Pacific Institute for Research and Evaluation

Results from the 2014 New Mexico Community Survey

Lei Zhang, Ph.D. Martha Waller, Ph.D., Liz Lilliott, Ph.D.

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Acknowledgements

Executive Summary

Funding from the Centers for Substance Abuse Prevention (CSAP) has been instrumental in funding New Mexico's Office of Substance Abuse Prevention's (OSAP) efforts to assess and evaluate prevention efforts across the state. Along with OSAP, New Mexico's State Epidemiological Outcomes Workgroup (SEOW) and Prevention Planning Consortium (PPC) developed a 5-Year Plan to use the Strategic Prevention Framework (SPF) process to target statewide indicators of substance abuse. To aid in statewide to community-level efforts to address these indicators, prevention partners developed a community survey referred to as the New Mexico Community Survey (NMCS). Topic areas included alcohol, tobacco, prescription drug use and some of the contributing factors related to their misuse. Also included are questions on mental health and access to help for behavioral health issues.

Data collection took place over the course of Fiscal Year 2014 using four different methodologies: 1) an invitation was mailed to a random selection of licensed NM drivers to take an on-line survey; 2) an ad was placed on the NM Motor Vehicles Division's website inviting guests to the website to take an on-line survey, 3) a paper and pencil in-person data collection process; and 4) an ad campaign on Facebook targeting 18 to 25 year olds to take an on-line survey. By the end of data collection, all 33 counties in NM were represented in the final aggregated data set. A total of 6,793 valid questionnaires were completed via the four different data collection strategies with most by far coming from in-person data collection.

We analyzed the data in several ways. First we weighted data to match Census 2013 data with regard to distributions of biological sex, age and race/ethnicity across the state so that data estimates more closely reflect a representative state sample. Next we looked at targeted outcomes by funding streams to examine prevalence estimates in communities with different sources of funding. The four sources of funding were Substance Abuse Prevention and Treatment (SAPT) Block Grant funds, Partnerships for Success II (PFS II) funding, Total Community Approach (TCA) funding, and Emerging Trend funding. Funding streams supported prevention efforts targeting one or more of the following substances: alcohol, prescription pain-killers, and illicit drug use. We also examined data by targeted outcomes comparing communities that targeted a specific substance with those that did not. Finally, we conducted NVivo software qualitative analysis upon the open-ended response option, categorizing responses by each intervening variable used by the state in its prevention efforts.

Major findings include:

Alcohol:

- There are no significant differences in alcohol consumption between target and comparison communities, a positive outcome considering that target communities presented with the highest rates in the past.

- Male alcohol consumption and related risk behaviors did not differ significantly between target and comparison communities, but did among women. Women in comparison communities reported significantly less alcohol consumption, drinking and driving and purchasing alcohol for minors than women in target communities.
- Non-Hispanic white men in comparison counties reported significantly less current drinking and purchasing alcohol for minors than non-Hispanic white men in target communities.
- Participants in comparison communities considered teen access to alcohol to be significantly more difficult than those from target communities.
- Target communities reported significantly greater likelihood of police involvement when some alcohol laws are violated compared to comparison communities.
- By far, underage youth who drink report getting alcohol from unrelated adults, at parties, or from adult family members than from other sources.

Prescription Pain-killers

- Past year prevalence of receiving a prescription for a pain-killer was significantly greater in comparison than in target communities.
- Past 30 day prescription pain-killer use to get high was significantly higher among men and women in comparison communities than in target communities.
- Significant differences in prescription pain-killer use between comparison and target communities most often occurred among non-Hispanic whites, and comparison communities fared worse.
- Among the whole sample, past 30-day prescription pain-killer use to get high was lowest among non-Hispanic whites (4.5%); Hispanics reported significantly more use to get high (7.4%), Native Americans reported significantly more than Hispanics (10.5%), and others reported the highest prevalence (12.9%).
- Young adults 18 to 20 reported the highest prevalence of prescription pain-killer use to get high and sharing prescription pain-killers with others. They also were less likely to perceive that there was great risk of harm associated with using prescription pain-killers for non-medical reasons compared to adults 21 and older.

Mental Health

- About 5.5% of New Mexican respondents met the WHO's critical threshold screening for severe mental illness.
- Almost 16% of the sample self-identified as having a mental health or drug or alcohol problem in the past year.
- Just over 4% of the sample reported suicidal ideation in the past year, while just over 11% of the sample reported receiving professional help to address mental health or drug or alcohol problems over the past year.

- Non-Hispanic whites (17%) and Native Americans (17.5%) reported the highest prevalence of mental health or substance abuse related problems over the past year.
- Young adults 18 to 20 years old most often met the threshold for severe mental illness (11%) and for suicidal ideation (10.7%), while young adults 21 to 25 were most likely to report a mental health or drug or alcohol problem in the past year (23.3%).

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 assist in state-level alignment of data collection and evaluation for prevention.

Prevention in New Mexico

The NM Office of Substance Abuse Prevention (OSAP) currently funds prevention programming in 22 of the 33 counties in NM. Figure 1 below highlights the 22 counties currently receiving prevention funding in yellow and the 11 with no OSAP funding in orange.

Figure 1: OSAP funded counties in New Mexico

Counties receive funding to target several statewide prevention priorities including underage drinking, binge drinking among all youth and adults, driving while intoxicated among youth and adults, and prescription pain-killer misuse and abuse among all ages. Depending on the original source of funding, some communities may be focused on all of these priorities and some may be focused on one or two. Also depending on the original funding source and the community needs assessment, communities may be implementing environmental-level prevention strategies, direct services prevention strategies, or both. All communities are expected to collect community survey data while those communities implementing direct services also implement the Strategies for Success, which is reported on elsewhere.

Methodology

The NM Community Survey

The New Mexico Community Survey (NMCS) has been implemented in NM since 2008. While the content has changed over time in response to changes in funding and prevention focus, the purpose has remained the same. The goal of the community survey is to track prevalence of alcohol and other substance use and associated risk behaviors in communities receiving funding from the NM Office of Substance Abuse Prevention (OSAP). The community survey is expected to be conducted yearly by communities and will ideally capture a representative sample of the funded communities and the target groups within those communities.

The survey content and data collection methodology was based upon the community survey protocol developed during the NM SPF SIG and SPE, which was reviewed and approved by PIRE's Institutional Review Board prior to implementation. All communities/organizations were trained on how to complete and follow the data collection protocol and enter data using a standard format.

In Fiscal Year 2014, four different data collection methodologies were implemented.

Data Collection Approach # 1

The first approach was implemented in September 2013 and involved a rigorous random sampling strategy in each county of the state. Working with the NM Motor Vehicles Division, 23,102 postcards were sent to a random selection of licensed NM drivers from 18 to 45 years old. Approximately 700 drivers, 350 18 to 25 year olds and 350 26-45 year olds, were randomly selected within each county to receive a postcard inviting them to take part in an on-line survey. In 10 counties, five receiving PFS II funding and five control counties, additional survey invitations were sent to 18 to 25 year olds because prevention efforts were specifically targeting that age group and it was felt that over sampling this age group would insure a large enough sample size for analyses. Incentives were offered to participants. The first 250 respondents completing the survey would automatically receive a gas card worth $20. Another 250 respondents would be randomly selected from all additional respondents to receive a $20 gas card.

To preserve the anonymity of the invitees, respondents, and their data, all correspondence to potential respondents was conducted through the vendor used by the MVD so that names and addresses of potential respondents and their data remained anonymous. Individual identification numbers were assigned to the potential respondents by the MVD that could be matched with a name at their end but PIRE never had access to any identifying information. In this way, PIRE could identify those invitees who had completed the survey and send reminder invitations only to those who had not by forwarding the individual IDs to the MVD. In addition, PIRE identified

invitees with invalid addresses and did not resend reminders to those potential respondents, thus saving printing and mailing costs.

The timeline for how this process was planned to take place and the reality of how it took place are quite different and at least in part, affected the success of this approach.   The first set of 23,102 cards was mailed in September of 2013 and reminder cards were to be mailed in October 2013 approximately one month after the first was mailed.   Instead they were mailed out in March of 2014 6 months after the initial invitation was sent. Between the first and second mailing, almost 20% of the initial invitation cards sent out were returned as not having deliverable addresses. The survey was planned to end on November 22, 2013 but technically ended on June 30, 2014 when the fiscal year ended. The first set of 250 gas cards were mailed in April of 2014 and ten cards were returned because the addresses were no longer valid. The second 250 have not yet been mailed. Only an additional 104 surveys were completed, which did not meet our minimum goal of 500 completed surveys.

Reasons for the failure of this approach are complex. In part, the approach may not have been the best approach for New Mexicans in general. Reliable internet access is not always available and many may not be willing to respond to a mailed invitation of this nature. Furthermore, the additional requirement of entering a web address in order to take the survey, rather than scanning a QR or bar code, for example, created an extra hurdle for those young people who may be more tech savvy. Finally, delays in arranging payment agreements ultimately led to the significant time delays, which meant the general continuity and flow of the process was disrupted and affected response rates.

Data Collection Approach # 2

The second data approach built on the original approach by taking advantage of the helpfulness and cooperation of the NM MVD and their access to a representative sample of NM residents. The NM MVD website receives a large amount of traffic from users renewing vehicle registrations and drivers licenses on-line. In 2012, 441,869 residents renewed their vehicles on-line and in the first 9 months of 2013, almost 14,500 residents renewed their licenses on-line. Therefore, we felt that this was an opportunity to reach many licensed drivers visiting the website. An ad for the on-line survey was created and posted on the website in November 2013. No incentive was offered to take the survey. The ad was removed in May of 2014. A total of 166 surveys were completed representing 12 counties in New Mexico.

This approach was hindered for two reasons. First, the lack of an incentive to take the survey likely decreased participation. Secondly, and perhaps more importantly, the original placement of the ad on the NM MVD website was not particularly visible by visitors unless they scrolled down to the bottom of the webpage. In addition, several months after the ad was placed on the website, the MVD revised their entire website and the ad was not transferred over to the new

website. When this was realized by PIRE, the MVD quickly moved the ad to a prominent location on the new website and it was much more visible to those visiting the site.

Data Collection Approach # 3

The third approach taken to collect data is the now routinized time and venue-based sampling within funded communities. This convenience sampling approach has been used by funded communities since 2008 and involves communities creating community-specific detailed data collection plans identifying the locations and times in the community where a representative sample of community residents can be asked to participate in the survey. Communities ideally replicate the protocol each year allowing for a comparable sample of adult residents to be surveyed each year and compared over the years. Depending on the size of the community, some are required by OSAP to collect data at local MVD offices as one of the locations. This is not always possible though in the smaller and more rural communities where there are few appropriate locations for collecting a representative sample of adults. Community data collection protocols are reviewed by the State Epidemiological Workgroup to ensure that communities are likely to capture a reasonably representative sample of adults.

Almost 6000 surveys were collected using this methodology, which constitutes 87% of the aggregated sample. These data came from the 22 counties where OSAP is funding prevention services. This approach to data collection has worked well for most communities in NM but not all, particularly larger communities such as Bernalillo County, where the geographic and socio-demographic diversity is much greater and makes it challenging to identify locations that are representative of the community. With new grantees in the county, we anticipate that this next year's data collection will be more comprehensive.

Data Collection Approach # 4

The final data collection approach used in FY14 was a pilot-test using Facebook ads to target and recruit 18 to 25 year olds to take the survey on-line. Six ads ran on Facebook for approximately 2 weeks and a daily and weekly incentive was offered to randomly selected individuals who completed the survey. During the two weeks, ads reached 115,789 NM residents age 18 to 25 and were seen approximately 4.6 times by each person. There were a total of 1715 unique clicks on the survey and 94% of the clicks were done using mobile devices. A total of 352 surveys were completed during this time from residents in 24 NM counties.

Data Collection Summary

Table 1 below provides a breakdown of the number of surveys collected by each survey methodology, the percent of the total sample that each type constitutes, and the number of counties from which data were collected. Ideally, we want all 33 counties to be represented in the data collection process, and while all counties were represented by at least one survey, the eleven counties not receiving OSAP funding were underrepresented. This you can see in Table

2, which lists the number of surveys collected from each county and the weighted percentage contributed to the total sample.

Table 1: Summary of Survey methodologies

Survey Methodology	N	Percent	NM Counties Represented
MVD Mail Out Invitation	354	5.2	32
MVD Website	166	2.4	12
PAPER- Convenience	5921	87.2	22
FACEBOOK (18-25 yr. olds)	352	5.2	24
Total	6793	100.0	33

Table 2: Completed questionnaires by County

County	N	Weighted %
BERNALILLO	432	5.6
CATRON	307	5.4
CHAVES	130	1.7
CIBOLA	237	2.2
COLFAX	255	4.2
CURRY	17	0.2
DE BACA	11	0.1
DONA ANA	381	5.7
EDDY	147	2.2
GRANT	340	5.6
GUADALUPE	15	0.2
HARDING	6	0.1
HIDALGO	269	4.1
LEA	219	3.1
LINCOLN	4	0.1
LOS ALAMOS	9	0.1
LUNA	161	2.9
MCKINLEY	314	3.1
MORA	18	0.2
OTERO	18	0.2
QUAY	36	0.4
RIO ARRIBA	493	6.8
ROOSEVELT	15	0.2
SAN JUAN	424	5.8
SAN MIGUEL	348	5.0
SANDOVAL	415	6.3

County	N	Weighted %
SANTA FE	480	7.4
SIERRA	212	4.5
SOCORRO	271	4.2
TAOS	374	6.2
TORRANCE	150	2.7
UNION	18	0.2
VALENCIA	267	3.6

Analysis

Prior to analysis, NMCS data from the four sources were combined. Given that the CS data are usually overrepresented by women and Native Americans are over sampled, post-stratification weighting was used to adjust the sampled data to match Census demographics. We used the latest available Census 2013 population data[1] of NM to create subgroups (or strata) that are a combination of biological sex, age groups and race/ethnicity. In a similar way, the subgroups of the CS data were created and the number of participants in each group was obtained, which was the sample size of each stratum for the NMCS sample. Then weights of NMCS strata were obtained via dividing NM Census strata population by their corresponding NMCS strata sample size.

Analyses were organized by prevention outcomes, including alcohol use, prescription drug use, cigarette use and mental health. Within alcohol and prescription drug use, we further conducted analyses by funding streams and prevention priority. There are four funding streams: 1) the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant; 2) the Partnerships for Success (PFS)-II State Incentive Grant; 3) NM Legislative funds for the Total Community Approach (TCA); and 4) Emerging Trend funding. Prevalence estimates were compared across funding streams and un-funded communities. Then we examined outcomes by comparing communities that targeted a specific substance with those that did not, regardless of funding sources. In all analyses, SAS Survey procedures were used to account for survey design and weights.

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[1] Retrieved from http://www.census.gov/popest/data/state/asrh/2013/SC-EST2013-ALLDATA6.html on September 2 2014.

Results

Demographics- Whole Sample

Table 3 presents the unweighted n and weighted percent for the sample demographics. Gender, age, and race/ethnicity estimates have been weighted so as to reflect close approximations to the actual NM population percentages despite the actual number of respondents, thus the discrepancies between the number reported and the weighted percents. Weighted estimates show the sample to be evenly split between men and women although more women completed the survey than men. Efforts were made in some communities to oversample 18 to 25 year olds although they reflect a relatively smaller portion of the actual state population. This over sampling was advantageous to communities targeting prevention strategies towards this young adult population. Hispanics and Native Americans were also more prevalent in the sample than in the population as a whole and thus, weighted percentages have de-emphasized their influence to approach a more representative estimate. Our survey sample was well educated compared to the general NM population with college educated adults more prevalent in our sample than in general. Approximately 8.5% of the sample reported having served or still serving in the military which, when weighted, increased to almost 12.5%. The percentage of respondents in the sample who identified as LGBT was 6.3%, which when weighted decreased slightly to 5.4%.

Table 3. Unweighted numbers and weighted percents for the sample demographics.

Gender	N	Weighted %
Mem	2625	49.1
Women	4012	50.9
Age	N	Weighted %
18-20	744	5.6
21-25	978	9.6
26-30	767	9.0
31-40	1164	16.1
41-50	1060	16.0
51-60	1065	18.0
61-70	613	13.9
70+	402	11.6
Race/ethnicity	N	Weighted %
Non-Hispanic White	2118	43.4
Hispanic or Latino	3262	43.7
Native American	1023	8.3
Other	390	4.6
Education	N	Weighted %
High school or less	2538	39.2
Some college	1727	26.4
College or above	1857	34.4

Military status	N	Weighted %
Active military or veteran	540	12.4
Sexual orientation	N	Weighted %
LGBT	385	5.4

Demographics by Funding Stream

Results by funding stream are reported in this section. Table 4 provides a breakdown of the sample by funding stream and gender. Three main funding streams are analyzed: 1) funding received from the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant; 2) funding from the Partnerships for Success (PFS)-II State Incentive Grant; and 3) NM Legislative funds for the Total Community Approach (TCA). We also have data from communities receiving no OSAP implementation funding during FY14 and these communities also serve as comparisons when we examine data by target outcome later in the report. Table 5 breaks the sample down by funding stream and race/ethnicity.

Table 4. Unweighted number and weighted percent of sample stratified by funding stream and gender.

		Men		Women	
Funding stream	Total N	N	Weighted %	N	Weighted %
SAPT	3507	1441	52.1	1977	47.9
PFS-II	1415	499	44.3	889	55.7
TCA	1576	619	50.8	919	49.2
Non-funded alcohol prevention sites	474	136	37.4	336	62.6
Non-funded Rx prevention sites	167	59	43.9	106	56.1

Note. Due to missing values in gender, the number of men and women do not add up to the total N.

Table 5. Unweighted number and weighted percent of sample stratified by funding stream and race/ethnicity.

	Non-Hispanic White		Hispanic or Latino		Native American		Other	
Funding stream	N	Weighted %	N	Weighted %	N	Weighted %	N	Weighted %
SAPT	903	37.3	1761	47.5	660	10.6	183	4.6
PFS-II	413	42.0	625	41.6	276	11.0	101	5.5
TCA	522	45.3	861	46.9	91	3.2	102	4.6
Non-funded alcohol prevention sites	323	78.7	132	19.1	10	0.9	9	1.3
Non-funded Rx prevention sites	55	42.4	99	51.6	5	1.6	8	4.4

Demographics by Prevention Priority

Given that some communities used OSAP funding to target alcohol-related outcomes, while other communities targeted prescription pain-killer misuse, and still others addressed both outcomes, it was important that analyses compare communities that targeted alcohol with communities that did not target alcohol and similarly, compare communities that targeted prescription pain-killer misuse to communities that did not. Table 6 provides the basic descriptive data of the respondents in communities that targeted alcohol and those in communities that did not target alcohol, which we treated as comparison communities. Table 7 presents similar data for those communities that targeted prescription pain-killer misuse and those that did not.

Table 6. Unweighted N and weighted percents of sample by demographic characteristics and targeting alcohol-related outcomes or not

	Target Alcohol		Comparison	
Total	4124		1147	
Gender	N	Weighted %	N	Weighted %
Men	1667	51.4	899	46.1
Women	2356	48.6	1550	53.9
Race/ethnicity	N	Weighted %	N	Weighted %
Non-Hispanic White	1035	36.0	1028	54.4
Hispanic or Latino	2202	50.3	961	33.5
Native American	671	9.2	347	7.3
Other	216	4.5	166	4.8

Table 7. Unweighted N and weighted percents of sample by demographic characteristics and targeting prescription pain-killer misuse or not

	Target Rx		Comparison	
Total	1147		5479	
Gender	N	Weighted %	N	Weighted %
Men	413	45.4	2153	50.1
Women	719	54.6	3187	49.9
Race/ethnicity	N	Weighted %	N	Weighted %
Non-Hispanic White	546	61.6	1517	39.4
Hispanic or Latino	354	26.1	2809	47.4
Native American	195	8.7	823	8.4
Other	52	3.6	330	4.8

Analysis by Survey Topic

Alcohol

We begin by providing a breakdown by funding stream of the prevalence of alcohol use items and related risk behaviors. In Table 8, the weighted prevalence estimate for each indicator is

provided as is the corresponding number of unweighted respondents. In the appendix, we provide a table of alcohol indicators broken down by funding stream and sociodemographic indicators.

Table 8. Weighted prevalence of alcohol use and related risk behaviors by funding stream.

Funding stream	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
SAPT	40.6 (1341)	18.6 (691)	4.5 (176)	2.8 (110)	3.1 (127)
PFS-II	42.1 (577)	20.7 (313)	4.9 (82)	3.4 (60)	3.1 (56)
TCA	37.1 (571)	17.8 (291)	3.5 (59)	1.9 (35)	2.5 (51)

Next we examine items by whether the community targeted alcohol-related outcomes. Figure 2 presents the prevalence of alcohol consumption and related risk behaviors in those communities implementing alcohol-related prevention strategies and those communities that did not. There were no statistically significant differences between target and comparison communities on the alcohol indicators. This can be interpreted positively since those communities targeting alcohol consumption were doing so because the baseline estimates of alcohol use and abuse indicated that these communities were at considerably greater risk than non-targeting communities. Furthermore, in previous years, target communities frequently reported significantly higher estimates than comparison communities.

Figure 2. Comparing target and comparison communities on alcohol indicators; weighted % reported.

The community survey includes questions addressing the key intervening variables, namely easy access to alcohol for underage persons and the perception of risk of legal consequences for violating alcohol laws. Table 9 shows the weighted percent of adults 18 and older who perceive that it is very or somewhat difficult for teens in their community to access alcohol in general and

then specifically from stores and restaurants in the community. Sadly few adult respondents in the sample felt that it was very or even somewhat difficult for teens to get alcohol in their communities either from friends, family, or at social gatherings. On the other hand, over half perceived that it was very or somewhat difficult for teens to purchase alcohol at stores or restaurants in the community. A significantly greater percentage of respondents in comparison communities than those in the target communities perceived access as very or somewhat difficult.   This suggests that target communities still have work to do (although so do comparison communities) to decrease social and retail access to alcohol.

One area that target communities have focused a great deal of effort is on increasing the perception of risk of being caught and facing legal consequences for breaking alcohol-related laws such as underage drinking, serving minors alcohol, and drinking and driving. Communities targeting this intervening variable are indeed making considerable progress and have surpassed comparison communities on some indicators. Significantly more respondents in target communities than in comparison communities perceived that it was very or somewhat likely that police in their community would arrest someone for providing alcohol to a minor or selling alcohol to someone who was already intoxicated, and would stop and arrest someone if they were driving while intoxicated.. While there remains room for improvement, these are promising findings for the target communities and for the state as a whole.

Table 9. Comparing target and comparison communities on alcohol intervening variables; weighted % & (n)

Access to alcohol	Very or somewhat difficult	
	Target	Comparison
Ease of access to alcohol by teens in the community	12.2 (394)	14.7 (324)*
Ease of access to alcohol by teens from stores and restaurants	57.1 (1808)	61.5 (1305)**
Perception of risk/legal consequences	Very or somewhat likely	
	Target	Comparison
Likelihood of police breaking up parties where teens are drinking	61.6 (2053)	60.4 (1280)
Likelihood of police arresting an adult for giving alcohol to someone under 21	65.3 (2262)	59.7 (1255)***
Likelihood of someone being arrested if caught selling alcohol to a drunk or intoxicated person	59.0 (2137)	52.1 (1175)***
Likelihood of being stopped by police if driving after drinking too much	74.1 (2809)	66.9 (1581)***
Likelihood of being convicted if stopped and charged with DWI	84.5 (3136)	83.6 (1882)

$*p \leq .05, **p \leq .01, ***p < .001$

The community survey asked underage adults 18 to 20 years old who reported current drinking how they obtained their alcohol in the past 30 days. Respondents could select multiple options. Table 10 displays where these young adults indicated they obtained their alcohol. By far, most indicated that an unrelated adult purchased it for them followed by having obtained it at a party.

Table 10. Comparing target and comparison communities on access to alcohol (ages 18-20); weighted % & (n)

Access to Alcohol	Target	Comparison
Bought it at a store	2.0 (9)	3.2 (6)
Bought it at a restaurant/bar/public place	1.5 (8)	1.2 (3)
Parent/guardian gave or bought it	2.4 (11)	4.8 (10)
Adult family member gave or bought it	5.6 (29)	7.7 (18)
Unrelated adult gave or bought it	14.2 (71)	18.3 (39)
Someone underage gave or bought it	3.9 (19)	5.1 (12)
Took it from home	3.3 (16)	2.6 (6)
Took it from store without paying	0.5 (3)	0.7 (2)
Got it in Mexico	0.5 (3)	1.2 (3)
Got it at a party	8.7 (44)	13.2 (28)
Got it some other way	1.9 (10)	3.4 (7)

Prescription Drugs

Table 11 below displays the weighted prevalence and corresponding unweighted n for key items measuring prescription pain-killer use, sharing of prescription of drugs and proper storing of prescription drugs. In the appendix we provide a table of prescription drug indicators broken down by funding stream and sex and race/ethnicity. In Table 11 we can see that Emerging Trend communities, most of which focused almost exclusively on prescription drug misuse, still have some of the lowest perceptions of risk of harm associated with taking prescription painkillers for non-medical reasons (77.5%). PFS II communities will begin to address the misuse and abuse of prescription pain-killers, but still have relatively high perception of risk of harm compared to other funding streams. We would hope to see the prevalence increase over time as PFS II communities begin to address this problem behavior in earnest over the next year or so. Fortunately, Emerging Trend (state) funded communities also reported lower prevalence of actually receiving a prescription for a pain-killer, which may indicate that there is less prescribing of prescription pain-killers in these communities. This would certainly correspond to the additional findings that respondents in Emerging Trend communities also reported the lowest prevalence of current pain-killer use for the purpose of getting high and past 30-day use in general. Communities receiving SAPT funding reported the highest percentage of respondents reporting past 30-day painkiller use to get high and the lowest prevalence of storing prescription medications safely.

Table 11. Prevalence of prescription pain-killer use by funding stream; weighted % & (n)

Funding stream	Great risk of harm using Rx pain-killers for a non-medical reason	Prevalence of receiving prescription painkiller	Past 30-day painkiller use to get high	Past 30-day prescription painkiller use	Given or shared prescription drugs with someone	Medication locked or safely stored away
SAPT	85.8 (2481)	30.7 (855)	8.4 (270)	15.8 (464)	6.4 (237)	54.2 (1215)
PFS-II	88.1 (1182)	29.2 (403)	5.7 (88)	14.8 (210)	5.7 (83)	59.3 (593)
TCA	88.9 (21.2)	30.7 (394)	5.1 (78)	13.4 (179)	4.6 (72)	58.4 (557)
Emerging Trend	77.5 (868)	25.3 (276)	4.7 (65)	11.6 (132)	4.6 (59)	56.4 (494)

The following graph (Figure 3) displays the prevalence for the same indicators but instead of by funding stream, compares communities that target prescription drug abuse and those that do not. We can see that communities that have been targeting prescription drug misuse and abuse and access fare slightly better than comparison communities on some indicators. Specifically, significantly fewer respondents in target communities reported receiving prescriptions of pain-killers over the past year, reported less use of prescription pain-killers to get high, and prescription pain-killer use in general than respondents in comparison communities. All of these findings would suggest that the efforts in targeted communities are paying off. On the other hand, respondents in target communities report significantly lower perceived risk of harm associated with misusing prescription pain-killers and no differences are evident between target and comparison communities on indicators of access including the sharing of prescription drugs with others and storing prescription drugs properly.

Figure 3. Comparing the prevalence of communities targeting prescription drugs to communities not targeting prescription drugs; weighted %.

$*p < .05, **p < .01, ***p < .001.$

Table 12 below provides a breakdown by target and comparison groups of respondents' reasons for using prescription pain-killers. Only those who had used prescription pain-killers in the past 30days were asked to respond to the question. Respondents in comparison communities not addressing prescription drug abuse were less likely than those in target communities to indicate their recent use of prescription pain-killers was for a legitimate pain identified by a health care provider. Respondents in comparison communities also reported significantly more use of prescription pain-killers for pain not identified by a health care provider than did respondents in target communities. They also reported using them for "other" reasons unidentified but assumed not to be pain related more so than those in target communities. This further suggests that communities that have been targeting the use of prescription pain-killers are having a positive effect on reducing the misuse of prescription pain-killers.

Table 12. Comparing target and comparison communities on reasons for using prescription pain-killers; weighted % & (n)

Reasons of Prescription Drug Use	Target	Comparison
Treat pain identified by doctors/dentists	79.9 (97)	65.3 (455)***
For pain not identified by doctors	8.5 (16)	15.1 (129)*
Have fun with friends socially	2.8 (6)	3.5 (36)
Help me sleep	5.7 (10)	7.9 (72)
Get high, messed up or stoned	3.5 (7)	3.7 (38)
Cope with anxiety or stress	5.8 (9)	5.7 (55)
Substitute for other drugs or medications	0.4 (1)	2.4 (19)
Affect the impact of other drugs	0.7 (1)	1.7 (17)
Cope with social pressure	1.5 (2)	1.1 (14)
Avoid the bad feelings of withdrawal	1.0 (1)	1.2 (14)
Another reason	0.8 (2)	4.1 (31)*

*$p <.05$, ***$p <.001$.

Table 13 presents the various places that respondents reported accessing the prescription pain-killers used. There are no significant differences between target and comparison communities here. By far, most respondents report having received a prescription for their pain-killers. However, in both target and comparison communities, a substantial percentage report accessing pain-killers in other ways, primarily from family members and friends. This suggests that social access remains an area of concern and one that prevention efforts can and should address.

Table 13. Comparing target and comparison communities on sources for prescription pain-killers; weighted % & (n)

Sources of Prescription Drug Use	Target	Comparison
A doctor/doctors prescribed	77.8 (98)	73.4 (510)
Family member shared	9.1 (15)	5.8 (59)
Friend shared	7.6 (13)	7.2 (69)
Bought from a dealer/stranger	1.9 (3)	1.7 (20)
Taken from a friend/relative	0.6 (1)	1.2 (12)
Bought on the internet	0.0 (0)	0.2 (3)
Bought in Mexico	0.6 (1)	0.6 (6)
Other places	2.0 (3)	1.4 (15)

Tobacco

Tobacco use is assessed in the community survey with three items. We report in the figure below (Figure 4) on the prevalence of use among the whole sample and by gender. In the appendix we provide a table of tobacco use indicators broken down by race/ethnicity, military status, and sexual orientation. Men significantly report more cigarette and tobacco use than women, and there is essentially no difference in the prevalence of men or women purchasing tobacco products for minors.

Figure 4. Tobacco use prevalence for whole sample and stratified by gender; weighted %

Mental Health

Questions on the status of respondents' mental health were included in the community survey for the purposes of tracking both current need of mental health services and actual use of mental health services across the state.

Six questions on the community survey 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.[2] 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 5 shows the prevalence of respondents who responded either "all of the time" or "most of the time" for the 6 items item individually. 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 5.4% 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 (see Figure 6). The alpha coefficient for this scale was α = .89, a respectable score of reliability.

Figure 5. The percent of respondents who reported they felt the following all or most of the time in the past 30 days; weighted %

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[2] 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.

Figure 6 includes the prevalence of the combined score indicating severe mental illness and three additional measures, both for the entire sample and stratified by gender. Gender differences are surprisingly limited across indicators. The prevalence of severe mental illness among women is only a percentage point higher than among men and the prevalence of mental health, drug, or alcohol problems in the past year was only about a percentage point lower among women than men. Even suicidal ideation showed little difference. One thing that Figure 6 clearly indicates is that fewer people are receiving professional help for mental health or substance abuse problems than would appear to need it.

Figure 6. Prevalence of mental health problems among the entire sample and stratified by gender.

Figure 7 presents the sources from which respondents sought professional mental health or treatment services. As might be expected, most respondents sought help from a therapist or counselor and/or from a primary care provider. Additionally, almost 17% sought assistance from a community behavioral health center.

Figure 7. Where respondents sought mental health and/or treatment services; weighted %

Note. Respondents could choose all options that applied.

Respondents were also asked about the type of treatment or therapy received. As can be seen in Figure 8, most reported receiving one-on-one therapy followed by medication.

Figure 8. Type of therapy or treatment received; weighted %

Note. Respondents could choose all options that applied.

Qualitative Analysis of Open-ended response question 43

Responses to the open-ended question 43 were transcribed at data entry, or directly written into online responses, and uploaded into QSR NVivo 10 coding software. A coding tree was developed using the major intervening variables as 'parent' tree nodes, where 'child' nodes were created and assigned to relevant text. Below is a summary of respondent comments on the NMCS. The summary is organized by intervening variable (social access, retail access, low enforcement, perceived risk, community norms, and individual factors) and illustrated throughout with representative quotations. The final section summarizes prominent themes that did not fit within the intervening variables, though some of these themes may somewhat overlap with, or closely relate to, the intervening variables. Wherever possible, alcohol and prescription drugs are discussed separately. Quotations are edited for readability. When identified, codes for community source was provided in parenthesis following the quote. The key for these codes is found below. There were no quotes identified from Santa Fe and Sandoval counties. Though possible, efforts were not made to compare responses by funding stream or comparison group.

BC= Bernalillo County	MC= McKinley County
CaC = Catron County	OC= Otero County
CiC= Cíbola County	SiC = Sierra County
CoC = Colfax County	SoC = Socorro County
DAC = Doña Ana County	SJC = San Juan County
EC= Eddy County	SMC =San Miguel County
GC = Grant County	TaC = Taos Count
HC = Hidalgo County	ToC = Torrance County
LeC = Lea County	UC= Union County
LuC = Luna County	

It is important to note that qualitative responses should be interpreted in terms of their research context. They are voluntarily offered, within the context of placement at the end of a rather lengthy survey, and are always a reflection of whatever the participant considered important to include, as needing elaboration. While responses like these should not be quantified, they offer some important cultural context to improve our prevention efforts. Individual providers should consider these responses in question 43 in order to gain a better understanding of local perceptions of harm, risk and access. These responses, especially when made in conjunction with quantitative results, can register with community policy makers.

Intervening Variables

Social Access

The ease of accessing drugs, alcohol, and cigarettes was a common theme throughout the questionnaires. Several respondents commented that, e.g., "Drugs and alcohol are everywhere (BC)." On this topic, most respondents indicated that parents and older friends or relatives often provided alcohol and cigarettes to underage kids. For example, one individual explained, "The

easiest way for a teen to get alcohol is by an older friend. It is very common in this area (SJC)." Several people reminisced about getting alcohol this way themselves when they were younger: "When I was underage, it was extremely easy for me to obtain alcohol. Never from stores, but people were always willing to buy it for me." Several respondents also commented that alcohol was often available to underage kids at private house parties. One individual explained, "The reason more teen parties involving alcohol use are not known to police is that they are frequently held in private residences out of the view of the public (DAC)."

Two respondents mentioned schools as a place where underage kids accessed substances. For example, one individual said, "APS schools are hella sketchy and that's how kids are getting most of their stuff. No one checks at the schools (BC)."

Few comments were made about social access to prescription drugs. One respondent mentioned that people at her husband's work place sometimes sold prescription drugs to one another (SJC). The lack of commentary could be a reflection of the incipient nature of painkiller prevention efforts throughout the state. Additionally, few are likely to make mention of a common practice that may nonetheless be construed as illegal.

Retail Access

Retail access to prescription drugs and alcohol was a prominent theme. Several respondents commented generally on retail access, including complaints about bars (SJC) and grocery stores selling alcohol (CiC, SJC), smoke shops (DAC), liquor stores along reservation boundaries (SJC), the issuance of new liquor licenses, and the sale of alcohol on Sundays and holidays (SJC). One individual commented, "Way too many places along the rez line selling alcohol, and most folks complain but no one is willing to stand up and close 'em due to laws and law makers and the revenue it brings to their pockets and community!!   (SJC)"

Numerous respondents from across the sites commented on the problem of over-serving, not carding, or selling alcohol to minors. Characteristic comments included: "I have found that liquor establishments card at certain times then go lacks [sic] unless they are busted (CoC)" "There are too many providers and they sell to drunk people all the time; (MC)" "People that are drunk can go into the store and get more drinks just because their friends work there (SJC)" and "Bars in this town over-serve to the point where people are literally too drunk to walk (SMC)."

Another prominent theme was inappropriate or excessive prescribing of drugs. For example, respondents said, "Too many people abuse prescription drugs, especially in this city, and too many doctors hand them out like candy (BC);" "Physicians are very quick to prescribe narcotics with little to no follow-up and there is no real way to track people who will go from doctor to doctor to obtain prescriptions (LC);" and "Pain meds far too easily given. Bigger problem than illegal drugs I sometimes think (SiC)." Numerous respondents blamed doctors and mental health professionals for being careless or overly willing to prescribe opiates and other addictive drugs. One individual stated, "I blame the pharmaceutical companies for the current problems with

young people and pain-killers and misuse of prescription drugs for anxiety etc. They promote them and get them hooked early on that a pill can cure or fix anything (TaC)." Another individual posited that the over-prescribing of drugs was "institutionalized" at the VA (ToC).

Low Enforcement

Low enforcement of drug and alcohol abuse was the most commonly discussed intervening variable by a significant margin. Many responses in this category were simply complaints about poor enforcement. Characteristic comments included: "Suspected or known drug houses never seem to be busted, even when it is apparent that drugs are being sold (GC);" "Gallup Police don't always get everybody who is drinking and driving (MC);" "Acerca de los adolescentes y el alcohol, la policía debería de hacer mejor su trabajo en esta situación (The police should do a better job regarding the situation of adolescents and alcohol) (TaC);" "Police are very slow to come up Highway 70 in a time of need!!! (DAC)" and "The police seem like they aren't doing their job (UC)." Many respondents also shared incidents that they had experienced of poor law enforcement. For example, one individual complained, "I live in a nice neighborhood where drugs have been dealt out of the house across my street. There's no evidence that police are paying attention that I can see (GC)." Another respondent reported, "A young man hit my brother's car, he tried to leave, he admitted smoking marijuana and prescription drugs were found in his car. He did not go to jail or have his car towed. They let him drive away (BC)." Other participants complained, e.g., that "The police catch the people that aren't doing anything (CiC)," while neglecting other serious issues, or suggested that "the police stop being concerned with traffic tickets and more on removing drugs (GC)."

Many respondents were specifically concerned that law enforcement was prejudiced or corrupt. For example, respondents commented, "Small communities so everybody knows everybody so it depends on what your last name is [whether] you get messed with by law enforcement (CaC);" "I think law enforcement is very prejudiced. They do their job according to the people they don't like and target them. Even if you are not doing anything wrong they will follow you and then make up something to stop you (GC);" and "I have heard rumors that drug pushers were not arrested because police were kin to them (GC)." Numerous participants echoed the opinion that police look the other way for their friends, relatives, or wealthy individuals. A couple of respondents suggested that the attitude of the police depended on race.

A number of respondents suggested that poor law enforcement was due to a lack of resources. They suggested larger numbers of police or better training. One individual commented that s/he was "shocked how few sheriff personnel are hired and how vast their terrain is (SoC)." A handful of commenters called for more DWI checkpoints, especially on weekends. In contrast, other participants complained that police had too much power or were themselves not obeying the law. Comments included: "The police are out of control (HC);" "New Mexico is a police state (SJC);" and "Stop cops from being trigger happy (SJC)!"

A large number of respondents complained about poor laws or inconsistent sentencing. In particular, numerous participants were concerned about lax laws and sentences for DUI/DWIs, complaining that, e.g., "New Mexico needs to do a better job of convicting repeat DWI offenders to prevent them from continuing to endanger other motorists and innocent families (MC)." Several commenters suggested that the law was too lenient on repeat DUI /DWI offenders. Similarly, other respondents suggested that the state should "Castigar un poco más duro a los que venden y consumen drogas." (To punish those that sell and use drugs a little harder) (SoC). A couple of participants explained that they "have faith in our law enforcement but I would like to see 1st offenders receive more punishment (MC);" or that "It's hard for the police to do their job when judges don't and won't back them up (MC)".

Respondents also frequently commented on needed reforms. The most common suggestion was for stricter laws and sentencing, especially for DWIs (e.g., "Stricter laws dealing with these issues. NM laws are too weak! (SJC)"); however, respondents also suggested lighter sentencing (e.g., "ease up on prison sentences for small amounts of drug possession (DAC)") and a lower drinking age.

It is important to acknowledge the larger context of these statements for New Mexico. This survey occurred at a time when there was heightened media coverage of problems with law enforcement in the state (and across the nation) that included questionable shootings and excess use of force. While the concern represented in this question for problems with law enforcement can be linked to a history of prevention programs' efforts to increase especially alcohol-related enforcement, it is also very likely that current events also played a part in participants' critique of local law enforcement. In either case, these statements are important for preventionists to consider, especially when planning their engagement with local law enforcement.

Perceived Risk of Harm

Perceived risk of harm to abusing substances was not widely commented on by respondents. One individual commented that youth in particular used substances "como un juego y piensan que nada les va a pasar (like a game, and they think that nothing is going to happen to them)." A handful of other respondents suggested that alcohol and drug use were glorified by the media or by older adults. Another individual explained that "Some people, children and adults included, think drugs are ok as long as they are prescribed by a doctor (HiC)." A third commenter worried that young people "think marijuana is ok to use. That it's no different than drinking beer or wine. That it is non-addicting (DAC)." A common suggestion was the need for more awareness, again especially for youth. Commenters said, e.g., "I think we need to make sure our kids are aware of the dangers (LeC)," and "prescription drugs need to carry more warnings and education about their addictive properties (SiC)."

Community Norms

Community norms were also not widely addressed in the questionnaires. One respondent said, "I think people here in this community drink and smoke weed too much that it is a natural thing. Family members allow it. Parents allow it and few people here might have less of a chance at a good future because they spend money on drugs and alcohol (SMC)." Another individual stated that the "Main problem with teen drinking comes from the rural areas where they think it's a right [sic] of passage for a 16-year-old to drink (SMC)."

Individual Factors

A number of respondents identified individual factors in drug and alcohol use. While not spoken of reflexively as a community norm, or cultural belief around ATOD use and abuse, many individual factors reported below should be viewed within the lens of community norms. For example, the most common individual factor that participants discussed was faith in a higher power. Characteristic comments included: "People need to read the Bible, go to church and trust Christ (DAC);" "I think a relationship with God would help with our drug problems (GC);" and "people turn to drugs generally when they have no faith in God and tomorrow (SoC)." The second most common individual factor identified by participants was family. One individual commented, "The problem starts in the home (SJC)," while another individual stated, "All abuses begin from childhood (SiC)." Several respondents also indicated that drug and alcohol use was a matter of individual responsibility and choice, commenting, e.g., that "Some people have the will to help themselves and some do not (LC)." Others opined that "Nothing helps because it's the person's choice to stop or continue (SJC)," and "People are who they are. We can't change anyone; they have to change their self (TaC)." Other individual factors identified by some respondents include values (e.g., "I am a normal young man that had a good home to grow up in and I credit my parents for raising me well enough to make the right choices in life. I believe that many of the issues you asked about will have more negative results if young people are raised in a home with no values or have parents that lack a moral compass (BC)"), finances (e.g., "I am able to acquire and pay for assistance. Not many in our community can do the same, especially those with severe issues (DAC)"), the need to manage physical pain (e.g., "I use prescription meds for pain, not for fun, but they do affect me in a 'high' way. But I am in so much pain all the time I can't function without them right now (TaC)"), personal relationships (e.g., "Bad break-ups lead to lots of alcohol and drugs (DAC)"), stress (e.g., "Life seems to be getting stressful for everybody, especially teenagers… Drugs and alcohol are the easiest quick fix (SMC)"), and trauma (e.g, "Often times substance use or addictive behavior is used as a coping tool for trauma or mental health issues SJC)").

Other Themes

Other themes discussed by participants included thoughts about what is needed in prevention, especially something for people, and especially youth to do in areas of few resources, and comments on needs for, and shortcomings of, services. Other drugs were also discussed, namely marijuana. Economic and race-based disparities, stigma, other community problems, especially the lack of resources were also discussed.

A particularly common issue identified by participants was a lack of public spaces for youth. For example, one individual commented, "I think we need more places for teens to hang out so that they don't just drink and smoke pot or cigarettes (SMC)." Participants identified several systemic issues connected to drugs and alcohol, including race ("I feel as if other ethnicity/races are given better treatment and advice to better themselves. Services should be publicized better to help every race (BC)") and poverty ("Growing up in an area of high poverty the likelihood of abusing drugs or alcohol is much higher than that of a person who is raised in a wealthy family environment. Poor people abuse themselves to cope with the harsh reality of their life (MC)"). Several individuals suggested that the stigmatization of those with mental illness or who use prescription drugs was a problem. For example, one person stated, "While I agree that prescription drug misuse/abuse/diversion is most certainly a problem, I also STRONGLY and EQUALLY believe that people such as myself who have a legit medical need for opioid pain medication should NEVER have to suffer needlessly or be treated like criminals because of the growing number of addicts and actual criminals (BC)." Respondents also identified a number of issues that they did not explicitly link to drug and alcohol use, including bullying, domestic violence, gangs, LGBT discrimination, and teen pregnancy.

Respondents made numerous suggestions about ways to prevent drug abuse in general. Many of these suggestions were targeted at youth. A common suggestion was that communities needed more activities, such as sports programs and movie theaters, especially for youth. For example, one individual said, "We need more activities that will be safe for our teenagers to keep them off the streets and keep them safe (EC)." Several commenters specifically suggested mandatory awareness programs in schools. Others suggested that increased supervision of youth would be helpful, opining that, e.g., "I think parents should take good care of their kids. And make sure they know what their kids are doing at all times and make sure they know their kid's friends (LuC)." Other respondents suggested the need for more educational and employment opportunities. For example, one individual commented, "I am witness to many people in my small community who are suffering from addiction of some kind, mainly because of the lack of work or jobs or education (TaC)." Other suggestions included the need for more community involvement (e.g., "The community needs to get involved (MC)"), increased funding for community activities, programming, and services (e.g., "More money for programs (EC)"), and better public transportation to prevent drunk driving (e.g., "Public transportation is the major issue regarding drunk driving. It is not nearly as common/available as it should be near bars (DAC)").

Several people included opinions on the legalization of marijuana. The majority supported legalization (e.g., "Marijuana should be legal for 18 years old and up. It would lower crime and increase income for this poor state (HiC)," and "Legalize marijuana. I'd rather have a 'stoner' driving next to me than some drunk individual who could take his or someone else's life in an instant (BC)"), but several individuals were against it (e.g., "I am totally against legalization of marijuana (DA)".

Finally, large numbers of respondents commented on the need for services or complained about their absence or inadequacy. Besides the survey's topic of substance abuse, this could also have been inspired by the final questions regarding mental health and access to services. The most common comments about services had to do with substance abuse services (e.g. rehabs, detoxes) and mental health services. Characteristic comments included: "You need more free in and out patient rehab centers in town (BC);" "One of the greatest issues in our county and village regarding substance abuse issues is the lack of counseling services in the area to assist with individuals dealing with depression, anxiety, other mental health issues, as well as a substance abuse issues (CaC);" and "There needs to be more promotion for NA and AA (CiC)." Numerous respondents simply indicated that, e.g., "There is not enough help for people with substance abuse problems or mental health issues (CiC)." Others indicated the need for more affordable services. For example, one individual complained, "Our community has very limited resources for drug and alcohol treatment. Those who can afford treatment go out of state and those who can't go on a long waiting list (SMC)." Another individual stated, "I have found that finding help for individuals without insurance does not yield options for local services like counseling or seeing a psychiatrist for psych medications at an affordable cost (OC)." Others suggested the need for more outreach (e.g., "Yes we do have a Recovery Program but there is hardly any outreach to these individuals (MC)"), culturally-specific services (e.g., "There should be more Native American-oriented programs for our area (MC)"), family therapy (e.g., "Parents need to be pressured more to attend family therapy to learn how to help their children with mental health/substance use problems rather than the system referring children to just individual therapy (LeC)"), and homeless shelters (e.g., "There are absolutely no rehab clinics or homeless shelters here in Gallup, therefore the cycle continues to abuse alcohol (MC)"), as well as faith-based treatments, youth-oriented programs, and suicide prevention services.

Summary & Discussion

The community survey remains an essential part of local and statewide monitoring and evaluation of OSAP's substance abuse prevention services, as well as efforts to collaboratively plan for and address ATOD prevention and mental health promotion, and building community readiness and capacity for data-driven substance abuse prevention. As an adult survey, one cannot determine sound outcomes for youth consumption, but important intervening variable data help communities identify their progress and issues in terms of perception of risk, access, and perception of harm. The data remain heavily derived from community-provider collected convenience sample, but with each implementation, improvements are made to planning and collection methodology in addition to the addition of new sites for data collection. This expansion has enabled PIRE to identify comparison and target communities according to outcome consumption indicators of prescription painkillers or alcohol, a pattern that can be sustained in the future even as OSAP expands its funding reach.

In terms of underage drinking, binge drinking, and DWI prevention alcohol-related outcomes, the most important finding is that target alcohol consumption measures did not vary significantly from those of comparison communities. This is good news, as historically these measures have remained higher than the rest of the state in target communities, as these communities were those originally identified for programming by their high alcohol-related consequences.

As in previous years, social access remains at the top of the list of intervening variables as a concern. Indeed, the near absence of commentary in question 43 about retail access to alcohol for minors is telling when compared to the strong response to alcohol access to minors through social sources. Our quantitative results back this up, highlighting the continued issue of how to address youth social access to alcohol in a state that is highly rural, low in resources (especially for enforcement), and where evidence-based strategies to address social access are limited.

Perception of risk of legal consequences for breaking alcohol-related laws has some encouraging results. The perception of risk is higher in target communities than in comparison communities; what we hope is a reflection of the years of work in these communities working to increase highly visible enforcement of alcohol-related laws, in spite of dwindling state resources for enforcement. That the open ended responses show considerable mention of enforcement also suggests a growing understanding in New Mexico that there is a relationship between strong and consistent enforcement and prevention. That open-ended responses also highlight the lack of enforcement also points to the lack of resources for it in general, and to the need in OSAP communities to be ever more creative and resourceful themselves in this area.

Prescription pain-killer results in the survey are also very encouraging, as most indicators for target communities show significantly more positive results than for comparison communities. Target communities currently consist of a small number of Emerging Trends-funded counties, so it will be interesting to observe NMCS responses going forward as PFS II and other communities

will be initiating pain-killer prevention implementation, as well as statewide media campaign addressing prescription pain-killers will go into effect in the next fiscal year, not to mention a growing national concern about opioid abuse problems. While many commented on excessive retail access to pain-killers from medical providers, few individuals commented in Q43 on social access to prescription pain-killers. It will be interesting to observe, as prevention efforts expand throughout the state specifically addressing pain-killer social access (as an issue identified especially in assessment data collection) whether social access concerns will receive more commentary. It is important to note that there may be a reluctance on the part of respondents to self-report prescription drug sharing, as such use is technically unauthorized by one's physician, and can be construed as against the law.

Mental health responses are also significant for reflection, especially in relation to other survey responses. We see significantly more people probably needing help than are getting help in this state. Commentary in question 43 reinforced this idea, as participants described difficulties with treatment and mental health services.

And while the social indicators of health or resources per se are not a focus of this survey, it is important to note how many responses to Question 43 illuminate these issues. That many in question 43 mentioned the lack of resources in terms of few activities and services, or poor enforcement speaks to the challenge that substance abuse in our state provides our state, especially its prevention.

Appendix A: Alcohol

Table A1. Alcohol use indicators comparing men and women in SAPT and non-SAPT communities; weighted % & unweighted (n)

	Men		Women	
Alcohol use	SAPT	Non SAPT	SAPT	Non SAPT
Past 30-day alcohol use	43.1 (588)	41.8 (493)	38.5 (728)	34.1 (717)**
Past 30-day binge drinking	22.4 (351)	24.8 (323)	14.6 (326)	13.2 (324)
Past 30-day drinking & driving	4.9 (81)	5.2 (78)	4.1 (91)	2.8 (73)*
Past 30-day binge drinking & driving	3.8 (66)	3.3 (52)	1.6 (39)	1.7 (48)
Past year purchased or provided alcohol for someone under 21	3.2 (61)	3.6 (59)	3.1 (64)	1.9 (55)**

*$p \leq .05$, **$p \leq .01$.

Table A2. Alcohol use indicators comparing men and women in PFS II and non-PFS II communities; weighted % & unweighted (n)

	Men		Women	
Alcohol use	PFS II	Non PFS II	PFS II	Non PFS II
Past 30-day alcohol use	46.1 (226)	46.7 (855)	39.1 (341)	35.3 (1104)
Past 30-day binge drinking	27.8 (150)	22.5 (524)*	14.6 (155)	13.6 (495)
Past 30-day drinking & driving	6.6 (42)	4.7 (117)	3.1 (36)	3.5 (128)
Past 30-day binge drinking & driving	4.6 (29)	3.3 (89)	2.1 (27)	1.5 (60)
Past year purchased or provided alcohol for someone under 21	3.7 (25)	3.3 (95)	2.6 (30)	2.5 (89)

*$p \leq .05$

Table A3. Alcohol use indicators comparing men and women in TCA and non-TCA communities; weighted % & unweighted (n)

Alcohol use	Men		Women	
	TCA	Non TCA	TCA	Non TCA
Past 30-day alcohol use	41.2 (245)	43.0 (836)	32.8 (312)	37.2 (1133)*
Past 30-day binge drinking	23.7 (157)	23.5 (517)	11.5 (125)	14.6 (525)*
Past 30-day drinking & driving	4.2 (30)	5.3 (129)	2.5 (26)	3.7 (138)
Past 30-day binge drinking & driving	2.6 (20)	3.9 (98)	1.1 (13)	1.8 (74)
Past year purchased or provided alcohol for someone under 21	3.2 (27)	3.5 (93)	1.8 (23)	2.7 (96)

*$p \leq .05$.

Table A4. Alcohol use indicators comparing race and ethnic groups in SAPT and non-SAPT communities; weighted % & unweighted (n)

Indicator	Non-Hispanic White		Hispanic		Native American		Other	
	SAPT	Non SAPT	SAPT	Non SAPT	SAPT	Non SAPT	SAPT	Non SAPT
Past 30-day alcohol use	47.5 (425)	38.5 (467)***	38.5 (668)	35.5 (574)	27.5 (188)	28.1 (106)	36.0 (60)	41.8 (87)
Past 30-day binge drinking	14.8 (147)	14.8 (197)	21.6 (381)	23.5 (351)	19.3 (132)	18.6 (70)	17.2 (31)	21.0 (46)
Past 30-day drinking & driving	4.0 (39)	3.0 (45)	4.4 (81)	4.7 (78)	6.8 (47)	5.8 (18)	4.8 (9)	7.3 (17)
Past 30-day binge drinking & driving	1.8 (18)	1.6 (26)	3.4 (60)	3.1 (52)	4.0 (27)	4.0 (13)	2.5 (5)	6.7 (15)
Past year purchased or provided alcohol for someone under 21	3.4 (38)	1.7 (26)*	2.6 (54)	3.5 (62)	4.8 (28)	3.5 (14)	3.5 (7)	6.4 (14)

*$p \leq .05$, ***$p \leq .001$.

Table A5. Alcohol use indicators comparing race and ethnic groups in PFS-II and non-PFSII communities; weighted % & unweighted (n)

Indicator	Non-Hispanic White		Hispanic		Native American		Other	
	PFS II	Non PFS II	PFS II	Non PFS II	PFS II	Non PFS II	PFS II	Non PFS II
Past 30-day alcohol use	51.3 (211)	40.2 (681)***	35.8 (235)	38.6 (1007)	29.6 (83)	27.0 (211)	45.1 (48)	37.0 (99)
Past 30-day binge drinking	20.3 (91)	13.4 (253)***	20.5 (136)	23.0 (596)	21.1 (59)	18.3 (143)	24.8 (27)	17.3 (50)
Past 30-day drinking & driving	3.5 (19)	3.4 (65)	4.8 (34)	4.5 (125)	7.0 (16)	6.3 (49)	11.8 (13)	4.2 (13)
Past 30-day binge drinking & driving	2.2 (12)	1.6 (32)	3.4 (25)	3.3 (87)	4.5 (11)	3.8 (29)	11.2 (12)	2.5 (8)***
Past year purchased or provided alcohol for someone under 21	2.5 (12)	2.4 (52)	2.7 (22)	3.1 (94)	3.8 (11)	4.5 (31)	10.3 (11)	3.3 (10)*

*p ≤.05, ***p ≤.001.

Table A6. Alcohol use indicators comparing race and ethnic groups in TCA and non-TCA communities; weighted % & unweighted (n)

Indicator	Non-Hispanic White		Hispanic		Native American		Other	
	TCA	Non TCA	TCA	Non TCA	TCA	Non TCA	TCA	Non TCA
Past 30-day alcohol use	39.2 (207)	43.5 (685)	36.2 (307)	38.7 (935)	21.3 (22)	28.4 (272)	36.0 (35)	40.0 (112)
Past 30-day binge drinking	13.5 (78)	15.3 (266)	22.9 (186)	22.3 (546)	9.8 (10)	20.0 (192)	16.3 (17)	20.1 (60)
Past 30-day drinking & driving	3.4 (20)	3.4 (64)	3.7 (34)	4.9 (125)	2.6 (2)	6.9 (63)	2.6 (3)	7.3 (23)
Past 30-day binge drinking & driving	1.4 (8)	1.8 (36)	2.4 (23)	3.6 (89)	1.6 (1)	4.3 (39)	2.6 (3)	5.4 (17)
Past year purchased or provided alcohol for someone under 21	1.4 (10)	2.8 (54)	3.5 (35)	2.8 (81)	1.8 (2)	4.6 (40)	4.0 (4)	5.5 (17)

Table A7. Alcohol use indicators comparing men and women in target and comparison communities; weighted % & unweighted (n)

Alcohol use	Men		Women	
	Target	Comparison	Target	Comparison
Past 30-day alcohol use	43.8 (690)	39.8 (361)	37.4 (856)	33.8 (538)*
Past 30-day binge drinking	23.8 (425)	22.6 (230)	14.7 (396)	12.2 (227)*
Past 30-day drinking & driving	5.0 (97)	4.9 (57)	3.9 (106)	2.6 (52)*
Past 30-day binge drinking & driving	3.7 (76)	3.3 (40)	1.6 (48)	1.8 (39)
Past year purchased or provided alcohol for someone under 21	3.5 (76)	2.9 (37)	3.1 (78)	1.8 (40)*

*$p < .05$.

Table A8. Alcohol use indicators comparing race and ethnic groups in target and comparison communities; weighted % & unweighted (n)

Alcohol Use	Non-Hispanic White		Hispanic		Native American		Other	
	Target	Comparison	Target	Comparison	Target	Comparison	Target	Comparison
Past 30-day alcohol use	46.6 (477)	38.2 (394)***	38.6 (833)	35.4 (356)	27.2 (190)	28.5 (102)	36.8 (74)	40.6 (68)
Past 30-day binge drinking	14.7 (168)	14.6 (164)	22.9 (497)	20.8 (204)	19.0 (133)	19.4 (69)	18.3 (40)	19.4 (34)
Past 30-day drinking & driving	3.8 (44)	2.9 (36)	4.6 (106)	4.4 (47)	6.7 (47)	6.2 (18)	4.8 (11)	7.6 (14)
Past 30-day binge drinking & driving	1.7 (20)	1.6 (23)	3.3 (76)	3.4 (35)	4.0 (27)	4.2 (13)	2.8 (7)	7.3 (13)*
Past year purchased or provided alcohol for someone under 21	3.1 (41)	1.7 (21)*	3.1 (78)	2.6 (32)	4.7 (28)	3.7 (14)	3.7 (9)	7.1 (12)

*$p < .05$, ***$p <.001$.

Table A9. Alcohol use indicators comparing veterans and LGBT in target and comparison communities; weighted % & unweighted (n)

Alcohol use	Veteran		LGBT	
	Target	Comparison	Target	Comparison
Past 30-day alcohol use	40.8 (118)	37.9 (85)	50.4 (118)	47.7 (57)
Past 30-day binge drinking	14.0 (47)	14.6 (36)	31.5 (82)	26.9 (34)
Past 30-day drinking and driving	3.9 (14)	3.9 (11)	8.2 (22)	6.6 (9)
Past 30-day binge drinking and driving	2.6 (10)	1.9 (6)	6.9 (19)	4.5 (6)
Past year purchased alcohol for someone under 21	3.7 (13)	1.1 (3)	8.3 (22)	7.2 (10)

Appendix B: Prescription Drugs

Table B1. Prescription drug use indicators comparing men and women in SAPT and non-SAPT communities; weighted % & unweighted (n)

	Men		Women	
Prescription drug use	SAPT	Non SAPT	SAPT	Non SAPT
Great risk of harm using Rx pain-killers for a non-medical reason	84.3 (1026)	84.6 (954)	88.1 (1399)	86.9 (1681)
Past year prevalence of receiving prescription painkiller	30.7 (353)	25.2 (282)	31.0 (484)	29.6 (573)
Past 30-day painkiller use to get high	9.7 (138)	5.0 (69)***	6.9 (124)	4.7 (104)**
Past 30-day prescription painkiller use	16.8 (209)	12.4 (149)	14.9 (246)	13.3 (265)
Given or shared prescription drugs with someone	6.2 (102)	4.7 (61)	6.7 (131)	5.0 (109)*
Medication locked or safely stored away	50.7 (443)	55.5 (431)	57.5 (739)	59.6 (919)

*$p \leq .05$, **$p \leq .01$, ***$p \leq .001$.

Table B2. Prescription drug use indicators comparing men and women in PFS II and non-PFS II communities; weighted % & unweighted (n)

	Men		Women	
Prescription drug use	PFS II	Non PFS II	PFS II	Non PFS II
Great risk of harm using Rx pain-killers for a non-medical reason	86.3 (407)	84.0 (1573)	90.3 (761)	86.5 (2319)
Past year prevalence of receiving prescription painkiller	25.4 (121)	28.6 (514)	32.4 (277)	29.5 (780)
Past 30-day painkiller use to get high	6.37 (35)	7.6 (172)	5.0 (50)	5.9 (178)
Past 30-day prescription painkiller use	14.2 (72)	14.7 (286)	15.2 (134)	13.7 (377)
Given or shared prescription drugs with someone	4.5 (25)	5.7 (138)	6.7 (57)	5.5 (183)
Medication locked or safely stored away	56.3 (187)	52.2 (687)	60.8 (420)	58.0 (1238)

Table B3. Prescription drug use indicators comparing men and women in TCA and non-TCA communities; weighted % & unweighted (n)

Prescription drug use	Men		Women	
	TCA	Non TCA	TCA	Non TCA
Great risk of harm using Rx pain-killers for a non-medical reason	87.1 (453)	83.6 (1527)	91.1 (690)	86.3 (2390)
Past year prevalence of receiving prescription painkiller	28.4 (144)	27.8 (491)	33.1 (241)	29.3 (816)
Past 30-day painkiller use to get high	4.7 (32)	8.2 (175)**	5.4 (43)	5.7 (185)
Past 30-day prescription painkiller use	12.4 (67)	15.3 (291)	14.2 (106)	14.0 (405)
Given or shared prescription drugs with someone	4.8 (30)	5.6 (133)	4.4 (41)	6.1 (199)
Medication locked or safely stored away	53.0 (182)	53.1 (692)	63.1 (361)	57.5 (1297)

**$p \leq .01$.

Table B4. Prescription drug use indicators comparing men and women in ET and non-ET communities; weighted % & unweighted (n)

Prescription drug use	Men		Women	
	ET	Non ET	ET	Non ET
Great risk of harm using Rx pain-killers for a non-medical reason	76.7 (309)	86.1 (1671)***	78.6 (550)	89.6 (2530)***
Past year prevalence of receiving prescription painkiller	25.8 (96)	28.4 (539)	24.8 (176)	31.6 (881)**
Past 30-day painkiller use to get high	5.1 (29)	7.8 (178)*	4.1 (33)	6.1 (195)*
Past 30-day prescription painkiller use	13.0 (55)	15.0 (303)	10.3 (74)	15.0 (437)**
Given or shared prescription drugs with someone	4.8 (24)	5.6 (139)	4.3 (33)	6.1 (207)
Medication locked or safely stored away	55.4 (161)	52.5 (713)	56.7 (325)	59.3 (1333)

*$p \leq .05$, **$p \leq .01$, ***$p \leq .001$.

Table B5. Prescription drug use indicators comparing race and ethnic groups in SAPT and non-SAPT communities; weighted % & unweighted (n)

Indicator	Non-Hispanic White		Hispanic		Native American		Other	
	SAPT	Non SAPT	SAPT	Non SAPT	SAPT	Non SAPT	SAPT	Non SAPT
Great risk of harm using Rx pain-killers for a non-medical reason	87.4 (697)	86.0 (999)	85.6 (1292)	85.3 (1216)	84.3 (370)	83.3 (289)	77.7 (122)	87.0 (171)
Past year prevalence of receiving prescription painkiller	33.6 (258)	27.8 (326)**	28.8 (429)	26.6 (390)	30.1 (123)	28.5 (92)	27.3 (45)	31.1 (61)
Past 30-day painkiller use to get high	6.2 (55)	3.4 (45)**	8.8 (134)	5.9 (89)**	11.0 (49)	10.0 (31)	18.5 (32)	7.9 (14)*
Past 30-day prescription painkiller use	15.3 (125)	13.2 (160)	15.9 (235)	12.4 (189)*	16.6 (73)	14.8 (48)	18.4 (31)	13.2 (27)
Given or shared prescription drugs with someone	7.0 (73)	4.0 (52)*	4.9 (92)	5.6 (85)	10.5 (59)	4.9 (17)**	7.7 (13)	7.7 (18)
Medication locked or safely stored away	47.8 (301)	53.4 (495)*	58.5 (626)	63.4 (648)*	63.1 (238)	64.7 (157)	47.7 (50)	59.4 (79)

*$p \le .05$, **$p \le .01$, ***$p \le .001$.

Table B6. Prescription drug use indicators comparing race and ethnic groups in PFS II and non-PFS II communities; weighted % & unweighted (n)

Indicator	Non-Hispanic White		Hispanic		Native American		Other	
	PFS II	Non PFS II	PFS II	Non PFS II	PFS II	Non PFS II	PFS II	Non PFS II
Great risk of harm using Rx pain-killers for a non-medical reason	91.2 (364)	85.3 (1332)**	86.3 (514)	85.2 (1994)	83.8 (223)	83.9 (436)	85.4 (81)	81.6 (212)
Past year prevalence of receiving prescription painkiller	31.3 (134)	29.8 (450)	26.3 (161)	28.1 (658)	29.6 (75)	29.3 (140)	33.9 (33)	27.8 (73)
Past 30-day painkiller use to get high	4.5 (21)	4.5 (79)	4.8 (31)	8.1 (192)**	11.3 (26)	10.2 (54)	11.3 (10)	13.4 (36)
Past 30-day prescription painkiller use	15.4 (67)	13.7 (218)	14.3 (93)	14.2 (331)	15.1 (37)	16.1 (84)	13.0 (13)	16.6 (45)
Given or shared prescription drugs with someone	6.2 (28)	5.0 (97)	5.3 (35)	5.2 (142)	4.2 (11)	10.0 (65)**	8.0 (9)	7.6 (22)
Medication locked or safely stored away	52.8 (164)	50.7 (632)	63.7 (289)	60.1 (985)	67.3 (130)	62.2 (265)	62.4 (38)	51.4 (91)

*p ≤.05, **p ≤.01, ***p ≤.001.

Table B7. Prescription drug use indicators comparing race and ethnic groups in TCA and non-TCA communities; weighted % & unweighted (n)

Indicator	Non-Hispanic White		Hispanic		Native American		Other	
	TCA	Non TCA	TCA	Non TCA	TCA	Non TCA	TCA	Non TCA
Great risk of harm using Rx pain-killers for a non-medical reason	93.0 (427)	84.4 (1269)***	85.1 (599)	85.6 (1909)	83.8 (60)	83.8 (599)	87.5 (82)	80.8 (211)
Past year prevalence of receiving prescription painkiller	34.5 (156)	28.7 (428)*	27.4 (198)	27.9 (621)	25.7 (15)	29.8 (200)	28.1 (25)	29.7 (81)
Past 30-day painkiller use to get high	3.4 (18)	4.9 (82)	6.8 (51)	7.6 (172)	6.8 (5)	10.9 (75)	5.1 (4)	15.6 (42)*
Past 30-day prescription painkiller use	15.8 (76)	13.5 (209)	10.9 (82)	15.3 (342)*	13.1 (9)	16.1 (112)	12.6 (12)	16.7 (46)
Given or shared prescription drugs with someone	2.9 (15)	6.0 (110)**	6.0 (44)	5.0 (133)	6.5 (5)	8.5 (71)	7.2 (8)	7.9 (23)
Medication locked or safely stored away	55.0 (191)	49.9 (605)	62.6 (304)	60.4 (970)	56.4 (25)	64.3 (370)	56.0 (37)	53.3 (92)

$*p \leq .05$, $**p \leq .01$, $***p \leq .001$.

Table B8. Prescription drug use indicators comparing race and ethnic groups in ET and non-ET communities; weighted % & unweighted (n)

Indicator	Non-Hispanic White		Hispanic		Native American		Other	
	ET	Non ET	ET	Non ET	ET	Non ET	ET	Non ET
Great risk of harm using Rx pain-killers for a non-medical reason	76.1 (402)	90.1(1244)***	77.3 (260)	86.6 (2168)***	84.2 (161)	83.9 (495)	88.4 (45)	81.3 (241)
Past year prevalence of receiving prescription painkiller	24.0 (122)	32.4 (446)***	29.3 (101)	27.7 (695)	23.9 (41)	31.0 (173)	20.5 (12)	31.0 (92)
Past 30-day painkiller use to get high	1.9 (12)	5.4 (85)***	9.9 (33)	7.2 (185)	9.0 (16)	11.0 (64)	6.7 (4)	14.3 (42)
Past 30-day prescription painkiller use	10.2 (53)	15.6 (227)**	14.9 (50)	14.2 (365)	14.1 (24)	16.1 (95)	7.6 (5)	16.9 (51)
Given or shared prescription drugs with someone	3.3 (20)	5.9 (102)*	7.0 (25)	5.1 (149)	5.1 (10)	9.0 (65)	8.3 (4)	7.5 (26)
Medication locked or safely stored away	53.1 (248)	50.0 (525)	64.1 (146)	60.2 (1083)	65.0 (82)	63.8 (313)	54.5 (18)	53.7 (107)

*p ≤.05, **p ≤.01, ***p ≤.001.

Table B9. Prescription drug use indicators comparing men and women in target and comparison communities; weighted % & unweighted (n)

Prescription drug use	Men		Women	
	Target	Comparison	Target	Comparison
Great risk of harm using Rx pain-killers for a non-medical reason	76.7 (309)	86.1 (1623)***	78.6 (550)	89.6 (2439)***
Past year prevalence of receiving prescription painkiller	25.8 (96)	26.8 (532)	24.8 (176)	31.5 (846)**
Past 30-day painkiller use to get high	5.1 (29)	7.9 (177)*	4.1 (33)	6.0 (188)*
Past 30-day prescription painkiller use	13.0 (55)	15.2 (299)	10.3 (74)	15.0 (423)**
Given or shared prescription drugs with someone	4.8 (24)	5.6 (137)	4.3 (33)	6.2 (201)
Medication locked or safely stored away	55.4 (161)	52.0 (686)	56.7 (325)	59.2 (1289)

*$p <.05$, **$p \leq .01$, ***$p <.001$.

Table B10. Prescription drug use indicators comparing race and ethnic groups in target and comparison communities; weighted % & unweighted (n)

Prescription drug use	Non-Hispanic White		Hispanic		Native American		Other	
	Target	Comparison	Target	Comparison	Target	Comparison	Target	Comparison
Great risk of harm using Rx pain-killers for a non-medical reason	76.1 (402)	90.1(1244)***	77.3 (260)	86.6 (2168)***	84.2 (161)	83.9 (495)	88.4 (45)	81.3 (241)
Past year prevalence of receiving prescription painkiller	24.0 (122)	32.4 (446)***	29.3 (101)	27.7 (695)	23.9 (41)	31.0 (173)	20.5 (12)	31.0 (92)
Past 30-day painkiller use to get high	1.9 (12)	5.4 (85)***	9.9 (33)	7.2 (185)	9.0 (16)	11.0 (64)	6.7 (4)	14.3 (42)
Past 30-day prescription painkiller use	10.2 (53)	15.6 (227)**	14.9 (50)	14.2 (365)	14.1 (24)	16.1 (95)	7.6 (5)	16.9 (51)
Given or shared prescription drugs with someone	3.3 (20)	5.9 (102)*	7.0 (25)	5.1 (149)	5.1 (10)	9.0 (65)	8.3 (4)	7.5 (26)
Medication locked or safely stored away	53.1 (248)	50.0 (525)	64.1 (146)	60.2 (1083)	65.0 (82)	63.8 (313)	54.5 (18)	53.7 (107)

*p <.05, **p ≤.01, ***p <.001.

Table B11. Prescription drug use indicators comparing military and sexual minority status in target and comparison communities; weighted % & unweighted (n)

Prescription drug use	Military		LGBT	
	Target	Comparison	Target	Comparison
Great risk of harm using Rx pain-killers for a non-medical reason	77.0 (59)	88.7 (375)	83.7 (37)	82.7 (264)
Past year prevalence of receiving prescription painkiller	38.7 (30)	36.0 (157)	35.7 (14)	30.5 (98)
Past 30-day painkiller use to get high	7.8 (7)	8.4 (42)	7.5 (4)	16.3 (50)
Past 30-day prescription painkiller use	16.8 (13)	17.7 (77)	11.4 (7)	19.4 (64)
Given or shared prescription drugs with someone	11.3 (10)	4.0 (23)	3.5 (3)	11.9 (41)
Medication locked or safely stored away	48.9 (31)	54.1 (175)	50.0 (15)	53.4 (115)

Appendix C: Tobacco

Table C1. Tobacco use indicators by age group; weighted percent & unweighted (n)

Age group	Any current cigarette use	Any current chewing tobacco use	Past year purchased tobacco for someone under 18
18-20	31.4 (201)	11.1 (65)	13.6 (84)
21-25	31.3 (272)	8.9 (65)	6.1 (48)
26-30	36.5 (234)	10.6 (59)	4.1 (26)
31-40	31.0 (304)	8.0 (63)	2.6 (26)
41-50	25.2 (217)	8.6 (62)	1.5 (15)
51-60	23.8 (216)	5.4 (42)	1.4 (15)
61-70	16.8 (100)	3.8 (22)	0.5 (3)
70+	9.4 (37)	2.3 (10)	0.5 (3)

Table C2. Tobacco use indicators by race and ethnic group; weighted percent & unweighted (n)

Substance	Non-Hispanic White	Hispanic	Native American	Other
Any current cigarette use	24.6 (521)	24.5 (728)	25.4 (247)	25.3 (85)
Any current chewing tobacco use	6.8 (130)	6.5 (175)	6.9 (51)	10.0 (32)
Past year purchased tobacco for someone under 18	2.0 (56)	3.0 (110)	4.2 (35)	4.8 (19)

Table C3. Tobacco use indicators by military and sexual minority status; weighted percent & unweighted (n)

Tobacco Use	Military	LGBT
Any current cigarette use	23.3 (128)	39.9 (145)
Any current chewing tobacco use	10.1 (59)	8.8 (31)
Past year purchased tobacco for someone under 18	1.6 (11)	6.5 (24)

Appendix D: Mental Health

Table D1. Mental health indicators by age group; weighted % & unweighted (n)

Age group	Mental Health Indicators			
	Presence of a serious mental illness	Having mental health, drug or alcohol problems in the past year	Suicidal thoughts in the past year	Received professional help on mental health, drug or alcohol problems in the past year
18-20	11.0 (69)	21.2 (146)	10.7 (71)	12.3 (87)
21-25	9.1 (70)	23.3 (196)	6.9 (54)	12.7 (113)
26-30	6.8 (42)	18.1 (126)	6.3 (37)	13.1 (93)
31-40	6.1 (60)	18.3 (192)	4.4 (42)	13.2 (144)
41-50	4.7 (45)	13.0 (123)	2.7 (26)	10.1 (101)
51-60	4.1 (38)	17.1 (152)	3.9 (37)	13.5 (131)
61-70	3.0 (17)	11.9 (66)	2.7 (17)	9.4 (52)
70+	2.5 (10)	6.4 (22)	0.5 (3)	4.1 (15)

Table D2. Mental health indicators by racial/ethnic group; weighted % & unweighted (n)

Mental Health	Non-Hispanic White	Hispanic	Native American	Other
Presence of a serious mental illness	4.2 (92)	6.2 (191)	5.9 (40)	8.5 (28)
Having mental health, drug or alcohol problems in the past year	17.0 (362)	14.4 (476)	17.5 (133)	12.9 (52)
Suicidal thoughts in the past year	3.8 (85)	3.6 (127)	7.0 (43)	8.5 (32)
Received professional help on mental health, drug or alcohol problems in the past year	11.3 (246)	10.1 (328)	18.2 (129)	8.5 (33)

Table D3. Mental health indicators by military and sexual minority status; weighted % & unweighted (n)

Mental Health	Military	LGBT
Presence of a serious mental illness	4.3 (25)	13.3 (46)
Having mental health, drug or alcohol problems in the past year	13.9 (79)	32.3 (118)
Suicidal thoughts in the past year	4.1 (30)	14.6 (52)
Received professional help on mental health, drug or alcohol problems in the past year	11.1 (71)	20.0 (72)

Appendix E: NMCS 2014 Survey Questions (only)

1. How easy do you think it is for teens in your community to get alcohol?

    ☐ Very easy   ☐ Very difficult
    ☐ Somewhat easy   ☐ Don't know
    ☐ Somewhat difficult

2. How easy do you think it is for teens in your community to get alcohol from stores and restaurants?

    ☐ Very easy   ☐ Very difficult
    ☐ Somewhat easy   ☐ Don't know
    ☐ Somewhat difficult

3. In your opinion, how likely are police in your community to break up parties where teens are drinking?

    ☐ Very likely   ☐ Not at all likely
    ☐ Somewhat likely   ☐ Don't know
    ☐ Not very likely

4. How likely are police in your community to arrest an adult for <u>giving</u> alcohol to someone under 21?

    ☐ Very likely   ☐ Not at all likely
    ☐ Somewhat likely   ☐ Don't know
    ☐ Not very likely

5. In your opinion, if someone was caught <u>selling</u> alcohol to a <u>drunk or intoxicated</u> person in your community, how likely is it that he/she would be arrested?

    ☐ Very likely   ☐ Not at all likely
    ☐ Somewhat likely   ☐ Don't know
    ☐ Not very likely

6. In your opinion, if you were driving after you had too much to drink, how likely is it you would be <u>stopped by police</u>?

    ☐ Very likely   ☐ Not at all likely
    ☐ Somewhat likely   ☐ Don't know
    ☐ Not very likely

7. If you were driving after you had too much to drink and were stopped and charged with DWI, how likely is it you would be <u>convicted</u>?

    ☐ Very likely   ☐ Not at all likely
    ☐ Somewhat likely   ☐ Don't know
    ☐ Not very likely

The next few questions ask about you in general.

8. How old are you?

   ☐ 18 to 20   ☐ 21 to 25
   ☐ 26 to 30   ☐ 31 to 40
   ☐ 41 to 50   ☐ 51 to 60
   ☐ 61 to 70   ☐ 71 or older

9. Are you: ☐ Male   ☐ Female

10. What city or town or village do you live in?

    _____

11. What is your home zip code? _____

12. How long have you lived in New Mexico?

    ☐ Less than 1 year
    ☐ 1 – 5 years
    ☐ More than 5 years
    ☐ I don't live in NM *(skip to end of survey)*

13. Which one or more of the following would you say is your race or ethnicity? *(Check all that apply.)*

    ☐ White
    ☐ Hispanic or Latino
    ☐ Black or African American
    ☐ American Indian
    ☐ Native Hawaiian or Other Pacific Islander
    ☐ Asian
    ☐ Alaska Native
    ☐ Other [Please write in your race/ethnicity]

       _____

14. Are you on active duty in the U.S. Armed Forces, military Reserves, or National Guard? *Active duty does not include training for the Reserves or National Guard.*

    ☐ Yes   ☐ No

15. Are you a veteran of the US armed forces?

    ☐ Yes   ☐ No

16. What is the highest grade or year of school you completed to date?
  ☐ Never attended school or only attended kindergarten
  ☐ Grades 1 through 8 (Elementary)
  ☐ Grades 9 through 11 (Some high school)
  ☐ Grade 12 (High school graduate)
  ☐ GED (High school equivalency exam)
  ☐ Some college or technical school
  ☐ College graduate
  ☐ Graduate or professional school graduate

17. Do you identify as (LGBT) Lesbian, Gay, Bisexual or Transgender?
  ☐ Yes
  ☐ No

The next questions are about substances some people use. Please remember that your responses will be kept anonymous.

18. Do you now smoke cigarettes every day, some days, or not at all?
  ☐ Every day
  ☐ Some days
  ☐ Not at all

19. Do you currently use chewing tobacco or snuff, every day, some days, or not at all?
  ☐ Every day
  ☐ Some days
  ☐ Not at all

20. Think specifically about the past 30 days. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage (if any)?
  ☐ None   *(skip to Question 25)*
  _____ Days in past 30 days (1-30)

21. Considering all types of alcoholic beverages, how many times during the past 30 days did you have 5 or more drinks on an occasion (if any)?

  _____ Times in past 30 days

22. During the past 30 days, how many times have you driven when you've had perhaps too much to drink?

  _____ Times in past 30 days

23. During the past <u>30 days</u>, have you driven a vehicle after drinking <u>5 or more</u> alcoholic beverages?

☐ Yes   ☐ No

24. *If you are 18 to 20 years old*, please answer this question: During the past 30 days, how did you get your alcohol? *(Check all that apply.)*
   ☐ I have not drunk alcohol in the past 30 days.
   ☐ I bought it at a store, such as a liquor store, convenience store, or grocery store.
   ☐ I bought it at a restaurant, bar or public place.
   ☐ My parent or guardian gave it or bought it for me.
   ☐ Another family member who is 21 or older gave it or bought it for me.
   ☐ Someone not related to me who is 21 or older gave it or bought it for me.
   ☐ Someone under age 21 bought or gave it to me.
   ☐ I took it from my home or someone else's home.
   ☐ I took it from a store without paying for it.
   ☐ I got it in Mexico.
   ☐ I got it at a party.
   ☐ I got it some other way. [Please describe]: _____

25. In the <u>past year</u>, have you purchased or otherwise provided tobacco (cigarettes, chew, snuff) for someone under 18, even if it was for your own child? *(not including tobacco used for religious purposes)*

☐ Yes   ☐ No   ☐ Don't know

26. In the <u>past year</u>, have you purchased or otherwise provided alcohol (beer, wine, liquor) for someone under 21, even if it was for your own child? *(not including alcohol used for religious purposes)*

☐ Yes   ☐ No   ☐ Don't know

27. How much do you think people risk harming themselves (physically or in other ways) using prescription pain-killers for a non-medical reason?

☐No risk
☐Slight risk
☐Moderate risk
☐Great risk

28. In the <u>past year</u>, were you <u>prescribed painkillers</u> by a medical professional *(even if you did not take them)?*

☐ Yes   ☐ No

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29. During the past 30 days, how many times did you use a **pain-killer** to get high, like Vicodin, OxyContin (also called Oxy or OC), or Percocet (also called Percs)?

☐ 0 times   ☐ 10 to 19 times
☐ 1 or 2 times   ☐ 20 to 39 times
☐ 3 to 9 times   ☐ 40 or more times

30. In the last <u>30 days</u>, did you <u>use</u> prescription pain-killers for any reason *(even if you were not prescribed them)?*

☐ Yes   ☐ No
If you did not take any prescription painkillers in the last 30 days, please skip to question # 34

31. If you've taken prescription painkillers in the last <u>30 days</u>, on how many days did you take them?
_____ days in the last 30 days (1-30)

32. If you took painkillers in the last 30 days, why did you take them? *(Check all that apply.)*
☐ To treat pain that my doctor or dentist identified (for example, injury, surgery, tooth extraction, illness)
☐ For pain not identified by my physician (e.g., minor injury)
☐ To have fun with a friend or friend(s) socially
☐ To help me sleep
☐ To get high, messed up or stoned
☐ To cope with anxiety or stress
☐ To substitute for other drugs or medications
☐ To affect the impact other drugs (for example, help me come down or to get me higher)
☐ To cope with social pressure
☐ To avoid the bad feelings of withdrawal
☐ Another reason *[Please describe]:*
_____

33. If you used painkillers in the <u>last 30 days</u> for any reason, where did you get them? *(Check all that apply.)*
☐ A doctor or doctors prescribed or gave them to me

☐ A family member shared them
☐ A friend shared them
☐ They were bought from a dealer or other stranger
☐ They were taken from a friend or relative without asking
☐ They were bought on the internet
☐ Purchased them in Mexico
☐ Other place: _____

34. In the <u>past year</u>, have you given or otherwise shared <u>any prescription drugs</u> with someone that was not prescribed them *(even if that person was a close friend or family member)?*

☐ Yes   ☐ No

35. Do you <u>currently</u> keep <u>all of your medications</u> locked or otherwise safely stored away so that others cannot get them *(including youth and family)?*

☐ Yes   ☐ No
☐ I do not have any medications

36. During the past <u>4 weeks</u> (28 days), how much of the time did you feel … *(Circle the best response)*

a) …so sad nothing could cheer you up?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
b) …nervous?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
c) …restless or fidgety?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
d) …hopeless?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
e) … that everything was an effort?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
f) …worthless?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
g)…anxiety?	All of the time	Most of the time	Some of the time	A little of the time	None of the time

37. <u>In the past year</u>, was there any time when you <u>thought</u> you had a mental health, nervous, emotional, drug or alcohol problem?

☐ Yes   ☐ No

38. At any time in the past 12 months, did you seriously think about trying to kill yourself?

☐ Yes   ☐ No

39. <u>In the past year</u>, have you ever sought help from someone other than your friends or family for your emotions, nerves, mental health, or your use of alcohol or drugs?

☐ Yes   ☐ No – *If you answer no, please skip to question 42.*

40. If you did receive help from someone other than your friends or family in the last year, where did you go? *(Check all that apply.)*

☐ Primary care provider (family medical practitioner, physician's assistant, nurse practitioner)

☐ Private therapist or counselor (such as a psychologist, psychotherapist, mental health nurse)

☐ A community mental health or substance abuse program

☐ A peer specialist, sponsor, or recovery coach

☐ Psychiatrist.

☐ Other healers like herbalist, acupuncturist, homeopath, chiropractor (for mental health or drug or alcohol problems)

☐ Faith-based services

☐ Spiritual healer (curandero/a, medicine man/woman)

☐ Emergency room (only for mental health or drug or alcohol problems)

☐ Inpatient behavioral health services or detox (where you stayed overnight)

☐ While in jail or prison

☐ Other health practitioner [Please describe]: _____

41. If you did have problems with your mental health or with drugs or alcohol, and received help, what kind of help was it? *(Check all that apply.)*

☐ One on one therapy or counseling

☐ Group therapy or counseling

☐ Self-help groups like 12- step, AA, NA, faith based groups

☐ A minister, priest or other spiritual guide/healer

☐ Inpatient (overnight)

☐ Emergency care

☐ Detox

☐ Medication

☐ Herbs, acupuncture or homeopathy

☐ Something else [Please describe]: _____

42. <u>In the last year</u>, how often were you <u>able to get help</u> for your mental health or substance abuse problems when you needed it?

☐ Always   ☐ Sometimes   ☐ Never   ☐ I didn't need it

43. Is there anything else you'd like to tell us or add about the issues we have asked about today?