Pacific Institute for Research and Evaluation

Results from the 2015 New Mexico Community Survey

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2015

This report is submitted to the New Mexico Office of Substance Abuse Prevention in fulfillment of contract requirements.

Suggested citation:

Zhang L, Waller MW, Lilliott E. (2016) Results from the 2015 New Mexico Community Survey: Evaluation of the Community Based Prevention Efforts. Pacific Institute for Research and Evaluation (PIRE), Chapel Hill, NC. April 2016.

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Acknowledgements

PIRE would like to recognize the significant support of various stakeholders in prevention in New Mexico. The Director and staff of the NM Office of Substance Abuse Prevention and participants in NM's State Epidemiological Outcomes Workgroup, in addition to local prevention providers and evaluators, were essential to the development of the community questionnaire and survey methodologies, review of local collection methodologies and protocols, and in the provision of feedback on analysis strategies. OSAP participating programs, in particular the former Community Survey participants and their evaluators, were instrumental in improving the current survey instrument and data collection methodology. New and old surveying agencies alike worked under limited time and budget constraints to gain the most representative samples possible. The continuous feedback from these dedicated community members has been essential to the success in collecting these data.

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 behavioral health services.

Data collection took place over the course of Fiscal Year 2015 using two methodologies: 1) a paper and pencil in-person data collection process and 2) an ad campaign on Facebook and Twitter targeting adults across the state 18 and older to take the survey on-line. Time and venue-based data collection resulted in 9,067 valid surveys representing 25 counties. On-line survey data collection resulted in 798 valid surveys representing all 33 NM counties. A total of 9,865 valid questionnaires were completed via the two different data collection strategies with 92% coming from in-person data collection methods.

We analyzed the data in several ways. First, we weighted data to match NM Census 2013 data with regard to distributions of gender, 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, and Total Community Approach (TCA) funding. Funding streams supported prevention efforts targeting one or more of the following substances and associated indicators: alcohol (underage drinking, adult or youth DWI and binge drinking), prescription painkillers (using painkillers to get high), and illicit drug use (only in the case of Eddy county). We also examined data by targeted outcomes comparing communities that targeted a specific substance with those that did not.

Major findings include:

Alcohol:

- There are no significant differences in alcohol consumption between target and comparison communities; a positive trend continues given that target communities presented with the highest rates in the past.
- Men in target communities tend to report more alcohol consumption and related risk behaviors than their counterparts in comparison communities, but the opposite is true

among women. Women in target communities reported significantly less alcohol consumption, drinking and driving, and purchasing alcohol for minors than women in comparison communities.

- Latino/as in comparison communities reported significantly less current drinking than their counterparts in target communities; and Native Americans in comparison communities engaged in significantly more binge drinking and purchasing alcohol for minors than Native Americans in target communities.
- Difficulty of teen access to alcohol did not differ between target and comparison communities.
- Comparison communities reported significantly greater likelihood of police involvement when some alcohol laws are violated compared to target communities.
- Almost half of underage youth who drink report getting alcohol at parties.

Prescription Painkillers

- Past 30 day prescription painkiller use for any reason was significantly greater in target than in comparison communities.
- More participants in target communities than in comparison communities report perceived great or moderate risk of using prescription painkillers for non-medical reasons and locked/stored safely their medication.
- Males in comparison communities reported significantly lower rates of past 30-day prescription painkiller use for any reason, sharing prescription painkillers or locking medication away.
- Significant differences in prescription painkiller 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 painkiller use to get high was lowest among non-Hispanic whites (2.1%); and others reported the highest prevalence of prescription painkiller use for any reason (19.3%).
- Young adults 18 to 20 reported the highest prevalence of prescription painkiller use to get high and sharing prescription painkillers with others. They also were less likely to perceive that there was great risk of harm associated with using prescription painkillers for non-medical reasons compared to adults 21 and older.

Mental Health

- About 5.4% of New Mexican respondents met the WHO's critical threshold screening for severe mental illness.
- Almost 13.4% of the sample self-identified as having a mental health or drug or alcohol problem in the past year.

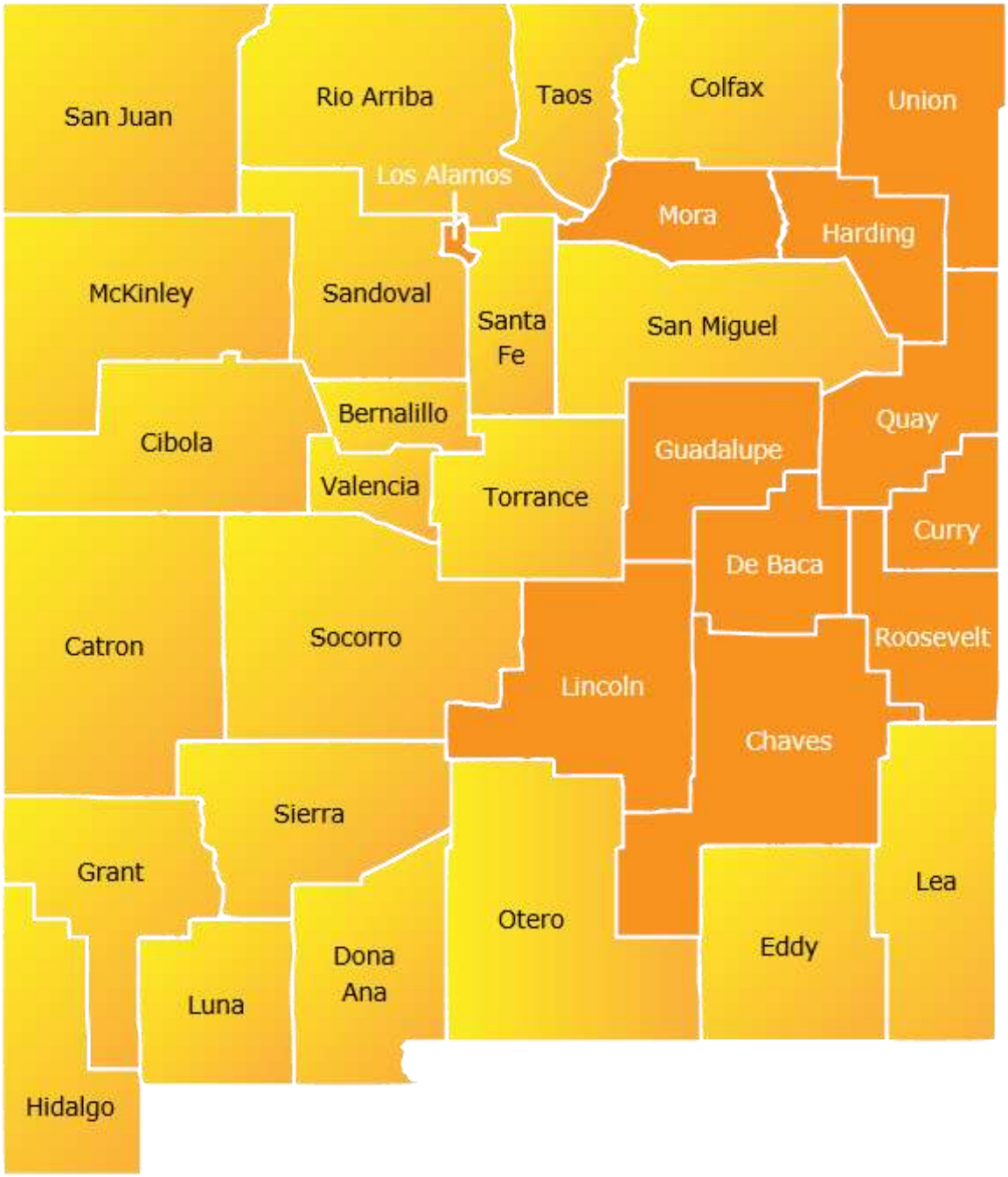
- Just over 4% of the sample reported suicidal ideation in the past year, and about 11.8% of the sample reported receiving professional help to address mental health or drug or alcohol problems over the past year.
- Young adults 18 to 20 years old most often met the threshold for severe mental illness (11.6%) and for suicidal ideation (9.3%). They were most likely to report a mental health or drug or alcohol problem in the past year (19.0%), and to seek help on mental health or drug/alcohol problems in the past year (16.0%).

Statewide and community-level results aid in evaluating current prevention programming, provide assessment for new and evolving programs, provide baseline estimates for new programs and in general, assist in state-level prevention planning and alignment of prevention needs and efforts.

Prevention in New Mexico

The NM Office of Substance Abuse Prevention (OSAP) in FY 15 funded prevention programming in 22 of the 33 counties in NM. Figure 1 below highlights the 22 counties receiving prevention funding in yellow and the 11 with no OSAP funding in orange.

Figure 1: OSAP funded counties in New Mexico



Programs 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 painkiller misuse and abuse among all ages. Depending on the original source of funding and needs assessment results, communities focus on two or more of these priorities (only Eddy County prioritizes illicit drug use, which is not mentioned in the NMCS, so this priority is not otherwise mentioned). 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, and those communities implementing direct services also implement the Strategies for Success, which is reported on elsewhere.

More projects beyond OSAP funded prevention programs are using the NMCS to obtain timely community-based data. These include local DWI programs, Drug Free Community grantees, as well as other community-based initiatives that partner with an OSAP-funded program in order to make community-wide impact.

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 shifts 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. Prevention communities in NM may represent towns, tribal lands or neighborhoods, however they most often represent counties.

The survey content and data collection methodology are based upon the Community Survey protocol developed during the NM SPF SIG and SPE, and PIRE's Institutional Review Board reviews and approves the statewide protocol prior to implementation. All communities/organizations were trained on how to complete and follow a local data collection protocol and enter data using a standardized codebook. The SEOW reviews and makes recommended changes to all protocols prior to implementation, and any changes to data collection sites must be approved by a PIRE representative.

In Fiscal Year 2015, we implemented two data collection methodologies.

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

The first 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 to increase the randomness and representativeness of the sample. This is not always possible in the smaller and more rural communities where there are few appropriate locations for collecting a representative sample of adults. Time and venue-based sampling is most frequently used as a sampling approach with hard-to-reach minority populations that may not be widely represented in a random sampling approach. While not typically used when trying to obtain a representative sample, it is a very useful approach in New Mexico, which is a predominantly rural state with low population density overall. In addition, access to landlines, cell phones, and the internet can be sporadic among much of the population. Therefore, identifying locations within the community where most people will be represented and identifying days and times that will capture a diverse sample of community members, is one way that communities can collect data from a broad cross-section of their community.

Members of the State Epidemiological Outcomes Workgroup (SEOW) review community-level data collection protocols to ensure the capture of a reasonably representative sample of adults. PIRE instructs community providers and local evaluators in appropriate data collection methodology and how to maintain respondents' confidentiality while completing the survey. This technique is initially challenging for many, but over time, providers have come to regard this process as imperative to improving the quality of the services they provide. This year, prevention providers tracked their data collection process in detail for submission with their end of year reports. This purpose of this was to compare the originally proposed in the data collection protocol to actual data collection. In particular, if some locations originally expected to be good places to collect data actually turned out not to be, then this information would help inform future planning. In this way, the next year's protocol will be a composite of the previous year's data collection log and planned protocol, helping providers make data collection more efficient and more representative of their communities.

Communities collected over 9,000 surveys with this methodology, which constitutes 92% of the aggregated sample. These data came from the 25 counties where OSAP funded 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. The geographic and socio-demographic diversity is much greater, making it challenging to identify truly representative locations. That said, an advantage of the larger, more urban communities, is that data can often

been collected at Motor Vehicle Departments, which are one of the few places that could be described as representative. Even so, the number of surveys collected from an MVD is often less than what could be collected at a local business.

As new sub-recipients are funded, we are seeing increased coverage across the state, particularly in more rural communities. In addition, local DWI programs and others are starting to conduct the Community Survey, which has helped increase the number of counties across the state collecting data so that comparisons can be made between OSAP prevention funded communities and those without.

Data Collection Approach # 2: On-line survey

The other data collection approach used in FY15 was the on-line implementation of the survey. Ads for the survey were placed on Facebook and on Twitter targeting NM residents 18 and older. (Ads can be seen in Appendix E.) We piloted this methodology in FY14 among 18 to 25 year-olds and it proved promising. Therefore, we invested further in this methodology this year and expanded the reach on the upper end. Ads ran for a total of 9 weeks. Six ads were created, three of which included people of various ages in them (young adults, parents, and older adults) and three of which were NM related landscapes. Each week, two ads were run on both Facebook and Twitter. The ad receiving the most "clicks" returned the following week along with a new ad. After all ads had been posted once, we included with the week's "winning" ad a previous losing ad so that ads changed over the 9 weeks with some regularity. We found that overall, ads did not differ much in the number of times any one was clicked on by respondents. From April 5, 2015 – June 7, 2015 (58 days) the Facebook ad was served 800,917 times with a frequency of 4.77 times per person. There was 8,372 clicks with 6,073 unique clicks. The click rate was .76%. The ad reached 99,612 people on mobile devices. For the Twitter ads there were 59,978 impressions, with 380 link clicks. The click rate was 0.63%.

We offered daily and weekly incentives to randomly selected individuals who completed the survey. After completing the survey, respondents were given the option to enter to win an incentive, an invitation that not all respondents chose to accept. Each day, we gave away four $20 gas cards to randomly selected respondents from that day. Each week, a respondent was randomly selected to receive two $20 gas cards from the week's respondents, for a total of 30 gas cards given out each week for 9 weeks.

Residents in 33 NM counties completed a total of 798 surveys during this time. If we combine the number of unique clicks from Facebook and all clicks from Twitter, (or 798/(6073 + 380)) the estimated response rate for the on-line portion of the survey is approximately 12%.

Data Collection Summary

Table 1 below provides a breakdown of the number of surveys collected for both methodologies, 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. Table 2 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
PAPER- Convenience	9067	91.9%	25
FACEBOOK (18+ yr. olds)	798	8.1%	33
Total	9865		

Table 2. Completed questionnaires by County compared to 2014 estimates

County	2015					2014	
	On-line	Paper	Total N	%	Weighted %	Total N	Weighted %
Bernalillo	250	694	944	9.5%	10.2%	432	5.6
Catron	2	299	301	3.0%	3.2%	307	5.4
Chaves	17	189	206	2.1%	1.7%	130	1.7
Cibola	10	355	365	3.7%	3.0%	237	2.2
Colfax	6	246	252	2.5%	2.9%	255	4.2
Curry	15	338	353	3.6%	3.9%	17	0.2
De Baca	3	143	146	1.5%	1.6%	11	0.1
Dona Ana	90	253	343	3.5%	3.9%	381	5.7
Eddy	16	302	318	3.2%	3.1%	147	2.2
Grant	15	199	214	2.2%	2.5%	340	5.6
Guadalupe	1	0	1	0.0%	0.0%	15	0.2
Harding	1	0	1	0.0%	0.0%	6	0.1
Hidalgo	3	311	314	3.2%	3.6%	269	4.1
Lea	17	416	433	4.4%	4.1%	219	3.1
Lincoln	10	0	10	0.1%	0.2%	4	0.1
Los Alamos	4	0	4	0.0%	0.1%	9	0.1
Luna	45	294	339	3.4%	3.5%	161	2.9
McKinley	8	599	607	6.1%	3.8%	314	3.1
Mora	1	0	1	0.0%	0.0%	18	0.2
Otero	18	270	288	2.9%	2.0%	18	0.2
Quay	3	0	3	0.0%	0.0%	36	0.4
Rio Arriba	15	486	501	5.1%	5.2%	493	6.8

County	2015					2014	
	On-line	Paper	Total N	%	Weighted %	Total N	Weighted %
Roosevelt	3	306	309	3.1%	3.5%	15	0.2
San Juan	38	412	450	4.5%	3.8%	424	5.8
San Miguel	8	315	323	3.3%	3.3%	348	5.0
Sandoval	60	465	525	5.3%	4.9%	415	6.3
Santa Fe	55	393	448	4.5%	5.1%	480	7.4
Sierra	4	325	329	3.3%	3.7%	212	4.5
Socorro	11	475	486	4.9%	5.9%	271	4.2
Taos	14	332	346	3.5%	4.0%	374	6.2
Torrance	8	298	306	3.1%	3.4%	150	2.7
Union	9	0	9	0.1%	0.1%	18	0.2
Valencia	38	352	390	3.9%	3.9%	267	3.6
Total	**798**	**9067**	**9895**	**99.7%**	**100%**	**6793**	**100.0**

Analysis

Prior to analysis, NMCS data from the communities and from the on-line survey 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 NM Census demographics. We used the latest available Census 2013 population data[1] of NM to create subgroups (or strata) that are a combination of gender, 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; and 3) NM Legislative funds for the Total Community Approach (TCA). We compared prevalence estimates 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.

[1] Retrieved from http://www.census.gov/popest/data/state/asrh/2014/SC-EST2014-ALLDATA6.html on July 17 2015.

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 and the weighted percent reported. 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 small portion of the actual state population. This over-sampling was advantageous to programs targeting prevention strategies towards this young adult population. 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 state estimate. Our survey sample was more educated than the general NM population; according to the US Census, 26.1% of adults 25 years or older in NM reported having a bachelor's degree compared to our weighted estimate of 32.1%. Approximately 6% of the sample reported having served or still serving in the military which, when weighted, increased to 7 %. The percentage of respondents in the sample who identified as LGBT was 5.5%, which when weighted decreased slightly to 4.9%.

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

Gender	n	Unweighted %	Weighted %
Men	3671	38.9	49.1
Women	5763	61.1	50.9
Age	**n**	**Unweighted %**	**Weighted %**
18-20	1025	10.4	5.6
21-25	1088	11.0	9.7
26-30	1183	12.0	9.1
31-40	1733	17.6	16.2
41-50	1578	16.0	15.7
51-60	1631	16.5	17.9
61-70	1103	11.2	14.1
70+	524	5.3	11.7
Race/ethnicity	**n**	**Unweighted %**	**Weighted %**
Non-Hispanic White	3268	33.1	42.4
Hispanic or Latino	4340	44.0	44.1
Native American	1657	16.8	8.7
Other	600	6.1	4.8
Education	**n**	**Unweighted %**	**Weighted %**
Less than high school	738	7.6	7.5
High school graduate/GED	2875	29.5	27.5

Some college/Technical school	3305	33.9	32.9
College graduate or higher	2822	29.0	32.1
Military status	n	Unweighted %	Weighted %
Active military or veteran	550	5.6	7.1
Sexual orientation	n	Unweighted %	Weighted %
LGBT	530	5.5	4.9

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. We analyze three main funding streams: 1) the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant; 2) the federal 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 prevention funding during FY15 -- 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	4871	1732	47.4	2899	52.6
PFS-II	1936	721	49.3	1150	50.7
TCA	1758	677	50.3	991	49.7

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	1478	39.1	2196	46.3	943	10.1	254	4.5
PFS-II	551	38.8	733	40.0	484	13.8	168	7.4
TCA	666	45.3	876	47.3	101	2.8	115	4.6

Demographics by Prevention Priority

All but one of the communities used OSAP funding to target alcohol-related outcomes, many communities targeted prescription painkiller misuse along with alcohol abuse, and still others had not yet identified any outcome as they were not yet in the implementation phase of the SPF

process or were not using OSAP funding. Therefore, it was important that analyses compare communities that specifically targeted alcohol abuse in their OSAP-supported prevention implementation with communities that did not; and similarly, compare communities that targeted prescription painkiller 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 painkiller misuse and those that did not.

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

	Target Alcohol		Comparison	
Total	6515		3350	
Gender	n	Weighted %	n	Weighted %
Men	2399	48.5	1272	50.3
Women	3867	51.5	1896	49.7
Race/ethnicity	n	Weighted %	n	Weighted %
Non-Hispanic White	2002	39.8	1266	46.9
Hispanic or Latino	2910	45.8	1430	41.2
Native American	1211	9.5	446	7.3
Other	392	5.0	208	4.6

Note. Due to missing values in gender, the number of male and female-identified participants do not add up to the total N.

Table 7. Unweighted N and weighted percent of sample by demographic characteristics and targeting prescription painkiller misuse or not

	Target Rx Painkillers		Comparison	
Total N	4505		5360	
Gender	n	Weighted %	n	Weighted %
Men	1609	47.0	2062	50.8
Women	2757	53.0	3006	49.2
Race/ethnicity	n	Weighted %	n	Weighted %
Non-Hispanic White	1501	42.8	1767	41.8
Hispanic or Latino	1829	41.8	2511	46.1
Native American	891	10.2	766	7.5
Other	284	5.2	316	4.6

Note. Due to missing values in gender, the number of male and female-identified participants do not add up to the total N.

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 given as is the corresponding number of unweighted respondents. In Table 9, we examine the same information stratified by gender. In Appendix A, 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.

	Weighted Percent				
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 (n=4553)	45.3	14.4	4.6	3.4	2.9
PFS-II (n=1936)	50.8	21.4	5.9	5.4	5.3
TCA (n=1758)	47.1	18.4	3.7	3.2	3.4

Table 9. Weighted prevalence of alcohol use and related risk behaviors by gender and funding stream.

	Men			Women		
Alcohol use	SAPT (n=1639)	PFS II (n=721)	TCA (n=677)	SAPT (n=2683)	PFS II (n=1150)	TCA (n=991)
Past 30-day alcohol use	54.1	55.5	52.3	38.7	46.2	42.4
Past 30-day binge drinking	19.5	28.8	23.1	9.8	13.9	13.0
Past 30-day drinking & driving	7.1	8.4	4.9	2.4	3.1	2.4
Past 30-day binge drinking & driving	5.4	8.4	4.0	1.6	2.3	2.1
Past year purchased or provided alcohol for someone under 21	3.6	6.5	3.8	2.2	3.9	2.9

Next we examined whether communities targeting alcohol were more effective than those not targeting alcohol by comparing those targeting alcohol-related outcomes and intervening variables to those not targeting alcohol-related outcomes and intervening variables. Figures 2-4 present the prevalence of alcohol consumption and related risk behaviors in those communities implementing alcohol-related prevention strategies compared to those communities that did not in both FY 2014 and FY 2015. In general, communities targeting alcohol-related outcomes and intervening variables do so because needs assessments determined that alcohol was of a considerable problem in the community. This can been seen in the figures below. Target

communities generally report higher prevalence of alcohol consumption and binge drinking as well as drinking and driving than comparison communities. Comparisons within FY2014 and FY2015 indicated that, in FY2014 target communities reported significantly more on past 30-day alcohol use, binge drinking and providing alcohol to minors than comparison communities, whereas in FY2015 these reported differences between target and comparison communities were not statistically significant. This pattern suggests that the prevention efforts in those target communities is effective at decreasing the indicators.

Figure 2. Comparing target and comparison communities on alcohol consumption indicators from FY 2014 and FY 2015; weighted % reported

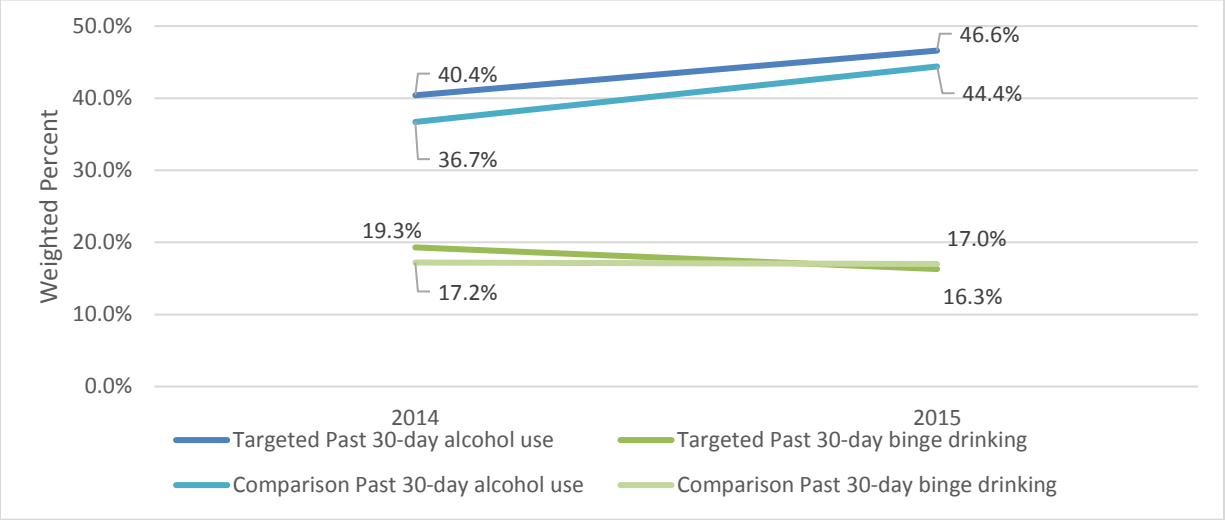


Figure 3. Comparing target and comparison communities on drinking and driving indicators from FY 2014 and FY 2015; weighted % reported.

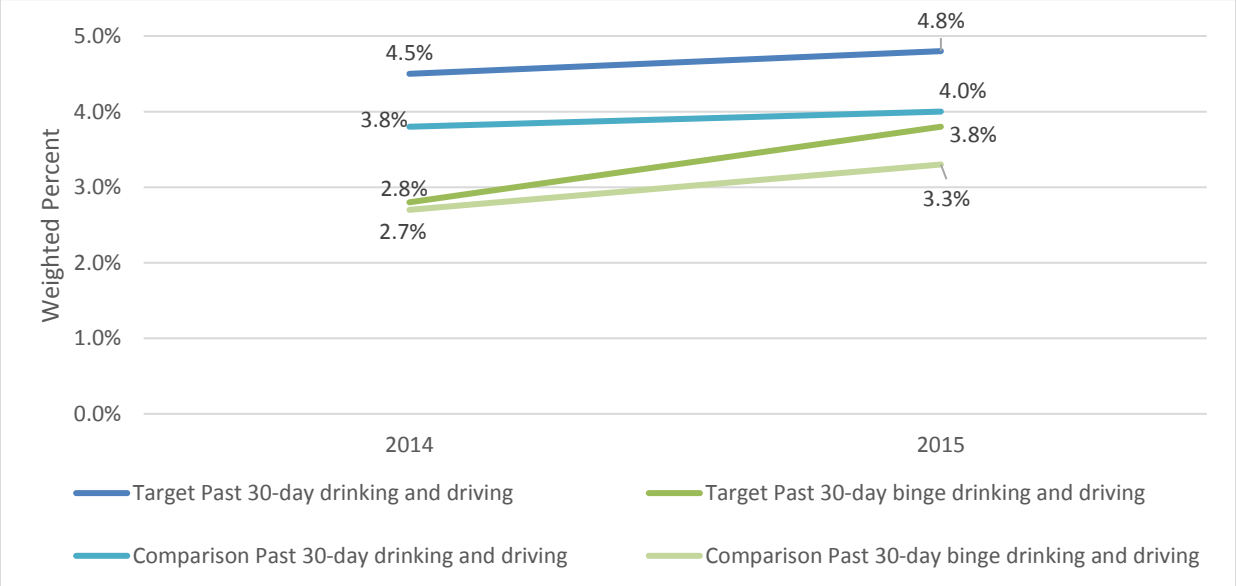
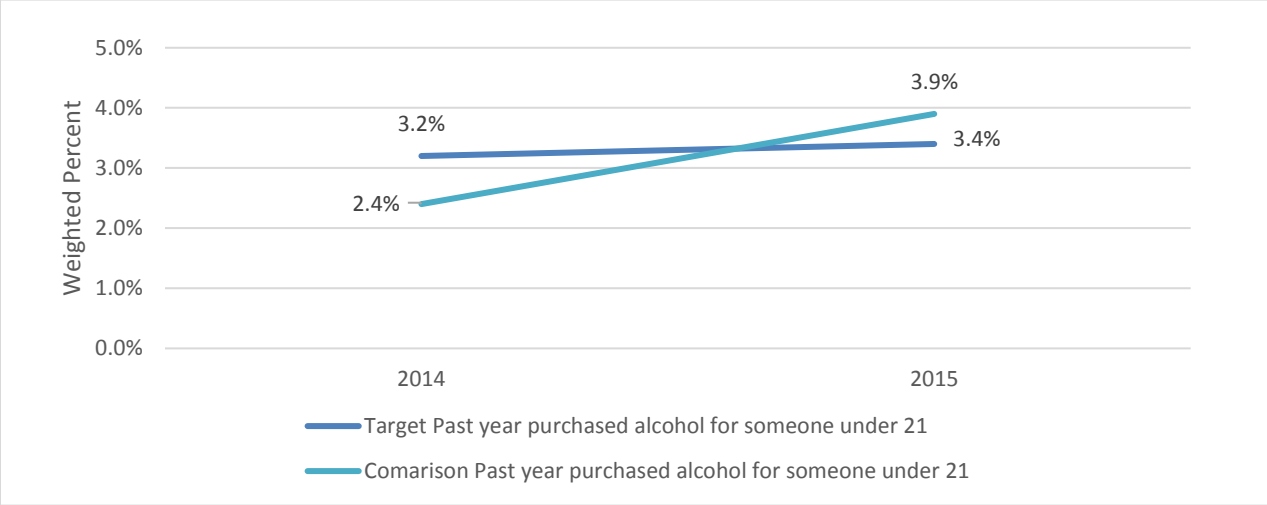


Figure 4. Comparing target and comparison communities on purchasing alcohol for minors from FY 2014 and FY 2015; weighted % reported.



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 10 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 considered it to be very or even somewhat difficult for teens to get alcohol in their communities in general. 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 (retail access). This gap suggests that social access is perceived to be more influential than retail overall. There is no significant difference in the perceptions that access is very or somewhat difficult between respondents in comparison communities and those in the target communities

We next examined whether the communities that targeted alcohol-related outcomes differed from comparison communities that did not target alcohol-related outcomes with respect to the perceived risk of facing legal consequences for breaking alcohol-related laws such as underage drinking, serving minors alcohol, and drinking and driving. We found that among those communities addressing the intervening variable perception of risk to reduce underage drinking and drinking and driving, the perception was significantly lower than in comparison communities in most categories. This speaks to why it is likely that actual alcohol consumption and related behaviors are perhaps higher in those communities targeting them. Lower estimates suggest that fewer people in those communities perceive that they will face legal consequences if they break the law; therefore, there is less of a deterrent for engaging in illegal alcohol-related behavior. This also speaks to continuing challenges in NM of cuts in enforcement funding, as well as the need for communities to work closely and creatively with law enforcement to address the perception of risk.

Table 10. 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	13.3 (688)	11.7 (294)
Ease of access to alcohol by teens from stores and restaurants	56.7 (2822)	56.4 (1375)
Perception of risk/legal consequences	**Very or Somewhat Likely**	
	Target	**Comparison**
Likelihood of police breaking up parties where teens are drinking ***	60.9 (3061)	65.3 (1626)
Likelihood of police arresting an adult for giving alcohol to someone under 21 ***	64.7 (3175)	69.7 (1677)
Likelihood of someone being arrested if caught selling alcohol to a drunk or intoxicated person	59.9 (3179)	61.1 (1535)
Likelihood of being stopped by police if driving after drinking too much***	72.6 (4135)	76.3 (2098)
Likelihood of being convicted if stopped and charged with DWI	84.1 (4648)	84.8 (2241)

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

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 11 displays where these young adults indicated they obtained their alcohol. Almost half of respondents indicated that they obtained it at a party followed by an unrelated adult purchased it for them. In addition, over 20% indicated an adult family member provided the alcohol to the minor.

Table 11. Comparing target and comparison communities on access to alcohol (ages 18-20); weighted % & (n)

Access to Alcohol (n=383)	Target	Comparison
Adult family member gave or bought it	22.2 (52)	22.2 (35)
Unrelated adult gave or bought it	31.9 (75)	38.9 (62)
Got it at a party	46.9 (106)	49.1 (78)
Parent/guardian gave or bought it	4.6 (11)	7.0 (10)
Took it from home	9.8 (22)	4.8 (8)
Bought it at a restaurant/bar/public place	4.7 (10)	2.5 (4)
Someone underage gave or bought it	9.0 (19)	11.5 (18)
Got it some other way	2.5 (6)	6.0 (9)

Prescription Drugs

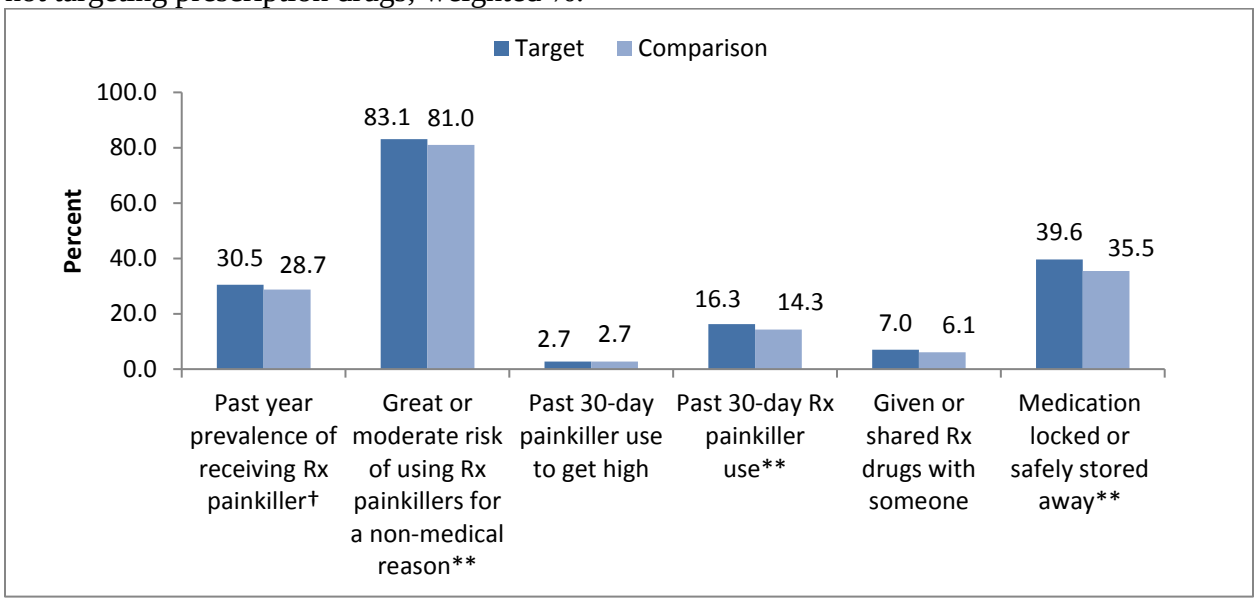
Table 12 below displays the weighted prevalence and corresponding unweighted n for key items measuring prescription painkiller use, sharing of prescription of drugs and proper storing of prescription drugs. In Appendix B we provide a table of prescription drug indicators broken down by funding stream and sex and race/ethnicity. In Table 11 we can see that communities receiving SAPT funding performed best on all prescription drug use measures. For instance, SAPT communities reported the highest percentage of respondents perceiving great or moderate risk of using Rx painkillers for non-medical reasons and lowest percentage of past 30-day painkiller use to get high. PFS II communities are specifically addressing the misuse and abuse of prescription painkillers and were identified for funding because of their Rx painkiller outcome statistics. Therefore, we would anticipate that PFS II counties would have worse estimates than SAPT-supported communities, which is generally the case. TCA counties showed mixed results. They were slightly better than the PFS II on the prevalence of receiving prescriptions for painkillers (31.0% vs. 32.3%) and Rx painkiller use in the past 30 days (15.9% vs. 17.5%) but worst for perceived risk of harm associated with Rx painkiller misuse (79.5%) and safely storing Rx painkillers (30.1%).

Table 12. Prevalence of prescription painkiller use by funding stream; weighted % & (n)

Funding stream	Prevalence of receiving Rx painkiller	Great or moderate risk of using Rx painkillers for a non-medical reason	Past 30-day painkiller use to get high	Past 30-day Rx painkiller use	Given or shared Rx drugs with someone	Prescription painkillers locked or safely stored away
SAPT (n=2857)	29.4	83.7	2.7	15.2	5.5	40.9
PFS-II (n=1936)	32.3	80.4	2.8	17.5	9.4	38.7
TCA (n=1444)	31.0	79.5	3.0	15.9	6.5	30.1

The following graph (Figure 5) 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 more respondents in target communities perceived risk of harm associated with misusing prescription painkillers (83.1%) and reported storing medication properly (39.6 %) than respondents in comparison communities; but they also reported higher rates of using prescriptions of painkillers in the past 30 days (16.3%) or receiving prescription painkillers last year (30.5%, marginally significant). On the other hand, no differences are evident between target and comparison communities on indicators of using painkillers to get high in the past 30 days or sharing of prescription drugs with others.

Figure 5. Comparing the prevalence of communities targeting prescription drugs to communities not targeting prescription drugs; weighted %.



†$p < .10$, **$p \leq .01$

Table 13 below provides a breakdown by target and comparison groups of respondents' reasons for using prescription painkillers. Only those who had used prescription painkillers in the past 30 days were asked to respond to the question, and respondents could select all options that applied to them. Not surprisingly, the majority of respondents in both target and comparison communities were almost equally likely to indicate that their recent use of prescription painkillers was for a legitimate pain identified by a health care provider. Respondents in comparison communities reported significantly fewer use of prescription painkillers for pain not identified by a health care provider than did respondents in target communities. They were also marginally more likely to use prescription painkillers to cope with anxiety or stress than target communities. It appears that target communities tended to report more use on most of these measures than comparison communities although these differences were not statistically significant.

Table 13. Comparing target and comparison communities on reasons for using prescription painkillers; weighted % & (n)

Reasons of Prescription Drug Use (n=1399)	Target	Comparison
Treat pain identified by doctors/dentists	76.6 (507)	77.7 (540)
For pain not identified by doctors***	19.7 (134)	10.4 (90)
Have fun with friends socially	2.9 (19)	2.3 (21)
Help me sleep	8.2 (53)	6.7 (51)
Get high, messed up or stoned	3.9 (28)	3.2 (26)
Cope with anxiety or stress†	4.9 (39)	7.2 (55)
Another reason	3.7 (29)	3.2 (27)

†$p < .10$, ***$p < .001$.

Table 14 presents the various means by which respondents accessed the prescription painkillers used. Significant differences were observed between target and comparison communities for only two responses. Target communities were more likely to obtain prescription painkillers from "other" locations (e.g., Mexico or internet) whereas comparison communities were more likely to buy from others such as friends, dealers or family members. By far, most respondents report having received a prescription for their painkillers. However, in both target and comparison communities, a substantial percentage report accessing painkillers 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 14. Comparing target and comparison communities on sources for prescription painkillers; weighted % & (n)

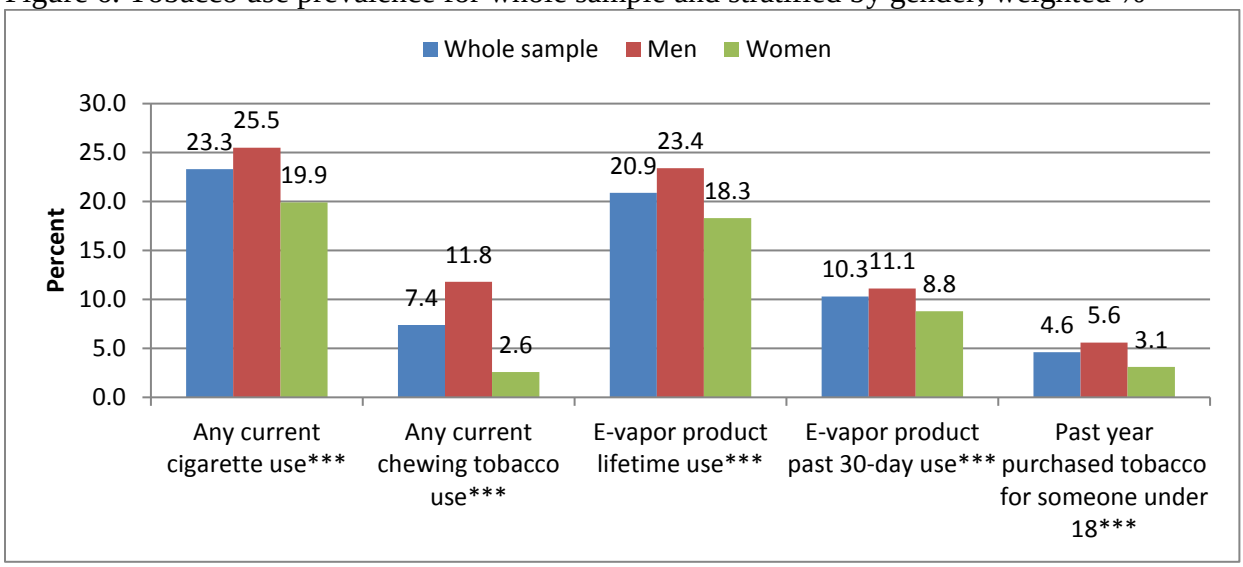
Sources of Prescription Drug Use (n=1399)	Target	Comparison
A doctor/doctors prescribed	85.3 (561)	82.2 (577)
Family member shared	8.0 (56)	5.8 (51)
Friend shared	6.2 (47)	6.2 (54)
Bought from somebody*	3.1 (22)	5.6 (44)
Taken from someone without asking	1.8 (11)	1.3 (11)
Other places***	6.0 (40)	1.7 (13)

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

Tobacco

We assess tobacco use in the Community Survey with five items including two new questions about electronic vapor products. We report in the figure below (Figure 6) on the prevalence of use among the whole sample and by gender. In Appendix C we provide a table of tobacco use indicators broken down by race/ethnicity, military status, and sexual orientation. Males report significantly more cigarette and tobacco use than women on every measure, and more men purchased tobacco products for minors than women.

Figure 6. Tobacco use prevalence for whole sample and stratified by gender; weighted %



****p* <.001.

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.

We selected six questions 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. spectable score of reliability.

shows the prevalence of respondents who responded either "all of the time" or "most of the time" for the six items individually. There was a 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

[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.

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 world's population that the WMHS is designed to identify (see Figure 7). The alpha coefficient for this scale was $\alpha = .89$, a respectable score of reliability.

Figure 7. The percent of respondents who reported they felt the following all or most of the time in the past 30 days; weighted %

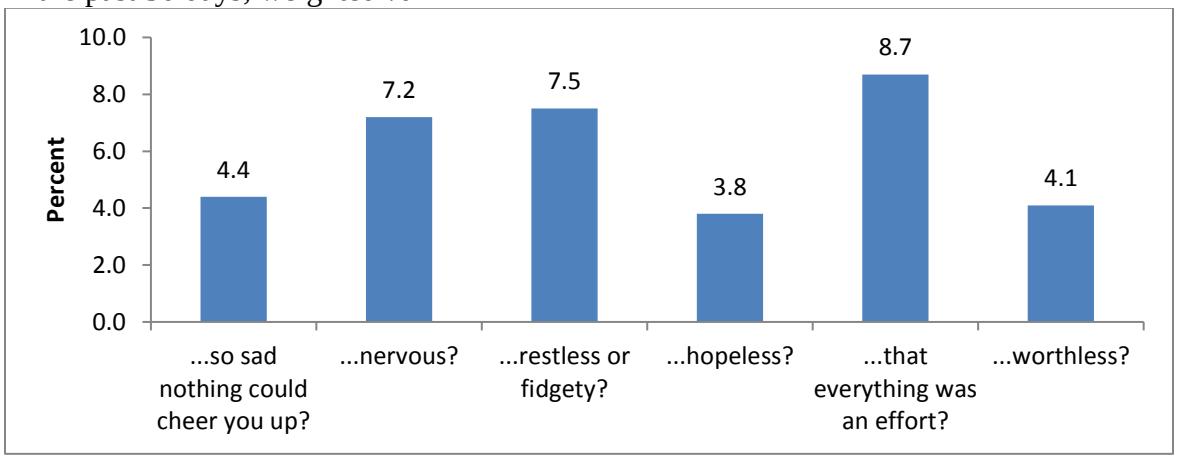
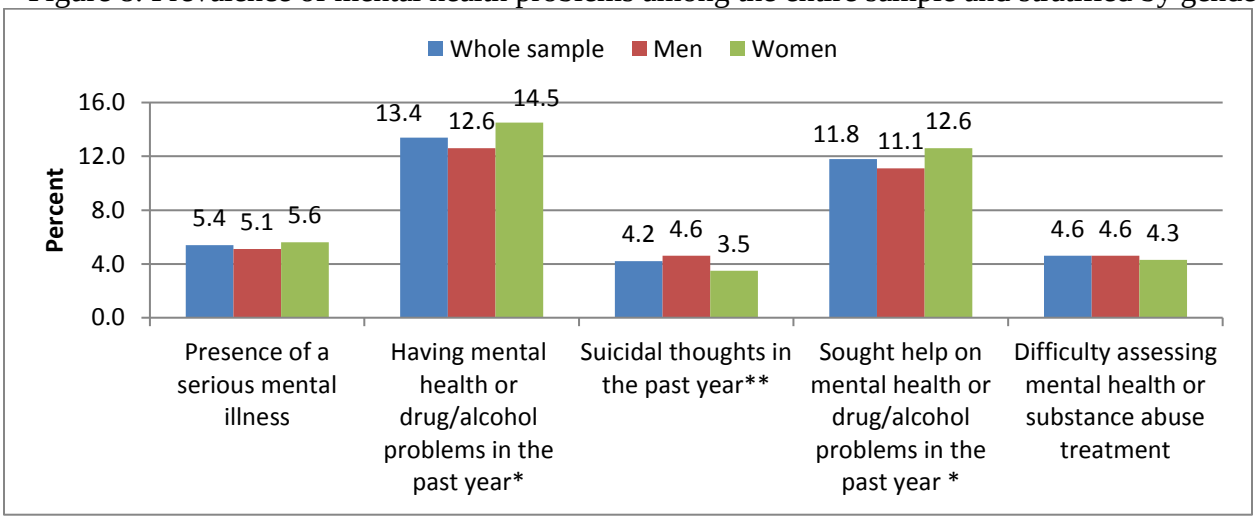


Figure 8 includes the prevalence of the combined score indicating severe mental illness and three additional measures, both for the entire sample and stratified by gender. Significantly more women reported having mental health, drug, or alcohol problems in the past year and have sought help for mental or drug use problems than men; yet men were more likely to show suicidal ideation than women (4.6% vs. 3.5%). Little difference was found between men and women on SMI or having difficulty assessing treatment for mental health/substance problems.

Figure 8. Prevalence of mental health problems among the entire sample and stratified by gender.



*p <.05, **p <.01.

Qualitative Analysis

The final question on the survey asks respondents if they would like to share anything with the researchers about the survey itself or the topics covered in the survey. Responses to the open-ended question were uploaded into QSR NVivo 10 coding software. Data analysis began first by constructing a coding tree inspired by the most common themes from the previous year. This included parent nodes, under which child nodes were created and aggregated under the relevant parent node theme. New codes were identified and coded appropriately. Quotations were edited for readability. The following summary details the major themes and issues that emerged from the dataset, including community norms, ease of access, enforcement and reform, individual factors, the need for services, and comments about the survey.

The primary substances of inquiry in the survey, alcohol and prescription painkillers, were discussed often in the same phrases, so analyzing the two separately here would not be appropriate. The topic of alcohol was mixed in to all of the themes and recognized as a major problem. "In our area alcohol is bad. They even allowed alcohol to be sold on the reservation in the casino, which goes against Native American laws in the past. It should be banned again. It is causing problems for people with alcohol and casino addictions. Alcohol should be taxed and harder to get." Another said, "Recovering alcoholic many years. The gateway drug is alcohol for every problem I have had since my teens!" Some suggested lowering the content, "Rather than having 6.0 beer they should make it 3.2. Reduce the alcohol content in whiskey or any liquor."

Painkillers and prescription medication. Respondents generally did not distinguish between prescription medication and painkillers themselves. This can be a consequence of the short space allowed for response, as well as the common perceptions of prescription "medications" as a unified category (as either "safe" as prescribed by a physician or "unsafe" as a drug, or kind of controlled substance).

Community/Social Norms. Many respondents commented simply that drugs and alcohol use and abuse was rampant in their community. Some commented succinctly, "I am appalled by the prevalence of alcohol & drug abuse in our community" and "NM definitely has a drug, alcohol and tobacco problem." Others described substance use as generational, for example:

> [Place] has a community drug abuse problem that has been the common way of life for many families for generations. If there were support to empower non-using family members to stand up for a healthy way of life, maybe some could break the cycle. Same for drug related crimes.

Another respondent provided similar solutions to inter-generational issues:

> Drug, alcohol abuse is generational of culture problem. I see elder abuse because kids and grandkids are addicted. Teaching parenting and accountability. Empower teachers. Arrest, take the profit out of meth/heroin dealers! Who is making money at the expense of addicting a generation?

Another respondent called it epidemic, saying, "I am aware that heroin is a big problem in [place] as a family member is addicted…It is an epidemic here & the city needs to open its eyes."

Parents are widely implicated for not supervising their children, and not teaching them to avoid drugs or alcohol (this was a dominant NVivo coding node). Many said, "Parents need to know what their children are doing," or, "Parents have to spend more time with their kids." Other respondents perceived families to be the main source of providing alcohol to their children. "Teenagers at [Name] High School told me they had plans to get drunk after prom. Parents gave them the alcohol."

Systemic Issues. Related to Community Norms, respondents felt the rampant use of drugs and alcohol was systemic and related to a variety of social and economic factors; many of the responses below relate to and engage with each other. One individual, representative of this perspective commented,

> Programs like the DARE program that use emotional manipulation on the children don't work. Only programs that are addressing the underlying issues -- generational poverty, drug use, abuse, neglect, violence, can have an impact on drug/alcohol use. The addiction is just an outcome of the underlying issues.

Poverty was a common observation; another said that the "state is poor and under-educated and huge problem with drugs and alcohol." Unemployment and a lack of alternative activities were also cited, with a number of people observing that rural areas are especially hard hit. Another commented that punishing addicts was misguided, saying,

> New Mexico does not go to the Source of the problem--companies that make and sell this very dangerous substance Alcohol. Instead they punish the victims of this disease, by making them pay with money, take licenses away, punishing the victims while the companies continue to sell this alcohol. That's where the problem is, the source.

A number of respondents drew links between mental illness and homelessness with drug abuse and easy access to drugs. In the passage below, one respondent details this process in their own community:

> The meth, heroin and prescription drug abuse problem in this community is overwhelming and heartbreaking. I have a child (now 21) who has been addicted to substances for 3 years. The ease she has been able to get these with-and the purity and affordability of the product are appalling. My daughter was able to access this lifestyle by tapping in to the VERY cooperative homeless population here (chronic homeless). The teens at my youngest daughter's school are always able to get any drug or alcohol from the chronic/addicted homeless folks on the plaza. If you are homeless, you will quickly/eventually be addicted to cope-with the mental health issues that keep you homeless. It is part of the lifestyle.

Ease of Access. Respondents generally perceived it to be easy to access drugs and alcohol in their community. They felt young people could easily access drugs and alcohol both socially, primarily through family members and friends; and through retail means either from a dealer, bootlegger, or not being carded at the store. “I am a recovering alcoholic, and I know how hard it is to quit. People don't drink because they want to, it is usually brought through family and friends.” Another respondent inferred that it affected all economic classes,

> Both my grandchildren have encountered drugs in high school. My granddaughter started using heroin and used 3 years before getting into recovery. My grandson said it's everywhere whether you're looking for it or not. He isn't using after watching his sister. The school they attend is in the Northeast Heights.

Another person commented briefly, “It is very easy for minors to get alcohol.” Respondents felt selling drugs and alcohol was purely financial: “There are a lot of people who bootleg/drug deal here in the community/ [Place]. These people sell to younger kids 10+ up. It don’t matter who, what age you are as long as there [sic] making money. They’re killing our people especially shortening young children’s lives. It’s not right!” Respondents also noted that alcohol use and even DWIs were common among teachers in the schools.

Regarding **retail access and promotion of alcohol**, a number of people suggested the hours or quantity sold be limited or even totally prohibited. “Close liquor stores.” Another said, “Liquor stores who are caught selling to minors or intoxicated people need heavier, harsher fines and time in jail, triple the fines versus what they pay now. We need to reduce liquor stores in [Place] and surrounding areas. DO NOT ISSUE ANY MORE LIQUOR LICENSES.” Some people suggested that the stores selling alcohol should card more and only sell once to the same person. Another person said, “I feel that local stores or bars that sell liquor (--the) owner should help individuals go to treatment and pay all the cost that is required.” An exception noted provocatively, “Nothing is going to stop underage drinking. Prohibition is the problem.” People felt the media was also responsible, saying, “Movies, commercials, ads still glamorize & encourage drinking!” And, “Prescription drugs should not be advertised in periodicals.”

Availability of painkillers. Regarding prescription drugs, respondents generally perceived them to be over-prescribed, widely abused, and commonly available through social networks:

> Doctors need to be controlled on their prescriptions to patients. If they [the patients] are selling the drugs they get, then obviously they don’t need them, and shouldn’t get them. I worked at a pharmacy for 10 years and saw all the painkillers prescribed by doctors to people that were abusing the medication or selling them. I blame the doctors for the drug problem they prescribe painkillers like it was candy.

Once again, respondents perceived retail access to be motivated by the seller’s financial needs: “Pain killers are too easily accessible for our youth and adults. It is a huge problem in the Valley. It is all about the money.” Another criticized the common practice of sharing of prescription

drugs, “In my opinion. I don't believe many people understand that you can't give prescriptions (pills) away. It needs to be expressed with great caution.”

Respondents also felt that prescription medication use results in addiction that leads to heroin. They said they wanted alternative mental health and medical services that do not include prescriptions for drugs:

> Is there mental health treatment in New Mexico except the prescribing of more drugs? As an ICU and home health nurse it appears that mental health is another source of drug abuse. The number of people I have seen on multiple psych meds is appalling and prescription pain meds is out of control.

One exception to these comments was in an elderly person who noted inadequate access to needed pain medication, a concern commonly heard in coalition meetings for newly established prevention programs especially in rural areas of the state.

Enforcement and Reform. Respondents overwhelmingly want stricter laws and greater enforcement and convictions for drunk drivers and drug dealers. “Police present-methods of testing are unreliable; wouldn't hold up in court of law: innocent get charged; guilty get released; system is broken.” Most felt low enforcement and low convictions were culpable. “We already have a lot of laws on the books, our courts need to follow through with the laws we already have and also to follow through with sentencing, we are too easy on offenders.” And, “I am a city metro bus driver. I see people driving irresponsibly from time to time. It seems as though reckless or poor driving habits are getting worse. I've seen underage in parks drinking, partying. It seems as though not much is done about it, even when police are called.” Some focused on the lack of resources behind the issue of low enforcement: “Find a way to increase our law enforcement staff to handle all of these folks”.

Another said, “Adults and young adults are not penalized for use of alcohol. Too many DWIs and they get off.” Police, prosecutors, and judges were blamed, from lack of response, to not convicting. Some felt more police was the solution. “In my community lack of police officers is a big problem.” Another said, “More police for enforcing the laws already on the books.” Someone felt, “Law is too scared to do anything.”

Some respondents felt police let their friends off or were even complicit:

> In our community (it) is who you know so (it) is very easy to get dismissed from the police or being convicted if you know the police. Or (if you) have someone that does (know the police it) is easy to get away of any issue concerning this survey. Only people that don't speak English or that don't have a relative with the police are the ones that get convicted or arrested. Sadly but is the (truth).

And, “Our city + town could use more law enforcement without discrimination!” And, “Police here are liars and let people drive away with their kids while under drugs or alcohol and don't follow laws.”

Some respondents felt that inconsistent enforcement was based upon the role that money plays: "DWI, Money gets you off the hook. It even clears your record. Rich get away with DWI!" And, "DWI laws usually do not impact wealthy people. Go to an event at a place like a country club, booze flows, everyone knows, but they all drive home." On the other hand, one individual thought that principally those who can pay are the ones burdened with paying the consequences for enforcement: "…It seems that the people who can pay fines are the ones who get in trouble. We have a huge population that are welfare people that abuse drugs and alcohol but are just a drain on the system so they seem to just get a slap on the hand and sent back out to do it all over again."

Many suggested solutions to poor enforcement. This participant, like many, was concerned about repeat offenders in particular:

> I believe New Mexico still fails in the area of law enforcement for DWI and JUDGES are failing miserably in the sentencing of frequent offenders. New Mexico should have a 3-strikes-and-you're-out with DWI offenders. I also believe that there should be a registry for all convicted DWI offenders that should have to be checked by stores that sell alcohol and by restaurants to prohibit sales or consumption by offenders.

Some people felt legalization of marijuana was a solution; their reasons varied from controlling it as a medicine, to taxing and legalizing all drugs, to simply decriminalize.

Regarding **taxing alcohol**, a number of respondents mentioned a lack of support for increasing the alcohol sales tax mostly because they did not feel it would solve the problem. "Underage drinking will happen no [matter] what either $.25 or $1 tax." Some disagreed with taxing on ideological grounds, saying, "Government won't change people. Rules and taxes only hurt people who pay/follow them. A paradigm shift needs to occur if these problems are to be solved." And, "We are taxed enough already. Seek help from non-profit foundations or go to the appropriations committee. Taxes on alcohol and cigarettes is a regressive taxation which unfairly targets the poor." Those in favor of taxing did feel making alcohol more expensive would help, and often qualified where they would want that money directed, commonly healthcare and schools. Some expressed specifically raising taxes on Pueblos and reservations, "All Indian Reservations should legalize all substances and charge a huge tax on all of the products."

Poor enforcement was also commonly linked to the idea of poor parenting discussed in 'social norms' above. Regarding underage drinking, many participants blamed parents along with poor enforcement: "The laws are way too lax on adults providing alcohol and hosting parties for the kids. Some have said if my kids are going to drink they can drink at home and they buy it for them or… keep it in the home so they can get it. New Mexico laws are not stiff enough!"

Individual factors. It is important to note that individual factors – such as reference to the origins of substance abuse as intergenerational or the notion that substance abuse was a matter of personal choice – are also expressions of social/community norms, already discussed above. There were a number of brief statements such as, "Alcohol and Drug abuse began at home," and

“Target drug abusing parents to break cycle!!” A grandparent also placed responsibility with themselves, “It is very important that we grandparents be healthy, emotional role models, both morally and spiritually: Be attentive to changes in our youth, look for information, to help those who want to receive help.”

Other respondents felt the responsibility falls to the individual alone to make a choice about one’s drug and alcohol consumption, “There will always be addicts among us. Some people are just weak.” And, “Decisions are up to the individuals,” or “I think that kids are going to get their hands on what they want. We can make it harder but we can't make it impossible.”

And last, faith was cited as a way to avoid or get away from substance use or mental health issues. “Christian principles should be taught in school,” And, “I would suggest to get a relationship with God. To keep your body, mind and spirit in check. That would help stop the youth and underage drinking problem and drug problem. That’s the only chance the community has at solving this problem.”

Treatment and Prevention Services. Respondents perceived an enormous need for more substance use and mental health programs in their communities. Many respondents observed there was not a single place in their community to seek help, and many others still cannot afford it. One surmised, “There are just not enough for aftercare- or intensive inpatient- that is affordable for the average person.” Another said, “I'm experiencing trauma that's recent, drug (heroin) abuse, significant mental illness(s). I cannot find help in any of these areas that I desperately need. If you’re not rich you're f**ed.” Another would like to see the legislature address supporting those organizations that do help:

> As an alcoholic in early recovery, I have been very impressed with the quality of care available to me and the compassion of the people who've helped me, especially at Tri-County and [Place] Detox. What dismays me is the constant struggle financially these organizations must constantly face despite their proven benefits, and despite the high rate of drug and alcohol abuse in the state of NM. Would really like to see the state legislature make treatment more of a state priority.

Related to systemic issues, some respondents blamed politics and politicians. **“**Very sorry that Governor Martinez dismantled our Behavioral Health system as well as our oh-so-important Medicaid Managed Care Programs.” And, “Thanks for your efforts-this is how healing starts (community wise). How can Susanna send our mental health monies to Arizona?!?”

The need for prevention services was the dominant theme by far. Targeting youth was the most common suggestion, and many felt starting younger is better. Representative comments include, “We need to start talking to these kids in elementary about drugs, not in high school by then it's too late. They’re not too young. High school is too late.” And, “I believe education at a very early age would definitely make a difference --start by setting the example at home, then follow-

up - starting as early as kindergarten." One person simply wrote, "Please! Please! Get help for our youth."

Ideas for prevention were varied, often straying from IOM-definitions; ideas linked to prevention included fewer jails, more treatment centers, less punishment and more education and awareness. "All listed prevention programs need to be more aggressive in informing the general public of their program goals, objectives and activities." "Focus on the teens and kids personal opinion and experiences, they are the best resource we have to learn about this topic. Addiction problems in New Mexico are worse than they seem." Some respondents wanted a return of the DARE program, for example, "Can the DARE program be brought back? It was a great and effective program in school." Other scare tactics were suggested, such as, "Kids need to be given more support in drug and alcohol prevention, especially in our area. They need to see actual examples, speak with people who are going through problems. Experience it first hand."

Large numbers of respondents expressed a desire for a greater number of alternative activities that would help with the idea that, "There is nowhere to go and nothing to do," especially for young folks. Sports, employment, and the promotion of healthy activities in the community were all widely suggested. "If New Mexico provided programs and activities that involved minors, we would see less underage drinking. Even an 18+night club where kids can go, bike events, really anything! Get our kids involved." "[Place] needs to have more activities for the youngster to do. Baseball field, boxing, karate. Something to keep them entertained, and offer it at no charge or very little cost." One person suggested the young people would not be so quick to abandon their community either, saying,

> The city and county need to have more things/activities for our children to do… cinema, batting cages, goofy golf, arcades, etc. We need to keep our children in the community and promote their wellbeing- then they will want to stay and help build the community that they grew up in- activities and positive reinforcement!

Survey comments: Finally, many respondents made suggestions for questions, others commented how taking it made them reflect on these issues more and become more aware. Still others expressed gratitude that people cared to ask these questions and "do something about it." And of course some felt it was boring, a waste of time, or unhelpful. A number of respondents did not appear to understand the importance of asking non-consuming people these questions. Some people requested the survey creators take care not correlate mental health with drug use or addiction; "#39 and 41 emotional issues should not be associated with drugs/alcohol."

Summary

The Community Survey continues to be 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. Important intervening variable data collected through the Community Survey help communities identify their progress and issues with regard to perception of risk, access, and perception of harm. New sites have been added to conduct the Community Survey and with each implementation, improvements are made to planning and collection methodology in order to achieve consistency across years although the nature of the Community Survey data remains non-probability sample.

With regard to underage drinking, binge drinking, and DWI prevention alcohol-related outcomes, target communities remain similar to comparison communities and they did not differ significantly from each other on alcohol consumption behaviors. It is a positive trend that we have seen since 2014 given that target communities were originally identified for prevention outreach 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. Almost half of underage youth who drink got alcohol at parties. Our quantitative and qualitative 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.

Target communities have maintained a similar lever of perceived risk of legal consequences for breaking alcohol-related laws as last year. It is a continuation 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.

As more communities have initiated painkiller prevention implementation, target communities showed greater awareness of risks associated with using prescription painkillers for non-medical reasons and had more people locking their medication than comparison communities. While many commented on excessive retail access to painkillers from medical providers, there appears to be a growing commentary on social access to prescription painkillers. In the past, painkiller access was almost exclusively commented upon as retail, so there appears to be a growing awareness of the dangers of social access.

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. The considerable commentary about behavioral health problems in this state also support this analysis. 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	54.1 (854)	50.5 (1005)*	38.7 (1005)	42.5 (1259)**
Past 30-day binge drinking	19.5 (350)	22.9 (479)*	9.8 (290)	13.5 (447)***
Past 30-day drinking & driving	7.1 (129)	6.2 (129)	2.4 (72)	2.7 (83)
Past 30-day binge drinking & driving	5.4 (101)	5.3 (111)	1.6 (53)	2.1 (69)
Past year purchased or provided alcohol for someone under 21	3.6 (63)	4.6 (97)	2.2 (6.1)	3.5 (109)**

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

Table A2. Alcohol use indicators comparing males 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	55.5 (385)	51.3 (1474)†	46.2 (482)	39.5 (1782)***
Past 30-day binge drinking	28.8 (209)	19.8 (620)***	13.9 (168)	11.3 (569)*
Past 30-day drinking & driving	8.4 (61)	6.2 (197)*	3.1 (34)	2.4 (121)
Past 30-day binge drinking & driving	8.4 (61)	4.7 (151)***	2.3 (27)	1.8 (95)
Past year purchased or provided alcohol for someone under 21	6.5 (47)	3.6 (113)***	3.9 (41)	2.6 (129)*

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

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

	Men		Women	
Alcohol use	**TCA**	**Non TCA**	**TCA**	**Non TCA**
Past 30-day alcohol use	52.3 (354)	52.0 (1505)	42.4 (416)	40.3 (1848)
Past 30-day binge drinking	23.1 (161)	20.9 (668)	13.0 (144)	11.5 (593)
Past 30-day drinking & driving	4.9 (37)	7.0 (221)*	2.4 (23)	2.6 (132)
Past 30-day binge drinking & driving	4.0 (30)	5.7 (182)	2.1 (21)	1.8 (101)
Past year purchased or provided alcohol for someone under 21	3.8 (29)	4.2 (131)	2.9 (33)	2.9 (137)

*$p \leq .05$.

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

	Non-Hispanic White		Hispanic or Latino		Native American		Other	
Indicator	**SAPT**	**Non SAPT**	**SAPT**	**Non SAPT**	**SAPT**	**Non SAPT**	**SAPT**	**Non SAPT**
Past 30-day alcohol use	47.9 (609)	49.4 (925)	46.0 (909)	45.6 (1042)	33.5 (316)	32.0 (222)	43.6 (92)	44.9 (157)
Past 30-day binge drinking	9.8 (132)	14.3 (284)***	17.4 (344)	23.2 (522)***	17.9 (161)	15.0 (103)	15.8 (33)	17.7 (61)
Past 30-day drinking & driving	3.7 (49)	3.8 (72)	4.9 (98)	5.6 (121)	5.4 (47)	3.2 (18)	6.5 (13)	3.3 (13)
Past 30-day binge drinking & driving	2.5 (32)	2.8 (50)	3.8 (76)	4.8 (104)	4.8 (44)*	2.6 (15)	4.1 (9)	6.3 (23)
Past year purchased or provided alcohol for someone under 21	2.6 (33)	3.4 (71)	2.6 (57)***	5.0 (113)	3.3 (27)	1.7 (12)	7.4 (14)	6.5 (23)

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

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

	Non-Hispanic White		Hispanic or Latino		Native American		Other	
Indicator	**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	57.0 (311)	47.1 (1223)***	52.9 (372)	44.4 (1579)***	30.4 (142)	33.8 (396)	45.5 (74)	43.9 (175)
Past 30-day binge drinking	17.7 (102)	11.4 (314)***	27.3 (189)	19.1 (677)***	15.1 (69)	17.2 (195)	20.4 (33)	15.6 (61)
Past 30-day drinking & driving	5.5 (32)	3.4 (89)*	7.6 (52)	4.8 (167)**	2.9 (10)	5.0 (55)	3.5 (7)	5.1 (19)
Past 30-day binge drinking & driving	4.5 (25)	2.3 (57)**	7.3 (49)	3.7 (131)***	2.0 (8)	4.6 (51)*	6.3 (11)	5.0 (21)
Past year purchased or provided alcohol for someone under 21	4.9 (28)	2.7 (76)**	7.0 (50)	3.2 (120)***	1.4 (6)	3.2 (33)	5.3 (9)	7.4 (28)

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

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

Indicator	Non-Hispanic White		Hispanic or Latino		Native American		Other	
	TCA	Non TCA	TCA	Non TCA	TCA	Non TCA	TCA	Non TCA
Past 30-day alcohol use	49.0 (317)	48.7 (1217)	45.8 (399)	45.8 (1552)	41.0 (39)	32.3 (499)	45.7 (51)	44.1 (198)
Past 30-day binge drinking	13.2 (89)	12.2 (327)	23.5 (200)	19.6 (666)*	19.7 (20)	16.4 (244)	16.4 (17)	17.0 (77)
Past 30-day drinking & driving	2.4 (15)	4.2 (106)	4.8 (40)	5.4 (179)	4.2 (4)	4.4 (61)	5.2 (6)	4.5 (20)
Past 30-day binge drinking & driving	1.8 (11)	2.9 (71)	3.9 (32)	4.4 (148)	5.5 (4)	3.8 (55)	8.2 (9)	4.7 (23)
Past year purchased or provided alcohol for someone under 21	2.5 (18)	3.3 (86)	3.9 (33)	3.8 (137)	3.9 (5)	2.5 (34)	9.4 (10)	6.3 (27)

*$p \leq .05$.

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	53.9 (1249)	48.7 (610)**	40.3 (1488)	41.6 (776)
Past 30-day binge drinking	22.1 (556)	20.1 (273)	10.8 (451)	13.7 (286)**
Past 30-day drinking & driving	7.4 (189)	5.1 (69)*	2.4 (99)	2.8 (56)
Past 30-day binge drinking & driving	6.0 (155)	4.2 (57)*	1.7 (77)	2.2 (45)
Past year purchased or provided alcohol for someone under 21	4.3 (109)	3.8 (51)	2.5 (98)	3.6 (72)*

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

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

	Non-Hispanic White		Hispanic or Latino		Native American		Other	
Indicator	Target	Comparison	Target	Comparison	Target	Comparison	Target	Comparison
Past 30-day alcohol use	50.0 (957)	46.9 (577)	47.0 (1335)	43.2 (616)*	31.7 (375)	35.7 (163)	45.1 (163)	43.0 (86)
Past 30-day binge drinking	12.4 (252)	12.5 (164)	19.9 (561)	21.5 (305)	15.1 (173)	20.4 (91)*	17.1 (62)	16.6 (32)
Past 30-day drinking & driving	4.1 (82)	3.3 (39)	5.6 (157)	4.5 (62)	4.0 (41)	5.5 (24)	5.2 (19)	3.5 (7)
Past 30-day binge drinking & driving	3.0 (58)	2.1 (24)	4.5 (128)	3.9 (52)	3.3 (37)	5.3 (22)	5.1 (20)	5.8 (12)
Past year purchased or provided alcohol for someone under 21	3.1 (61)	3.0 (43)	3.6 (110)	4.3 (60)	1.8 (22)	4.8 (17)**	6.1 (21)	8.3 (16)

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

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

	Military		LGBT	
Alcohol use	Target	Comparison	Target	Comparison
Past 30-day alcohol use	50.0 (158)	49.1 (102)	57.8 (198)	55.7 (99)
Past 30-day binge drinking	16.6 (57)	13.6 (31)	19.7 (75)	19.2 (39)
Past 30-day drinking and driving	7.3 (25)	2.7 (6)*	6.8 (26)	5.7 (11)
Past 30-day binge drinking and driving	6.4 (20)	3.7 (9)	6.9 (22)	5.5 (11)
Past year purchased alcohol for someone under 21	7.0 (23)	3.2 (8)*	9.1 (28)	11.6 (21)

*$p < .05$

Appendix B: Prescription Drugs

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

Prescription drug use	Men		Women	
	SAPT	Non SAPT	SAPT	Non SAPT
Past year prevalence of receiving Rx painkiller	30.1 (264)	28.6 (711)	29.2 (484)	30.5 (1170)
Great or moderate risk of using Rx painkillers for a non-medical reason	82.7 (754)	79.6 (2008)*	86.2 (1426)	83.8 (3158)*
Past 30-day painkiller use to get high	3.2 (36)	2.8 (77)	2.1 (40)	2.3 (91)
Past 30-day Rx painkiller use	16.3 (147)	15.3 (391)	14.4 (235)	14.6 (557)
Given or shared Rx drugs with someone	5.6 (57)	6.7 (189)	5.6 (101)	6.9 (273)
Medication locked or safely stored away	39.0 (187)	33.3 (458)*	42.9 (319)	38.5 (801)

*$p < .05$.

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

Prescription drug use	Men		Women	
	PFS II	Non PFS II	PFS II	Non PFS II
Past year prevalence of receiving Rx painkiller	31.7 (205)	28.3 (770)	33.2 (350)	29.4 (1304)*
Great or moderate risk of using Rx painkillers for a non-medical reason	78.9 (532)	80.7 (2230)	83.0 (893)	84.8 (3691)
Past 30-day painkiller use to get high	2.6 (19)	3.0 (94)	2.2 (28)	2.2 (103)
Past 30-day Rx painkiller use	19.6 (130)	14.7 (408)**	15.2 (165)	14.4 (627)
Given or shared Rx drugs with someone	11.4 (83)	5.3 (163)***	7.0 (80)	6.4 (294)
Medication locked or safely stored away	38.3 (147)	33.8 (498)	39.0 (253)	40.0 (867)

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

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
Past year prevalence of receiving Rx painkiller	29.7 (148)	28.8 (827)	32.3 (255)	29.7 (1399)
Great or moderate risk of using Rx painkillers for a non-medical reason	77.6 (394)	80.9 (2368)	82.7 (641)	84.8 (3943)
Past 30-day painkiller use to get high	3.0 (17)	2.9 (96)	2.8 (21)	2.1 (110)
Past 30-day Rx painkiller use	16.9 (84)	15.3 (454)	14.7 (118)	14.5 (674)
Given or shared Rx drugs with someone	6.1 (35)	6.5 (211)	6.5 (52)	6.5 (322)
Medication locked or safely stored away	25.6 (72)	36.6 (573)***	34.4 (140)	40.6 (980)*

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

Table B4. Prescription drug use indicators comparing race/ethnic groups in SAPT and non-SAPT communities; weighted % & unweighted (n)

Indicator	Non-Hispanic White		Hispanic or Latino		Native American		Other	
	SAPT	Non SAPT	SAPT	Non SAPT	SAPT	Non SAPT	SAPT	Non SAPT
Past year prevalence of receiving Rx painkiller	32.2 (275)	32.6 (746)	28.3 (311)	27.6 (849)	26.3 (170)	24.0 (240)	17.8 (23)	28.5 (129)*
Great or moderate risk of using Rx painkillers for a non-medical reason	88.6 (835)	85.8 (1898)*	81.8 (864)	79.3 (2442)	73.9 (468)	73.3 (711)	78.0 (92)	71.9 (310)
Past 30-day painkiller use to get high	1.9 (20)	2.1 (46)	3.3 (36)	2.7 (87)	3.3 (21)	2.4 (24)	3.6 (5)	9.6 (35)*
Past 30-day Rx painkiller use	16.4 (145)	15.8 (361)	14.8 (161)	14.7 (448)	12.6 (77)	9.8 (101)	12.4 (15)	21.3 (91)*
Given or shared Rx drugs with someone	6.4 (67)	7.2 (179)	4.7 (51)	6.5 (214)*	5.8 (41)	4.2 (43)	2.0 (3)	11.9 (52)***
Medication locked or safely stored away	33.8 (125)	25.4 (313)**	45.7 (244)	45.5 (712)	47.5 (140)	38.6 (214)*	38.0 (21)	34.6 (86)

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

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

Indicator	Non-Hispanic White		Hispanic or Latino		Native American		Other	
	PFS II	Non PFS II	PFS II	Non PFS II	PFS II	Non PFS II	PFS II	Non PFS II
Past year prevalence of receiving Rx painkiller	37.6 (205)	31.5 (816)**	31.9 (216)	27.0 (944)*	23.0 (110)	25.7 (300)	24.0 (42)	26.9 (110)
Great or moderate risk of using Rx painkillers for a non-medical reason	87.1 (465)	86.5 (2268)	78.2 (546)	80.3 (2760)	73.1 (343)	73.7 (836)	70.1 (111)	74.4 (291)
Past 30-day painkiller use to get high	1.5 (8)	2.2 (58)	3.5 (24)	2.8 (99)	2.3 (13)	2.9 (32)	6.8 (10)	8.8 (30)
Past 30-day Rx painkiller use	19.7 (105)	15.3 (401)*	17.7 (119)	14.1 (490)*	10.6 (55)	10.9 (123)	18.8 (30)	19.5 (76)
Given or shared Rx drugs with someone	9.7 (58)	6.5 (188)**	11.7 (78)	5.1 (187)***	3.9 (20)	5.2 (64)	9.2 (16)	9.9 (39)
Medication locked or safely stored away	29.8 (84)	27.0 (354)	45.5 (189)	45.6 (771)	40.4 (113)	42.3 (241)	39.0 (35)	33.6 (72)

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

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

	Non-Hispanic White		Hispanic or Latino		Native American		Other	
Indicator	**TCA**	**Non TCA**	**TCA**	**Non TCA**	**TCA**	**Non TCA**	**TCA**	**Non TCA**
Past year prevalence of receiving Rx painkiller	34.2 (181)	32.1 (840)	27.4 (181)	27.9 (979)	28.1 (26)	24.7 (384)	35.6 (38)	24.0 (114)*
Great or moderate risk of using Rx painkillers for a non-medical reason	83.1 (437)	87.4 (2296)*	77.5 (513)	80.4 (2793)	69.3 (62)	73.8 (1117)	70.8 (72)	73.8 (330)
Past 30-day painkiller use to get high	3.1 (17)	1.8 (49)	2.2 (15)	3.0 (108)	N/A (0)	2.9 (45)	10.5 (9)	7.8 (31)
Past 30-day Rx painkiller use	17.2 (91)	15.8 (415)	13.7 (89)	14.9 (520)	7.6 (7)	11.0 (171)	29.8 (29)	17.1 (77)**
Given or shared Rx drugs with someone	5.2 (29)	7.4 (217)	7.1 (48)	5.9 (217)	2.5 (2)	5.0 (82)	16.0 (16)	8.3 (39)*
Medication locked or safely stored away	25.4 (78)	28.0 (360)	35.7 (117)	47.4 (839)***	27.3 (14)	42.7 (340)*	28.6 (18)	37.0 (89)

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

Table B7. Prescription drug use indicators comparing men and women in target and comparison communities; weighted % & unweighted (n)

	Men		Women	
Prescription drug use	**Target**	**Comparison**	**Target**	**Comparison**
Past year prevalence of receiving Rx painkiller	30.6 (443)	27.7 (532)	30.5 (784)	29.8 (870)
Great or moderate risk of using Rx painkillers for a non-medical reason	81.5 (1222)	79.6 (1540)	85.3 (2210)	83.8 (2374)
Past 30-day painkiller use to get high	2.9 (50)	2.9 (63)	2.1 (64)	2.3 (67)
Past 30-day Rx painkiller use	17.8 (264)	14.0 (274)**	14.7 (380)	14.4 (412)
Given or shared Rx drugs with someone	8.1 (133)	5.2 (113)***	6.0 (168)	7.0 (206)
Medication locked or safely stored away	38.4 (312)	32.0 (333)**	41.0 (532)	38.5 (588)

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

Table B8. Prescription drug use indicators comparing race/ethnic groups in target and comparison communities; weighted % & unweighted (n)

	Non-Hispanic White		Hispanic or Latino		Native American		Other	
Prescription drug use	**Target**	**Comparison**	**Target**	**Comparison**	**Target**	**Comparison**	**Target**	**Comparison**
Past year prevalence of receiving Rx painkiller	34.0 (472)	31.3 (549)	29.4 (514)	26.7 (646)	24.8 (220)	24.9 (190)	21.2 (61)	30.4 (91)*
Great or moderate risk of using Rx painkillers for a non-medical reason	88.6 (1288)	85.0 (1445)**	80.6 (1745)	79.5 (1917)	75.1 (656)	71.9 (523)	73.6 (191)	73.0 (211)
Past 30-day painkiller use to get high	1.8 (28)	2.3 (38)	3.4 (60)	2.5 (63)	2.5 (24)	3.0 (21)	5.7 (15)	10.5 (25)
Past 30-day Rx painkiller use	17.7 (248)	14.6 (258)*	15.9 (275)	13.8 (334)	11.7 (106)	9.8 (72)	15.8 (42)	22.3 (64)
Given or shared Rx drugs with someone	7.5 (121)	6.6 (125)	7.2 (126)	5.3 (139)*	5.0 (48)	4.8 (36)	5.9 (18)	13.0 (37)**
Medication locked or safely stored away	31.6 (203)	24.6 (235)**	45.7 (419)	45.5 (537)	43.5 (202)	39.7 (152)	38.0 (53)	32.8 (54)

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

Table B9. Prescription drug use indicators comparing military and sexual minority status in target and comparison communities; weighted % & unweighted (n)

	Military		LGBT	
Prescription drug use	**Target**	**Comparison**	**Target**	**Comparison**
Past year prevalence of receiving Rx painkiller	40.2 (80)	34.4 (107)	34.1 (77)	34.6 (95)
Great or moderate risk of using Rx painkillers for a non-medical reason	84.0 (161)	77.2 (248)	76.0 (172)	73.4 (194)
Past 30-day painkiller use to get high	6.3 (14)	5.3 (17)	5.7 (15)	6.8 (18)
Past 30-day Rx painkiller use	16.0 (629)	14.0 (672)*	24.8 (57)	18.1 (52)
Given or shared Rx drugs with someone	7.2 (15)	8.1 (28)	14.0 (33)	14.6 (40)
Medication locked or safely stored away	39.8 (42)	29.0 (55)	39.0 (50)	31.0 (46)

*$p < .05$

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	E-vapor product lifetime use	E-vapor product past 30-day use	Past year purchased tobacco for someone under 18
18-20	24.9 (245)	11.2 (102)	45.9 (464)	25.9 (257)	13.2 (122)
21-25	29.2 (293)	11.5 (104)	41.2 (426)	21.1 (216)	7.8 (80)
26-30	29.1 (329)	8.8 (90)	31.3 (347)	15.3 (167)	7.3 (77)
31-40	27.5 (457)	9.7 (138)	24.3 (388)	12.0 (195)	4.8 (78)
41-50	25.7 (385)	6.7 (97)	18.2 (260)	8.6 (128)	5.1 (74)
51-60	24.9 (390)	6.9 (90)	14.9 (227)	6.9 (109)	2.5 (40)
61-70	15.1 (166)	4.3 (41)	10.2 (107)	3.6 (40)	1.7 (19)
70+	11.2 (59)	3.7 (22)	5.1 (29)	2.6 (16)	1.9 (12)

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

Tobacco Use	Non-Hispanic White	Hispanic or Latino	Native American	Other
Any current cigarette use	20.8 (721)	24.5 (1061)	26.4 (384)	28.4 (158)
Any current chewing tobacco use	7.7 (234)	6.4 (263)	9.5 (128)	10.8 (59)
E-vapor product lifetime use	18.5 (671)	23.8 (1145)	15.9 (272)	26.0 (160)
E-vapor product past 30-day use	8.0 (305)	12.2 (587)	8.9 (143)	15.3 (93)
Past year purchased tobacco for someone under 18	3.1 (112)	5.6 (260)	5.9 (85)	7.5 (45)

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

Tobacco Use	Military	LGBT
Any current cigarette use	23.4 (130)	38.0 (212)
Any current chewing tobacco use	14.1 (78)	10.6 (57)
E-vapor product lifetime use	19.7 (116)	42.0 (241)
E-vapor product past 30-day use	11.3 (69)	24.6 (146)
Past year purchased tobacco for someone under 18	5.0 (32)	13.3 (75)

Appendix D: Mental Health

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

	Mental Health Indicators				
Age group	**Presence of a serious mental illness**	**Having mental health, drug or alcohol problems last year**	**Suicidal thoughts last year**	**Sought help on mental health or drug/alcohol problems last year**	**Difficulty assessing mental health or substance abuse treatment**
18-20	11.6 (110)	19.0 (194)	9.3 (92)	16.0 (168)	5.3 (55)
21-25	6.8 (71)	17.9 (194)	7.0 (75)	14.2 (153)	4.8 (50)
26-30	7.3 (77)	16.6 (186)	4.7 (52)	12.9 (143)	7.2 (76)
31-40	5.8 (91)	15.5 (270)	4.4 (69)	13.8 (242)	5.0 (86)
41-50	6.2 (85)	12.7 (197)	4.3 (60)	12.8 (194)	4.7 (69)
51-60	5.0 (74)	14.5 (228)	3.8 (57)	12.7 (203)	5.2 (80)
61-70	3.3 (32)	10.2 (107)	1.7 (18)	9.6 (101)	2.8 (30)
70+	1.5 (8)	4.8 (24)	1.7 (9)	3.8 (19)	2.1 (10)

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

Mental Health Indicators	**Non-Hispanic White**	**Hispanic or Latino**	**Native American**	**Other**
Presence of a serious mental illness	4.7 (164)	5.7 (250)	5.7 (85)	9.8 (49)
Having mental health, drug or alcohol problems last year	14.1 (501)	12.1 (553)	14.2 (243)	18.4 (103)
Suicidal thoughts last year	3.5 (123)	4.3 (191)	4.4 (74)	8.0 (44)
Sought help on mental health or drug/alcohol problems last year	11.8 (412)	11.1 (496)	13.4 (229)	15.1 (86)
Difficulty assessing mental health or substance abuse treatment	4.1 (145)	4.5 (187)	5.1 (80)	8.5 (44)

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

Mental Health Indicators	**Military**	**LGBT**
Presence of a serious mental illness	5.1 (26)	17.3 (89)
Having mental health, drug or alcohol problems last year	12.4 (70)	29.9 (158)
Suicidal thoughts last year	4.1 (25)	18.8 (100)
Sought help on mental health or drug/alcohol problems last year	13.6 (81)	25.6 (129)
Difficulty assessing mental health or substance abuse treatment	6.1 (34)	13.8 (69)

Appendix E: Facebook and Twitter Ads