State of New Mexico OSAP Prevention Programs

Site Name & ID#: New Mexico

Community Survey Findings Sheet- 2019
All Modules

Prevention Goals and Objectives (only those referencing the NMCS)

Goal 1: Reduce underage drinking in New Mexico.

Objective 1a: Reduce social access to alcohol by minors by… (e.g. implementing PWHLTM; increasing party surveillance efforts, etc.)

Objective 1b: Reduce retail access to alcohol by minors by… (e.g., increasing SID checks of retailers and increasing retail education, server training, etc.)

Objective 1c: Increase perception of risk of being caught by …(e.g., increasing highly visible enforcement and monitoring efforts; using media to increase visibility, etc.)

Goal 2: Reduce binge drinking among adults in New Mexico.

Goal 3: Reduce drinking and driving among adults in New Mexico.

Objective 3.a: Increase perception of risk of being caught

Goal 4: Reduce prescription pain killer misuse and abuse among youth and adults in NM.

Objective 4.a: Reduce social access to prescription painkillers by … (increasing parents' self-reported locking up of painkillers; reducing parent sharing with others; increasing pharmacy direct education of patients; creating and implementing institutional policies so that medical providers increase their direct education of patients; by developing and disseminating a "provider guide" so that medical providers increase their direct education of patients, etc.)

Objective 4.b: Increase awareness of prescription painkiller harm & potential for addiction, and to increase awareness of dangers of sharing, how to store and dispose of prescription drugs safely by … (e.g., implementing a media campaign)

Brief Description of Community & Population:

New Mexico is a large, mostly rural state. Most of the population of the state lives in six relatively urban areas including Albuquerque, Las Cruces, Rio Rancho, Santa Fe, Roswell, and Farmington. There are 33 counties in NM. Five-year estimates from the US Census' American Community Survey indicate there were just over two million residents of NM who are 18 and older living in the state. Of those, just under half (49.5%) were male. Of the entire population,

49.1% were Hispanic, 37.1% were non-Hispanic white, 10.9% Native American or Alaskan Native representing at least 22 different tribes, while approximately 7% were African American/Black, Asian, or a combination of races. Approximately 27% have a college bachelor's degree and 85.0% have at least a high school degree. The median income is $46,718 and 19.7% of New Mexicans are living at or below the poverty line[1].

Data Collection Method and Brief Sample Description

Data Collection Approach # 1: Time and Venue-Based Convenience Sampling

The first approach taken to collect community-level data is a time and venue-based sampling strategy within OSAP funded communities. This convenience sampling approach has been used by OSAP funded communities since 2008 and involves communities creating community-specific data collection protocols that identify locations in the community where a representative sample of community residents frequent and times of day during which residents will be asked to participate in the survey. Communities are asked to attempt to replicate the protocol each year to create comparable samples of respondents, which can then be compared over time. Larger communities with active Motor Vehicle Departments are required by OSAP to collect data at the local MVD offices as one of multiple data collection locations. In smaller, rural, and tribal communities, prevention programs must identify locations or events that attract a representative sample of the community instead. If data collection occurs at an event, the event should occur annually, so that the data collection can be replicated.

Community data collection protocols are reviewed by members of the State Epidemiological Outcomes Workgroup (SEOW) to ensure that communities are likely to capture a reasonably representative sample of adults based on their protocols. Local community providers and local evaluators are instructed in appropriate data collection methodology and how to maintain respondents' confidentiality while completing the survey. While laborious and challenging for communities initially, over time, many prevention programs have come to regard it as imperative to improving the quality of the services they provide. Prevention communities are asked to track their data collection process in detail and submit a log of data collection activities with their end of year reports to the Office of Substance Abuse Prevention. The purpose of this is to compare what was originally proposed in the data collection protocol prior to data collection to how data collection actually occurred. In particular, communities would note particularly fruitful places to collect data for planning in future years.

A total of 5,108 surveys were collected using this methodology, which constitutes 42.3% of the aggregated sample. We are unable to calculate a response rate using this methodology.

Data Collection Approach # 2: On-line survey via Social Media Ads

To supplement the convenience sample, another data collection approach used in FY19 was the implementation of an on-line version of the survey. Recruitment ads were placed on Facebook

[1] All New Mexico demographic statistics from the U.S. Census https://www.census.gov/quickfacts/NM

and Instagram targeting NM residents who are 18 and older. This methodology was piloted in FY14 among 18 to 25-year olds and then implemented in FY15 - FY18 for all adult residents 18 and older. Ads were run on both Facebook and Instagram. Facebook uses an algorithm to determine the optimal placement for ads based primarily on the number of hits the ads received on either social media platform. Ads were created targeting young adults, parents, and elderly, and varied in format from storyboards, animated, and static photos. Eighteen ads (9 in English and 9 in Spanish) ran for a total of 9 weeks from February 24, 2019 to April 27, 2019.

Over the 9 weeks, the Facebook ads led to 431,914 impressions, reaching 94,664 people, 4,374 unique clicks on the survey link itself and 2,618 surveys completed, at the cost of approximately $1.91 per completed survey. This translates into a 2.8% response rate of people clicking on the survey link and 59.8% of those who clicked on the survey link actually completing the survey. Most of the eleven ads were shown on Facebook, with the exception of two that were shown more often on Instagram.

Weekly incentives were offered to randomly selected individuals who completed the survey. After completing the survey, respondents were invited to enter to win an incentive, however, this was optional and not all respondents chose to do so. Each week, three $100 checks were given away to randomly selected respondents who completed the survey that week. At the end of the online data collection, a final $500 check was given to one randomly selected respondent among all respondents who had not been selected to receive weekly cash prize.

Data Collection Approach # 3: Time and Venue-Based Data collection using Qualtrics App and iPads

Similar to Approach # 1 described above, communities could make use of the on-line survey and design their data collection protocol to reflect recruitment locations and strategies that would allow for and encourage potential respondents to complete the survey on-line. Elements of the time and venue-based recruitment strategies still applied but strategies could also include

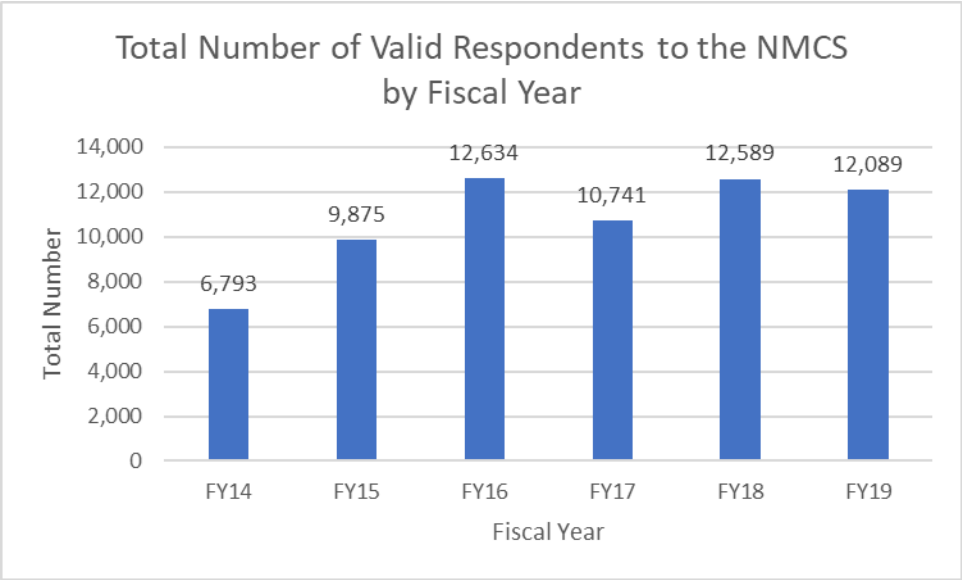
1- providing take-home QR-codes, so people could complete the survey on their smart phones at their convenience
2- providing tablets to complete the survey on-line while waiting (e.g., at the MVD)
3- providing direct links to the survey via mailings or emails

Most often this approach was combined with Approach #1, but some communities successfully collected data only using tablets, QR codes, and links to the survey. This approach most often appealed to communities with younger populations, but at least two of the more rural communities also successfully used these alternative approaches.

A total of 3,337 surveys were collected using the on-line survey via iPads, the on-line link or QR codes.

Total Combined Sample

In FY2019 a total of 12,089 completed questionnaires were collected compared with 12,589 in FY2018, 10,741 in FY17, 12,634 in FY16, 9875 in FY15, and 6,793 in FY14. All 33 counties were represented in the data, although five counties had very few respondents.



Analysis Approach

Prior to conducting the analyses, we weighted the data to match NM Census 2018 data regarding the distributions of gender, age, and race/ethnicity across the state so that our estimates more closely reflect a representative state sample. While this is ultimately a convenience sample, the intent behind weighting the overall sample is to reduce the overall influence of subpopulations that are typically over-represented in our sample (e.g., young adults, Native Americans, and women). In particular, the over-representation of young adults would inappropriately inflate our state-level substance use estimates. Univariate and bivariate analyses were conducted using SAS.

Results: Core Module

PLEASE NOTE: In this report, all N's (n's) provided are unweighted and reflect the actual sample, but the percentages are weighted to reflect the population of NM with respect to age, race/ethnicity and gender. In addition, the tables do not always contain the actual wording of the question. Please refer to the survey itself for precise language.

I. Demographic Characteristics

Descriptive statistics are provided for age, gender, race/ethnicity, education, New Mexico residency, military service and sexual orientation.

Table 1.1 Demographic characteristics of community

Number of eligible respondents	N= 12,089
Characteristics	%
Age	
18-20	5.3
21-25	8.9
26-30	9.0
31-40	16.6
41-50	14.6
51-60	16.4
61-70	15.6
71 or older	13.6
Gender	
Male	49.1
Female	50.9
Race/Ethnicity	
White	40.7
Hispanic	45.7
Native American	8.5
Other	5.1
Education level[1]	
Less than high school	5.8
High school or GED	21.9
Some college	25.5
College or above	31.1
Currently an undergraduate	15.8
New Mexico Residency	
Less than 1 year	4.0
1-5 years	10.3
More than 5 years	85.7
Active Duty in the Military Service or Veteran	7.5
Identify as LGBT	8.1
Parent/Caretaker of Someone under 21 living in the household	32.2
Past 30-day housing stable	96.3
Number of Spanish Paper Surveys[2]	857

[1] Education levels are mutually exclusive.

[2] Percentages are weighted, sample numbers are un-weighted,

II. Alcohol Outcomes and Intervening Variables

Response distributions are provided below for the alcohol-related intervening variables and outcomes. Percentages of dichotomized outcomes by age groups are provided as well.

Table 2.1. Means, ranges and percentages of alcohol use outcomes overall and by sex.

Outcomes	Overall			Men	Women
	% of Yes	Mean (SD)	Range	% of Yes	% of Yes
# of drinks a week (n=11,423)	NA	2.0 (0.06) drinks	0-100	NA	NA
Heavy drinkers[a] (n=11,424)	3.6	NA	NA	4.0	3.4
Past 30-day alcohol use (n=11,474)	46.7	NA	NA	51.1	42.7
Past 30-day binge drinking					
All respondents (n=11,388)	16.1	0.8 (0.03) times	0-89	19.8	12.8
Current users[b] only (n=5,263)	35.3	1.7 (0.07) times	0-89	39.2	31.0
Past 30-day driven under influence					
All respondents (n=11,518)	3.2	0.1 (0.01) times	0-89	4.4	2.1
Current users[b] only (n=5,208)	7.0	0.2 (0.02) times	0-89	8.6	5.0
Past 30-day driven after binge drinking					
All respondents (n=11,523)	2.7	NA	NA	3.8	1.6
Current users[b] only (n=5,211)	5.9	NA	NA	7.4	3.8

[a] Heavy drinkers are defined as more than 7 drinks in a week for women (approximately 1 drink a day) and more than 14 a week for men (approximately 2 drinks a day).

[b] Current users: anyone who has had alcoholic drink in the past 30 days.

Table 2.2 Percentages of alcohol use outcomes by age groups among all respondents.

Age Range	**Past 30-day alcohol use %**	**Past 30-day binge drinking %**	**Past 30-day driven under influence %**	**Past 30-day driven after binge drinking %**
18-25	53.3	23.8	4.7	4.3
18-20	38.6	17.3	3.0	3.6
21-25	62.0	27.6	5.7	4.7
26-30	56.3	23.9	7.0	5.1
31-40	53.4	20.9	4.8	4.0
41-50	48.1	17.3	3.3	2.9
51-60	43.7	14.9	2.0	1.2
61-70	40.2	9.5	1.6	1.7
71+	34.3	5.5	0.7	0.8

Table 2.3 Perceptions of risk/legal consequences of alcohol consumption (Total Sample).

Perception of risk/legal consequences	%				
	Very likely	**Somewhat likely**	**Not very likely**	**Not at all likely**	**Don't know**
Likelihood of police breaking up parties where teens are drinking	18.1	30.0	21.4	7.6	23.0
Likelihood of police arresting an adult for giving alcohol to someone under 21	26.3	25.9	18.8	7.4	21.6
Likelihood of being stopped by police if driving after drinking too much	30.0	33.8	19.1	5.0	12.1
	Strongly disagree	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly agree**
Problems due to drinking hurts community financially	11.4	5.4	15.1	37.4	30.8
Access to alcohol	**Very easy**	**Somewhat easy**	**Somewhat difficult**	**Very difficult**	**Don't know**
Ease of access to alcohol by teens in the community	42.3	31.5	8.5	2.8	14.9
Ease of access to alcohol by teens in the community from stores and restaurants	8.9	22.1	29.9	19.2	19.9
Social Access	**Total**	**Men**	**Women**		
Provided alcohol for minors in past year	2.4	2.8	1.9		

Table 2.4 Percentages of perceived risk/legal consequences of alcohol consumption by age groups.

Access to Alcohol	Age groups (%)								
	18-20	**21-25**	**18-25**	**26-30**	**31-40**	**41-50**	**51-60**	**61-70**	**71 +**
Very or somewhat difficult for teens to access to alcohol in the community	10.3	11.8	11.3	14.7	13.5	16.5	14.8	11.8	10.3
Very or somewhat difficult for teens to access to alcohol from stores and restaurants	64.7	68.8	67.3	64.4	63.9	63.5	62.3	57.5	49.2
Purchasing and/or sharing of alcohol with a minor over past year (Yes)	4.6	7.5	6.4	3.9	2.0	1.7	2.1	0.5	0.8
Permissive Attitudes to providing alcohol to minors	**18-20**	**21-25**	**18-25**	**26-30**	**31-40**	**41-50**	**51-60**	**61-70**	**71 +**
Never okay to provide alcohol to minors.	32.9	46.3	41.3	59.3	69.2	71.2	72.6	69.9	68.4
Perception of risk/legal consequences (alcohol)	**18-20**	**21-25**	**18-25**	**26-30**	**31-40**	**41-50**	**51-60**	**61-70**	**71 +**
Very or somewhat likely for police to break up parties where teens are drinking	63.2	62.5	62.8	59.3	60.4	63.7	60.5	68.0	60.7
Very or somewhat likely for police to arrest an adult for giving alcohol to someone under 21	61.2	65.6	64.0	61.7	63.8	68.2	68.1	71.9	66.6
Very or somewhat likely being stopped by police if driving after drinking too much	74.0	70.9	71.0	69.7	71.3	74.1	74.3	72.8	72.7
Agree or strongly agree that problems due to drinking hurts community financially	55.8	59.1	57.9	67.1	63.5	66.6	71.5	74.1	76.5

Figure 2.1. Sources of obtaining alcohol for respondents 18-20 years old who reported drinking alcohol in the past 30 days. (n=441)

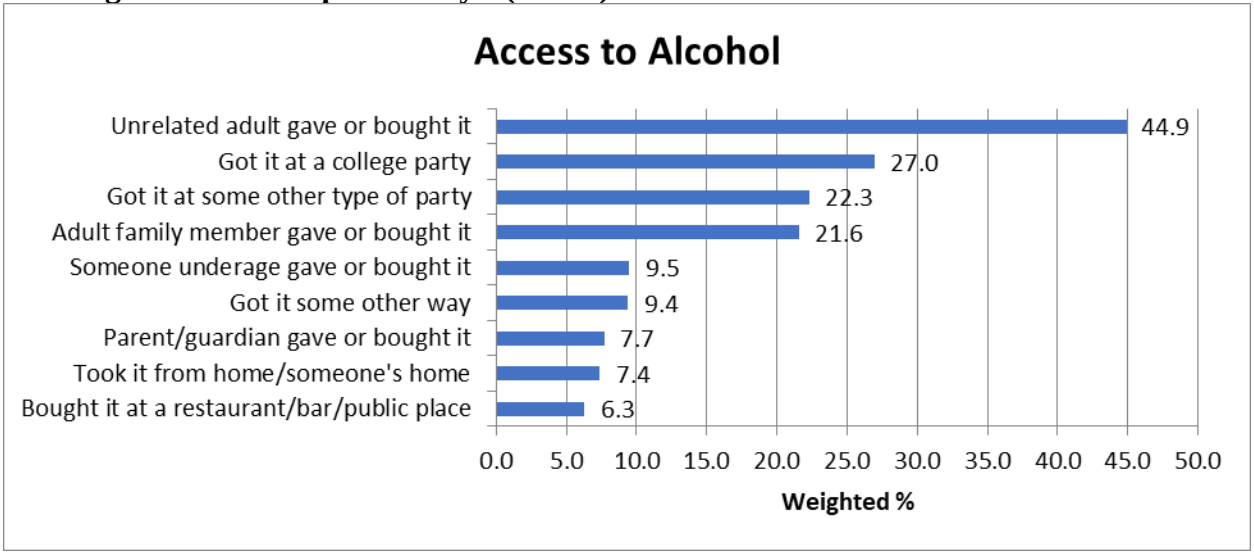
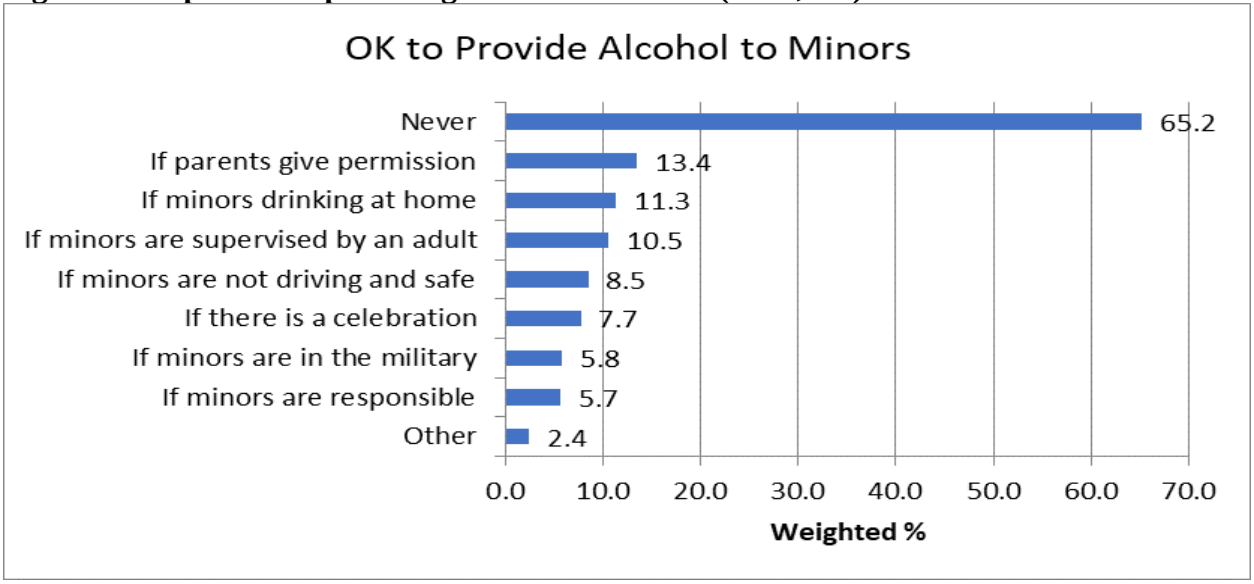


Figure 2.2. Opinions of providing alcohol to minors. (n=12,089)



III. Prescription Painkiller Outcomes and Intervening Variables

Distributions of each response category are provided below for the prescription painkiller-related intervening variables and outcomes. Percentages of dichotomized outcomes by age groups are provided as well.

Table 3.1. Means and percentages of prescription drug use outcomes overall and by sex.

Outcomes	%			
	Overall		Men	Women
	% of Yes	Mean (Std Error)	% of Yes	% of Yes
Prevalence of receiving Rx painkiller past year (n=11,582)	24.1	NA	22.8	25.5
Past 30-day Rx painkiller use for any reason (n=11,417)	11.1	10.1 (0.4) days (current users[a] only)	10.3	12.0
Past 30-day painkiller use to get high				
All respondents (n=11,481)	2.4		2.7	2.0
Current users* only (n=1,210)	21.4		27.1	16.8

Note. Ns are for overall estimates only.

*Current users: anyone who has used Rx painkillers in the past 30 days.

Table 3.2 Access to naloxone

Outcomes	% of Yes	Don't Know
When having been prescribed painkillers last year…		
Were prescribed naloxone as well (n=2,708)	5.6	6.7
Talked about risks in using Rx painkillers by …		
Healthcare provider (n=2,742)	50.8	NA
Pharmacy staff (n=2,742)	32.0	NA
Talked about storing Rx painkillers safely by…		
Healthcare provider (n=2,742)	33.2	NA
Pharmacy staff (n=2,742)	24.6	NA
Have access to naloxone when having used painkillers in the past 30 days (n=564)	12.5	NA

Table 3.3. Percentages of prescription drug use outcomes by age groups among all respondents.

Ages	Prevalence of receiving Rx painkiller past year	Past 30-day Rx painkiller use for any reason	Past 30-day Rx painkiller use to get high
18-25	17.8	7.7	2.2
26-30	19.7	9.7	3.2
31-40	22.8	9.7	2.9
41-50	24.1	10.8	2.0
51-60	27.1	12.8	2.1
61-70	29.6	13.3	1.9
71 +	25.3	13.1	2.4

Table 3.4 Estimates for prescription painkiller intervening variables.

Risk of Harm	%			
	No risk	Slight risk	Moderate Risk	Great risk
Perceived risk of harm with misusing Rx painkillers (n=11,282)	6.0	9.1	24.9	60.0
Social Access	**Yes**	**No**		
Giving or sharing Rx painkillers in past year (n=11,284)	5.1	94.9		
Rx painkillers stored in locked box or cabinet* (n=4,476)	41.5	58.5		

*We exclude respondents who indicate they have no prescription painkillers from this estimate.

Table 3.5. Estimates (percentages) for prescription painkiller intervening variables by age groups.

Risk of Harm	Age Range						
	18-25	26-30	31-40	41-50	51-60	61-70	71 +
Perceived moderate or great risk of harm with misusing Rx painkillers	80.1	81.2	83.2	81.8	87.3	88.9	90.6
Social Access	**18-25**	**26-30**	**31-40**	**41-50**	**51-60**	**61-70**	**71 +**
Giving or sharing Rx painkillers in past year	5.7	6.0	5.6	6.2	4.8	5.0	2.8
Rx painkillers stored in locked box or cabinet*	41.9	44.8	44.8	42.7	37.7	39.5	40.7

*Excluding respondents who indicate they have no prescription painkillers from this estimate.

Figure 3.1. Reasons for prescription painkillers use among current users. (n=1,222)

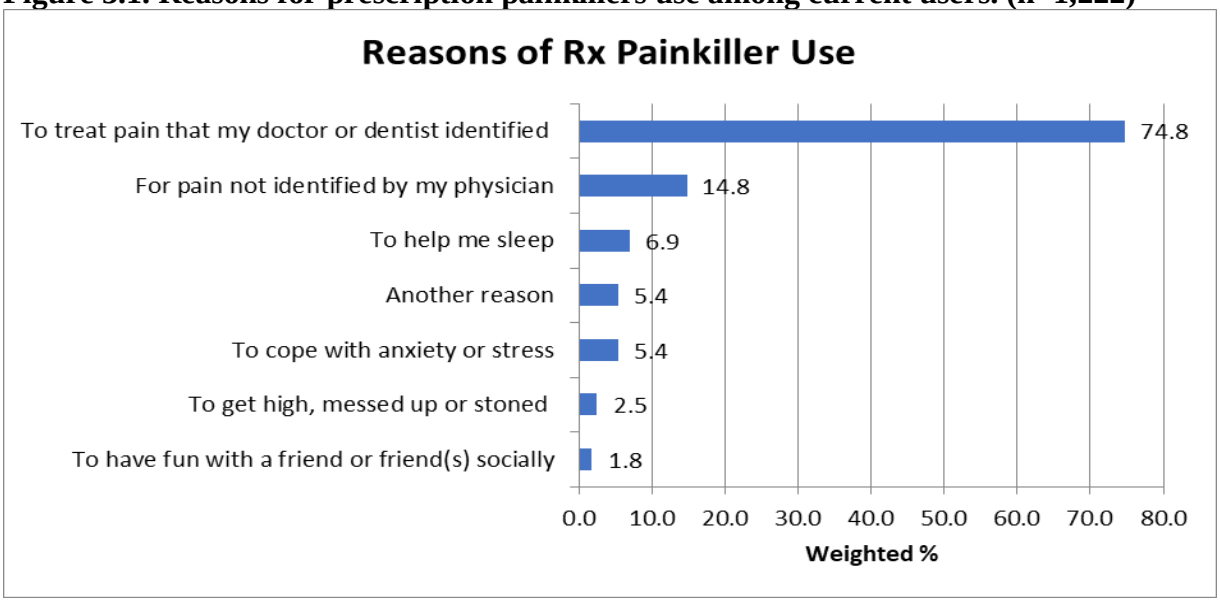


Figure 3.2. Sources of prescription painkillers among current users. (n=1,222)

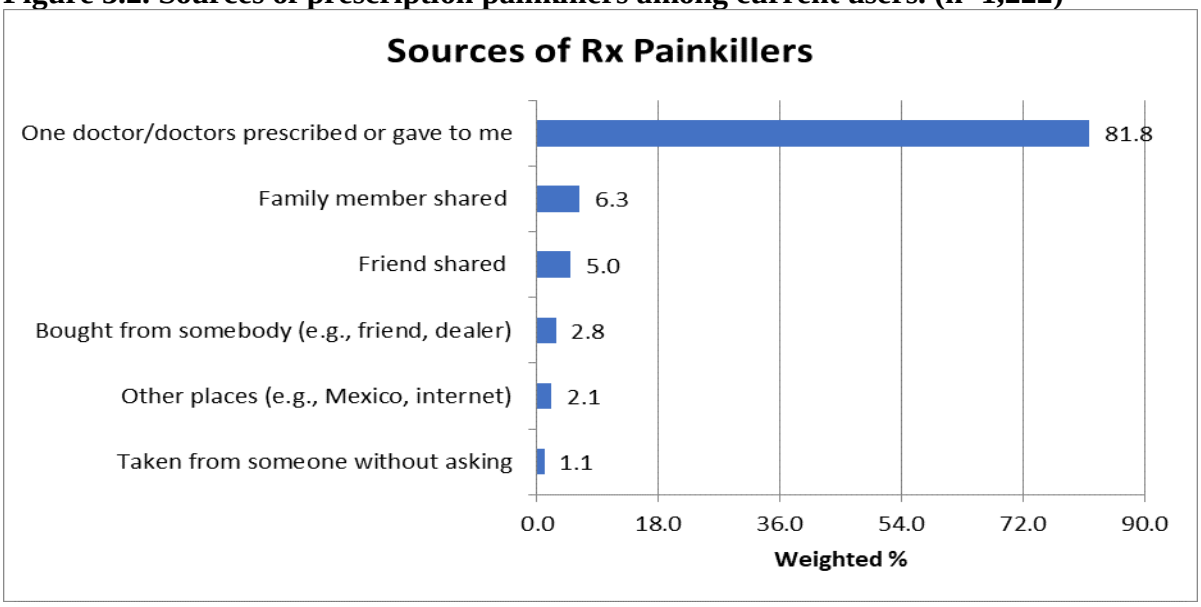
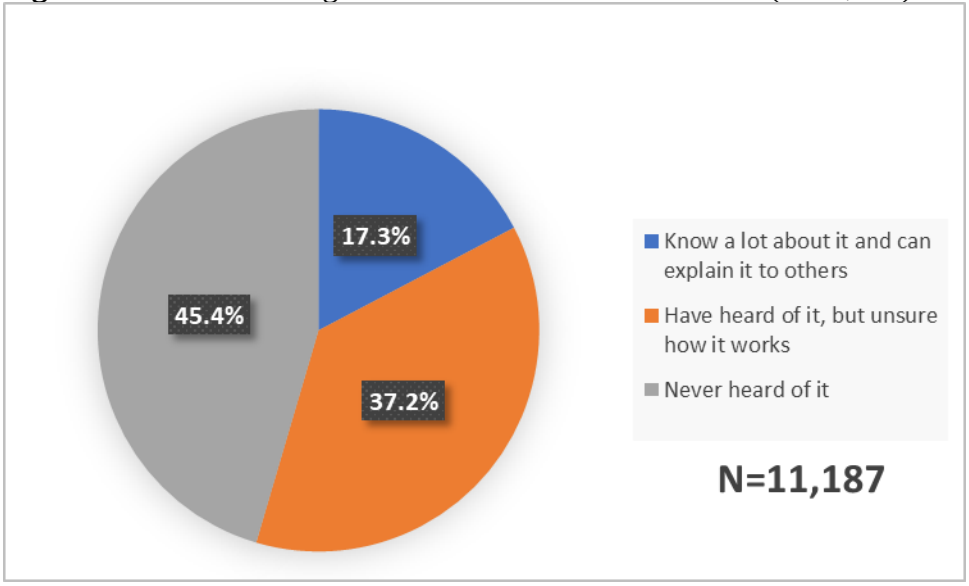


Figure 3.3 Understanding of the NM Good Samaritan Law (n=11,187)



IV. Parental behaviors

Percentages are provided below for overall sample and by biological sex for access to ATOD via parents.

Table 4. Parents of minors residing in household reporting providing ATOD to a minor last year

Outcomes	%		
	Overall	Men	Women
Parents who reported NEVER OK to provide alcohol to a minor (n=4,298)	72.8	70.1	75.0
Parents who reported providing alcohol to a minor (n=4,021)	2.6	2.8	2.4
Parents who reported sharing Rx drugs (n=4,067)	5.3	4.2	6.2
Parents who reported locking up Rx painkillers*(n=1,715)	50.4	48.1	51.9

*Excluding respondents who indicate they have no prescription painkillers from this estimate.

Results: Non-Core Modules

Please note that the Community and College modules are excluded from this state-level summary report due to very few participating communities.

V. Opioid Module (Non-Core)
Percentages are provided below for the opioid outcomes of interest.

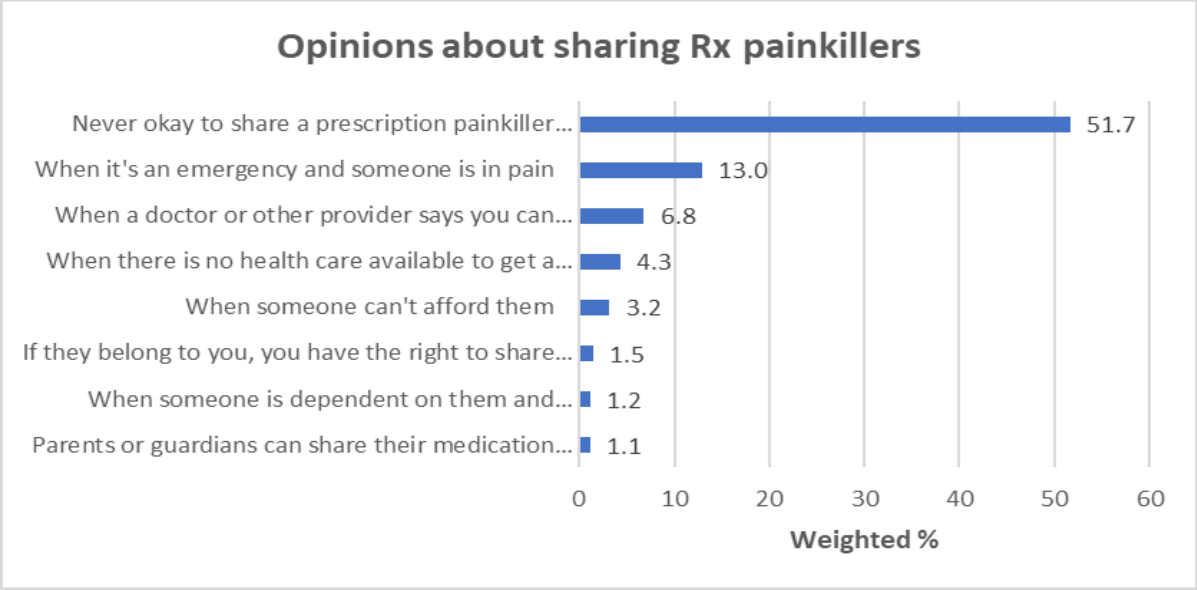
Table 5.1 Knowledges about family members/friends who use Rx painkillers or heroin

Outcomes	% of Yes
Having family members or friends who often use Rx painkillers (n=2,330)	14.9
These Rx painkiller users are at risk of overdose (n=318)	58.9
Some of these Rx painkiller users live with you (n=293)	15.7
Having family members or friends who often use heroin (n=2,330)	8.1
These heroin users are at risk of overdose (n=167)	88.1
Some of these heroin users live with you (n=162)	7.9

Table 5.2 Access to and knowledge about Naloxone/Narcan

Outcomes	% of Agree or Strongly Agree
Have Naloxone/Narcan (n=1,528)	25.6
Know how to get Naloxone/Narcan (n=1,543)	20.6
Know how to use Naloxone/Narcan (n=1,538)	21.6

Figure 5. Opinions about sharing Rx painkillers with others (n=2,330)



VI. Tobacco Outcomes and Intervening Variables (Non-Core)

Distributions of each response category are provided below for the tobacco-related outcomes.

Table 6. Percentages of cigarette/tobacco any use outcomes overall and by sex.

Tobacco Indicators	%		
	Overall	Men	Women
Cigarette: current use (n=1,073)	17.7	22.8	11.5
Chewing Tobacco: current use (n=1,072)	6.4	8.4	3.7
E- Cigarette: lifetime use (n=1,068)	20.5	24.1	15.9
E- Cigarette: past 30-day use* (n=1,071)	9.0	10.0	8.1
Purchased or provided tobacco to a minor in past year (n=960)	5.2	5.2	5.6

*****Among all respondents.

VII. Mental Health (Non-Core)

Percentages are provided below for overall sample and by biological sex for the mental health outcomes of interest.

Table 7. Percentages of mental health outcomes overall and by sex

Outcomes	%		
	Overall	Men	Women
Met critical threshold for serious mental illness* (n=1,621)	9.8	8.8	10.7
Self-identified having mental health or drug/alcohol problems in the past year (n=1,685)	22.1	21.1	22.9
Suicidal thoughts in the past year (n=1,684)	7.7	7.7	7.5
Sought help on mental health or drug/alcohol problems in the past year (n=1,676)	16.6	15.9	17.4
Had difficulty accessing treatment for mental health or substance abuse problems (n=1,673)	6.5	5.9	7.3

*Serious mental illness is defined as having ≥ 13 points on the WHO screening scale.

Summary of 2019 Community Survey Findings

In FY19, the number of valid respondents to the NMCS was again large and all 33 counties were represented in the final sample. Results presented in this report are weighted estimates to reflect state population estimates. This is necessary because our sample is slightly younger, and more female and Native American than the state population. Approximately 4% of our weighted sample identified as being housing unstable and 32% reported being a parent or caretaker of someone under 21 who was living in the household. This measure allowed us to examine the extent to which parents of minors are providing alcohol or other drugs to minors. Seven- and one-half percent of the weighted sample indicated being currently or formally active in the military and just over eight percent indicated being lesbian, gay, bisexual, transgender or questioning. These prevalence estimates are similar to last year's estimates.

Not quite half of the weighted sample indicated drinking alcohol in the past 30 days. In general, most alcohol indicators remained stable across the past two years, except for 30-day binge drinking which increased just under two percent. Summary Table 1 presents prevalence estimates from the NMCS starting in 2017. For comparison, 2017 BRFSS age-adjusted estimates indicated that 52.6% of NM adults reported past 30-day alcohol use, 5.7% were chronic heavy drinkers, 14.7% reported episodic heavy (binge) drinking[2] and 1.4% (2016 estimate -- the most recent) reported driving after having too much to drink[3].

Summary Table 1. Alcohol indicator trends (whole sample)

Alcohol Outcome Indicators	FY17	FY18	FY19
Average number of drinks a week	2.2	1.9	2.0
Percent Past 30-day alcohol use	47.6	46.9	46.7
Percent of Heavy Drinkers	4.0	3.2	3.6
Percent Past 30-day binge drinkers	16.3	14.4	16.1
Percent Past 30-day driven under the influence	3.5	3.7	3.2
Percent Past 30-day driven after 5+ drinks	2.8	2.8	2.7

As shown in Table 2.2., young adults, ages 21-25 reported the largest percentage (27.6%) of binge drinking, closely followed by 26-30 year olds (23.9%). These two age groups also self-reported the highest percentage of driving under the influence of alcohol with 7.0% of 26-30 year olds and 5.7% of 21-25 year olds reporting having done so in the last 30-days.

Most underage young adults reported accessing alcohol either from an adult or at parties. Thus, social access to alcohol remains the most common way that underage persons access alcohol in New Mexico, while access to alcohol directly from retailers such as bars and stores is far less common among minors. Summary Table 2 presents trend data on perception of risk and access

[2] BRFSS data defines "heavy episodic drinking" as > 5+ drinks on one occasion in past 30 days, 4+ for women
[3] All BRFSS data for New Mexico can be found at:
https://ibis.health.state.nm.us/query/selection/brfss/_BRFSSSelection.html

measures from the NMCS. Across the past three years, perception of social access to alcohol by teens has remained at a relatively high level. This suggests that prevention planners should consider moving beyond general awareness to action strategies that reduce the acceptability of adults providing access to minors.

Summary Table 2. Alcohol related perception of risk of getting caught and youth access to alcohol indicator trends (whole sample)

Alcohol Perception Indicators	FY17	FY18	FY19
Percent Very Likely police breaking up teen drinking parties	18.5	17.8	18.1
Percent Very Likely police arresting adult providing alcohol to minor	26.2	26.2	26.3
Percent Very Likely being stopped if driving intoxicated	30.8	28.9	30.0
Percent Very Easy social access to alcohol by teens	44.0	43.8	42.3
Percent Very Easy retail access to alcohol by teens	10.6	11.1	8.9
Percent provided alcohol to a minor in past year	3.9	2.9	2.4

The stability in the perception of risk-related outcomes are noteworthy. Generally, community respondents perceive some, but not enough risk in getting caught while underage drinking. One exception to the trend, however, is encouraging. The FY19 state estimate indicates that fewer adults believed that retail access by minors was "very easy."

The high percentage of respondents who agreed or strongly agreed that problems due to drinking caused financial harm to their community also indicates a high degree of support for prevention action in communities. This perception increased with age, with about 56% of 18 to 20-year olds agreeing with the statement compared to approximately 77% of those 71 years or older (see Table 2.4). The data suggest that communities understand the problems related to alcohol and that they are ready to support change.

Summary Table 3 examines prescription painkiller outcomes over the past three fiscal years. There is a decreasing trend in receiving a prescription for an opioid in the past year among participants. Past 30-day use for any reason or to get high is slightly decreasing as well.

Summary Table 3. Prescription painkiller indicator trends (whole sample)

Prescription Painkiller Outcome Indicators	FY17	FY18	FY19
Average number of days used Rx painkillers in past 30-days	9.0	10.6	10.1
Percent receiving a Rx painkiller in past year	28.0	25.9	24.1
Percent past 30-day Rx painkiller use for any reason	13.5	11.9	11.1
Percent past 30-day Rx painkiller use to get high	3.1	2.8	2.4

We asked respondents if, when prescribed prescription opioids, they were also prescribed naloxone. As shown earlier in Table 3.2, only 12.5% of participants currently using opioids

reported access to naloxone. In FY18, 5.4% indicated they were also prescribed naloxone and in FY19, this increased slightly to 5.6%. However, it is noteworthy that 6.7% of respondents indicated that they did not know if they were prescribed naloxone. We also asked whether the health care provider spoke with them about the risks involved in using prescription opioids. As shown in in Table 3.2, 50.8% FY19 of participants who were prescribed opioids in the last year indicated that the healthcare provider talked with them about opioid safety. As reported by participants, pharmacists were less involved in discussions about opioid safety -- only 32.0% of participants prescribed opioids noted that their pharmacist spoke with them about safety. However, the difference between health care providers and pharmacists was less dramatic for conversations about proper opioid storage. Just over 33% and almost 25% of participants who were prescribed opioids reported talking to their health care provider and pharmacist, respectively, about safe storage practices.

Most respondents using opioids, used them as prescribed for pain (74.8%, see Figure 3.1). Another 14.8% of respondents used opioids for pain that was not identified by a doctor or a dentist, raising concerns about safety while using outside of regular monitoring from medical staff. We remain concerned that 6.3% and 5.0% of responding using opioids received them from a family member or friend, respectively. Despite common stereotypes, FY19 data did not show that New Mexicans, living in a border state, received opioids from Mexico or the internet. Only 2.1% of respondents using opioids cited these as their drug source.

New Mexico led the nation in passing a Good Samaritan Law in 2007. This law protects people seeking to help a friend or family member who they suspect has overdosed on drugs. The Good Samaritan Law is known widely outside of New Mexico and more than 20 states have adopted similar laws. However, our data in Figure 3.3 show that under half (45.4%) of the 11,187 respondents who answered this question had heard of this law. Another 37.2% of respondents had heard of the law, but do not know how it works.

Few communities included the mental health module this fiscal year and as can be seen in Summary Table 4 the overall number of respondents has decreased significantly since FY17. Therefore, these results should be interpreted with caution. Just under a quarter of these survey respondents reported mental health or drug/alcohol concerns in the last year. Many New Mexicans (16.6%) were willing and able to seek help for their mental health, yet a troubling 6.5% (Table 7) reported difficulty accessing the help that they desired. The need for accessible and high-quality behavioral health care remains considerable in New Mexico.

Summary Table 4. Mental Health indicator trends

Outcomes	% FY17 (N=4,780)	FY18 (N=2,098)	FY19 (N=1,685)
Met critical threshold for serious mental illness*	8.7	10.9	9.8
Self-identified having mental health or drug/alcohol problems in the past year	17.8	22.4	22.1
Suicidal thoughts in the past year	4.9	8.2	7.7
Sought help on mental health or drug/alcohol problems in the past year	14.7	18.0	16.6

There remains room for growth and improvement in all targeted areas of prevention, but it must be considered in context of the other problems facing the population. While alcohol and prescription opioid use are decreasing, much remains to be done to address the contributing factors associated with problem alcohol and prescription opioid use. Survey respondent agreement remains high with the statement that alcohol abuse, including underage drinking, creates problems in communities, as does support for the enforcement of existing laws. Thus, popular support seems to be in place to take broader actions on these issues. Prevention providers must continue to build relationships in their communities with stakeholders who can influence local policy and action. The development of MOUs with stakeholders can help maintain continuity over time and through staff turnover. Demonstrating in concrete ways how prevention efforts at a local level have reduced death and saved money also helps make the argument for the value of continued prevention efforts.

Community prevention providers should be commended for their efforts to continually improve their own capacity and knowledge. Their commitment to the improvement of the health and well-being of their communities remains the reason why changes are taking place at all given that most are bombarded daily with problems. Building capacity, organizing and targeting efforts strategically and effectively, encouraging, supporting, and maintaining relationships to add to the ongoing web of support all remain important and needed actions on the part of local providers. The role of a prevention provider is multifaceted and demanding on many fronts. People skills are vital, as are planning, organization and implementation skills. Finally, the willingness to be open and flexible yet committed to the research is a fine line to walk yet is needed in order to be both culturally responsive and sensitive while also implementing evidence-based prevention strategies with integrity and fidelity.