Site Name & ID#: _____New Mexico_____

Community Survey Findings Sheet- 2018
All Modules

Prevention Goals and Objectives (only those referencing indicators in the NMCS)

Goal 1: Reduce underage drinking in New Mexico.
  Objective 1a: Reduce social access to alcohol by minors by… (increasing perception of risk of being caught; increased law enforcement efforts)
  Objective 1b: Reduce retail access to alcohol by minors by… (increasing perception of risk of being caught; increasing SID checks of retailers and increasing retail education, server training, etc.)
  Objective 1c: Increase perception of risk of being caught

Goal 2: Reduce binge drinking among adults in New Mexico.
  Objective 2.a: Increased perceived risk of legal consequences for breaking alcohol-related laws by high publicizing sobriety checkpoints and saturation patrols.

Goal 3: Reduce drinking and driving among adults in New Mexico.
  Objective 3.a: Increased perceived risk of legal consequences for breaking alcohol-related laws by high publicizing sobriety checkpoints and saturation patrols.

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 … (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 approximately one and half million residents of NM who are 18 and older living in the state. Of those, just under half (49.1%) were male. Of the entire population, 47.4% were Hispanic, 39.2% were non-Hispanic white, 8.5% Native American or Alaskan Native representing at least 22 different tribes, while just under 5% were African American/Black, Asian, or a combination of races. Approximately 26.4% have a high school degree, another 23.6% have some college education, 7.8% have an associate's degree, 14.8% have a bachelor's degree and 11.5% have a graduate or professional degree. Among 18 to 64-year olds, 19.8% live below the poverty line and among just 18 to 34-year olds, 25.4% live below the poverty line. Unemployment is around 9% but of those living below the poverty line, just over 40% are unemployed. Just over 26% of residents speak English less than "very well".

Data Collection Method and Brief Sample Description in COMPARISON TO PREVIOUS YEARS' SAMPLES (e.g., information from your data tracking table)

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

The first approach taken to collect community-level data is a simple 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, if communities found that some locations, originally expected to be good places to collect data, actually turned out to not be good locations or did not pan out for whatever reason, then this information would be recorded and be particularly useful to next year's planning of the data collection process.

A total of 6,964 surveys were collected using this methodology, which constitutes 50% of the aggregated sample. Unfortunately, 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 FY18 was the implementation of an on-line version of the survey. Recruitment ads were placed on Facebook 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, FY16, and FY17 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. A total of 11 ads were created targeting young adults, parents, and elderly, and varied in format from storyboards, animated, and static photos. Ads ran for a total of 9 weeks from February 25, 2018 to April 29, 2018.

Over the 9 weeks the ads led to 343,355 impressions, reaching 113,604 people, 5,070 clicks on the survey link itself and 2172 surveys completed, at the cost of approximately $2.30 per completed survey. This translates into a 4.5% response rate of people clicking on the survey link and 42.8% 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. Ads varied in their ability to resonate with viewers. Facebook scores ads between 1 and 10, with 10 indicating the highest relevance and 1, the lowest relevance. Relevance scores ranged between 4 and 6, with four ads scoring 6, six ads scoring 5, and one ad scoring 4. A total of 3,060 surveys were collected by recruiting directly through the Facebook ads or 24.3% of the sample.

Daily and 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 day, four $20 gas cards were given away to randomly selected respondents who completed the survey that day. Each week, a randomly selected respondent was selected to receive two $20 gas cards from the week's respondents for a total of 30 gas cards given out each week for nine weeks.

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

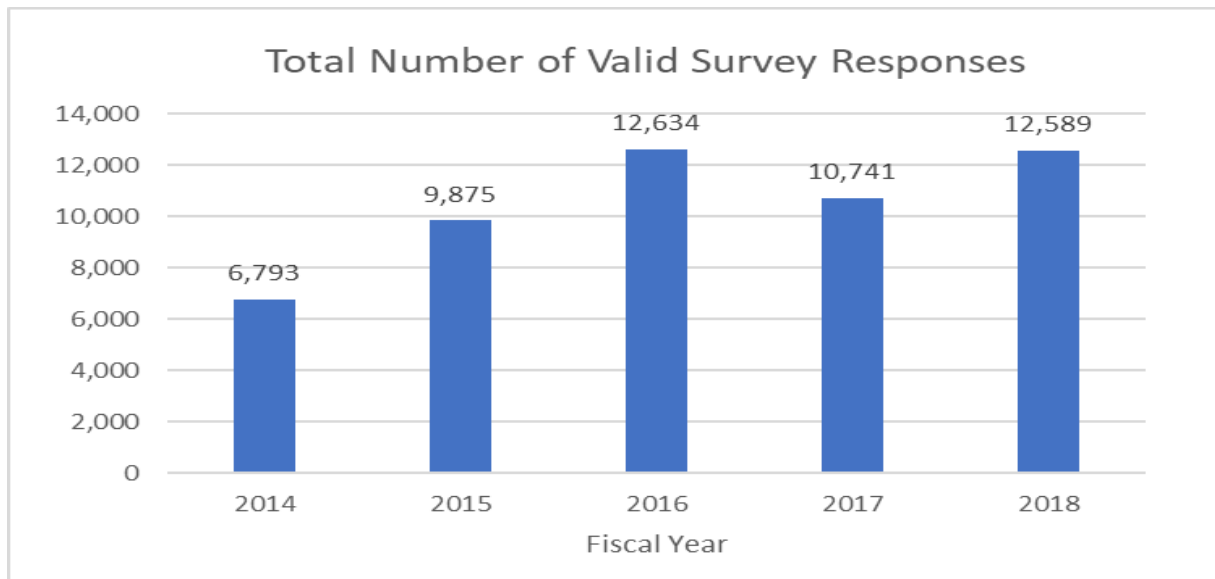 1- providing QR-codes to take, so people could complete the survey on their smart phones at their convenience

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, however, this was not entirely the case, and at least two more rural communities successfully used alternative approaches.

A total of 3231 surveys were collected using the on-line survey via iPads (n=562), the online link (n=2636) or QR codes (n=33).

Total Combined Sample

In FY18 a total of 12,589 completed questionnaires were collected compared with 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 completed questionnaires representing them.

Total Number of Valid Survey Responses

Fiscal Year	Responses
2014	6,793
2015	9,875
2016	12,634
2017	10,741
2018	12,589

Analysis Approach

Data from the communities and the on-line data collection are cleaned and aggregated prior to conducting analyses. In addition, we weight the data to match NM Census 2017 data with regard to 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 post-hoc is to reduce the overall influence of subpopulations that are typically over represented in our sample, specifically, young adults, Native Americans, and women while simultaneously increasing the influence of subpopulations underrepresented. For example, the over-representation of young adults would tend to increase our state-level substance use estimates and would mislead us into thinking that we have more substance use than we might. Alternatively, too many older women may depress our substance use rates and lead us to incorrectly assume that we have less substance use than we do.

Therefore, we control for these discrepancies in our sample statistically by adding a weight variable in our analyses.

Univariate and bivariate analyses were conducted using SAS 9.4 version and weighted to reflect population estimates.

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.

Please note when interpreting these findings that 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[2]

Number of eligible respondents	N= 12,589
Characteristics	**%**
Age	
18-20	5.4
21-25	9.1
26-30	8.9
31-40	16.6
41-50	14.6
51-60	16.9
61-70	15.4
71 or older	12.9
Gender	
Male	49.1
Female	50.9
Race/Ethnicity	
White	41.2
Hispanic	45.1
Native American	8.6
Other	5.1
Education level[1]	
Less than high school	5.8
High school or GED	21.2
Some college	24.0
College or above	32.0
Currently an undergraduate	17.0
New Mexico Residency	
Less than 1 year	3.9
1-5 years	10.7
More than 5 years	85.4
Number of Spanish Paper Surveys[2]	360

[1] Education levels are mutually exclusive.

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

Table 1.2 Demographic characteristics of community

Number of eligible respondents	N= 12,589
Characteristics	%
Active Duty in the Military Service or Veteran	8.8
Identify as LGBTQ	7.4
Parent/Caretaker of Someone under 21 living in the household	30.9
Past 30-day housing stable	95.0

II. Alcohol Outcomes and Intervening Variables

Distributions of each response category 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 (standard error)	Range	% of Yes	% of Yes
# of drinks a week (n=12,585)	NA	1.9 drinks (0.1)	0-114	NA	NA
Heavy drinkers[a] (n=11,941)	3.2	NA	NA	3.4	3.2
Past 30-day alcohol use (n=11,966)	46.9	NA	NA	51.2	43.1
Past 30-day binge drinking					
All respondents (n=12,004)	14.4	0.7 times	0-31	18.4	10.4
Current users[b] only (n=5,456)	31.1	1.5 times	0-31	36.7	24.4
Past 30-day driven under influence					
All respondents (n=12,032)	3.7	0.1 times	0-69	4.9	2.4
Current users[b] only (n=5,483)	7.9	0.2 times	0-69	9.8	5.6
Past 30-day driven after binge drinking					
All respondents (n=12,024)	2.8	NA	NA	3.5	2.0
Current users[b] only (n=5,477)	6.0	NA	NA	6.9	4.6

[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 %
18-20	34.7	13.9	3.9	4.0
21-25	63.0	27.1	7.5	6.7
18-25	**52.6**	**22.2**	**6.2**	**5.7**
26-30	55.7	20.5	6.9	4.8
31-40	52.0	19.9	4.6	3.1
41-50	48.0	17.7	3.7	2.3
51-60	45.5	12.1	2.5	2.2
61-70	42.5	6.3	2.0	1.2
71+	33.6	3.2	0.7	0.7

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	17.8	31.0	20.2	8.0	23.0
Likelihood of police arresting an adult for giving alcohol to someone under 21	26.2	25.7	17.9	8.3	22.0
Likelihood of being stopped by police if driving after drinking too much	28.9	34.4	18.7	5.6	12.4
	Strongly disagree	**Disagree**	**Neither agree nor disagree**	**Agree**	**Strongly agree**
Problems due to drinking hurts community financially	11.6	5.1	15.2	36.7	31.5
Access to alcohol	**Very easy**	**Somewhat easy**	**Somewhat difficult**	**Very difficult**	**Don't know**
Ease of access to alcohol by teens in the community	43.8	30.7	8.1	2.6	14.8
Ease of access to alcohol by teens in the community from stores and restaurants	11.1	21.6	28.8	18.8	19.8
Social Access	**Total**	**Men**	**Women**		
Provided alcohol for minors past year	2.9	3.1	2.7		

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	13.2	11.5	12.2	13.5	12.2	12.5	14.0	12.8	10.0
Very or somewhat difficult for teens to access to alcohol from stores and restaurants	59.0	62.7	61.4	60.5	64.8	60.3	57.9	59.5	47.3
Purchasing and/or sharing of alcohol with a minor over past year (Yes)	5.3	12.1	9.6	3.7	2.4	2.4	1.5	0.7	0.9
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.	38.2	40.4	39.6	58.3	68.0	68.8	73.7	70.5	68.8
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	60.2	63.2	62.1	60.6	63.8	65.5	64.7	63.7	61.4
Very or somewhat likely for police to arrest an adult for giving alcohol to someone under 21	60.9	62.7	62.1	62.7	65.6	67.5	69.6	66.8	68.9
Very or somewhat likely being stopped by police if driving after drinking too much	77.0	69.6	72.2	70.1	72.4	75.0	73.0	71.0	71.2
Agree or strongly agree that problems due to drinking hurts community financially	54.3	59.5	57.6	62.9	63.3	67.9	71.4	75.4	77.8

Figure 2.1. Sources of obtaining alcohol for respondents 18-20 years old who reported drinking alcohol in the past 30 days. (n=531)
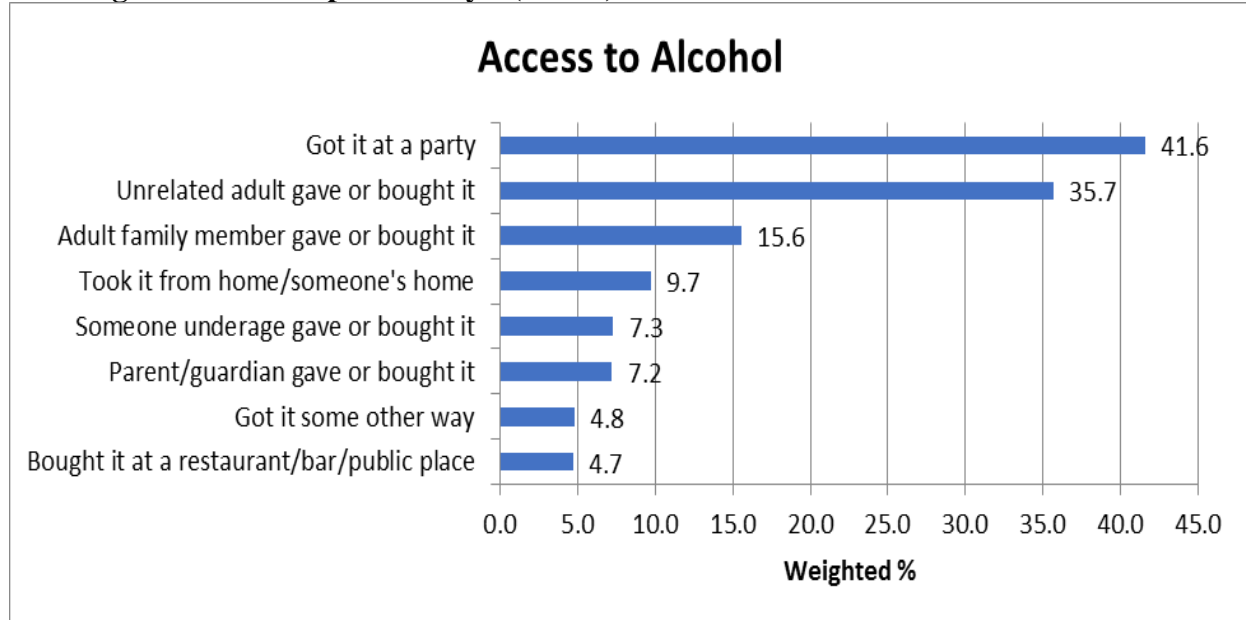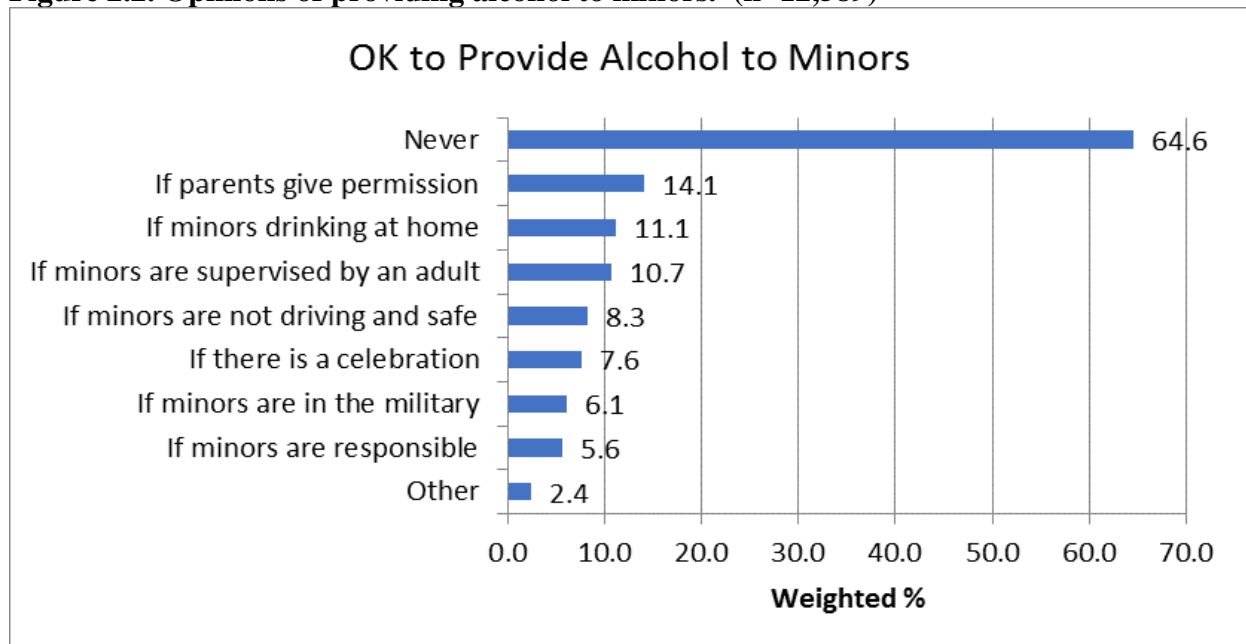
Access to Alcohol

Source	Weighted %
Got it at a party	41.6
Unrelated adult gave or bought it	35.7
Adult family member gave or bought it	15.6
Took it from home/someone's home	9.7
Someone underage gave or bought it	7.3
Parent/guardian gave or bought it	7.2
Got it some other way	4.8
Bought it at a restaurant/bar/public place	4.7

Figure 2.2. Opinions of providing alcohol to minors. (n=12,589)

OK to Provide Alcohol to Minors

Opinion	Weighted %
Never	64.6
If parents give permission	14.1
If minors drinking at home	11.1
If minors are supervised by an adult	10.7
If minors are not driving and safe	8.3
If there is a celebration	7.6
If minors are in the military	6.1
If minors are responsible	5.6
Other	2.4

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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 (standard error)	% of Yes	% of Yes
Prevalence of receiving Rx painkiller past year (n=12,070)	25.9		23.8	28.0
Past 30-day Rx painkiller use for any reason (n=11,910)	11.9	10.6 days (0.4) (current users[a] only)	11.0	12.7
Past 30-day painkiller use to get high				
All respondents (n=11,918)	2.8		2.9	2.4
Current users* only (n=1,373)	22.6		26.1	18.4

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=3,027)	5.4	6.5
Talked about risks in using Rx painkillers by …		
Healthcare provider (n=3,078)	51.8	NA
Pharmacy staff (n=3,078)	33.7	NA
Talked about storing Rx painkillers safely by…		
Healthcare provider (n=3,078)	32.1	NA
Pharmacy staff (n=3,078)	26.1	NA
Have access to naloxone when having used painkillers to get high in the past 30 days (n=733)	14.3	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	18.3	9.2	3.5
26-30	21.3	9.1	3.0
31-40	23.8	10.6	3.6
41-50	26.0	11.0	2.4
51-60	29.9	15.0	2.9
61-70	30.6	14.2	1.7
71 +	29.7	13.0	2.2

Table 3.4 Estimates for prescription painkiller intervening variables (Total Sample).

Risk of Harm	%			
	No risk	Slight risk	Moderate Risk	Great risk
Perceived risk of harm with misusing Rx painkillers	3.3	8.4	25.1	63.2
Social Access	**Yes**	**No**		
Giving or sharing Rx painkillers in past year	5.3	94.7		
Rx painkillers stored in locked box or cabinet*	38.5	61.5		

*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	82.0	85.6	86.4	86.8	91.0	92.8	92.8
Social Access	**18-25**	**26-30**	**31-40**	**41-50**	**51-60**	**61-70**	**71 +**
Giving or sharing Rx painkillers in past year	6.8	6.4	6.3	6.2	4.1	4.8	2.6
Rx painkillers stored in locked box or cabinet*	39.0	40.3	42.4	37.8	39.4	33.2	37.6

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

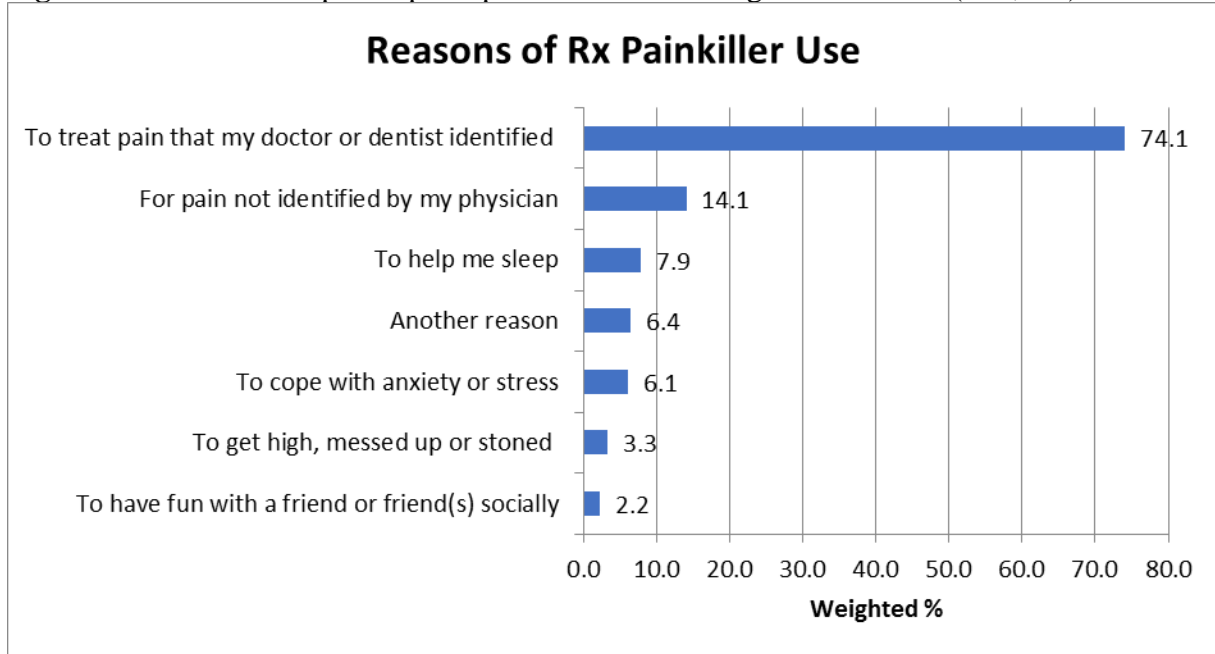**Figure 3.1.** Reasons for prescription painkillers use among current users. (n=1,398)

Reasons of Rx Painkiller Use

Reason	Weighted %
To treat pain that my doctor or dentist identified	74.1
For pain not identified by my physician	14.1
To help me sleep	7.9
Another reason	6.4
To cope with anxiety or stress	6.1
To get high, messed up or stoned	3.3
To have fun with a friend or friend(s) socially	2.2

Figure 3.2. Sources of prescription painkillers among current users. (n=1,398)

Sources of Rx Painkillers

Source	Weighted %
One doctor/doctors prescribed or gave to me	83.3
Family member shared	5.3
Friend shared	4.9
Bought from somebody (e.g., friend, dealer)	3.7
Other places (e.g., Mexico, internet)	1.9
Taken from someone without asking	1.7
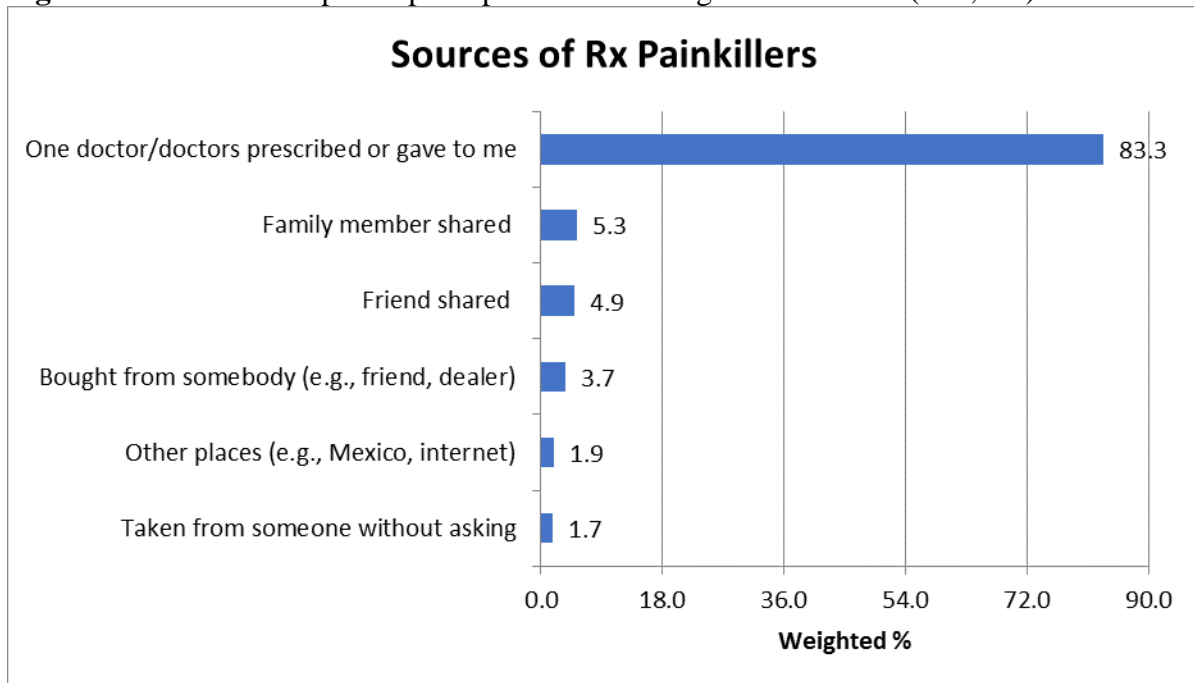
Figure 3.3 Understanding of the NM Good Samaritan Law (n=11,862)

Legend:
- Know a lot about it and can explain it to others
- Have heard of it, but unsure how it works
- Never heard of it

16.7%
36.7%
46.6%

N=11,862
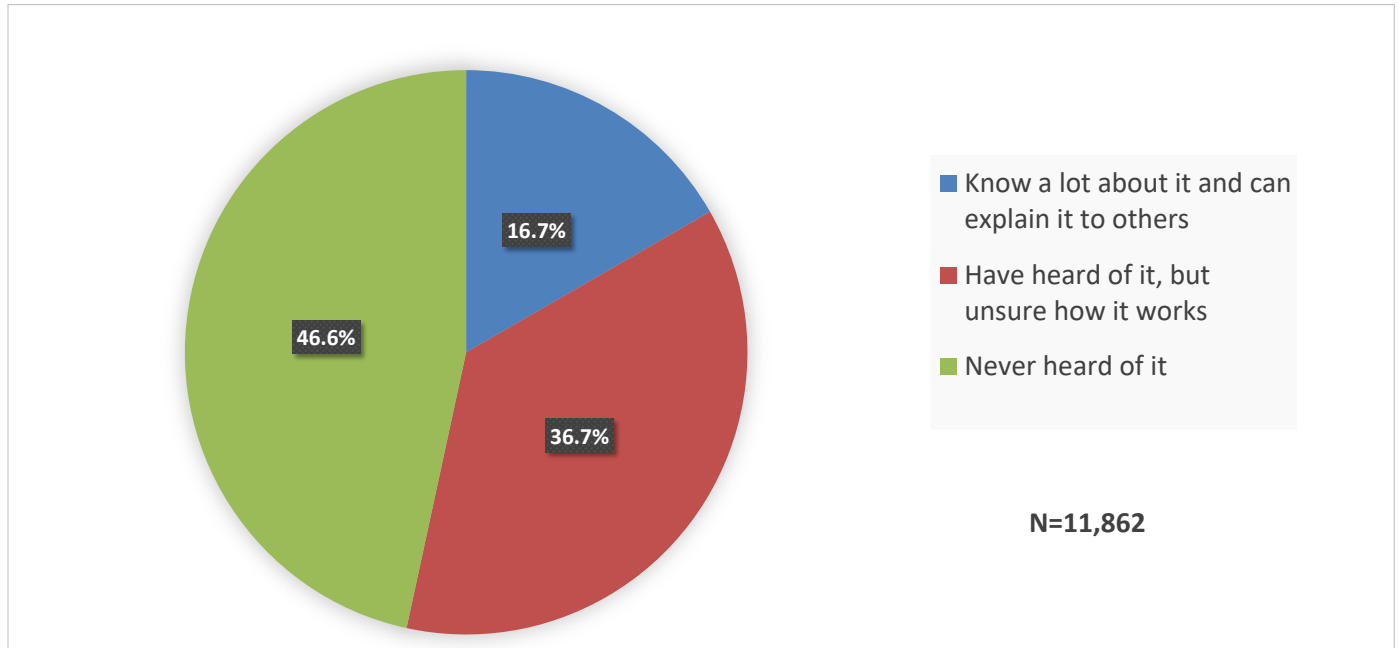
IV. Parental behaviors

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=4,067)	71.3	66.9	75.3
Parents who reported providing alcohol to a minor (n=3,808)	2.3	2.2	2.4
Parents who reported sharing Rx drugs (n=3,828)	5.5	4.3	6.3
Parents who reported locking up Rx painkillers*(n=1,760)	45.9	43.6	47.8

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

V. Media Campaign

Table 5.1 Media campaign message recognition overall and by sex

Campaign Names (N= 12,589)	%		
	Overall	Men	Women
Suck It Up!	3.1	3.6	2.5
Good Drugs Gone Bad	3.5	3.7	3.2
Parents Who Host Lose the Most	6.2	5.7	6.6
A Dose of R$_x$eality	7.6	7.5	7.5
Up and Away and Out of Sight	2.1	2.2	1.9
Wake Up Now	3.7	4.3	3.1
Never heard of any of these	73.9	72.7	75.7

Table 5.2. Interpretation of media campaign message overall and by sex (limited to participants who only selected one interpretation)

A Dose of R$_x$eality Campaign Message (N=10,838)	%		
	Overall	Men	Women
Stay in school if you want to be successful.	12.4	14.3	10.7
Rx drugs can be dangerous if not used as intended	66.6	63.4	70.2
Reality is harsh, but medication can help.	3.2	3.3	2.7
Daily exercise is good for your health.	4.3	5.2	3.2
Take your medication as directed by your doctor.	10.2	10.0	10.2
Vaccinate your kids.	3.3	3.7	2.9

Optional Modules

Please select modules that you have implemented and delete the ones not used.

I. Community module

Percentages are provided below for consolidated response categories of all questions

Table 1. Distribution of responses in community module

Outcomes (N=1,053)	**%**		
	Disagree	**Agree**	**Neutral**
Underage drinking is a problem in my community.	6.0	75.6	18.4
Support local law enforcement efforts to prevent underage drinking	4.4	89.0	6.6
Heavy drinking is a problem in my community	4.9	81.5	13.6
Support local efforts to prevent heavy drinking	4.4	86.9	8.7
Drinking and driving is a problem in my community	5.0	83.2	11.8
Support local law enforcement efforts to prevent drinking and driving	3.5	91.2	5.3
I support the enforcement of laws prohibiting serving the intoxicated	3.6	90.7	5.7
The overuse of alcohol harms the personal safety and well-being of community members	2.9	90.8	6.4
Past year experienced problems associated with alcohol misuse in my community	16.8	66.9	16.3

Note. Disagree = strongly disagree + disagree; agree= strongly agree + agree; neutral= neither agree nor disagree.

II. College Community module

We are not presenting college community module data outcomes here because only one small college community collected these data.

III. Tobacco Outcomes and Intervening Variables
Distributions of each response category are provided below for the tobacco-related outcomes.

Table 3. Percentages of cigarette/tobacco any use outcomes overall and by sex.

Tobacco Indicators	%		
	Overall	Men	Women
Cigarette: current use (n=234)	12.2	17.5	8.4
Chewing Tobacco: current use (n=231)	1.7	2.3	1.5
E- Cigarette: lifetime use (n=233)	17.0	16.4	15.8
E- Cigarette: past 30-day use* (n=233)	7.3	8.6	6.0
Purchased or provided tobacco to a minor in past year (n=226)	1.8	1.7	1.9

*Among all respondents.

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

Table 4. Percentages of mental health outcomes overall and by sex

Outcomes	%		
	Overall	Men	Women
Met critical threshold for serious mental illness* (n=2,010)	10.9	9.6	12.2
Self-identified having mental health or drug/alcohol problems in the past year (n=2,092)	22.4	20.1	25.0
Suicidal thoughts in the past year (n=2,098)	8.2	7.9	8.4
Sought help on mental health or drug/alcohol problems in the past year (n=2,097)	18.0	16.2	20.0
Had difficulty accessing treatment for mental health or substance abuse problems (n=2,083)	7.1	6.1	8.5

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

V. Opioid Module

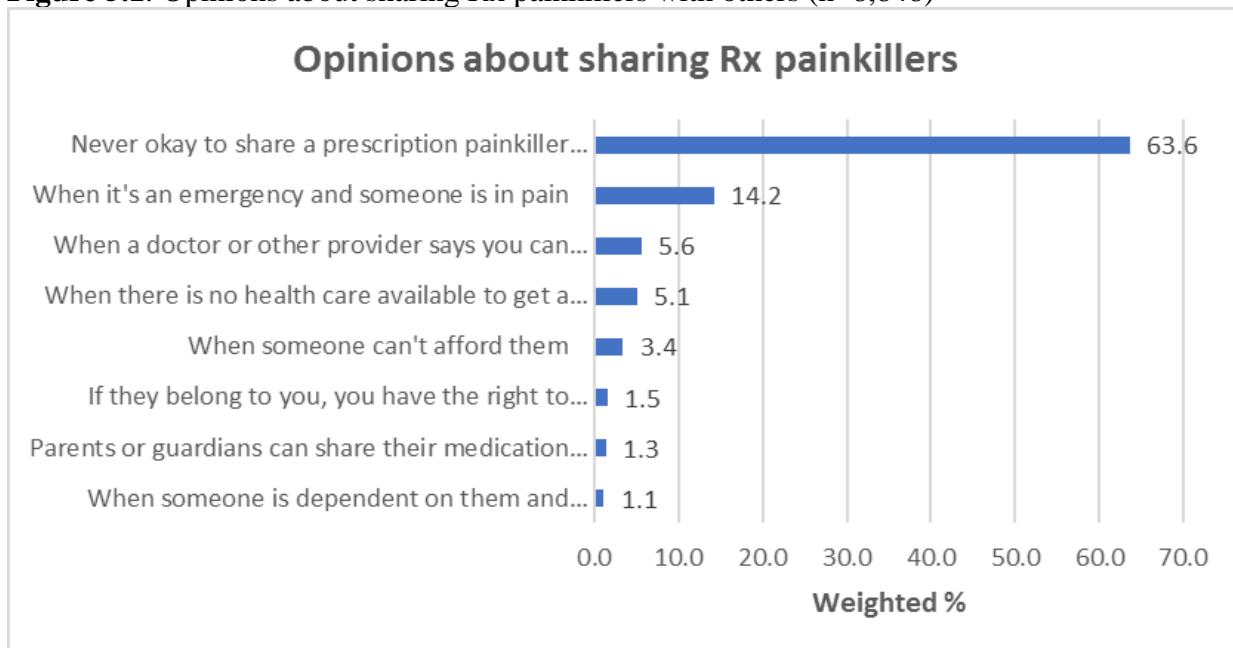Percentages are provided below for the opioid outcomes of interest.

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=8,848)	23.1
These Rx painkiller users are at risk of overdose (n=2,086)	52.4
Some of these Rx painkiller users live with you (n=1,978)	19.9
Having family members or friends who often use heroin (n=8,848)	8.7
These heroin users are at risk of overdose (n=794)	86.9
Some of these heroin users live with you (n=769)	10.8

Table 5.2 Access to and knowledge about Naloxone/Narcan

Outcomes	% of Agree or Strongly Agree
Have Naloxone/Narcan (n=7,145)	21.2
Know how to get Naloxone/Narcan (n=7,207)	21.3
Know how to use Naloxone/Narcan (n=7,204)	22.1

Figure 5.1. Opinions about sharing Rx painkillers with others (n=8,848)

Opinions about sharing Rx painkillers

	Weighted %
Never okay to share a prescription painkiller...	63.6
When it's an emergency and someone is in pain	14.2
When a doctor or other provider says you can...	5.6
When there is no health care available to get a...	5.1
When someone can't afford them	3.4
If they belong to you, you have the right to...	1.5
Parents or guardians can share their medication...	1.3
When someone is dependent on them and...	1.1

Summary of 2018 Community Survey Findings

The survey sample this year is large and all 33 counties were represented. Results presented in this report are weighted estimates to reflect state population estimates and not local level demographics. This is necessary since our sample is slightly younger and more female and Native American than the state population as a whole. Approximately 5% of our sample identified as being housing unstable and 31% reporting 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. Almost 9% of the sample indicated being currently or formally active in the military and almost 7.5% indicated being lesbian, gay, bisexual, transgender or questioning. These prevalence estimates are similar to last year's estimates.

Not quite half of the sample indicated drinking alcohol in the past 30 days. In general, there are slight decreases since FY16 in most alcohol indicators. Past 30-day binge drinking decreased this past year by almost 2 percentage points. This corresponds to declining trends in binge drinking and other problem alcohol use seen in other state data. Summary Figure 1 presents prevalence estimates from the NMCS starting in 2016. For comparison, aggregated 2014-2016 BRFSS age-adjusted estimates indicate that 48.9% of NM adults reported past 30-day alcohol use, 5.4% are chronic heavy drinkers, 14.5% report current binge drinking and 1.3% report driving after having too much to drink.

Summary Figure 1. Alcohol indicator trends (whole sample)

Alcohol Outcome Indicators	FY16	FY17	FY18
Average number of drinks a week	2.0	2.2	1.9
Percent Past 30-day alcohol use	47.5	47.6	46.9
Percent of Heavy Drinkers	3.5	4.0	3.2
Percent Past 30-day binge drinkers	16.1	16.3	14.4
Percent Past 30-day driven under the influence	3.5	3.5	3.7
Percent Past 30-day driven after 5+ drinks	2.9	2.8	2.8

As we would expect, young adults, 18 to 25, account for the most binge drinking and driving while intoxicated. In addition, most underage young adults report accessing alcohol at parties indicating that social access to alcohol remains the most common way that underage persons access alcohol in New Mexico and that access to alcohol from retailers such as bars and stores is far less common among minors.

There has been little change in the perception of risk and perceived access to alcohol indicators over time. This suggests that continued effort to move these intervening measures remains important and that providers need to consider how they can exert greater influence on the perceptions of community residents with regard to their perceived risk of getting caught by police. Interestingly, well over 60% of respondents agreed or strongly agreed that problems due to drinking caused financial harm to their community. This perception increased with age, with about 54% of 18 to 20-year olds agreeing with the statement (still over 50%!) compared to

almost 78% of those 71 years or older. Summary Figure 2 presents data beginning in FY16 on perception of risk and access measures from the NMCS.

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

Alcohol Perception Indicators	FY16	FY17	FY18
Percent Very Likely police breaking up teen drinking parties	16.7	18.5	17.8
Percent Very Likely police arresting adult providing alcohol to minor	25.1	26.2	26.2
Percent Very Likely being stopped if driving intoxicated	29.3	30.8	28.9
Percent Very Easy social access to alcohol by teens	37.5	44.0	43.8
Percent Very Easy retail access to alcohol by teens	9.5	10.6	11.1
Percent provided alcohol to a minor in past year	3.1	3.9	2.9

Interestingly, fewer 18 to 20-year olds are agreeing that it is never okay to provide alcohol to a minor. In FY16, the percent of 18 to 20-year olds who supported this statement was 43.6%, compared with 40% in FY17, and only 38.2% in FY18. This declining trend is in contrast with decreasing (slightly) past 30-day alcohol use among this same age group over the same time frame (Past 30-day alcohol use among 18 to 20-year olds in FY16 = 36.9%, FY17 = 39.7%, FY18 = 34.7%).

In examining prescription painkiller outcomes over the past three fiscal years, we find that there is a decreasing trend in receiving a prescription for an opioid in the past year among both men and women and past 30-day use of prescription opioids has also decreased.

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

Prescription Painkiller Outcome Indicators	FY16	FY17	FY18
Average number of days used Rx painkillers in past 30-days	9.5	9.0	10.6
Percent receiving a Rx painkiller in past year	29.9	28.0	25.9
Percent past 30-day Rx painkiller use for any reason	15.6	13.5	11.9
Percent past 30-day Rx painkiller use to get high	3.9	3.1	2.8

We asked respondents if, when they were prescribed prescription opioids, the provider also prescribed Narcan. In FY17, 4.3% indicated they were also prescribed Narcan, and in FY18, this increased slightly to 5.4%.   We also asked whether the health care provider spoke with them about the risks involved in using prescription opioids. In FY17, 68.9% indicated that the healthcare provider or pharmacist spoke with them, compared to 51.8% of healthcare providers in FY18 and 33.7% of pharmacists. Although not exactly the same measure, it suggests a possible increase in in health care providers and pharmacists speaking with patients about the hazards of opioid use. Proper and safe storage of opioids is less often spoken about with patients

and should increase if prevention providers are working with pharmacists and healthcare providers widely across their communities. Access to naloxone when using painkillers to get high in the past 30 days decreased from FY17 (20.6%) to FY18 (14.3%) which is problematic given the efforts to increase Narcan training and distribution over the past year.

Among communities that administered the opioid module, just over 23% indicated having a friend or family member who often uses prescription painkillers. Of the 23%, over half felt that the friend of family member was at risk of overdose, and almost 20% lived with the person. These are individuals who should be trained and provided Narcan. Additionally, almost 9% reporting having a friend or family member who uses heroin. Just over 20% of the sample either already had access to Narcan, knew how to get Narcan, and knew how to use Narcan.

Few communities collected the mental health module this year. However, of those that did, over 10% met the clinical threshold for experiencing serious mental illness. This would suggest that many New Mexican's may be suffering from serious mental illness and identify as having mental health or drug and alcohol problems. The need for accessible and high quality behavioral health care remains a considerable need in New Mexico.

Summary Figure 4. Mental Health indicator trends

Outcomes	%		
	FY16 (N= 12,634)	FY17 (N=4,780)	FY18 (N=2,098)
Met critical threshold for serious mental illness[*]	7.5	8.7	10.9
Self-identified having mental health or drug/alcohol problems in the past year	17.6	17.8	22.4
Suicidal thoughts in the past year	5.4	4.9	8.2
Sought help on mental health or drug/alcohol problems in the past year	13.9	14.7	18.0

Comparing our mental health estimates with those from the BRFSS, we find that aggregated 2014-2016 age adjusted estimates indicate that 18.2% indicated they experienced 6 or more days in the past month when their mental health was not good while 12.2% reported 14 or more days when their mental health was not good. Over 20% reported a doctor had diagnosed them with depression. We must note that the BRFSS does not use the same questions for mental health as those used by the NMCS, however, we feel our weighted prevalence estimates are relatively similar to those captures from the BRFSS. Increases seen in FY18 likely are a reflection of the characteristics unique to those communities that administered the instrument this year and may overestimate statewide prevalence estimates.

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. Participant 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. Almost 67% of respondents reported experiencing problems in the past year associated with alcohol misuse in the community. This suggests that people are motivated to create change locally if that energy can be tapped into by the local providers and coalitions. Addressing social access to alcohol and prescription drugs remains a key means of reducing underage drinking and opioid misuse but requires ongoing and constant effort to create the change needed. Intermittent and sporadic messaging is inadequate and ineffective in creating the needed changes in the perception of risk as well as knowledge and awareness. Increasing the perception of risk of getting caught and facing legal consequences requires significant coordination and cooperation with local law enforcement while simultaneously increasing the high visibility of law enforcement efforts to enforce local alcohol laws. Increasing the perception of risk of harm and the proper storage of prescription drugs, all require continuing and ongoing education messaging to the public. The next step for community programs in the process of building capacity and expertise is to create the tools necessary to plan and coordinate activities so that they support and complement each other, creating a synergy that reaches beyond the current supporters and informs, energizes, and motivates community members to become involved and consciously act to create local change in attitudes, norms, intentions, and eventually, behavior.

Much progress has been made to streamline and match strategies to goals and objectives, with the use of the SMART document. The next step is to increase fidelity to the strategies by assessing the dosage and reach of the strategies in addition to assuring the content of messaging matches the strategy. Increasing the dosage and the reach of media outreach, while simultaneously making sure the messaging is on point will increase the effectiveness of media focused prevention strategies. Other strategies will require greater partnership building among key stakeholders and efforts by more than just the prevention coordinator. Involvement of coalition and community members, local lawmakers, schools, faith-based organizations, and service agencies is needed to increase law enforcement efforts, hold local businesses accountable, encourage and help parental monitoring of children, and create policy to help in all of these areas.

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.