevention Enhancement Grant, the Office of Substance Abuse Prevention (OSAP) conducted several important activities meant to enhance and increase coordination of prevention goals, services and outcomes in New Mexico.

Starting with forming a group of engaged state-level stakeholders, the Prevention Policy Consortium (PPC), and through continued work with our State Epi and Outcomes Workgroup and related sub-committees, OSAP developed a Mini-Plan followed by a 5-Year Plan to use the SPF process to target statewide indicators in substance abuse. As a means to aid in statewide to community-level efforts to address these indicators, SPE partners developed a community survey. This survey's methodology and questions were based upon community surveys collected under the SPF SIG funding. Question areas included alcohol, tobacco, prescription drug use and some of the contributing factors related to their misuse. Also included this year were questions on mental health and access to help for behavioral health issues.

Data collection guidelines were provided to participating communities, and protocols were reviewed by the SEOW workgroup. An online or paper and pencil version was offered. Surveys were collected in 27 of 33 counties in New Mexico. Findings were analyzed according to three principal groups: OSAP communities, former SPF SIG Communities and Comparison Communities. Also implemented were gender and cross-sectional analysis, longitudinal analysis with previous Community Surveys with the SPF SIG (FY 10, 09, 08), and comparisons with other similar statewide data sources.

Major findings include:

- The perception of risk that one will be caught and face legal consequences because of providing/selling alcohol to minors or intoxicated patrons, and/or drinking and driving has generally decreased since the end of the SPF SIG in 2010.
- Males remain more likely than females to report current engagement in alcohol-related risk behavior such as binge drinking and drinking and driving, as well as providing alcohol to minors.
- Prevalence of alcohol-related risk behaviors have generally increased among both males and females since 2010, although the increase is greater among males.
- Social access routes remain the most common way underage youth are accessing alcohol.
- On average, 25% of respondents reported receiving at least one prescription from a doctor for an opioid pain-killer in the past year.
- Approximately 15% reported past 30-day use of prescription pain-killers.
- Almost 7 % indicated sharing their prescription pain-killers with another person.
- Non-Hispanic whites are most likely to report past 30-day prescription pain-killer use.
- Adults 50 and older reported the highest prevalence of past 30-day prescription pain-killer use.

- Veterans and active duty military personnel are more likely to have been prescribed and to report current use of a prescription pain-killer.
- Current binge drinkers reported more current prescription drug use than non-binge drinkers.
- A mental health screening tool identified about 4% of respondents as possibly having a serious mental illness.
- Few differences by gender were found for mental health items.
- African Americans, Asian/Pacific Islanders and “Others” reported the highest prevalence of mental health problems followed by non-Hispanic whites.
- Adults ages 30 to 39 report the greatest prevalence of mental health, drug, or alcohol problems in the past year; 18 to 20 year olds report more frequent mental distress in the past 30 days and suicidal ideation in the past year.
- Almost 50% of respondents who reported having a mental health, drug, or alcohol problem in the past year received professional help to address the problem.
- Binge drinkers were more likely to report mental health problems than non-binge drinkers and were slightly more likely to have received professional help for the problem.

Statewide and community-level results will aid in evaluating current prevention programming, assessment for new and evolving programs, as baseline measures for the Partnerships for Success II evaluation, and in general to assist in state-level alignment of data collection and evaluation for prevention.

Project Background

In the Fall of 2011, the New Mexico Office of Substance Abuse Prevention (OSAP) received the Strategic Prevention Framework State Prevention Enhancement grant (SPE) administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Prevention (CSAP). The SPE grant was designed to strengthen and extend SAMHSA's national implementation of the Strategic Prevention Framework (SPF) in order to extend the SPF to a broader scale and support communities of high prevention need nationwide.

The SPF process is an integral part of SAMHSA's mission to reduce the impact of substance abuse and mental illness upon America's communities. With a broad, national scope, the SPE grant is intended to support States and Tribes in enhancing their prevention infrastructures to reduce the impact of substance abuse. Through stronger, more strategically-aligned prevention infrastructures, SPE States and Tribes will be better positioned to implement data-driven, evidence-based prevention programs, policies and practices in their communities. In New Mexico, the SPE is a 1-year cooperative agreement intended to support the State in strengthening the current prevention infrastructure to support more strategic, comprehensive systems of community-oriented programming. The SPE is a planning grant to foster more responsive, interactive State and Tribal systems that can better respond to the complexities of evolving health-related initiatives for communities of high need.

Key SAMHSA/CSAP requirements for SPE recipients include the development of two State prevention plans: 1) a Capacity Building/Infrastructure Enhancement Plan for submission on the 3rd month of the grant (referred hereinafter the Mini-Plan) and 2) a final comprehensive, 5- year Strategic Prevention Plan. The Mini-Plan addresses the building of capacity and infrastructure in the following areas: 1) Coordination of Services, 2) Data Collection, Analysis, and Reporting, 3) Performance Evaluation and Monitoring, and 4) Training and Technical Assistance. The Mini-Plan was approved by CSAP in January of 2012 and was used as a guide when writing the Five-Year Prevention Plan (discussed in more detail below).

In addition to developing the two plans, OSAP was required to bring together State agency leaders engaged with substance abuse prevention and mental health across the lifespan. Several groups evolved as a result. First, within the working State Epidemiological Outcomes Workgroup (SEOW), four subgroups were created to focus on emergent topics in substance abuse prevention. These included prescription drug abuse, substance abuse and mental health needs among the elderly, suicide, and health disparities among high risk groups including sexual minorities and Native Americans. Subgroups met regularly to identify and review data and research in order to assess prevalence and identify evidence-based prevention practices for each of these topic areas. Groups then discussed how to best address substance abuse and mental health problems across the State. Based on the prevention-focused SEOW's model, the Behavioral Health Services Division

(BHSD) started a mental health and substance abuse treatment-oriented SEOW. These SEOW workgroups were principally funded by the SEOW continuation grant, but significantly informed the work that followed with the Prevention Policy Consortium (PPC).

The key members of this group include The Human Services Department (Behavioral Health Services Division, OSAP, Medicaid); the Department of Health (Epidemiology and Response Division, Office of School and Adolescent Health, Office Rural and Primary Care); the Children Youth and Families Department (Juvenile Justice, Early Childhood Division, Enforcing Underage Drinking Laws); the Department of Finance Administration (DWI programs); the Department of Transportation (Traffic Safety Bureau); the Aging and Long Term Services Department; the US Attorney Office; National Guard; the Indian Affairs Department; and the Public Education Department.

The Five Year Plan outlined 8 major outcome-focused goals:

- GOAL 1: Increase state capacity to plan, implement, monitor and evaluate a coordinated prevention system in order to achieve ATOD-related Goals 2-8.
- GOAL 2: Reduce binge drinking and underage drinking by 5% in New Mexico by June 2017.
- GOAL 3: Reduce alcohol-related injury and death by 5% in New Mexico by June 2017.
- GOAL 4: Reduce alcohol-related motor vehicle crashes and deaths by 5% in New Mexico by June 2017.
- GOAL 5: Reduce the misuse of prescription drugs by 5% among New Mexicans by June 2017.
- GOAL 6: Reduce prevalence of poor mental health and its consequences in New Mexico by June 2017.
- GOAL 7: Reduce or maintain Synar non-compliance of tobacco sales below 10% by/until June 2017.
- GOAL 8: Reduce second hand smoke exposure, smoking, and tobacco use by 5% by June 2017.

The goal of the SPE was to initiate and improve planning for substance abuse prevention on the State level, yet there remained the importance of sharing information with community-level prevention advocates. Community preventionists had long expressed concern for the lack of alignment for prevention from the different state agencies with which they engaged, and were encouraged by this focused effort. Community-level preventionists (OSAP and others) also showed appreciation for the support provided to conduct the Community Survey, so that they could not only gain important assessment and evaluation data, but they could build capacity with their community partners. We describe the NM Community survey next.

The New Mexico Community Survey

In May of 2012, New Mexico prevention providers and community leaders implemented the New Mexico Community Survey (NMCS). Based upon a successful community survey approach developed during the SPF SIG, the 2012 NMCS included questions about alcohol, tobacco, and prescription drug consumption in addition to perception of risk and mental health items. When possible, survey items were identical to those from national surveys such as the Behavioral Risk Factor Surveillance Survey (BRFSS) and the National Survey on Drug Use and Health (NSDUH). Alcohol-related questions were the same as those in previous SPF SIG community surveys and therefore, were able to be compared across years. Tobacco, prescription drugs and mental health questions were new to this year's survey, which meant we could not compare with prior community surveys, although when possible we compared with estimates from national surveys. As in previous years, a Spanish language survey was provided. The 2012 NMCS provided a community-level baseline for these new measures.

Methodology

The survey content and data collection methodology was based upon the community survey protocol developed during the SPF SIG, and was reviewed and approved by PIRE's Institutional Review Board prior to implementation. Local organizations were identified to collect surveys in their communities. SAPT-OSAP funded communities were reached out to first. Next, with a mind to building capacity in the collection and use of data, non-SAPT block grant communities and organizations known to be engaged in prevention (such as Drug Free Communities grant recipients or state prevention initiatives such the Total Community Approach communities and DWI councils) were identified to collect data in comparison communities. All communities/organizations were trained by PIRE on how to complete and follow the data collection protocol and enter data using a standard format. Community data collectors were contacted weekly to monitor progress and adherence to protocols.

These community-level organizations conducted the survey among a convenience sample of community residents 18 and older, representing 27 counties, 3 major metropolitan areas, and 5 Native American communities across the state. Surveys were offered either on-line or as paper and pencil, in Spanish or English. Participating organizations had 4 weeks in which to collect surveys. Each organization was required to develop a community-specific data collection protocol that identified, who, when, where and how surveys would be collected in the community. These were reviewed by SEOW members who provided feedback for improving the samples and gave final approval to proceed. Data were entered by community members or evaluators and data files were sent to PIRE where cleaning took place. Some participants were reassigned to a different site ID based on where the individual reported he/she lived.

Table 1: Counties, major metropolitan areas, and Native American communities grouped within three funding subgroups.

Funding Subgroup	County, major metropolitan & NA areas	N
Current OSAP Funded Sites (May also have been a SPF SIG community)	San Juan County	448
	Taos County	313
	Colfax County	302
	Bernalillo County	212
	Rio Arriba County	373
	Valencia County	283
	Santa Fe County	334
	South Valley, Albuquerque	102
	Albuquerque, Bernalillo County	415
	Laguna Pueblo	217
	Santa Clara Pueblo	147
Past SPF SIG funded communities (not currently funded by OSAP)	McKinley County	351
	Catron County	306
	Grant County	353
	Hidalgo County	291
	Luna County	328
	Mescalero Apache Tribe	145
Comparison Sites (never funded by OSAP)	Union County	158
	Otero County	224
	Lincoln County	193
	Cibola County	218
	Doña Ana County	263
	Guadalupe County	143
	Mora County	154
	San Miguel County	190
	Chaves County	525
	Eddy County	19
	Lea County	51
	Curry County	109
	Roosevelt County	56
	Torrance County	241
	Sandoval County	284
	Las Cruces, Doña Ana County	215
	Zia Pueblo	130
	Cochiti Pueblo	137
	Not in the survey counties	9

For the purpose of simplifying the results, we grouped respondents based on where they lived into 3 funding subgroups (see Table 1 for a listing of communities in each subgroup). These three groups were: 1) FY12 OSAP funded communities, 2) currently unfunded communities previously funded through the Strategic Prevention Framework State Incentive Grant (SPF SIG), which focused on alcohol-related outcomes, and 3) all other communities that currently did not and had not previously received OSAP prevention funding. We chose to delineate the 3 groups in this way so that we could examine if any residual effects from the SPF SIG prevention efforts existed. We hypothesized that currently-funded communities would have the best alcohol results, previous SPF SIG communities would have moderate alcohol results because of having focused on the outcome for 6 years during the SPF SIG, and finally, that the comparison communities would have the worst alcohol effects. However, complicating these predictions was the fact that high baseline rates influenced the decision to provide funding in SPF SIG communities. We did not hypothesize any differences by these three subgroups for prescription drug and mental health measures.

Data were analyzed by age, collapsed into five distinct categories: 18-20, 21-29, 30-39, 40-49, and 50 and older. Age was of specific interest to the evaluators in order to determine use of and access to alcohol by underage adults, and age differences among prescription pain-killers use, specifically among young adults and the “mature” respondents. We were also interested in mental health and access to mental health services across the lifespan.

Respondents were allowed to select multiple race/ethnicities to describe themselves. Race/ethnicity was then coded hierarchically. All respondents identifying as Hispanic regardless of other classifications were classified as Hispanic, followed by all non-Hispanic Native Americans, all non-Hispanic whites, and all other categories of race/ethnicity including African Americans/blacks and Asian/Pacific Islanders.

We chose not to weight the data collected for the FY12 survey because when weighting in previous years, we have found that the results change very little and created confusion among local evaluators and providers. Weighting would also delay providing results to communities and the State.

Finally, one important point should be made for interpretation purposes. In 2012, because of scheduling complications, the survey was conducted for only 1 month in May rather than for 2 months in February and March as in previous years. This difference in timing may have influenced our estimates. One should be aware of this when comparing 2012 NMCS data with 2010 NMCS data as we do later. In particular, we think that young adults and/or college students may be most influenced by the timing of the survey. Substance use behaviors are likely to increase during holidays and vacations. The 2012 NMCS took place after spring break and at the end of the school year for colleges and universities, a time when alcohol consumption often increases. Therefore, when asked about past 30-day substance use we might expect that younger respondents in this survey would report higher rates of alcohol use than in previous years. It

seems unlikely for older adults to be as influenced by the timing of the survey, but it remains a possibility for the entire sample.

At the same time, it is important to consider the difficulties that collecting surveys in February and March provide. Especially in rural New Mexico, sudden extreme weather can severely limit communications and participant access in general.

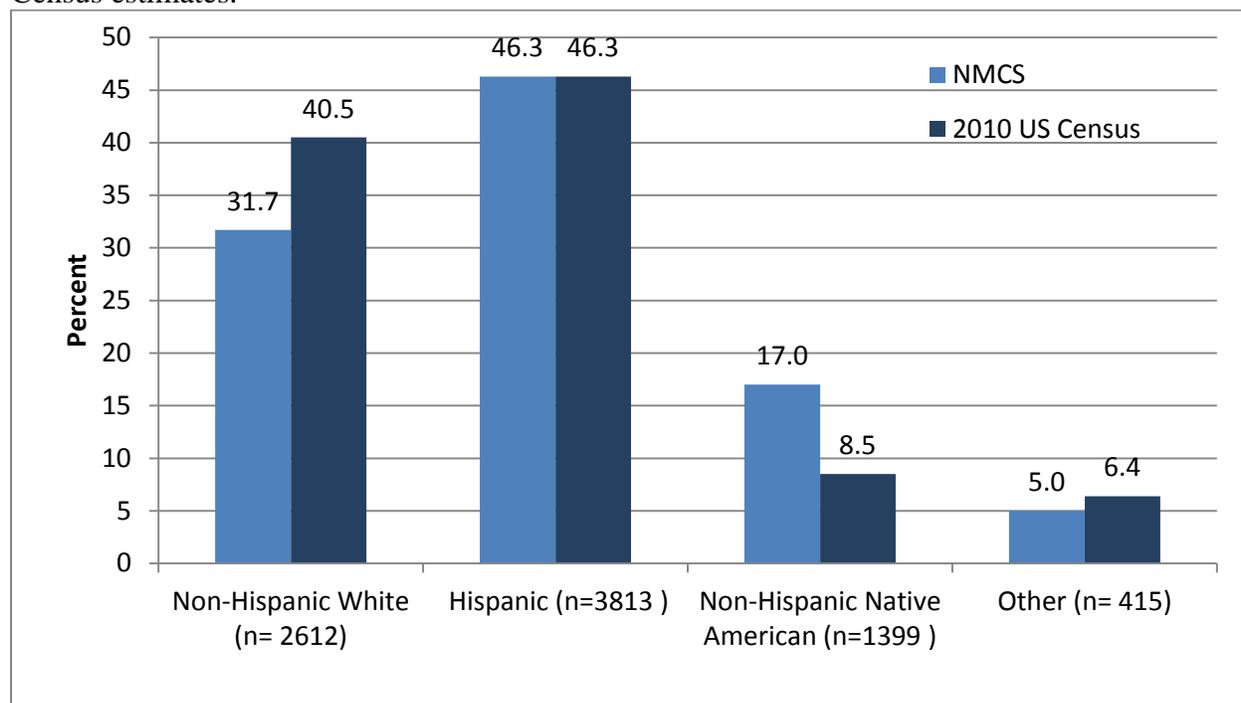
Results

Demographics

There were 9,176 surveys completed. All respondents with missing data for age or location were removed from the sample. Those who indicated living outside of the state were also removed from the sample. The final valid sample size was 8,239. The age range of the final sample was 18 to 97; 789 were less than 21 years old; 7540 were 21 or greater. The sample was 60.6% female and 39.4% male. Figure 1 provides the breakdown of race/ethnicity in the community survey sample compared to the 2010 U.S. Census break-down. In general, the 2012 NMCS sample is under-representative of non-Hispanic whites and over-representative of Native Americans. Surprisingly, the percentage of Hispanics in the NMCS 2012 sample matched exactly the percentage in the 2010 U.S. Census, even though the 2010 U.S. Census queries Hispanic differently.

We also compared the race/ethnicity distribution in the NMCS 2012 with the 2011 NM BRFSS sample. The BRFSS data were more likely to be non-Hispanic white (55%) and less likely to be Hispanic (35%) when compared to the 2010 Community Survey data.

Figure 1: Race/ethnicity distribution in 2012 NM Community Survey compared with 2010 U.S. Census estimates.



Females represented about 60.6% of the sample making 39.4% of the sample male. Finally, approximately 9% of the 2012 NMCS sample identified as a veteran of or currently on active duty in the U.S. Armed Forces.

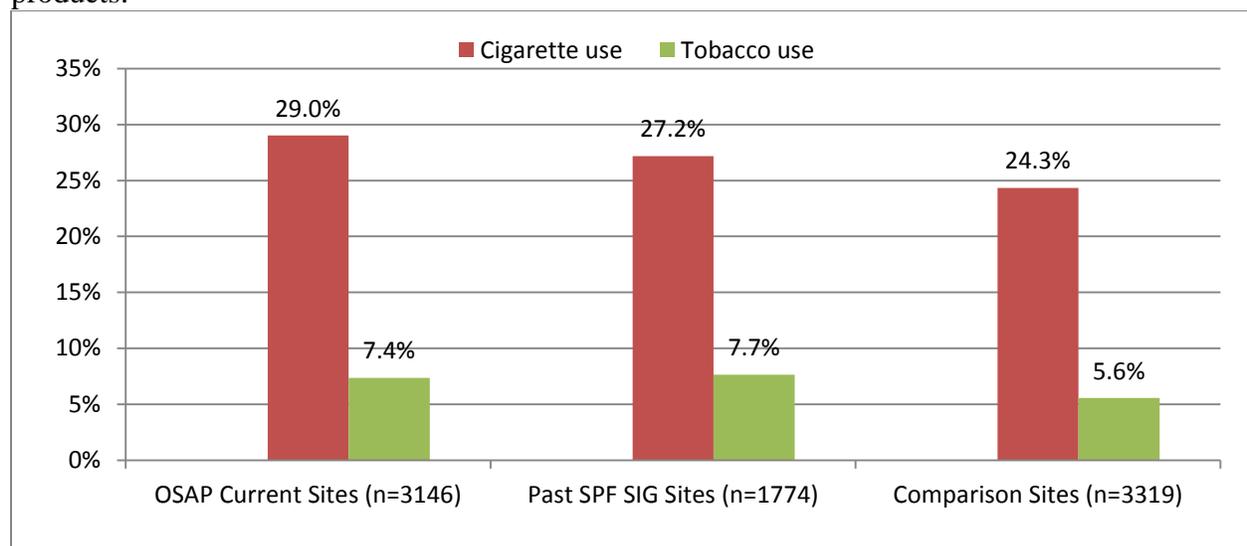
Tobacco Use

Smoking and use of tobacco products remains an important public health problem among New Mexico's youth and adults alike. In recent years, New Mexico's OSAP has worked hard through its SYNAR funding to reduce youth initiation of smoking and current cigarette smoking and has been largely effective in doing so based on yearly evaluations that reveal that sales to minors in the state are well under the 20% recommended by the Federal Government. Yet there remains incredible variability among counties across the state with some counties at close to twice the rate for the state as a whole. Furthermore, 30-day smoking prevalence among NM youth is still higher than the U.S. as a whole.

The 2012 NMCS included three items related to tobacco use: current smoking of cigarettes; use of other tobacco products; and because the sample for the NMCS was of legal age to purchase tobacco products, providing cigarettes and/or other tobacco products to minors.

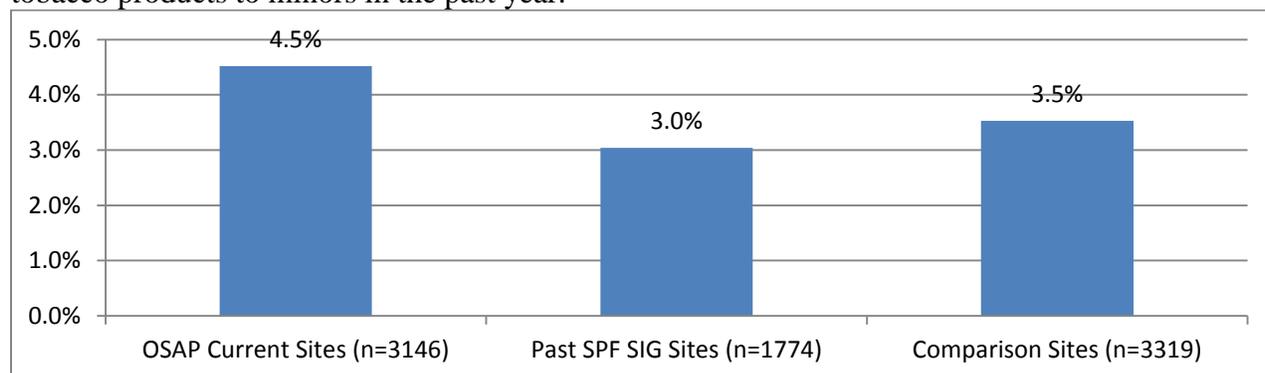
Figure 2 illustrates the prevalence of self-reported current cigarette and other tobacco use by each funding subgroup. Current cigarette use is highest among FY12 OSAP-funded communities and lowest among comparison communities.

Figure 2: Percentage of respondents who reported currently smoking cigarettes or using tobacco products.



Similarly, while the differences are not large, FY12 OSAP-funded community respondents reported providing minors with cigarettes and/or tobacco products more often than past SPF SIG sites and comparison communities. See Figure 3.

Figure 3: Percentage of respondents who reported providing cigarettes, chew, snuff or other tobacco products to minors in the past year.



Summary

As this is the first year that the NMCS collected data on current tobacco use and providing of tobacco products to minors, this is the first time we report these data. Our estimates of current smoking are slightly higher than the statewide estimate of 21.5% from the 2011 NM BRFSS for the same question: “Do you now smoke cigarettes every day, some days, or not at all?” As in the BRFSS, we included as current smokers or tobacco users those who reported using every day or some days. Interestingly, as previously noted, in our sample females were more heavily represented than in the BRFSS sample. When the BRFSS data are weighted, the proportion of males versus female is essentially equal. However, when examining the unweighted BRFSS data the sample was 60% female, essentially the same as in the 2012 NMCS. Higher estimates in the 2012 NMCS may be the result of not weighting the data or could reflect differences in data collection methodology. The NMCS is an anonymous paper or on-line survey using a convenience sample, whereas the BRFSS is an anonymous phone survey.

Alcohol Perceptions of Risk and Consumption Behaviors

Every year since 1981, NM has had the tragic honor of ranking 1st, 2nd, or 3rd in the U.S. in alcohol-related death. Alcohol abuse and misuse, underage drinking and binge drinking, drinking and driving all contribute to this ranking. The Strategic Prevention Framework State Incentive Grant (SPF SIG) spanned 6 years, ending in 2010. The targeted goal of that project was to reduce alcohol-related motor vehicle crash fatalities (ARMVCF) among young adults. Funded communities worked towards achieving this goal by trying to reduce the precursors to ARMVCF, including underage alcohol consumption, binge drinking, and drinking and driving. Focus was given towards changing environmental causes of problem drinking behaviors, referred to as Intervening Variables (IVs) or Contributing Factors (CFs). These included (1) retail access to alcohol by minors and intoxicated patrons; (2) social access to alcohol by minors; (3) low

perceived risk of legal consequences for being caught drinking as a minor, providing or selling alcohol to minors or the intoxicated, and drinking and driving; (4) alcohol promotion and advertising, (5) low pricing of alcohol, (6) low enforcement of drinking and drinking and driving laws, and (7) social norms that encourage underage drinking, binge drinking, and drinking and driving. The NMCS was used to assess changes in some of these known CFs that prevention programs in NM were trying to change, in particular the ones that could not or were not evaluated otherwise.

By 2012, IVs that were being addressed by prevention programs had been reduced to what OSAP, with the support of the SEOW, had been determined the most effective for our communities to implement: (1) reducing retail access, (2) reducing social access, and (3) increasing the perceived risk of legal consequences. In the 2012 NMCS, two IVs were assessed, retail access to alcohol by teens, and perception of risk of getting caught if engaging in illegal alcohol-related risk behaviors (increased law enforcement efforts could be assessed by other methods). A total of 6 questions were included on retail access to alcohol for underage youth and perception of risk of legal consequences. For those 18-20 who had drunk in the last 30 days, one question on social access was asked. Table 2 displays the percent of respondents who reported the ideal response to the 6 questions by the 3 funding subgroups. Note that the NM YRBS/YRRS survey also has a question regarding access to alcohol, but response options are different, as is the population of 30-day drinkers (high school students versus under 21 adults) so we are unable to compare our estimates with those from the 2011 YRRS.

Generally, there is little difference between the three funding groups for most of the measures. Interestingly though, some of the lowest percentages of ideal responses are among the past SPF SIG sites. The SPF SIG ended in 2010 and the communities in this subgroup stopped receiving funding from OSAP for prevention purposes. It appears likely that among this subgroup of communities, there is a fairly rapid decline in in perception of risk of legal consequences, associated with no longer receiving prevention funding and by extension, no longer working to increase the perception of risk. This may also mean that local law enforcement is no longer as actively involved in enforcement activities that previously increased the perception of risk. It should again be noted, that SPF SIG communities were selected for funding originally based on the risk factors in the community, meaning that SPF SIG funded communities were at higher risk for ARMVCFs than comparison communities from the beginning and in all likelihood had corresponding lower perceptions of risk.

Table 2: Perception of the ease of retail access to alcohol and likelihood of legal consequences of illegal alcohol-related behaviors.

Perception of risk/legal consequences	OSAP Current Sites (n=3146)	Past SPF SIG Sites (n=1774)	Comparison Sites (n=3319)
	Very difficult	Very difficult	Very difficult
Teens in the community to get alcohol from stores and restaurants	29.4%	30.1%	28.1%
	Very likely	Very likely	Very likely
Likelihood of police breaking up parties where teens are drinking	21.4%	20.0%	22.8%
Likelihood of police arresting an adult for giving alcohol to someone under 21	32.7%	27.6%	31.4%
Likelihood of someone being arrested if caught selling alcohol to a drunk or intoxicated person	27.7%	20.8%	24.0%
Likelihood of being stopped by police if driving after drinking too much	36.9%	35.5%	33.2%
Likelihood of being convicted if stopped and charged with DWI	56.6%	51.8%	55.9%

Comparing NMCS 2010 to 2012

We wanted to compare 2012 NMCS data with the 2010 NMCS data on the same measures to determine any change over time in perceived risk of legal consequences. Figures 4-8 graph this comparison by funding subgroups. It appears that for some measures there was observable decline among SPF SIG communities whether they were currently funded through OSAP or no longer receiving funding. Respondents in SPF SIG funded communities in 2010 were more likely to report that it was very likely that police would break up a party where teens were drinking compared to 2012 past SPF SIG sites and currently funded sites (some of which were also previous SPF SIG sites). See Figure 4. The same pattern emerged for the perception of risk of being arrested for providing alcohol to a minor and selling alcohol to someone who was intoxicated, both of which decreased in 2012. See Figures 5 & 6. The greatest decline, however, is seen among the SPF SIG sites that are no longer funded, which suggests that the lack of funding of coalition-based prevention may in part be associated with poorer outcomes. Indeed, currently funded OSAP sites increased the perception of risk associated with selling alcohol to drunk or intoxicated patrons.

Interestingly, in 2012, the perception of risk of being caught by police if driving after drinking was slightly greater than in 2010. See Figure 7. Since the end of SPF SIG support, OSAP has worked diligently to encourage all funded programs to link highly visible enforcement with increasing the perception of risk of arrest for those enforcement efforts. It is possible that this focus is reflected in this encouraging shift. On the other hand, communities may have found it comparatively easier to address drinking and driving prevention than underage access to alcohol and risk of legal consequences of providing alcohol to minors because of the many years of prevention work targeting driving after drinking.

Figure 4: Percent of respondents who think it is very likely police would break up parties where teens are drinking in 2010 and 2012.

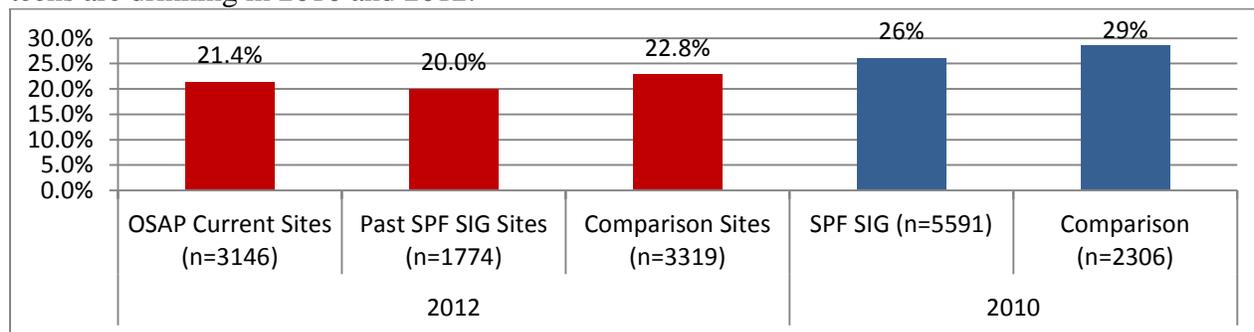


Figure 5: Percent of respondents who think it is very likely police in their community would arrest an adult for giving alcohol to someone under 21: 2010 and 2012

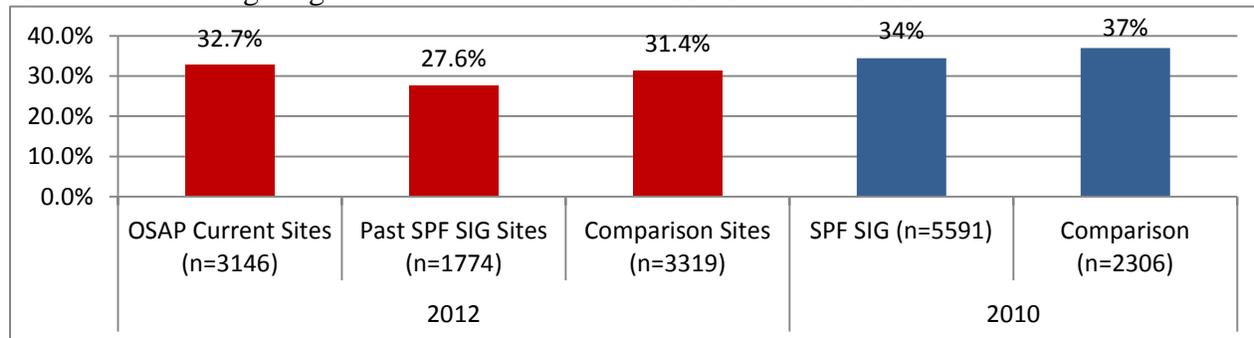


Figure 6: Percent of respondents who think it is very likely one would be arrested if caught selling alcohol to a drunk or intoxicated person in 2010 and 2012.

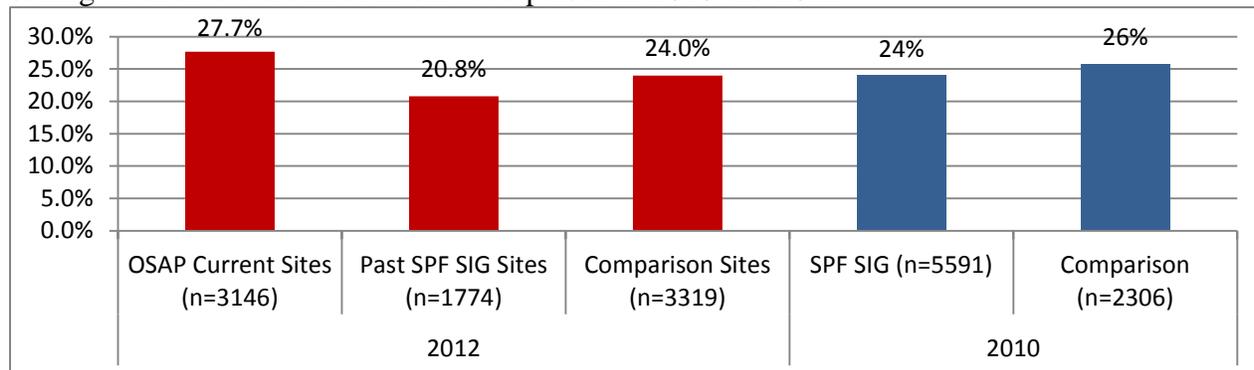


Figure 7: Percent of respondents who think it is very likely one would be stopped by police if driving after drinking too much in 2010 and 2012.

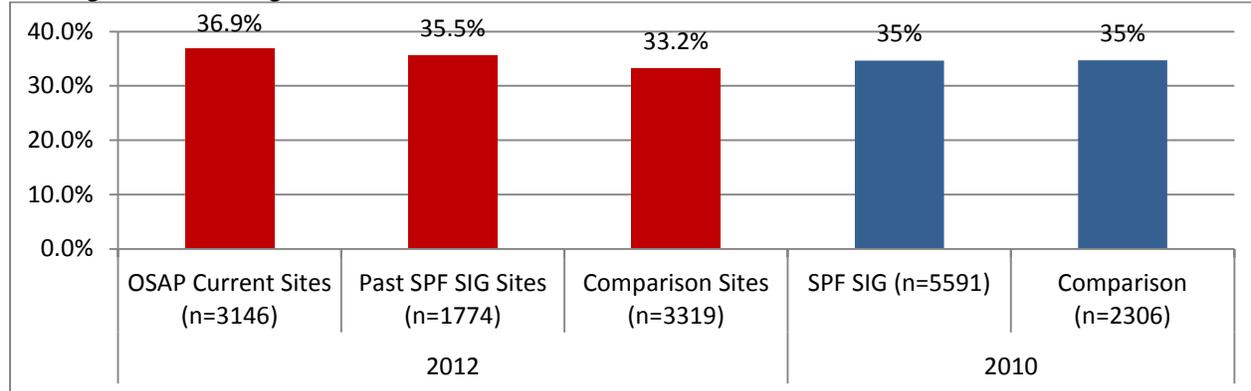
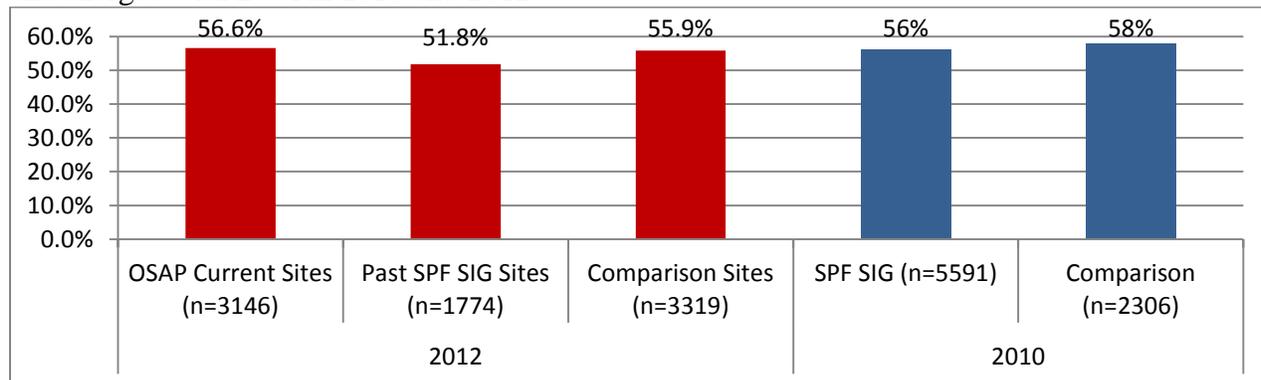


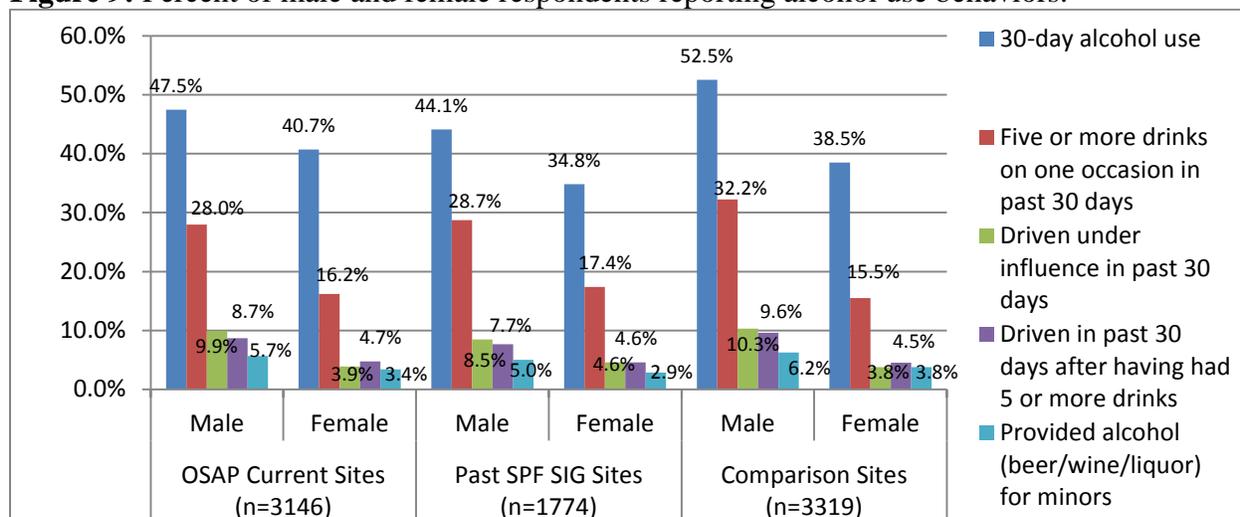
Figure 8: Percent of respondents who think it is very likely one would be convicted if stopped and charged with DWI in 2010 and 2012.



2012 NMCS consumption results for men and women

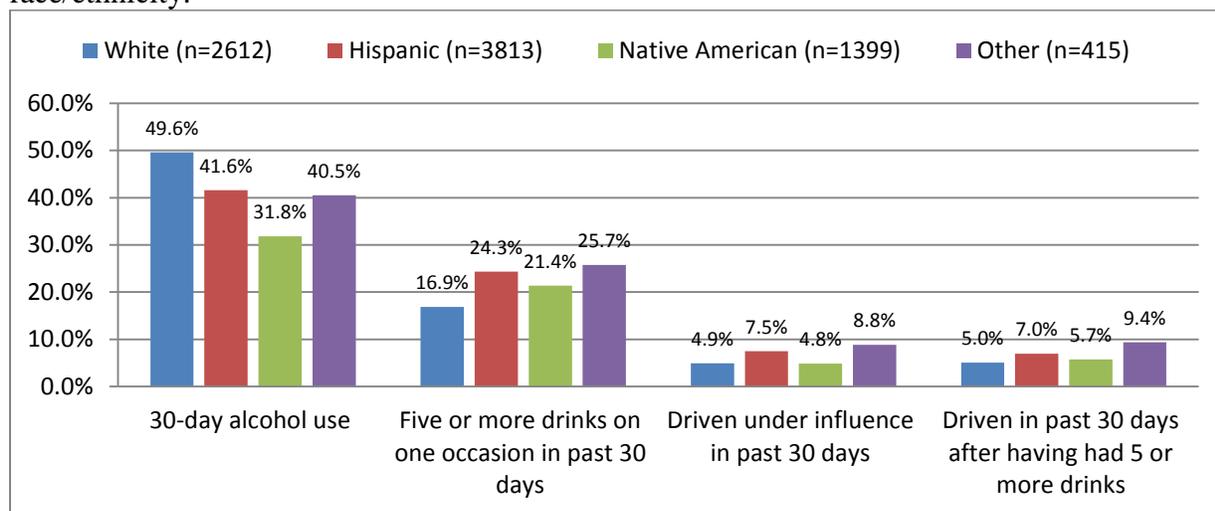
We assessed the 2012 NMCS alcohol consumption and related risk behaviors and examined these responses by gender. Past 30-day alcohol use was lower among males in currently-funded and past SPF SIG communities compared to males in comparison communities. Males in comparison communities were slightly more likely to have driven under the influence and driven after having 5 or more drinks in the past 30 days. Males in comparison communities were slightly more likely to report having provided alcohol to minors in the past year compared to currently funded OSAP communities and past SPF SIG communities. These findings suggest that the prevention efforts of currently and previously-funded communities to reduce problem alcohol use have made a difference at least among males. This pattern does not hold for females, where only slight differences exist among funding subgroups. See Figure 9. The gender disparity may reflect dominant social stereotypes perhaps held by some providers, that men should be the focus of alcohol prevention interventions.

Figure 9: Percent of male and female respondents reporting alcohol use behaviors.



When examined by race/ethnicity, we find that non-Hispanic whites are most likely to report drinking any alcohol in the past 30 days, but least likely to report binge drinking (five or more drinks at one sitting). Hispanics and other racial/ethnic groups are most likely to report current binge drinking and drinking and driving after binge drinking and under the influence. Non-Hispanic Native Americans are least likely to report any 30-day drinking, but those that did were more likely than non-Hispanic whites to report binge drinking. Figure 10 breaks down these estimates.

Figure 10: Prevalence of current alcohol consumption and related risk behaviors by race/ethnicity.



When comparing 2010 NMCS data with 2012 NMCS data on the same measures there are again patterns that suggest a 2012 increase in alcohol consumption and drinking and driving. See Figures 11-14. The increase is most notable among males but exists among females as well. This is most worrisome given how much progress was achieved on these indicators during the SPF SIG. Whether these increases are due to the loss of funding to comprehensively address problem drinking behaviors, or other circumstances such as economic declines or a change of survey timing to later in the year remains uncertain. Nonetheless, it appears likely that NM's progress in address alcohol-related risk behaviors is backsliding. It will take examining crash data to examine whether this finding extends to increases in ARMVCFs.

Figure 11: Percent of respondents who reported past 30-day alcohol use.

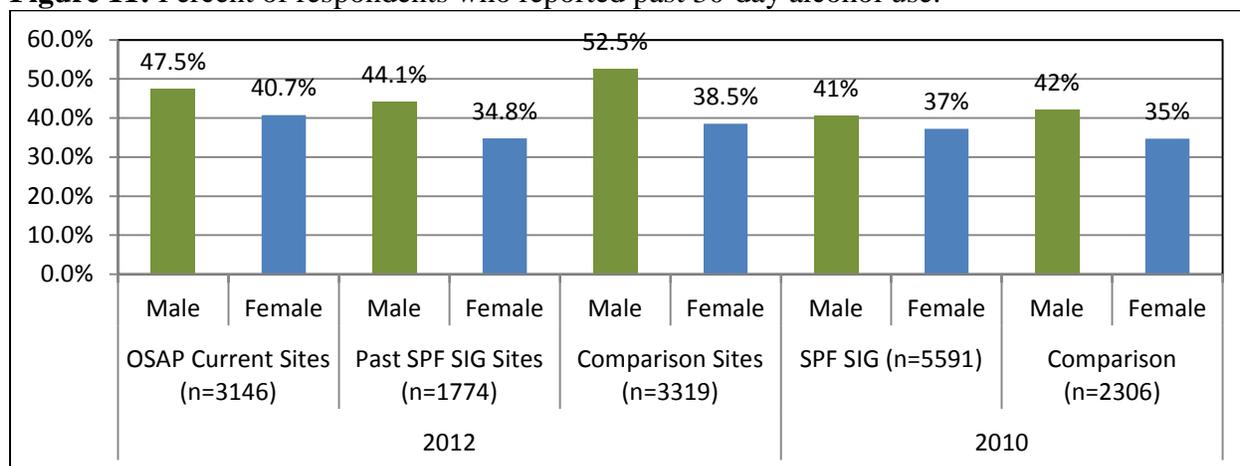


Figure 12: Percent of respondents who reported drinking five or more drinks on at least one occasion in past 30 days.

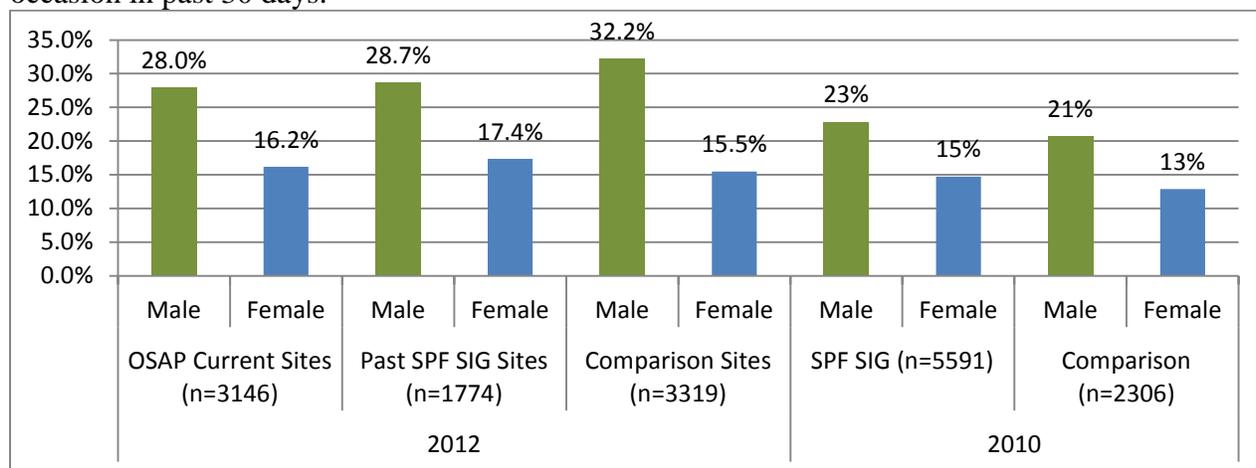


Figure 13: Percent of respondents who reported driving after having too much to drink in past 30 days.

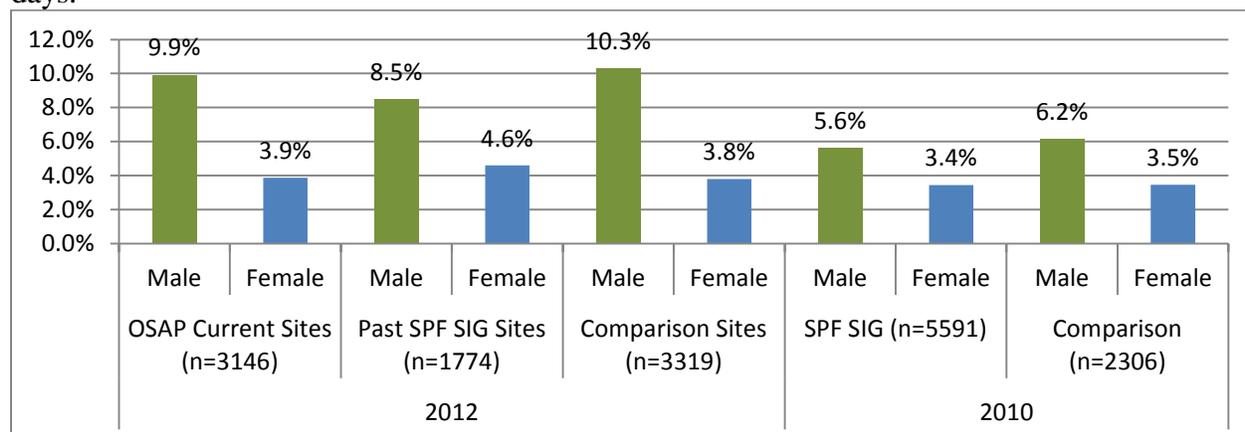
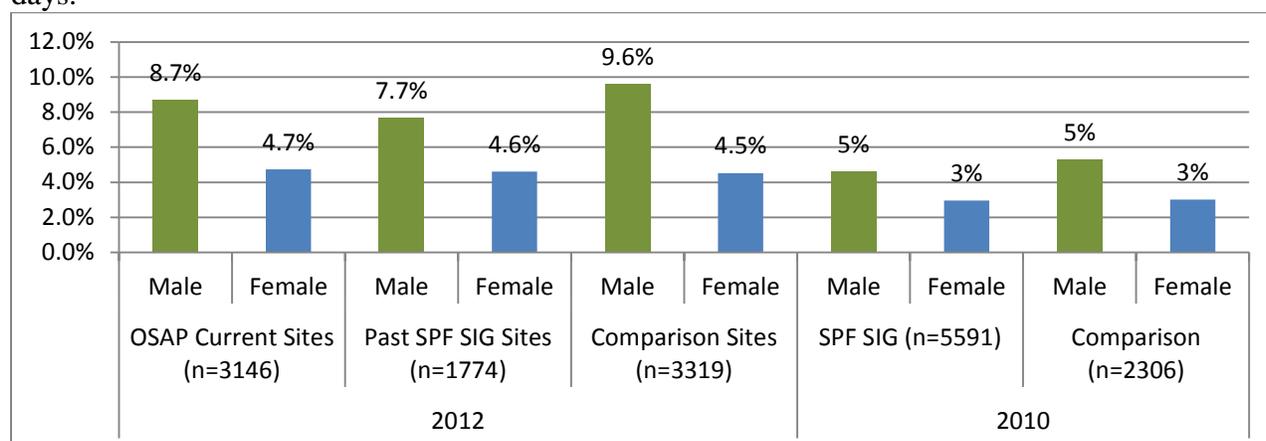


Figure 14: Percent of respondents who reported driving after having 5 or more drinks in past 30 days.



Comparison of 2012 NMCS and NM-BRFSS

The random sample that makes up the NM BRFSS data is perhaps the most representative sample available of adults 18 and older in NM. Questions from the BRFSS were deliberately selected for inclusion in the NMCS to allow us to compare NMCS findings with the findings from the representative sample of the BRFSS. However, this comparison is not ideal since the NMCS was a convenience sample and the survey was conducted in 27 of 33 counties. Figures 15 & 16 below compare 2011 BRFSS estimates (the most recent available) to 2010 and 2012 NMCS estimates on the same alcohol measures. Note that the NMCS survey was not administered in 2011. Among the NMCS data, we can see increases between 2010 and 2012 as previously discussed. Differences between the NMCS and the BRFSS data are less predictable. Past 30-day drinking is slightly lower among the 2010 and 2012 NMCS samples than in the 2011 BRFSS sample, whereas past 30-day binge drinking is slightly higher among the NMCS samples.

Figure 15: Comparing 2011 BRFSS estimates with 2010 and 2012 NMCS estimates of past 30-day drinking.

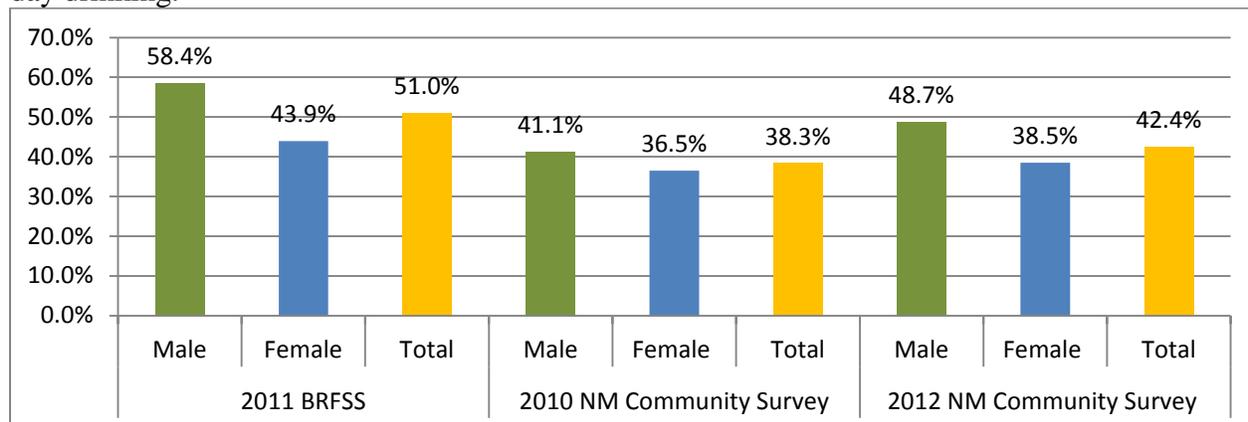
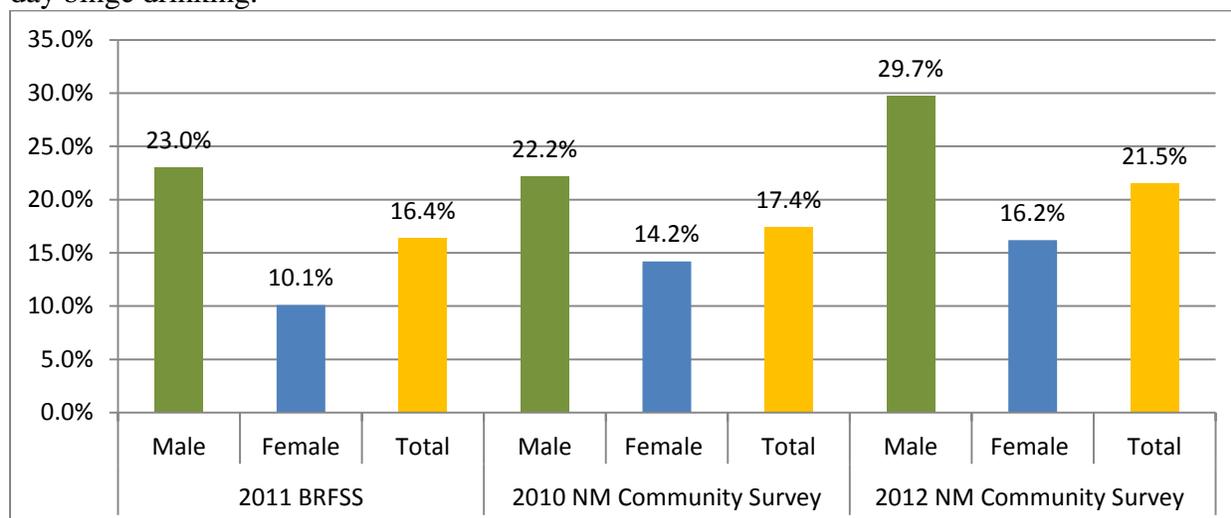


Figure 16: Comparing 2011 BRFSS estimates with 2010 and 2012 NMCS estimates of past 30-day binge drinking.

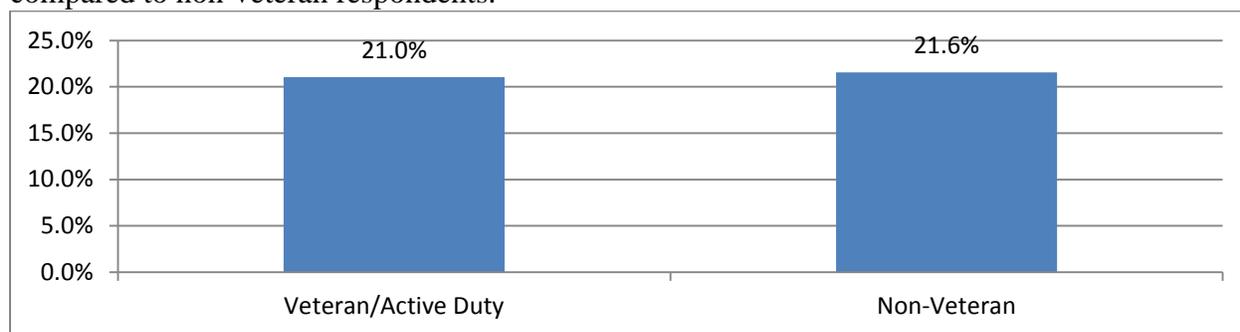


The BRFSS asks about past 30-day driving after having had too much to drink only every other year. This question was last asked in 2010, when less than 1% of NM respondents indicated they had driven after having had too much to drink, compared to approximately 6% in the 2010 NMCS and 9% across the entire 2012 NMCS sample. This discrepancy likely reflects influences of the way in which data were collected: the use of a phone survey versus a paper survey or the convenience sampling of the NMCS versus the Random Digit-Dial (landline) sampling of the BRFSS.

Veteran and current military personnel

For the first time, the 2012 NMCS asked respondents if they were currently on active duty in the U.S. Armed Forces or a veteran of the U.S. Armed Forces. We examined this subgroup on several of the risk behaviors assessed. Figure 17 is the percent of binge drinking among veterans or active duty respondents compared to non-veterans. Of interest is the seemingly lack of meaningful differences between these two groups of respondents on past 30-day binge drinking.

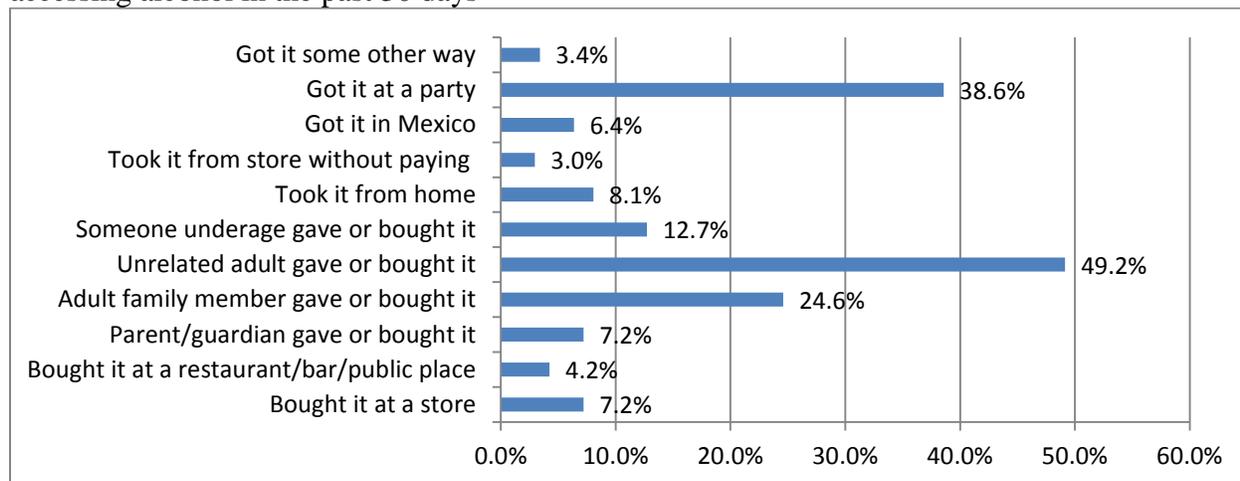
Figure 17: Prevalence of past 30-day binge drinking among veterans or active duty respondents compared to non-veteran respondents.



Underage access to alcohol

There is considerable interest in understanding how underage drinkers access alcohol. The NMCS includes a question specifically on this topic for 18 to 20 year olds. Figure 18 displays the responses to the question, “During the past 30 days, how did you get your alcohol?” This question was only completed by underage respondents who reported drinking alcohol in the past 30 days, so the overall sample of respondents for this question is considerably smaller than for other questions. Respondents were allowed to select as many options as applied. Not surprisingly, social access is by far the most common means of accessing alcohol as a minor (adult). In particular, having a legal adult purchase alcohol to give to the minor, drinking at a party, or having a family member (other than parent) provide it were the most common methods by which respondents indicated they accessed alcohol as minors. This speaks to an overwhelming need to address underage social access to alcohol in NM. At the same time, there remains a considerable percentage (17%) of underage respondents who indicated obtaining alcohol by purchasing it at a store, or having someone else under 21 purchase alcohol for them. This suggests that minors are still able to purchase alcohol in at least some locals. Retail access has been heavily addressed among OSAP funded and SPF SIG programs and considerable progress has been made. Nevertheless, there remains work to be done to decrease retail access while simultaneously addressing the even bigger problem of social access, possibly through social host laws, party patrols, and enforcing laws against providing alcohol to minors in general. Figure 18 displays the percent of each place where underage drinking adults obtained alcohol in the last 30 days.

Figure 18: Percentage of underage current drinkers who identified each of the listed means of accessing alcohol in the past 30 days



Summary

Alcohol remains a persistent public health problem in NM. Decreasing trends found during the SPF SIG appear to be reversing and may be increasing once again. This is of considerable concern. The financial costs associated with problem alcohol use are huge and the emotional costs of injury or loss of life are immeasurable. Perceptions of risk are decreasing, which suggests the need for a comprehensive campaign that coordinates federal, State, and local law enforcement agencies and judicial systems, local prevention providers and coalitions, school administrators and educators, as well as state and local media outlets and state government to address perception of risk of legal consequences for breaking alcohol-related laws. In addition, a broad NM approach to decreasing social access remains elusive, yet a consistent and concentrated effort must be a focus of future prevention efforts to prevent underage drinking if there are to be noticeable reductions.

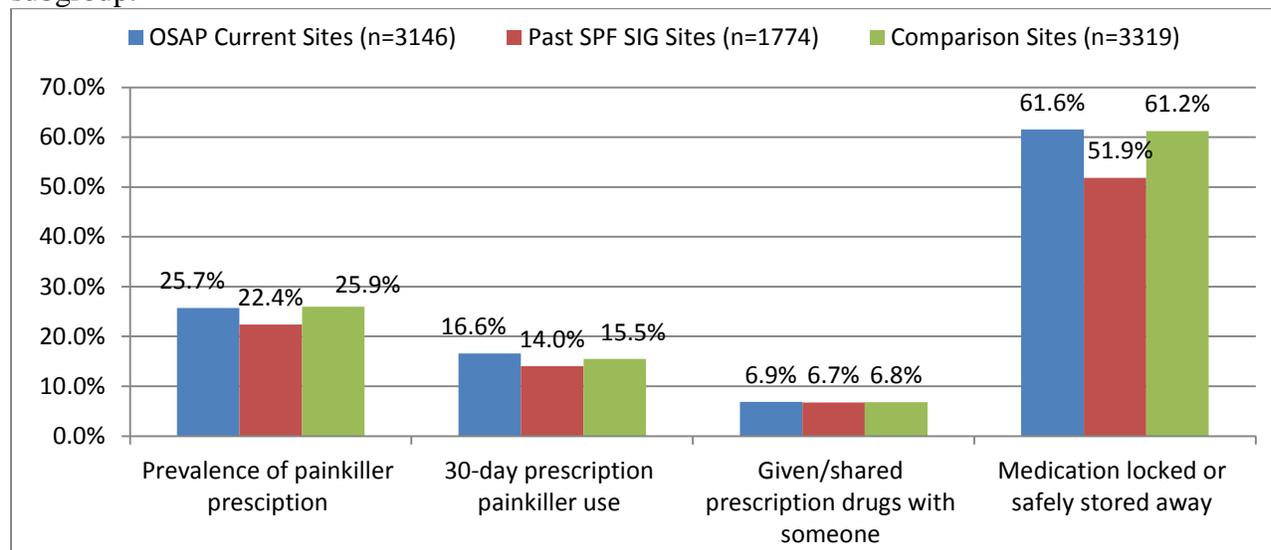
Prescription Pain-killers

In 2012 for the first time the NMCS included questions on prescription pain-killer use, in response to sharp increases in drug-induced deaths and prescription drug overdoses.

Approximately 40% of drug overdose deaths were attributable to prescription drugs between 2005 and 2009, the most common of which were prescription opioids or pain-killers. New Mexico's average drug-induced death rate from 2005 to 2009 was 21.4 per 100,000 population compared to 11.4 for the U.S. as a whole. The death rate by county varies dramatically, suggesting that access to prescription painkillers may vary accordingly. Further investigation is needed to see if there are key access points that can be eliminated that would decrease access to prescription pain-killers and reduce unintended overdoses.

Seven questions were included on the 2012 NMCS that addressed prescription pain-killers in particular. These questions had not been included in earlier versions of the NMCS, nor could we identify particularly strong measures of prescription pain-killer use that could be used in a survey of this kind. As such, the intention of including these was to gain a sense of both the prevalence of prescriptions issued for opioids and current opioid use, as well as risk factors such as reasons for use, sharing of prescription opioids, and storage of prescription medications. Figure 19 below provides a breakdown of four of these topic areas across funding groups. In general, past SPF SIG sites were generally lower across all prescription pain-killer measures. We can see that the prevalence of having received at least one prescription for pain-killers for a medically-identified problem in the past year is around 25%. This does not exclude the possibility of receiving multiple prescriptions during the year, which at least anecdotally, is reported to occur with some frequency. Regardless of the likelihood of multiple prescriptions, that a quarter of respondents reported receiving pain-killer prescriptions in the last year suggests an enormous amount of opioids available for personal misuse and abuse as well as for misuse and abuse within the broader networks of social access. About 15% of respondents reported having used a prescription pain-killer for any reason in the past 30 days. Almost 7% of respondents report having shared their prescription pain-killers with others. Interestingly, over half of respondents indicated that they store their medications safely, but women were more likely to endorse this than men.

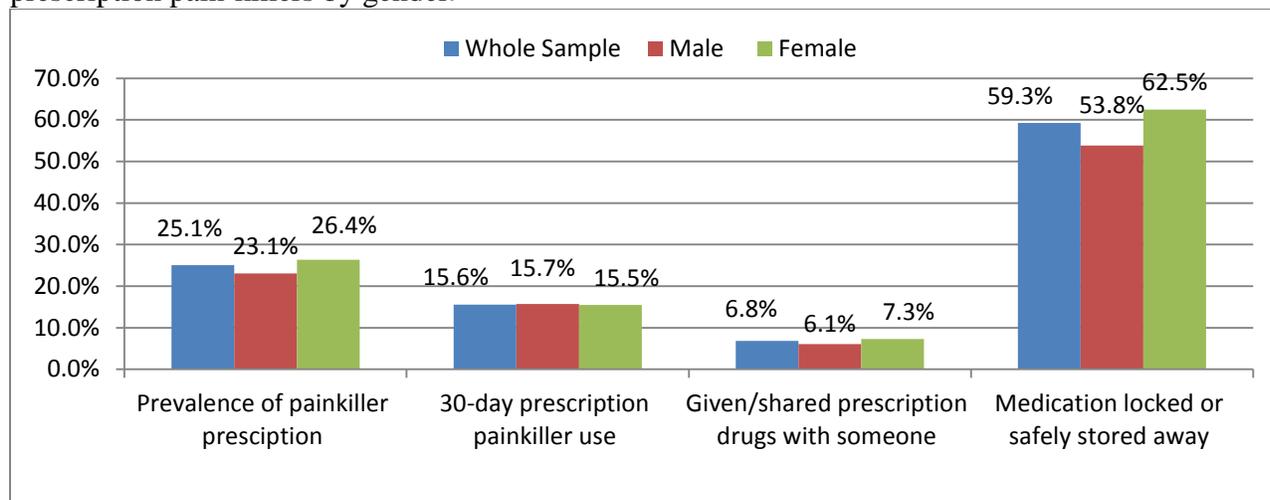
Figure 19: Percent of respondents who reported receiving prescriptions in past year, using in past 30-days, sharing in the past year, and currently safely storing prescription pain-killers by funding subgroup.



Pain-killer use by gender, race/ethnicity and age group

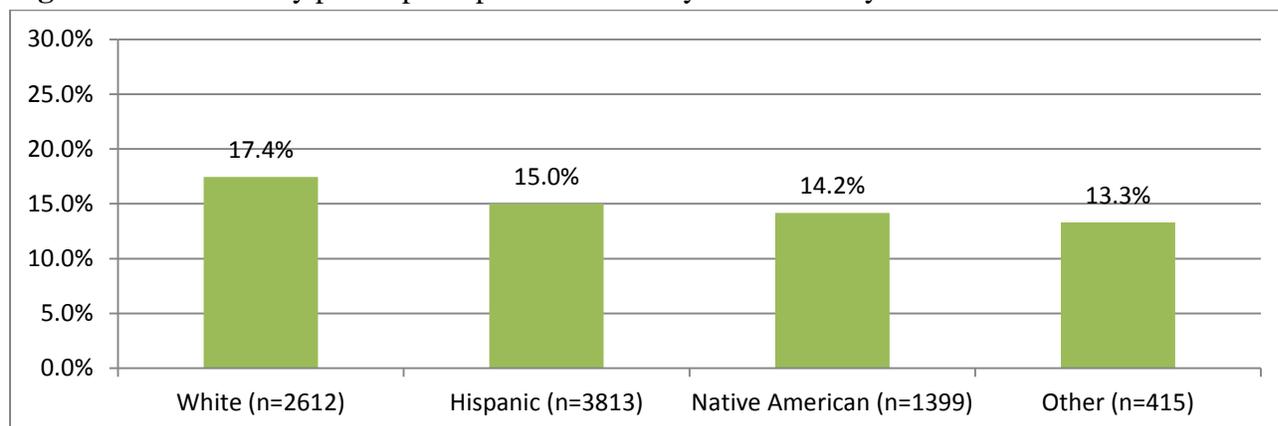
Examining these same indicators stratified by gender, we see that females report receiving prescriptions for pain-killers only slightly more frequently than males although past 30-day use does not really differ. Women are also slightly more likely to share their medication with others. Finally, as previously mentioned, women are more likely to report storing their prescription medications properly. See Figure 20.

Figure 20: Percent of respondents who reported prescriptions for and use, sharing, and storage of prescription pain-killers by gender.



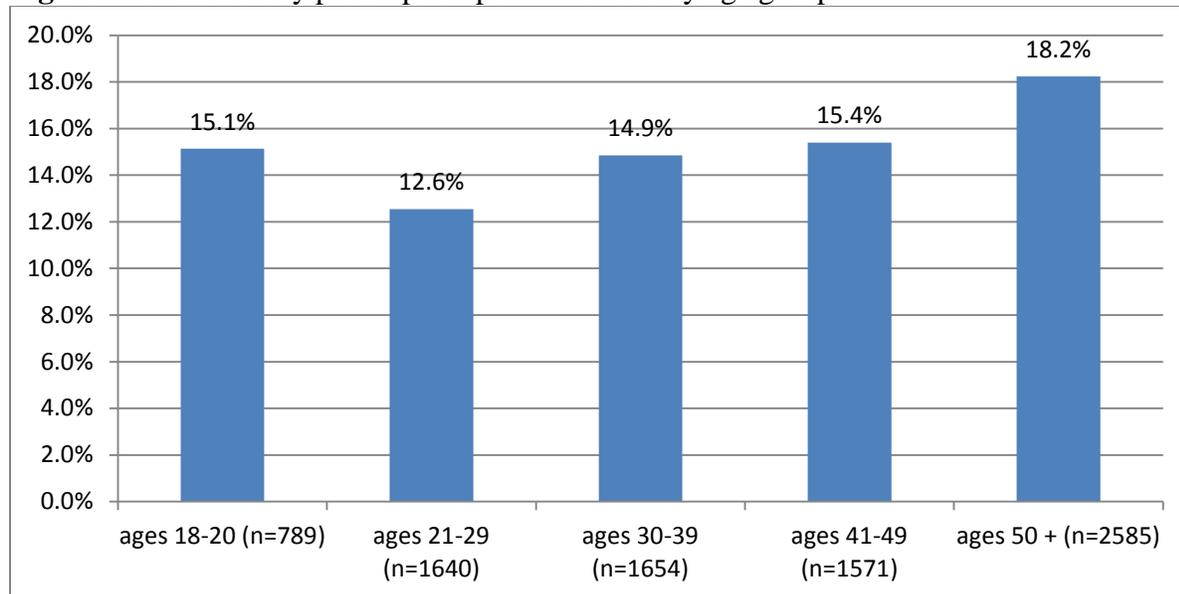
Non-Hispanic whites report the highest prevalence of current use of prescription pain medications followed by Hispanics, Native Americans, and other race/ethnicities. Figure 21 displays past 30-day prescription pain-killer use by race/ethnicity.

Figure 21: Past 30-day prescription pain-killer use by race/ethnicity.



Not surprisingly, prescription pain-killer use increases as age increases, with use being most common among respondents 50 and older. However, 18 to 20 year olds report more use than 21 to 39 year olds. Figure 22 displays current use by age.

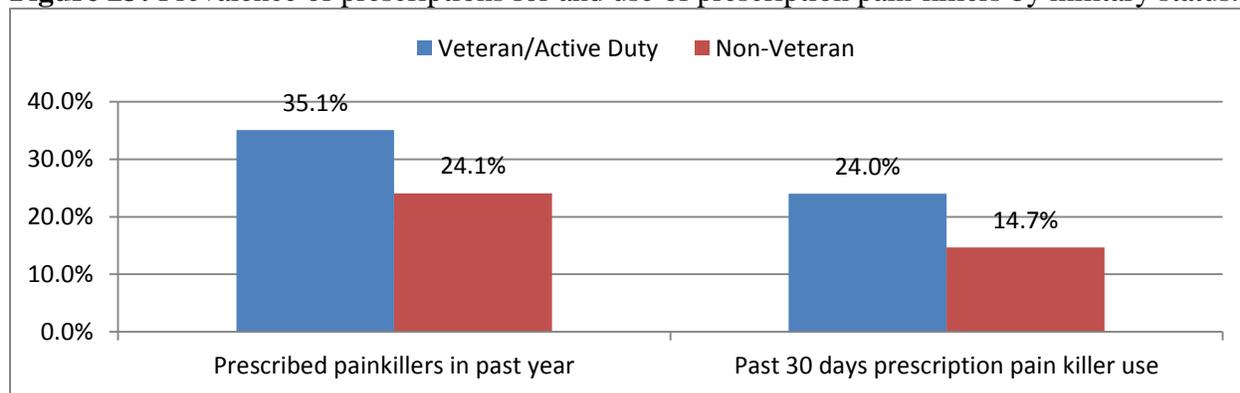
Figure 22: Past 30-day prescription pain-killer use by age group.



Military personnel and prescription pain-killers

Veterans and active duty military personnel are more likely than others to report having been given at least one prescription for pain-killers in the past year (35% vs. 24%), and greater current prescription pain-killer use than non-military respondents (24% vs. 14.7%). This may be attributable in part to injuries sustained while in the military although these data do not allow us to examine this. However, we can assume a far greater prevalence of pain-killers being prescribed in the last year among veteran and active duty respondents as well as more current use of prescription pain-killers. See Figure 23 below.

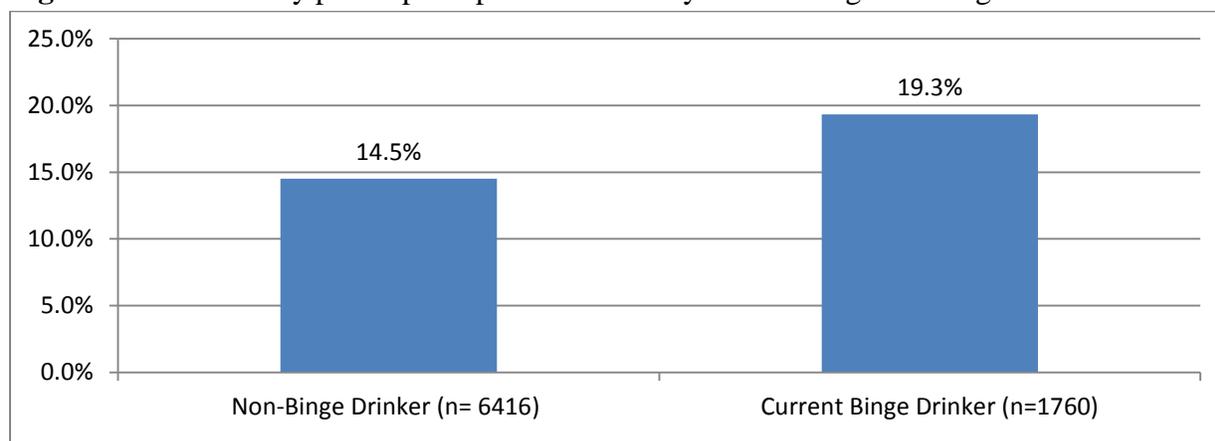
Figure 23: Prevalence of prescriptions for and use of prescription pain-killers by military status.



Binge drinking and prescription drug use

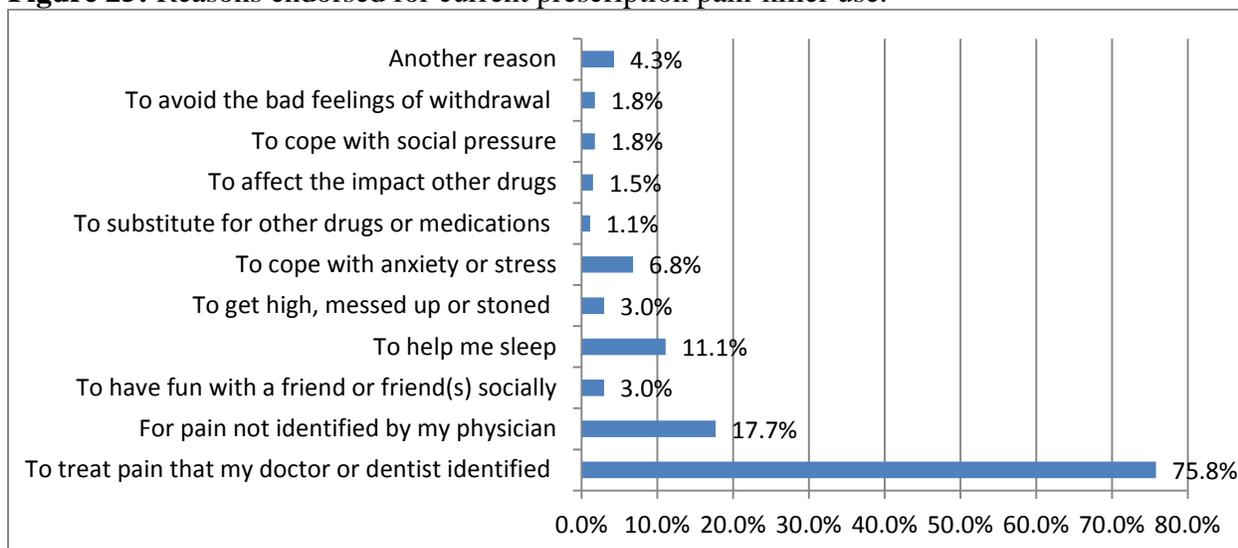
We examined the possible co-occurring risk behaviors of binge drinking and prescription drug use. Figure 24 graphs this relationship. Current binge drinkers were more likely to report current prescription pain-killer use (19.3%) as compared to non-binge drinkers (14.5%). Although it is impossible to determine if the drinking occurred concurrently with prescription drug use, the potential for this to occur exists. The ‘legal’ nature of both drugs often allow for their users to imagine that their use, as well as their combination is harmless; and binge drinking and painkiller use cause decreases in judgment that make it easier for individuals to combine their use. Prescription drug use with heavy alcohol use is a recipe for accidental overdose or poisoning to occur.

Figure 24: Past 30-day prescription pain-killer use by current binge drinking behavior

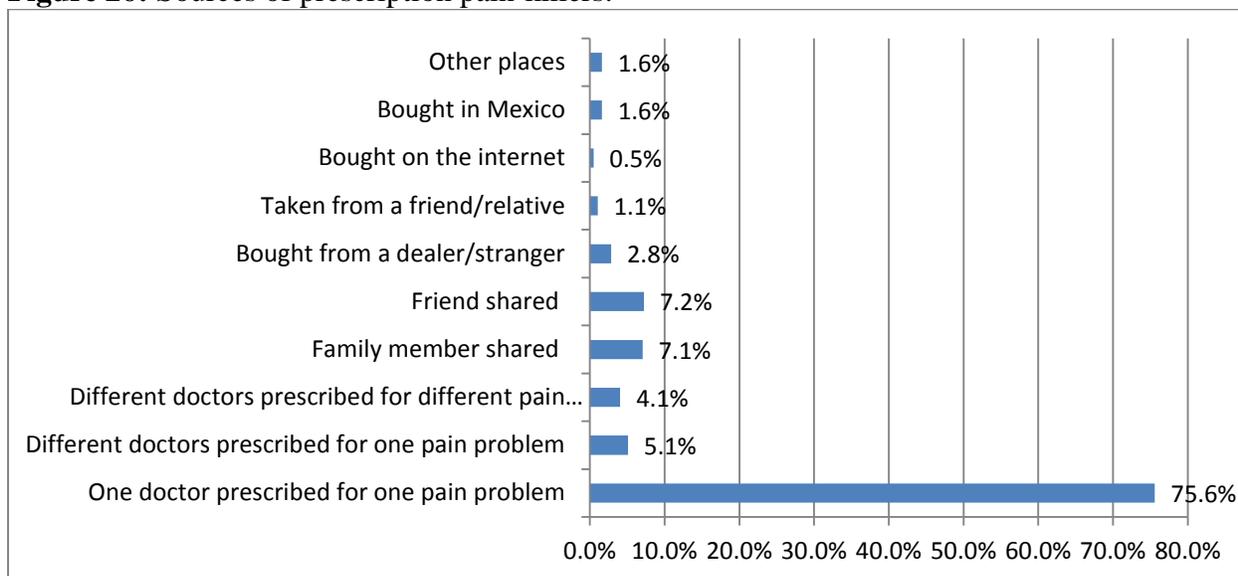


Reasons for prescription pain-killer use and sources of painkillers

Not surprisingly, current users of prescription pain medications indicate that they principally use them for legitimate pain identified by a doctor (75.8%). See Figure 25. Almost 18% of the sample reported using prescription pain medications for pain not identified by a doctor. This suggests that respondents are using medication left over from a previous prescription or are accessing pain medications from a family member, friend, or someone else rather than with a doctor’s prescription. Just over 11% indicate that they used prescription pain meds in the past 30 days to help them sleep, and another 6.8% to help them cope with anxiety or stress. It is encouraging to observe that over 75% of 30-day pain-killer users reported using them with a physician’s approval, yet there remains about 24% of current users of prescription pain-killers who used them for reasons not approved by a physician. Respondents were allowed to select all explanations that applied to their use.

Figure 25: Reasons endorsed for current prescription pain-killer use.

Finally, current users of prescription pain meds were asked about where they obtained their medication; respondents were allowed to select all of the responses that applied to them. Over 75% indicated that only one doctor prescribed the medication for a legitimate medical reason. About 14% claimed that a friend or family member gave them the medication, and approximately 9% said that multiple doctors had prescribed pain medications for one or more pain problems. See Figure 26.

Figure 26: Sources of prescription pain-killers.

Summary

Prescription drug abuse and associated overdose hospitalizations and deaths are on the rise in NM. Most of these overdoses are the result of prescription opioid or pain-killer use. About 25% of respondents report that they have received a prescription for a pain-killer from a physician in the past year suggesting that there is at least the potential for large, readily available quantities of pain-killers for potential misuse and abuse. While most respondents report using pain medication in the last 30 days in order to address medically-legitimized pain, there is also a considerable portion of respondents who report using prescription pain-killers for other than their intended reasons. Veterans and active duty military personnel appear at greater risk for prescription pain-killer use as do binge drinkers. Females share their prescription meds more frequently than males but also are more likely to store their prescription pain medications securely. Use of prescription pain meds appears to increase gradually with age with the exception of 18 to 20 year olds who report more use than 21 to 39 year olds. Whether this is due to legitimate reasons, such as sports injuries or dental work, common in adolescence or to recreational or other misuse/abuse is unknown. Younger adults are more likely to have insurance coverage as well (through school or parents) that will allow for such prescriptions. We examined the prevalence of self-reported prescription pain-killer use to get high among the high school 2011 YRRS sample to see if it was at least similar to our estimate among 18 to 20 year olds. The 2011 NM YRRS estimate for past 30-day prescription drug use to get high was 11.3% compared with 15% among 18-20 year olds in the 2012 NMCS. Unlike the YRRS, the NMCS does not ask respondents whether they used the pain-killers for the purpose of getting high in the same question about current use. Yet, given the prevalence of misuse in high school students, it is likely not all use among 18 to 20 year olds in the 2012 NMCS is for legitimate medical reasons.

These estimates serve only as a baseline because this is the first time they have been asked on the NMCS. We have no trend data to examine prescription pain-killer use among adults in NM at this time. Given the capacity built among NM preventionists in addressing retail and social access to tobacco products and alcohol, also “legal” drugs, access to prescription pain medication may be an effective place to introduce and focus prevention efforts.

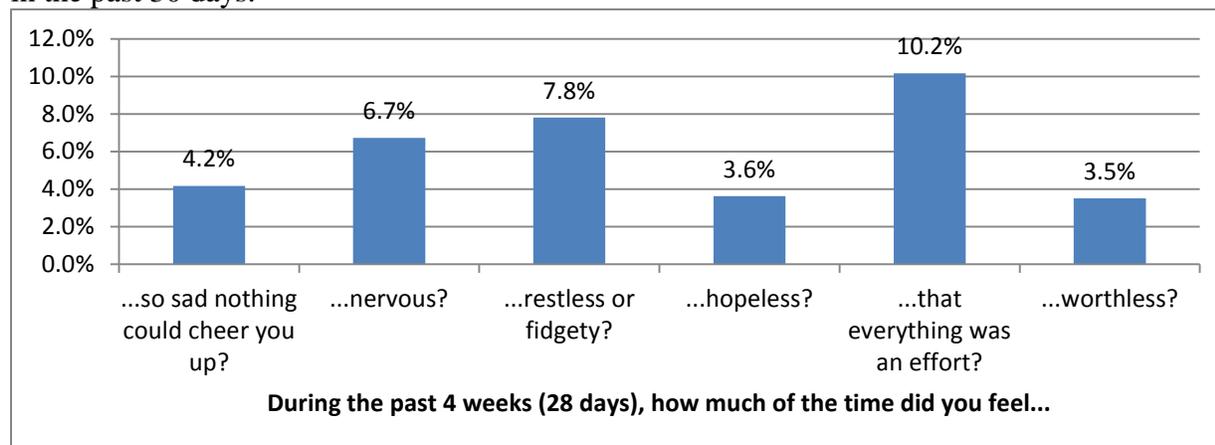
Mental Health

In order to provide additional needs assessment data to the NM Behavioral Health Department, the 2012 NMCS included measures of mental health. Twelve questions were asked of respondents to ascertain various degrees of mental health problems.

Six of the questions were selected from the World Health Organization’s (WHO) World Mental Health Surveys (WMHS). They are also included on the U.S. National Health Interview Survey

(NHIS), self-administered version.¹ Each question begins with the stem, “During the past 4 weeks (28 days) how much of the time did you feel...” followed by six different endings. Respondents replied on a 5-point scale (0-4) from none of the time to all of the time. Figure 27 shows the prevalence of respondents who responded either “all of the time” or “most of the time” for each item. There was a fairly low prevalence of respondents indicating they felt poorly all or most of the time for the six indicators. The item “...feeling that everything was an effort” stands out as relatively high compared with the other measures. A total score across the six items of 13 or more suggests the presence of a serious mental illness (SMI - such as major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder, panic disorder, post-traumatic stress disorder (PTSD) and borderline personality disorder). As a symptom screening tool, the scale does not actually diagnose or identify those respondents who may currently be successfully treated for a serious mental illness. Just over 4% reported a total score of 13 or greater indicating the presence of a SMI, which coincides closely with the estimated 5-8% of the population the WMHS is designed to identify. The alpha coefficient for this scale was $\alpha = .88$, a respectable score of reliability.

Figure 27: The percent of respondents who reported they felt the following all or most of the time in the past 30 days.



Using a question similar to one found on the NM BRFSS, respondents were asked to report the number of days during the past 30 days that his/her mental health, emotions or nerves were “not good”. Interestingly, a large percentage of respondents (13%) chose not to answer this question. This may have something to do with how the question was asked or interpreted when on a written survey versus a phone survey. The terminology “not good” may be too vague for respondents to

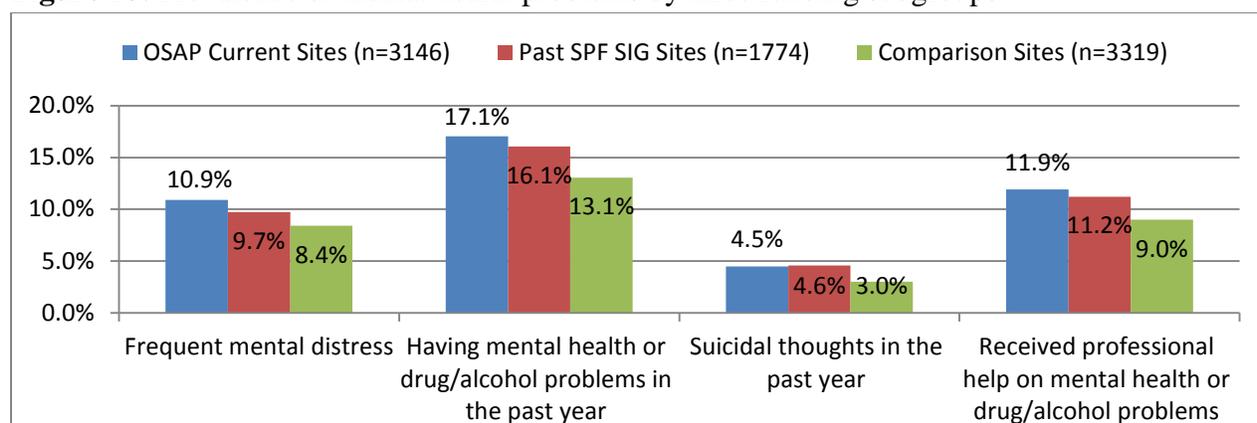
¹ Kessler, R.C., Barker, P.R., Colpe, L.J., Epstein, J.F., Gfroerer, J.C., Hiripi, E., Howes, M.J, Normand, S-L.T., Manderscheid, R.W., Walters, E.E., Zaslavsky, A.M. (2003). Screening for serious mental illness in the general population. *Archives of General Psychiatry*. 60(2), 184-189.

know how best to respond, and the phrase “mental health” can have a wide variety of interpretations in New Mexico, where there is often social stigma attached to the phrase. Finally, choosing the number of days adds an additional challenge to answering the question. Regardless, it is clear this question in particular was answered far less than other questions on the survey.

Mental health by prevention funding subgroup

Figure 28 below provides a breakdown of prevalence for four measures of mental health by funding subgroup. For the first item, poor mental health, also referred to as frequent mental distress (FMD), was defined as 14 or more days where mental health was “not good.” Comparison communities always reported a lower prevalence of mental health problems than respondents in either currently OSAP funded communities or in previous SPF SIG communities. A surprising 17.1% of respondents in OSAP communities indicated they had experienced a mental health, drug or alcohol problem in the past year as compared to 13.1% among respondents in comparison communities. On the positive side, however, a larger percentage of respondents in currently-funded OSAP communities also received help from a health care professional. With one exception, mental health would appear to be slightly worse in OSAP communities, followed by previous SPF SIG communities, and finally comparison communities. There were no hypotheses made about how mental health problems would be distributed by community funding type given that mental health has not been a focus of OSAP funded prevention programs. Differences in mental health may reflect that OSAP-funded communities and previous SPF SIG communities were initially selected because of high need particularly for alcohol-related risk behaviors. To the extent that problem drinking is also associated with poor mental health, this may help explain the mental health relationships between the funding categories.

Figure 28: Prevalence of mental health problems by three funding subgroups.

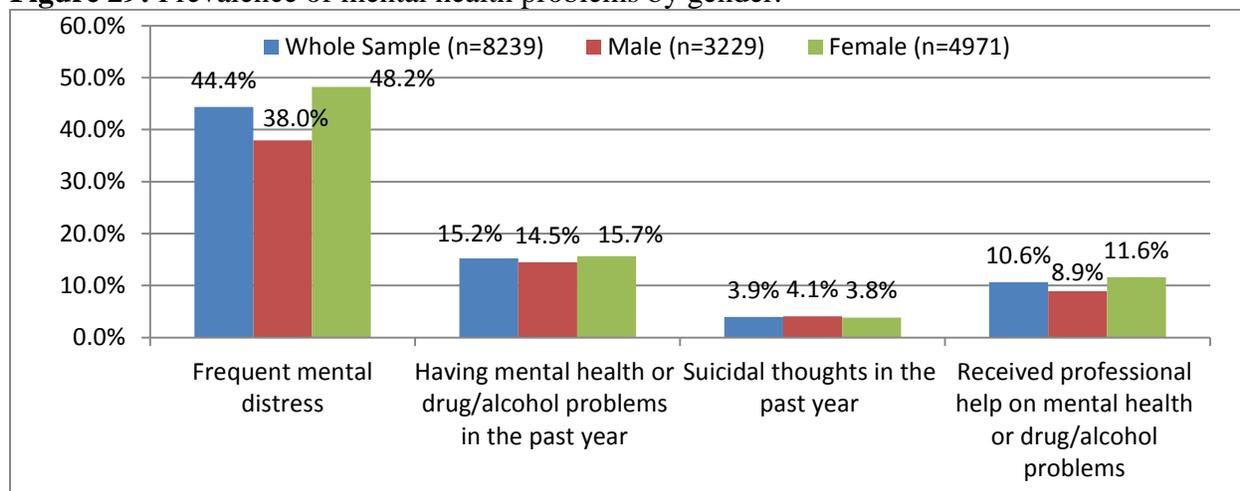


*Frequent mental distress is defined as 14 or more days when mental health was “not good”.

Mental health by gender

Gender differences in mental health measures are typically found in the research literature; females generally report more internal mental health problems such as depression and anxiety whereas males more often report externalized mental health problems such as engaging in risk behaviors such as substance use, DWI, or aggression. Not surprisingly, females more often reported experiencing 14 or more days of poor mental health or FMD compared to males. Interestingly however, other gender differences were minimal at best and in the case of suicidal ideation, males were slightly higher than females. This difference is of concern since males are more often successful at committing suicide than females because the methods typically used by males are more fatal. Figure 29 displays the differences in prevalence by gender compared to the whole sample.

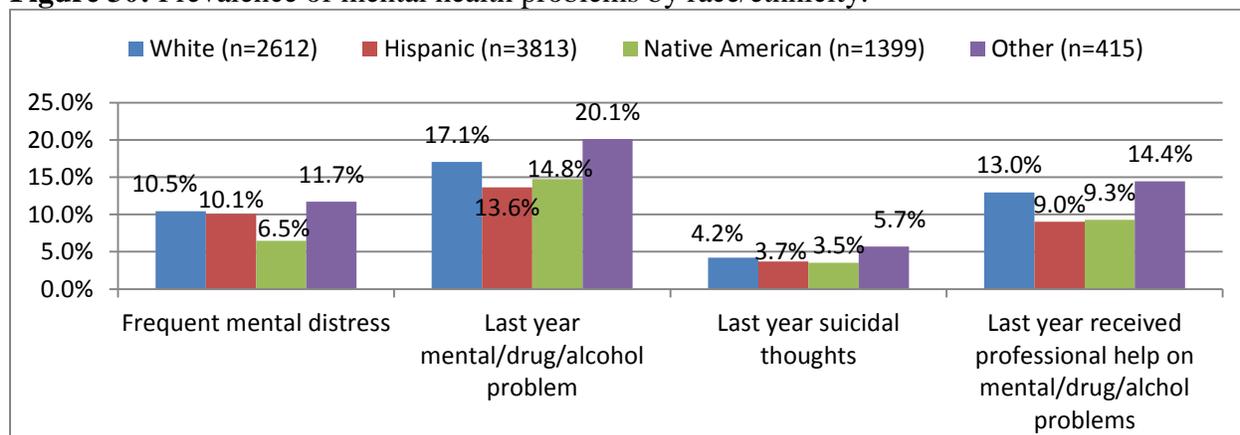
Figure 29: Prevalence of mental health problems by gender.



*Frequent mental distress is defined as 14 or more days when mental health was “not good”.

Mental health by race/ethnicity

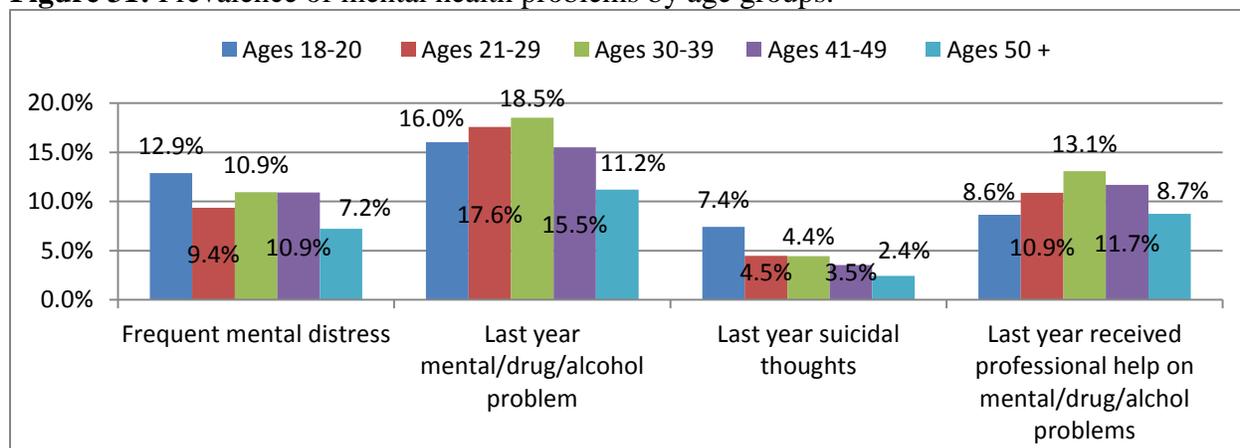
Mental health varied by race/ethnicity. Other race/ethnicities, including African Americans/blacks, and Asian/Pacific Islanders, reported the highest prevalence of FMD, past mental health, drug, or alcohol problems, and suicidal ideation, but also report a higher prevalence of receiving professional help to address the problem(s). Compared to Hispanics and Native Americans, non-Hispanic whites report a higher prevalence of a mental health, drug, or alcohol problem in the past year and receiving professional help for the problem. Non-Hispanic whites are only slightly more likely to report FMD in the past 30 days compared with Hispanics. Native Americans were least likely to report FMD in the past 30 days. Non-Hispanic whites, Hispanics, and Native Americans differed only slightly on their prevalence of suicidal ideation. Hispanics and Native Americans were least likely to have received professional health for their mental health problems. See Figure 30.

Figure 30: Prevalence of mental health problems by race/ethnicity.

*Frequent mental distress is defined as 14 or more days when mental health was “not good”.

Mental health by age groups

Mental health risk changes over the lifespan. Many adolescents experience depression and suicidal ideation during high school that resolves as they age. At the same time, unaddressed mental health or substance abuse issues in adolescence can deepen into more severe mental illness and/or addiction in adulthood. Figure 31 compares the five age groupings on the mental health measures. Compared to all other age groups, 18 to 20 year olds report the highest prevalence of frequent mental distress in the past 30 days and of suicidal ideation in the past year. They were also least likely to receive professional help for their mental health problems. Past-year mental health, drug, or alcohol problems were most prevalent among 30 to 39 year olds, but were surprisingly prevalent across all age groups. Those 50 and older reported a lower prevalence of mental health problems compared to the other ages, yet still reported a considerable prevalence of FMD in the past 30 days and mental health problems in the past year. Along with 18 to 20 year olds, mature adults are less likely to have received professional help for mental health problems.

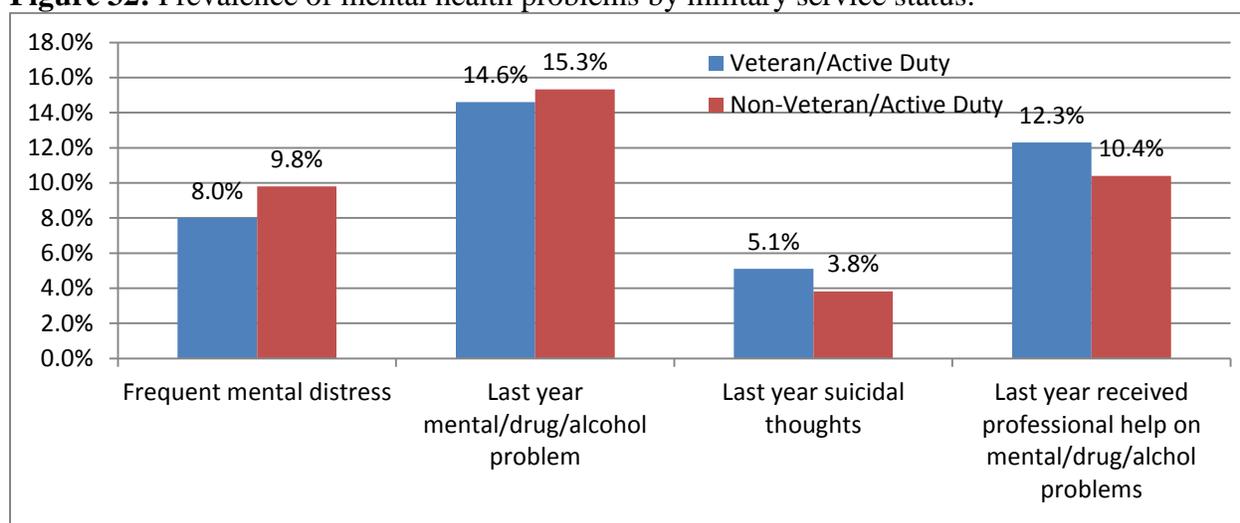
Figure 31: Prevalence of mental health problems by age groups.

*Frequent mental distress is defined as 14 or more days when mental health was “not good”.

Military service and mental health

When examining mental health status among those who were veterans or are active duty military personnel, we found a lower prevalence among those in the military among with respect to past 30 day frequent mental distress and in mental health, drug, or alcohol problems in the past year. On the other hand, current or prior military personnel were slightly more likely to report suicidal ideation and receiving professional help than non-military respondents. Overall, differences were smaller than anticipated. Figure 32 below compares former and current military personnel with civilians.

Figure 32: Prevalence of mental health problems by military service status.



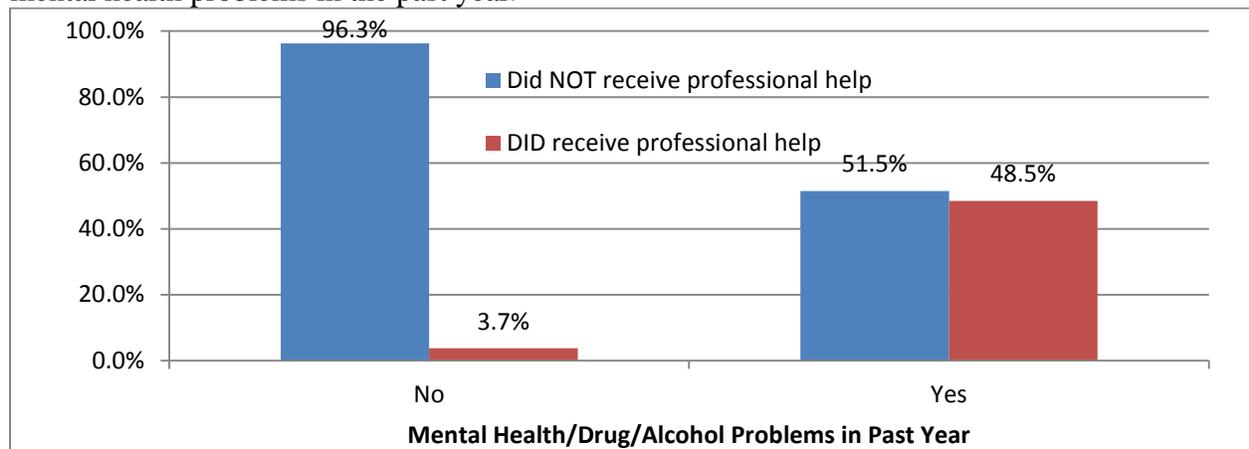
*Frequent mental distress is defined as 14 or more days when mental health was “not good”.

Mental health and access to care

Across the whole sample, among those who reported a mental health, drug or alcohol problem in the past year, just over half did not access any professional help² for their problem. Almost 4% who did not indicate a mental health, drug or alcohol problem in the past year reported receiving professional help for a mental health problem although as expected most did not. This suggests that only about half of those needing professional mental health assistance are receiving it. Figure 33 displays this association between mental health problems and receiving professional care.

² Note that “professional help” included private and public behavioral health agencies, as well as 12-step, faith based and alternative kinds of help that licensed service providers may not consider “professional.” The intent was to determine whether individuals were looking for outside help, rather than turning to friends, family or the internet for example. This definition also acknowledges that many of these non-licensed kinds of providers do consider their help to be professional.

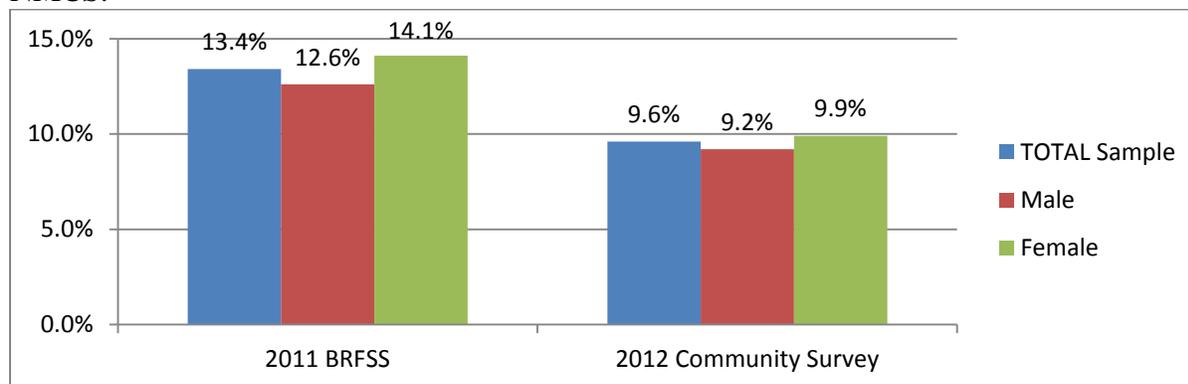
Figure 33: Prevalence of receiving professional help dependent on whether one has experienced mental health problems in the past year.



Comparison of 2012 NMCS and NM-BRFSS

When 2012 NMCS mental health data are compared with 2010 BRFSS measure for past 30-day mental health, the BRFSS reports a higher prevalence of respondents with Frequent Mental Distress (FMD) in the past 30 days. See Figure 34. The higher prevalence of FMD found among the BRFSS sample may have much to do with the question itself and how it is interpreted on a written survey versus on a phone survey. As previously mentioned, over 1000 respondents on the 2012 NMCS did not respond to this question. We examined whether these non-respondents might differ on other mental health indicators from those who did respond. Interestingly, when we examined the data for this possibility, we found that that these non-respondents were less likely to report mental health problems on all other mental health indicators compared to the rest of the sample. (Results not shown.)

Figure 34: Prevalence of frequent mental distress in past 30 days in 2010 NM BRFSS and 2012 NMCS.

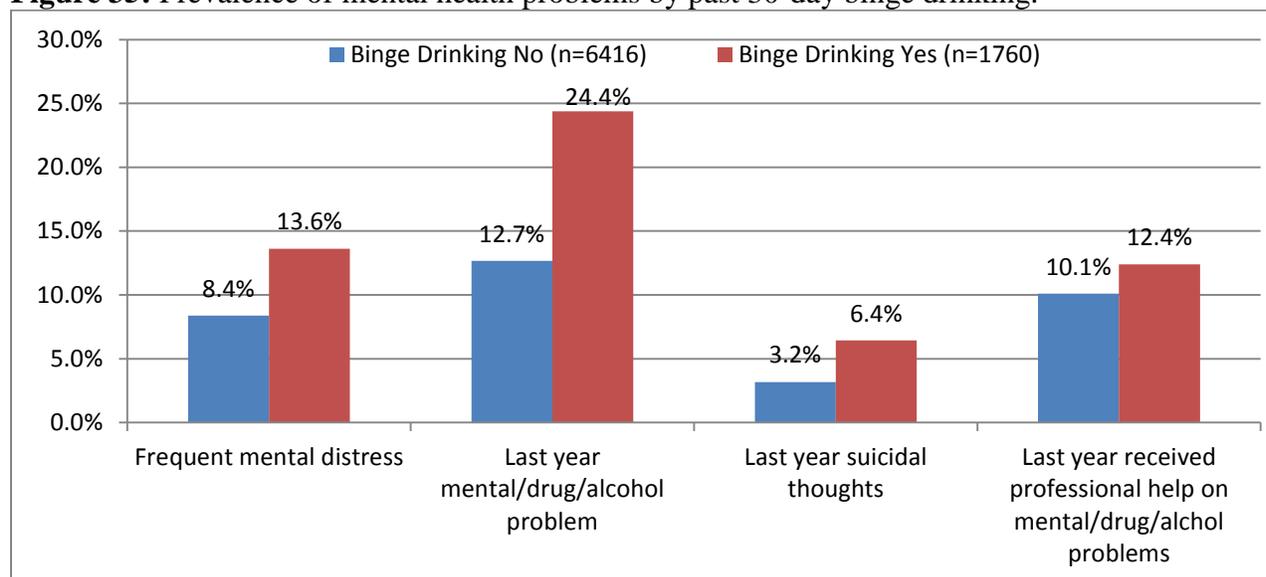


*Frequent mental distress is defined as 14 or more days when mental health was “not good”.

Binge drinking and mental health

Mental health is known to be correlated with substance use; therefore, we examined the mental health measures by whether respondents were current binge drinkers or not. Not surprisingly, binge drinkers reported a much greater prevalence of frequent mental distress in the past 30 days, mental health, drug, or alcohol problems in the past year, suicidal ideation in the past year, and greater use of professional mental health services, although this last distinction was not as outstanding as the others. (See Figure 35.)

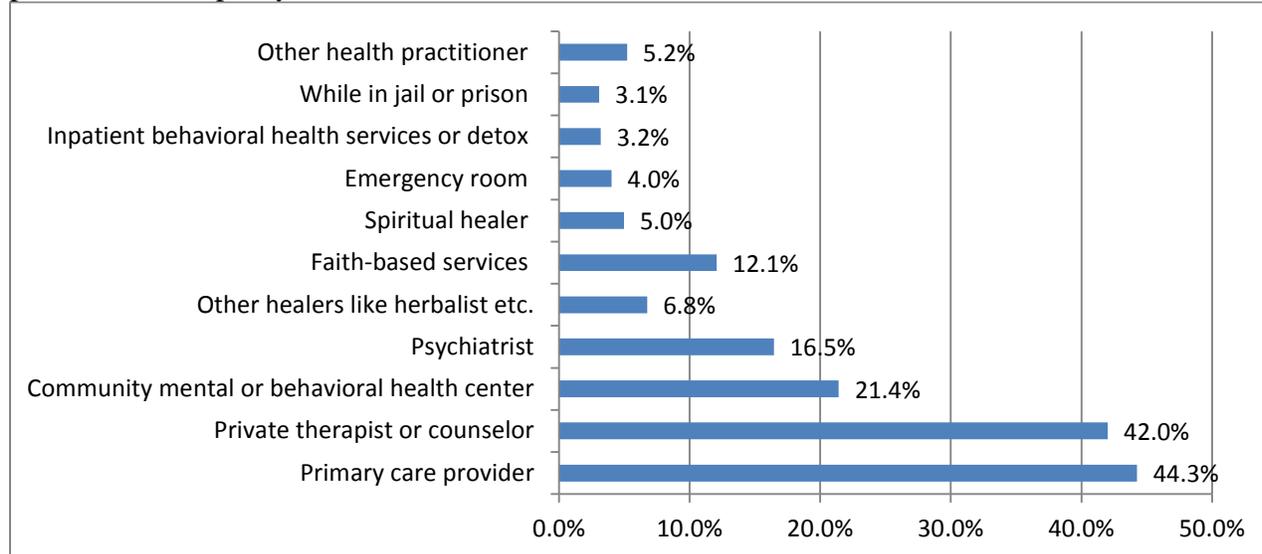
Figure 35: Prevalence of mental health problems by past 30-day binge drinking.



Sources and types of mental health treatment

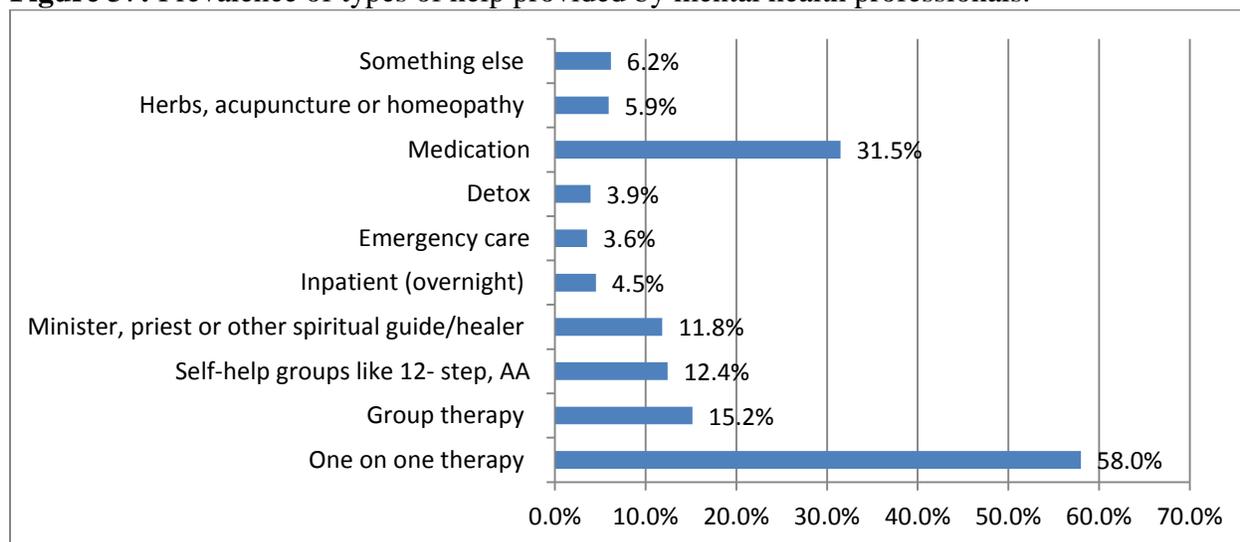
Those respondents who indicated having received professional help in the past year were asked two additional questions about where and what kind of help they received. Respondents selected all responses that applied to them. Just over 44% reported going to their primary care provider for help. Alternatively 42% saw a private therapist or counselor. Far fewer, although still a lot, went to a community mental or behavioral health center (21.4%), and 16.5% reported they saw a psychiatrist. The use of faith-based services was also relatively prevalent. Alternative approaches, including healers and spiritualists, were least prevalent overall. A small minority indicated receiving services while in jail or in an in-patient setting. Respondents could have accessed multiple sources for treatment. Figure 36 breaks down the various responses provided by respondents.

Figure 36: Prevalence of where respondents went to receive professional help for mental health problems in the past year.



Respondents were also asked to identify the “type” of help received such as individual or group counseling, medications, or other types. One-on-one therapy was by far the most prevalent form of treatment received followed by medication. This suggests many may be receiving what is considered best practice in the treatment of mental health problems, a combination of therapy with medication. Group therapy, self-help/12-step programs, and faith based services were also used with some frequency. Figure 37 provides a breakdown of various types of help received for mental health problems.

Figure 37: Prevalence of types of help provided by mental health professionals.



Summary

In 2012, the NMCS included questions about mental health for the first time. These questions provide a baseline for mental health in NM. Mental health varies by county although the reasons for that variation are not clear. It may be related to variations in substance use/abuse such that greater mental health problems occur with greater alcohol and substance use and/or it may be related to lower access to mental health and drug prevention/treatment services. Differences by gender as well as veteran status are surprisingly minimal whereas there is greater discrimination by race/ethnicity and age. Young adults 18 to 29 and 30 to 39 year-olds seem to be most at risk for mental health problems. Respondents who fell into the “other” category for race/ethnicity such as African American or Asian/Pacific Islanders, experienced the highest prevalence of mental health problems compared to all other race/ethnicity categories. Native Americans and Hispanics are least likely to have accessed professional mental health services in the past year. Almost half of those respondents indicating they had experienced a mental health, drug, or alcohol related problem in the past year also received professional help, leaving half with untreated mental health or addiction problems. As with prescription pain-killer use, binge drinking is associated with greater mental health and/or addiction problems. Estimates of mental health in the 2012 NMCS differ from estimates from the 2011 NM BRFSS, a phone survey. The methods by which the survey was administered likely plays a role in these differences. The one mental health question that was asked on both surveys and allowed us to make superficial comparisons between the two surveys had many missing responses on the NMCS, which may also explain the lower prevalence found in our 2012 sample.

County Level Estimates

In 2012 there was a sufficient sample size to acquire county-level estimates for most of the counties in NM and 3 major metropolitan areas in the state.³ The over-sampling of Native Americans also allowed us to look at estimates among the Native American communities separate from other racial ethnic groups.

Tables 38 and 39 provide the prevalence estimates by counties where data were collected, three major metropolitan areas, and Native Americans. Table 38 shows substance use estimates while Table 39 shows prescription pain-killer use and mental health estimates. When interpreting these estimates, it is important to note that the sample size within each community varies considerably. Four counties were combined so as to have a large enough sample to size to reliably report estimates. In particular, estimates for the past 30-day mental health measure are problematic given that such a high percentage of respondents did not answer the question. In looking at the tables, one can see significant variation of prevalence estimates among the geographic areas across the state. Explanations for these variances remain to be discovered.

³ For the county level estimates, data from Eddy, Lea, Roosevelt, and Curry Counties were combined because of the small sample sizes from each.

Table 3: Percent of respondents reporting positively to questions on tobacco & alcohol use by “community” (defined by the geographic area where respondent lives).

Community	Past 30 day cigarette use	Past 30 day tobacco use	Past 30-day alcohol use	Past 30-day binge drinking	Past 30-day drinking & driving	Past 30-day binge drinking & driving	Past year purchased/provided alcohol for someone under 21	Total N
Bernalillo	28.0	4.3	44.6	22.8	5.2	5.7	5.2	729
Catron	24.8	5.6	37.7	11.2	1.0	2.3	1.6	306
Chaves	22.4	3.2	42.0	22.1	5.5	7.7	3.2	525
Cibola	23.6	4.7	34.9	17.7	3.3	4.2	1.5	218
Colfax	37.4	21.3	51.3	24.3	12.8	10.7	4.6	302
Doña Ana	23.3	2.5	48.1	27.1	11.6	8.7	9.1	478
Eddy_Lea_Curry_Roosevelt	21.4	4.3	51.9	22.7	8.2	6.0	8.4	235
Grant	24.4	5.4	44.6	14.5	2.6	4.3	3.8	353
Guadalupe	19.7	4.5	48.6	22.9	4.3	4.3	3.7	143
Hidalgo	35.1	9.2	45.7	35.6	12.3	7.6	4.3	291
Lincoln	20.0	5.2	52.9	14.1	2.1	2.7	0.0	193
Luna	32.0	10.2	37.7	24.6	9.9	9.0	5.0	328
McKinley	22.5	8.8	28.0	20.3	6.0	4.6	4.4	351
Mora	25.4	7.3	34.4	15.6	3.3	3.3	1.4	154
Otero	29.9	11.6	38.7	21.2	0.5	3.2	1.9	224
Rio Arriba	26.1	7.3	37.2	18.7	4.6	5.4	2.2	373
San Juan	18.8	5.8	42.6	19.2	3.6	4.4	3.7	448
San Miguel	33.9	8.7	59.8	36.0	11.1	10.5	14.5	190
Sandoval	17.3	3.2	46.8	17.3	1.1	2.1	2.6	284
Santa Fe	27.7	5.6	45.5	18.5	5.7	5.4	3.8	334
Taos	31.0	5.1	49.5	22.0	7.4	8.1	3.8	313
Torrance	31.4	6.7	32.2	12.6	2.9	2.9	3.6	241
Union	35.5	20.1	44.0	25.5	18.0	15.5	4.4	158
Valencia	38.6	13.6	55.7	28.8	12.1	9.9	10.9	283
South Valley	31.4	5.9	40.0	26.7	8.9	6.9	5.1	102
Albuquerque	30.8	5.3	47.2	22.2	4.8	5.6	6.1	415
Las Cruces	26.5	1.4	56.3	29.4	12.6	7.9	12.2	215
Native American	26.7	3.6	30.4	21.2	5.3	6.9	2.3	776

Table 4: Percent of respondents reporting positively to Rx drug use and mental health questions by “community” (defined by the geographic area where respondent lives).

County	Past year prescribed painkillers by a medical professional for a medical problem		Past 30 days use prescription pain killers for any reason		Past 30-day bad health		Past year had mental health/drug/alcohol problem		Past 12 months suicidal thoughts		Past year receive professional help for mental health/alcohol/drug problems		Total N
	Yes	n	Yes	n	Yes	n	Yes	n	Yes	n	Yes	n	
Bernalillo	23.0	701	16.0	702	9.8	635	17.1	707	2.8	708	11.2	703	729
Catron	26.1	306	11.8	306	7.8	306	13.4	306	3.6	306	6.5	306	306
Chaves	27.5	498	15.3	497	11.9	462	20.5	512	5.9	512	12.6	508	525
Cibola	20.9	196	16.2	197	7.7	181	16.4	201	5.5	200	11.0	200	218
Colfax	36.4	294	25.3	297	21.0	157	10.9	293	5.8	293	8.0	289	302
Doña Ana	26.9	458	15.6	462	6.2	435	8.5	469	2.4	468	6.3	463	478
Eddy_Lea_Curry_Roosevelt	32.6	230	14.4	229	11.5	218	18.1	232	3.0	233	12.5	232	235
Grant	25.0	352	15.6	352	15.9	352	23.3	352	4.8	352	19.3	352	353
Guadalupe	21.5	135	9.7	134	2.3	129	13.2	136	1.5	137	6.6	137	143
Hidalgo	26.3	285	18.0	284	13.6	257	15.7	286	5.2	288	12.3	285	291
Lincoln	26.7	180	13.3	181	6.8	191	11.1	189	1.6	190	9.5	190	193
Luna	23.7	316	17.0	317	7.5	280	14.6	322	4.3	323	11.8	322	328
McKinley	14.9	350	10.0	351	5.2	348	13.1	350	5.1	351	9.4	351	351
Mora	25.0	140	16.2	142	9.8	143	8.1	149	4.0	149	7.4	148	154
Otero	15.1	219	12.4	217	6.7	223	10.0	221	3.2	221	8.1	221	224
Rio Arriba	22.2	360	10.6	360	10.3	331	11.0	365	3.3	366	8.1	359	373
San Juan	29.0	438	16.0	437	10.8	415	26.5	442	6.4	441	17.6	431	448
San Miguel	18.7	187	14.4	188	9.7	185	15.5	187	5.3	188	11.2	187	190
Sandoval	28.0	275	16.1	273	7.3	207	12.2	278	0.7	278	11.5	270	284
Santa Fe	24.5	318	15.9	320	12.6	294	19.4	324	4.0	323	15.5	322	334
Taos	23.1	290	13.5	289	9.1	265	18.2	303	4.3	303	11.0	301	313
Torrance	29.4	228	17.0	229	8.8	182	10.6	226	1.8	227	6.9	219	241
Union	35.4	158	27.9	158	20.3	69	3.9	156	1.3	157	2.6	154	158
Valencia	24.4	275	19.3	274	14.1	191	13.7	278	7.2	277	9.1	275	283
South Valley	13.3	98	10.2	98	12.8	86	19.6	97	3.1	97	12.4	97	102
Albuquerque	25.3	400	17.3	400	9.7	361	18.2	406	3.5	406	11.2	401	415
Las Cruces	31.0	213	15.1	212	5.9	204	6.1	212	1.0	211	4.3	211	215
Native American	23.7	718	15.0	718	6.4	719	14.8	748	3.1	747	8.7	739	776
N		7907		7914		7175		8032		8038		7964	8320

Community Survey Conclusions

The 2012 New Mexico Community Survey surveyed over 9,000 New Mexicans on tobacco, alcohol, and prescription pain-killer usage and related risk behaviors, in addition to mental health status. In previous years, the NMCS focused solely on alcohol use, related risk behaviors, and contributing factors to these behaviors. New data on tobacco use, prescription pain-killer use, and mental health status among adults provide a better understanding on a community level and at the state level as to the broader prevention needs of the New Mexico population. These data will be tracked over time and be provided to state and local stakeholders to assist in prevention planning. The data should be used to inform the strategic direction and use of prevention funding and programming to target high need, high risk, and high population areas and to extend the reach of prevention services currently provided.

Longitudinal analysis of the alcohol indicators revealed some changes in undesirable directions. Perceptions of the risk of being caught and facing legal consequences for engaging in alcohol-related illegal behavior decreased between 2010 and 2012. Based on the SPF SIG logic model, the decrease in perception of risk may lead to future increases alcohol consumption particularly among minors and drinking and driving leading to more alcohol-related fatalities. During the NM SPF SIG, communities focused much of their efforts on preventing ARMVCFs by increasing the perception of risk of being caught drinking and driving. These findings suggest a negative impact from the withdrawal of SPF SIG resources both on a state and community level after the completion of the grant and a simultaneous cut in state funds in response to a funding crisis. SPF SIG initiatives used a coalition-based approach to pull together various entities to work on aligned goals. The immediate decrease in funding compromised both the scope of prevention activities as well as the coalition-based approach. Especially in the perception of risk questions, we saw disappointing declines, which are likely linked to the easing up of pressure upon law enforcement representatives to enforce the law in the absence of preventionists to do this. Capacity built in communities dissipated when individuals lost their positions for lack of funding, and when there was little motivation or support on the State level to continue to create a focused impact. State entities, long accustomed to silo-ed approaches, strapped for resources and experiencing a shift in government with new priorities, had not yet made coordinating efforts a priority. The SPE grant allowed prevention stakeholders to begin the planning process to create the coordination currently lacking in the State. The year-long planning process culminated in a 5-year strategic prevention plan identifying targeted goals and objectives and the process for achieving them.

Baseline estimates of tobacco and prescription pain-killer use and mental health status will allow for the tracking of progress towards targeted prevention goals over time. To our knowledge, the effectiveness of mental health prevention and efforts to increase access to treatment services has not been examined, but these data may help in that process. The capacity within treatment-focused state and local entities will need to be built in order to make the best use of these mental

health data as a tracking mechanism. These data can begin to inform that process should it be desired.

From these baseline data, we can see that regular cigarette use among adults in NM remains high. Considerable focus has been on reducing access to minors but prevention strategies and policies to address adult smoking need consideration. This may well be something that can be targeted through employer smoking cessation programs to reduce health insurance costs. Prescriptions for pain-killers are commonplace in NM, which in all likelihood leads to greater access to and misuse of these drugs by those for whom they were not prescribed. Respondents indicated sharing their pain-killers with others. Proper use and disposal of prescription drugs needs to be addressed in addition to the wide-spread over-prescription of pain-killers. Veterans and respondents on active duty with the armed forces report receiving more prescriptions for pain-killers and greater current use of pain-killers than civilians. A special effort needs to be made to identify and address these risk behaviors among this unique population. Approximately 4% of respondents were identified as having a serious mental illness. Not quite 10% reported experiencing frequent emotional distress in the past 30 days. The prevalence of respondents reporting a mental, drug, or alcohol problem in the past year ranged from 11.2% among adults 50 and older to 18.5% among 30-39 year-olds. Just about half of those who reported a mental, drug, or alcohol problem actually received any professional help for the problem. The prevalence of suicidal ideation in the past year is highest among 18 to 20 years at 7.4%. Current binge drinkers reported more mental health problems than non-current binge drinkers.

These results inform stakeholders about the task that lies ahead in the coming years. They help identify subpopulations that may need additional attention or special interventions, and stakeholders will need to identify how best address these needs. Prevention science has identified effective evidence-based prevention strategies for tobacco, alcohol, and other drugs. Research and evaluation of prevention programming continues to identify more to add to the existing arsenal. Two tasks in particular are essential so that efforts at every level are of the highest caliber: building state and local capacity to understand the science behind prevention, and working across state and local agencies in order to provide a comprehensive and effective prevention strategy.

Recommendations and plans for future community surveys

Fully two-thirds of the content on the 2012 NMCS was new, which means that there were some questions that were less discriminating than others. While presenting findings to stakeholders, suggestions were made on how to improve the survey for future years. These have included creating several questions that assess perceived stigma associated with mental illness, addiction and help seeking as barriers to accessing care. Stigma is a well-documented barrier to getting help, and such information will surely help any efforts to address the negative impacts of poor mental health. Other recommendations included adding a specific question of perceived ease of social access to alcohol for minors; revising the respondent age question to use age range categories; including a life satisfaction or quality of life question; assessing SES with a proxy measure of educational attainment; removing the question on frequent mental distress, adding a

query for access to informal social support for behavioral health issues and effectiveness of care, and adding in a measure(s) of sexual orientation. The survey is intended to be short enough so as not to be burdensome, therefore, the addition of questions to the community survey needs to be considered with much care to the survey respondents.

The timing of the survey will ideally be the same from year to year to allow for more confidence in comparing data longitudinally, which was not the case for the 2012 survey. Furthermore, it would further strengthen the confidence in the data findings if a mechanism were able to be created and maintained over time to capture a truly random sample of residents. One relatively simple way to do this would be through taking a random sample from the Motor Vehicle Department's database of registered drivers in the state. Preliminary discussion as to how this might be made possible has occurred although details have not yet been shared nor has an agreement been made at this time.