Results from the 2016 New Mexico Community Survey

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2016

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

Suggested citation:

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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 and 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 (see Appendix F to review survey).

Data collection took place in the spring of Fiscal Year 2016 using two methodologies; both methodologies relied on convenience samples. The first approach was a time and venue based in-person data collection process. Respondents completed questionnaires in person at locations and times strategically identified to represent community residents. Questionnaires were administered via paper and pencil, using a data collection app on iPads, tablets, and smartphones, or directly online via laptops provided. Potential respondents were solicited in strategically identified venues in communities across the state. This time and venue-based data collection resulted in 10,242 valid surveys representing 32 counties. The second approach involved recruitment of potential respondents via an ad campaign on Facebook targeting residents across the state who were 18 and older to take the survey on-line. On-line survey recruitment and data collection resulted in 2,392 valid surveys representing all 33 NM counties. A total of 12,634 valid questionnaires were completed via the two different data collection strategies with about 81% coming from in-person data collection methods.

We weighted the data to match NM Census 2015 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, and analyzed these weighted data in several ways. 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 Partnerships for Success 2015 (PFS 2015). 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 outcomes comparing communities that targeted a specific substance with those that did not. Although the targeted communities were selected because of concerns about these substance abuse issues, the goal is to change this trajectory across time so that there are positive

trends in these indicators in the targeted communities. Finally, in our discussion we compared noteworthy findings with those from earlier years.

Our findings indicated the following:

Alcohol

- Men and women in target communities reported more past 30-day binge drinking and driving than in comparison communities. Women in target communities also reported significantly more past 30-day alcohol use than women in comparison communities.
- Non-Hispanic whites in comparison communities engaged in significantly more binge drinking than their counterparts in target communities, but Latino/as in comparison communities reported significantly less current drinking than their counterparts 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 than in target communities.
- The main alcohol sources for underage youth are from parties and unrelated adults providing it to them.
- The trends in alcohol-related outcomes over the past few years were more favorable in targeted than comparison communities, and thus there is indication that prevention efforts are making a difference in the communities that most need attention to alcohol-related issues.

Prescription Painkillers

- There are no significant differences in prescription painkiller use between target and comparison communities.
- Men in comparison communities and women in target communities reported significantly higher rates of past 30-day painkiller use to get high. Women in target communities also reported significantly higher rates of past year receiving prescription painkillers.
- Past 30-day prescription painkiller use to get high was lowest among non-Hispanic whites (2.7%); and others (the category of unknown race/ethnicity selection) reported the highest prevalence of prescription painkiller use for any reason (17.7%).
- 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.
- Community members in both target and comparison communities indicated greater awareness of the risks associated with using prescription painkillers for non-medical

reasons, and thus there is indication that prevention efforts are making a difference across the state.

Mental Health

- Based on the survey results, an estimated 7.5% of New Mexicans met the WHO's critical threshold screening for severe mental illness.
- Survey estimates indicated that 18% of the population self-identified as having a mental health or drug or alcohol problem in the past year.
- Survey estimates indicated that over 5% of the population had suicidal ideation in the past year, and about 14% received 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 (15.8%) and for suicidal ideation (11.5%). Adults 21-25 were most likely to report a mental health or drug or alcohol problem in the past year (25.2%), and to seek help on mental health or drug/alcohol problems in the past year (19.1%).
- Compared to the 2015 Community Survey results, the estimates moved in the negative direction for all mental health items. Thus, there is reason to be concerned about the broader behavioral health trends in the state and the impact that these interdependent issues have on substance abuse prevention efforts in our communities.

Prevention in New Mexico

The NM Office of Substance Abuse Prevention (OSAP) in FY 16 funded 35 prevention programs in 24 of the 33 counties in NM. Figure 1 below highlights the 24 counties receiving prevention funding in yellow and the nine with no OSAP funding in orange.

Figure 1: OSAP funded counties in New Mexico in Fiscal Year 2016
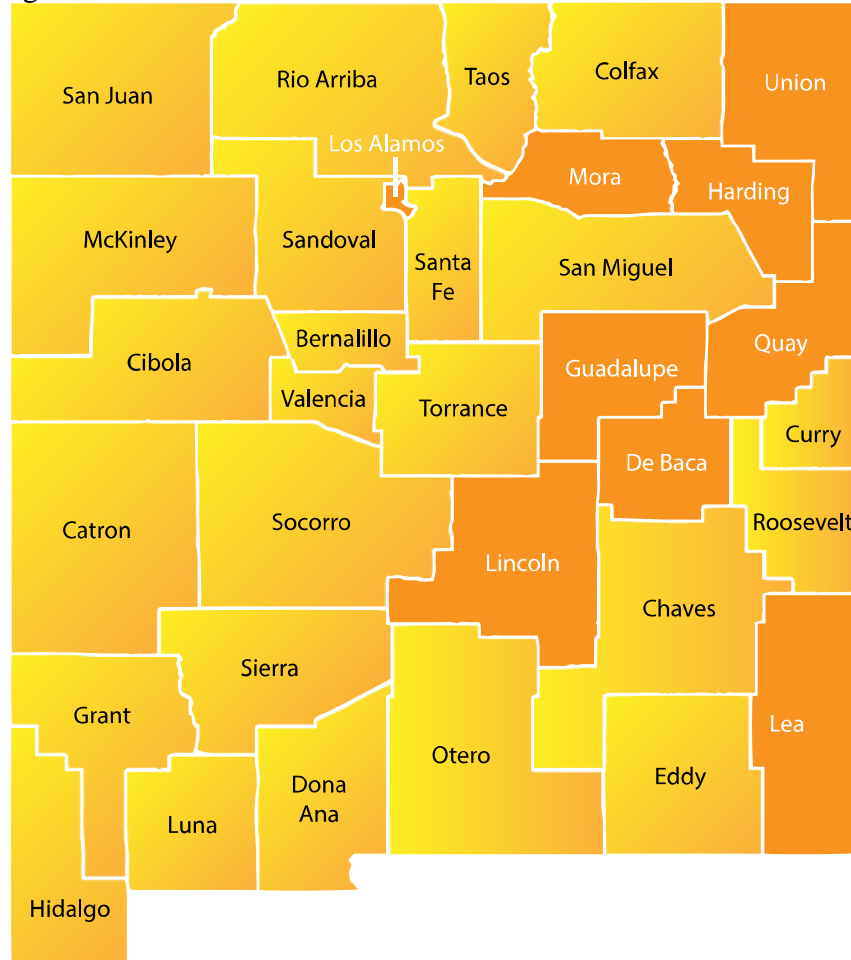
Programs receive funding to target several statewide prevention priorities including underage drinking, binge drinking among all youth and adults, driving while intoxicated among youth and adults, and prescription painkiller misuse and abuse among all ages. Depending on the original source of funding 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 to make community-wide impact.

Methodology

The NM Community Survey

The New Mexico Community Survey (NMCS) has been implemented in New Mexico 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 the prevalence of alcohol and other substance use among adults and associated risk behaviors in communities receiving funding from OSAP. The Community Survey is conducted yearly by funded communities and ideally captures a representative sample of adult residents in the funded communities and the targeted subgroups within those communities. Prevention communities in NM may represent towns, tribal lands, colleges/universities or neighborhoods; however they most often represent counties.

The survey content and data collection methodology have evolved over time but are based upon the content and protocol originally developed during the NM SPF SIG. PIRE's Institutional Review Board reviews and approves the statewide protocol prior to implementation each year. This protocol requires that all programs are trained on how to develop a strategic, locally-targeted data collection protocol and that they submit a comprehensive local protocol that identifies any targeted subpopulations, strategic locations and times to collect data. Members of the SEOW review, provide feedback and ultimately approve community protocols prior to local data collection taking place. Programs must follow their local data collection protocol and enter data collected using a standardized codebook.

In Fiscal Year 2016, we implemented the two data collection methodologies described below.

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 programs 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. Especially in larger communities, local MVD offices are a common location used to increase the randomness and representativeness of the

sample. Smaller and more rural communities create protocols that use diverse locations, as there are few appropriate locations (especially MVDs) 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, has become an important way that programs can collect data from a broad cross-section of their community.

This follows a Community Based Participatory Research approach in drawing upon community knowledge and initiative in data collection. Community initiative is complemented with technical expertise provided by the SEOW and the coordination of OSAP and PIRE. PIRE instructs community providers and local evaluators in appropriate data collection methodology and how to maintain respondents' confidentiality while completing the survey, and members of the SEOW review community-level data collection protocols to ensure the capture of a reasonably representative sample of adults. This technique was 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 is the second year that providers have been required to track their data collection process in detail for submission with their end of year reports. The purpose of this was to compare the originally proposed approach in the data collection protocol to actual data collection in order to improve the planning process the following year. For example, 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. This also helps future data collection planners know where to start in the case of staff turnover, a common event in NM. 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.

In FY2016, in addition to paper-pencil questionnaires used by communities, we also employed iPads with a PIRE-developed Qualtrics app installed to collect data. The app allowed for data to be collected on the device without the necessity to be connected to the internet at the same time. Several programs piloted this approach and collected data with iPads in combination with onsite laptop computers. Only one program – a university -- used this as a sole data collection approach. Most combined it with traditional paper and pencil data collection. Communities collected well over 9,000 paper surveys (77% of the aggregated sample) and 458 surveys via iPad with Qualtrics (4% of the total sample).

This approach to data collection has worked well for most communities in NM. However, particularly for larger communities, such as Bernalillo County, a time and venue-based approach can be problematic. The geographic and socio-demographic diversity is much greater in these larger counties than in rural areas, 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 amongst the best locations for recruiting a representative sample of the full population.

Challenges such as these mean that while the ideal is a similar sample across years, programs rarely are able to replicate the same protocol from year to year. Programs first are asked to address issues with representativeness reflected in the previous year of data collection: if the gender or racial/ethnic distribution of participants is significantly different than that of the census for that area, then data collection should adjust for this by altering their data collection strategy. Programs always confront practical issues that shape their ability to return to the same location each year: a new store or MVD manager does not allow data collection to occur, a location closes or is undergoing renovations, individuals' relationships with area businesses and agencies change so that data may or may not be collected, and local events (political, social, weather) can impact where, when and how data are collected. Programs also can shift in their capacity to organize data collection, gain permission to collect data, and understanding and managing data collection itself.

As new sub-recipients are funded, we have seen increased coverage across the state, particularly in more rural communities. Local DWI programs and others are starting to conduct the NMCS data as well, 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.

We currently do not calculate response rate for this approach, due to the community-based and diverse nature of this process (from community to site to individual data collector) and the considerable additional resources it would require to make such calculations possible.

Data Collection Approach # 2: On-line survey
The other data collection approach used in FY16 was the on-line recruitment and implementation of the NMCS. Ads for the survey were placed on Facebook targeting NM residents 18 and older. (Appendix E shows these advertisements.) We piloted this methodology in FY14 among 18 to 25 year-olds and expanded to include all NM residents 18 and older in FY15. We continued this methodology for FY16. This year, the on-line survey was switched to a new on-line platform hosted by Qualtrics. Qualtrics allows for the survey to be attached to a QR code so that people can directly scan the QR code with their smart phones and take the survey without needing to see the Facebook ad.

Ads ran for a total of 11 weeks. Six ads were created, three of which depicted people of various ages (young adults, parents, and older adults) and three of which were NM-related landscapes. Each week, two ads ran on Facebook. We offered daily and weekly incentives to randomly selected individuals who completed the survey. After completing the survey, respondents had the option to enter to win an incentive. 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 11 weeks.

From March 20, 2016 to June 4, 2016 (77 days) there were 584,963 impressions, reaching 177,649 unique people on average 3.29 times each at a cost of $13.63 per 1,000 people reached. There were 12,257 total clicks on the link to go to the survey. The click rate was 6.9%. When we consider unique clicks, which Facebook defines as three clicks from one person, there were 9,044. From 1,120 completed surveys we calculate a response rate of 9.1% if we use total clicks as the denominator, or 12.4% if we consider the unique clicks as the denominator. Most ads were viewed on mobile news feeds (23%) or audience network (65%), in comparison to desktop news feeds (3%) or desktop right columns (9%). Most website clicks resulted from the audience network (80%). A total of 1,120 surveys were collected recruiting directly through the Facebook ads.

Some communities used the QR code in heavily trafficked areas to allow people to take the survey later at their leisure and some colleges used the QR code to enable students to complete the survey on their own smartphone during onsite data collection. And finally, some sent email invitations to individuals or groups which sent them directly to the on-line survey and circumvented the Facebook approach.

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 nine 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	9,784	77.4	32
Online - FACEBOOK (18+ yr. olds)	1,120	8.9	33 (total online)
Qualtrics App	458	3.6	20
Online – Non-FACEBOOK	1,272	10.1	
Total	12,634		

Table 2. Completed questionnaires by County, 2016 compared to 2015

County	2016						2015				
	Qualtrics App	Online	Paper	Total	%	Weighted %	Online	Paper	Total	%	Weighted %
Bernalillo	261	441	903	**1605**	12.7	12.9	250	694	**944**	9.5	10.2
Catron	1	7	296	**304**	2.4	3.1	2	299	**301**	3.0	3.2
Chaves	1	72	292	**365**	2.9	2.7	17	189	**206**	2.1	1.7
Cibola	2	17	359	**378**	3.0	2.7	10	355	**365**	3.7	3.0
Colfax	0	8	165	**173**	1.4	1.5	6	246	**252**	2.5	2.9
Curry	1	58	312	**371**	2.9	2.9	15	338	**353**	3.6	3.9
De Baca	0	4	152	**156**	1.2	1.3	3	143	**146**	1.5	1.6
Dona Ana	17	136	342	**495**	3.9	4.4	90	253	**343**	3.5	3.9
Eddy	0	25	283	**308**	2.4	2.4	16	302	**318**	3.2	3.1
Grant	3	98	222	**323**	2.6	2.9	15	199	**214**	2.2	2.5
Guadalupe	0	6	1	**7**	0.1	0.1	1	0	**1**	0.0	0.0
Harding	0	1	0	**1**	0.0	0.0	1	0	**1**	0.0	0.0
Hidalgo	6	73	238	**317**	2.5	2.7	3	311	**314**	3.2	3.6
Lea	0	27	2	**29**	0.2	0.3	17	416	**433**	4.4	4.1
Lincoln	0	21	2	**23**	0.2	0.3	10	0	**10**	0.1	0.2
Los Alamos	8	7	4	**19**	0.2	0.2	4	0	**4**	0.0	0.1
Luna	0	107	281	**388**	3.1	2.9	45	294	**339**	3.4	3.5
McKinley	6	19	645	**670**	5.3	3.8	8	599	**607**	6.1	3.8
Mora	0	3	3	**6**	0.0	0.1	1	0	**1**	0.0	0.0
Otero	1	39	260	**300**	2.4	2.4	18	270	**288**	2.9	2.0
Quay	0	3	1	**4**	0.0	0.0	3	0	**3**	0.0	0.0
Rio Arriba	3	36	611	**650**	5.1	5.2	15	486	**501**	5.1	5.2
Roosevelt	1	19	331	**351**	2.8	2.5	3	306	**309**	3.1	3.5
San Juan	25	426	640	**1091**	8.6	6.9	38	412	**450**	4.5	3.8
San Miguel	0	36	258	**294**	2.3	2.3	8	315	**323**	3.3	3.3
Sandoval	16	95	418	**529**	4.2	4.3	60	465	**525**	5.3	4.9
Santa Fe	25	418	770	**1213**	9.6	10.0	55	393	**448**	4.5	5.1
Sierra	0	12	406	**418**	3.3	4.1	4	325	**329**	3.3	3.7
Socorro	37	30	543	**610**	4.8	4.3	11	475	**486**	4.9	5.9
Taos	31	47	311	**389**	3.1	3.6	14	332	**346**	3.5	4.0
Torrance	1	44	273	**318**	2.5	2.8	8	298	**306**	3.1	3.4
Union	2	8	2	**12**	0.1	0.1	9	0	**9**	0.1	0.1
Valencia	10	49	458	**517**	4.1	4.2	38	352	**390**	3.9	3.9
Total	458	2392	9784	**12634**	100%	100%	798	9067	**9865**	99.7	100.2

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 2015 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 federal Partnerships for Success (PFS)-II State Incentive Grant; 3) the NM Legislative funded Total Community Approach (TCA), and 4) the federal Partnerships for Success (PFS) 2015. 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.

Quantitative Analysis 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 to reflect close approximations to the actual NM population percentages, thus the discrepancies between the number and the weighted percent reported (e.g., 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

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[1] Retrieved from http://www.census.gov/popest/data/state/asrh/2015/SC-EST2015-ALLDATA6.html on July 8 2016.

sample was more educated than the general NM population; according to the US Census (2015 American Community Survey 1-Year Estimates), 26.5% of adults[2] in NM reported having a bachelor's degree compared to our weighted estimate of 32.9%. Approximately 6.5% of the sample reported having served or still serving in the military which, when weighted, increased to 8 %. The percentage of respondents in the sample who identified as LGBT was 6.4%, which when weighted decreased slightly to 5.5%.

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

Gender	n	Unweighted %	Weighted %
Men	4779	39.2	49.1
Women	7408	60.8	50.8
Age	n	Unweighted %	Weighted %
18-20	1627	12.9	5.5
21-25	1654	13.1	9.7
26-30	1331	10.5	8.9
31-40	2028	16.1	16.3
41-50	1811	14.3	15.2
51-60	1983	15.7	17.6
61-70	1392	11.0	14.6
70+	808	6.4	12.2
Race/ethnicity	n	Unweighted %	Weighted %
Non-Hispanic White	4543	36.0	42.0
Hispanic or Latino	5497	43.5	44.7
Native American	1705	13.5	8.4
Other	889	7.0	4.9
Education	n	Unweighted %	Weighted %
Less than high school	837	6.7	6.4
High school graduate/GED	3195	25.6	25.2
Some college/Technical school	3472	27.8	28.5
College graduate or higher	3660	29.3	32.9
In college	1318	10.6	7.0
Military status	n	Unweighted %	Weighted %
Active military or veteran	821	6.5	8.0
Sexual orientation	n	Unweighted %	Weighted %
LGBT	792	6.4	5.5

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[2] Retrieved from http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_1YR_S1501&prodType=table on September 21, 2016.

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 four 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; 3) the NM Legislative-funded Total Community Approach (TCA); and 4) the federal Partnerships for Success (PFS) 2015. Each funding stream is listed in order of initiation of implementation, with PFS 2015 programs still in the "SPF" phase, not yet in implementation. We also have data from communities receiving no prevention funding during FY2016 -- 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	5521	2068	49.8	3199	50.2
PFS-II	1865	600	43.9	1199	56.1
TCA	1913	759	52.4	1048	47.5
PFS 2015	2744	1119	49.0	1588	51.0

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	1950	40.9	2549	46.9	625	7.0	397	5.1
PFS-II	426	30.3	820	47.5	539	18.7	80	3.4
TCA	795	46.0	909	47.0	107	3.4	102	3.6
PFS 2015	999	42.8	1040	39.6	443	10.7	262	6.9

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, analyses compared communities that specifically targeted alcohol abuse in their OSAP-supported prevention implementation with communities that did not; and 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	8664		3970	
Gender	n	Weighted %	n	Weighted %
Men	3161	48.4	1618	50.6
Women	5154	51.6	2254	49.4
Race/ethnicity	n	Weighted %	n	Weighted %
Non-Hispanic White	2786	38.7	1757	49.3
Hispanic or Latino	3854	46.2	1643	41.4
Native American	1443	10.3	262	4.1
Other	581	4.8	308	5.2

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	6824		5810	
Gender	n	Weighted %	n	Weighted %
Men	2607	49.1	2172	49.2
Women	4011	50.9	3397	50.8
Race/ethnicity	n	Weighted %	n	Weighted %
Non-Hispanic White	2481	43.6	2062	40.3
Hispanic or Latino	2647	40.5	2850	49.4
Native American	1206	10.9	499	5.5
Other	490	5.0	399	4.8

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. All communities that received SAPT, PFS II or TCA funding implemented underage drinking and/or alcohol abuse prevention programs. 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.

Funding stream	Weighted Percent				
	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=5521)	48.5	14.3	3.6	3.1	2.8
PFS-II (n=1865)	45.5	18.4	3.2	3.1	2.2
TCA (n=1913)	43.9	16.0	3.9	3.2	3.3
PFS 2015 (n=2744)	47.1	19.1	4.6	3.2	5.4

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

	Men				Women			
Alcohol use	SAPT (n=2068)	PFS II (n=600)	TCA (n=759)	PFS 2015 (n=1119)	SAPT (n=3199)	PFS II (n=1199)	TCA (n=1048)	PFS 2015 (n=1588)
Past 30-day alcohol use	50.8	51.4	48.7	54.2	46.1	41.1	38.0	43.3
Past 30-day binge drinking	18.8	25.3	19.2	24.6	9.9	13.2	11.6	13.3
Past 30-day drinking & driving	4.7	4.1	4.7	5.7	2.4	2.4	2.7	2.8
Past 30-day binge drinking & driving	4.1	4.0	3.9	4.3	1.9	2.3	1.6	1.6
Past year purchased or provided alcohol for someone under 21	2.6	2.9	3.5	6.4	2.5	1.8	2.9	4.2

Next, we compared alcohol-related outcomes and intervening variables across time to examine whether communities targeting alcohol were more effective than those not targeting alcohol. Figures 2-4 present the prevalence of alcohol consumption and related risk behaviors in these two types of communities from FY 2014 to FY 2016. In general, communities targeting alcohol-related outcomes and intervening variables do so because needs assessments determined that alcohol was a considerable problem in the community. Therefore, target communities tend to report higher prevalence of alcohol consumption and binge drinking as well as drinking and driving than comparison communities. Comparisons across FY2014 - FY2016 showed that in FY2014 target communities reported more on past 30-day alcohol use, binge drinking, and drinking and driving; whereas in FY2015 and FY2016, these reported differences between target and comparison communities were reducing. Noticeably, the percentage of respondents who provided alcohol to minors in comparison communities had increased whereas target

20

communities had decreased to a lower level than comparison communities (Figure 4). This pattern suggests that the prevention efforts in those targeted communities had a positive impact on the relevant indicators.

Figure 2. Comparing target and comparison communities on alcohol consumption indicators from FY 2014 to FY 2016; weighted % reported
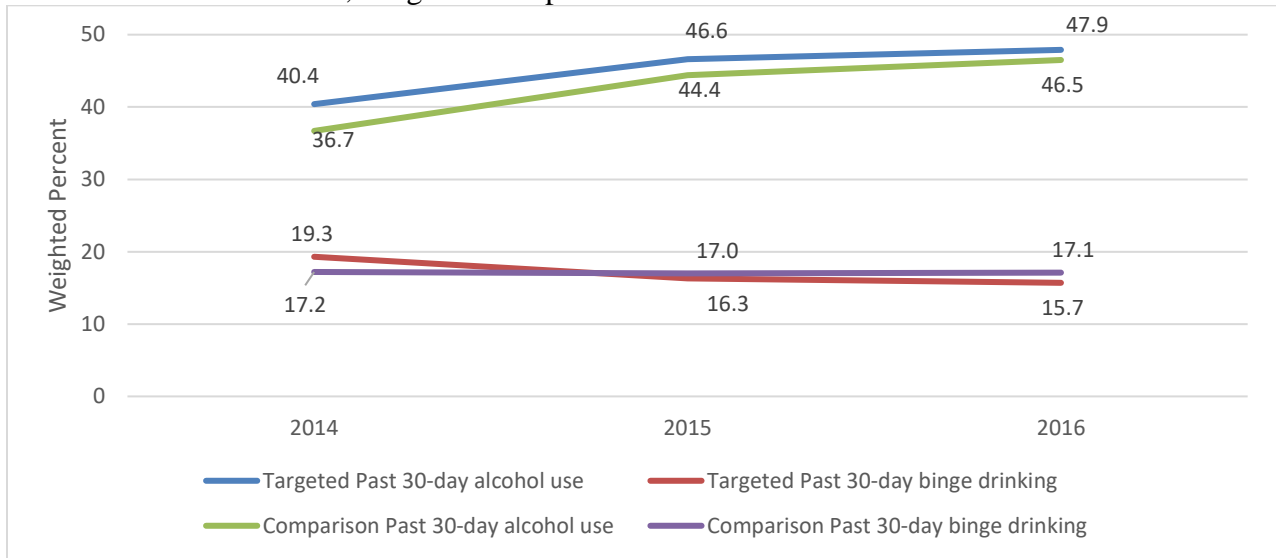
Figure 3. Comparing target and comparison communities on drinking and driving indicators from FY 2014 to FY 2016; weighted % reported.
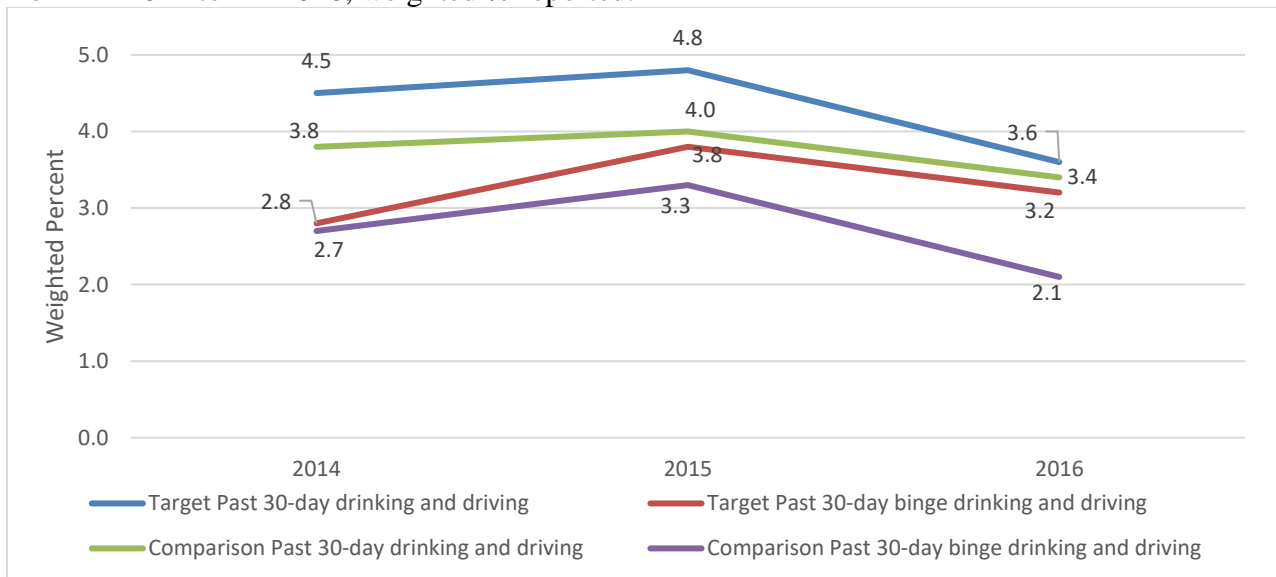
Figure 4. Comparing target and comparison communities on purchasing alcohol for minors from FY 2014 to FY 2016; weighted % reported.
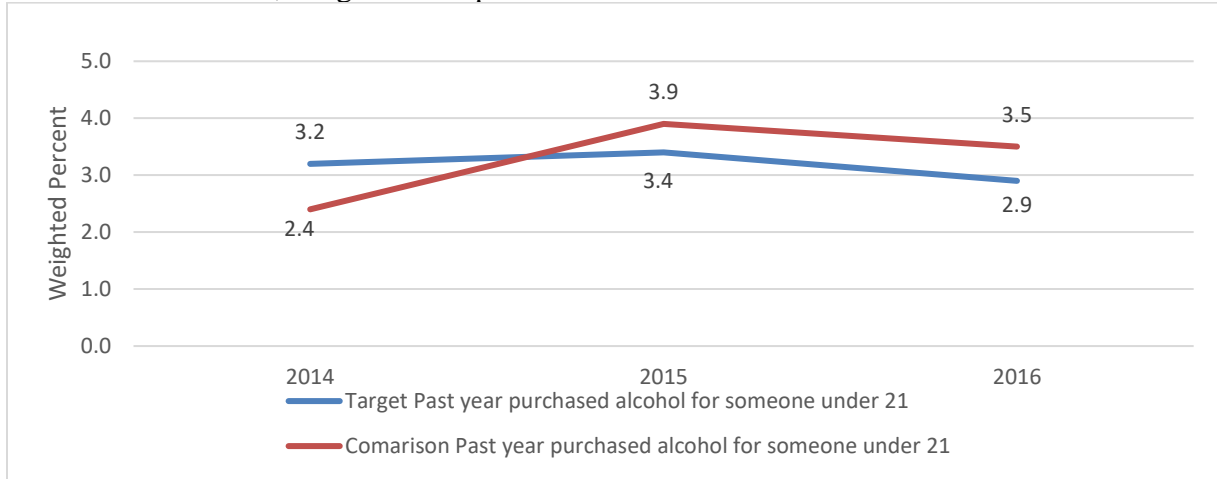
The Community Survey includes questions to measure key NM intervening variables, namely easy access to alcohol for underage persons and the perception of risk of legal consequences for violating alcohol laws. Table 10 shows the weighted percent of adults 18 and older who perceive that it is very or somewhat difficult for teens in their community to access alcohol in general and then specifically from stores and restaurants in the community. As in FY2015, 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 60% of the respondents in target communities perceived that it was very or somewhat difficult for teens to purchase alcohol at stores or restaurants in the community (retail access). Social access continues 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 target communities.

We next examined whether target communities differed from comparison communities with respect to the perceived risk of facing legal consequences for breaking alcohol-related laws such as underage drinking parties, providing 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 every category. This speaks to why it is likely that actual alcohol consumption and related behaviors are perhaps higher in those communities targeting them. As in FY2015, 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 % & unweighted (n)

Access to alcohol	Very or Somewhat Difficult	
	Target	Comparison
Ease of access to alcohol by teens in the community	13.5 (939)	12.9 (390)
Ease of access to alcohol by teens from stores and restaurants	60.7 (4001)	58.9 (1722)
Perception of risk/legal consequences	**Very or Somewhat Likely**	
	Target	Comparison
Likelihood of police breaking up parties where teens are drinking ***	61.5 (3953)	66.9 (1941)
Likelihood of police arresting an adult for giving alcohol to someone under 21 ***	64.9 (4109)	71.5 (2009)
Likelihood of someone being arrested if caught selling alcohol to a drunk or intoxicated person*	60.3 (4156)	62.6 (1882)
Likelihood of being stopped by police if driving after drinking too much*	73.8 (5464)	76.2 (2504)
Likelihood of being convicted if stopped and charged with DWI***	81.5 (5742)	85.7 (2707)

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

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 equal number of respondents indicated that they obtained it at a party or an unrelated adult purchased it for them. In addition, over 16% 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 % & unweighted (n)

| Access to Alcohol (n=603)	Target	Comparison
Adult family member gave or bought it	16.8 (63)	17.2 (41)
Unrelated adult gave or bought it	37.0 (139)	40.2 (94)
Got it at a party	36.5 (143)	44.1 (104)
Parent/guardian gave or bought it	7.1 (25)	6.6 (15)
Took it from home	7.0 (26)	7.7 (17)
Bought it at a restaurant/bar/public place	4.6 (16)	5.1 (11)
Someone underage gave or bought it	9.3 (36)	11.8 (27)
Got it some other way	5.3 (21)	3.7 (10)

Prescription Drugs

Table 12 below displays the weighted prevalence and corresponding unweighted *n* for key items measuring prescription painkiller use, sharing of prescription 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. All communities that received SAPT, PFS II or TCA funding had implemented prescription painkiller prevention programs. In Table 12 we can see that TCA communities reported the highest prevalence rates on past 30-day prescription painkiller use for any reason (18.3%), past 30-day painkiller use to get high (4.7%) and past year receiving prescription painkillers (32.2%). A lower percentage of respondents in TCA communities than other communities were likely to lock or store prescription painkiller safely (35.6%). At the same time, more respondents in TCA communities (88.2%) perceived great or moderate risk of using prescription painkillers for non-medical reasons than other communities and were least likely of giving or sharing prescription drugs (5.1%).

Prevalence rates of prescription painkiller use in SAPT and PFS II communities were similar. SAPT communities have the lowest percentage of past 30-day painkiller use for any reason (15.1%) and PFS II communities have the lowest percentage of past year receiving prescription painkillers (30.5%). While PFS 2015 communities had not yet started prevention implementation; they looked comparable to SAPT or PFS communities on most of measures. They reported the lowest percentage of respondents perceiving great or moderate risk of using prescription painkillers for non-medical reasons (81.9%) and lowest percentage of past 30-day painkiller use to get high (3.3%), but the highest for sharing prescription painkiller (6.5%).

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

Funding stream	Past 30-day Rx painkiller use for any reason	Past 30-day painkiller use to get high	Past year prevalence of receiving Rx painkiller	Great or moderate risk of Rx painkiller non-medical use	Given or shared Rx drugs with someone	Rx painkillers locked or safely stored away
SAPT (n=2233)	15.0	3.6	30.8	84.4	5.1	41.5
PFS-II (n=1865)	15.4	4.1	30.5	83.5	5.8	40.2
TCA (n=1334)	18.3	4.7	32.2	88.2	5.1	35.6
PFS 2015 (n=2744)	15.5	3.3	30.8	81.9	6.5	38.5

The following graph (Figure 5) displays the prevalence for the same indicators comparing communities that target prescription drug abuse with those that do not. In FY2016, no statistically significant differences were observed between target and comparison communities, except the prevalence of receiving prescription painkillers in the past year; target communities were higher than comparison communities (30.7% vs. 29.0%), and this difference was marginally significant.

Figure 5. Comparing the prevalence of communities targeting prescription drugs to communities not targeting prescription drugs; weighted %.
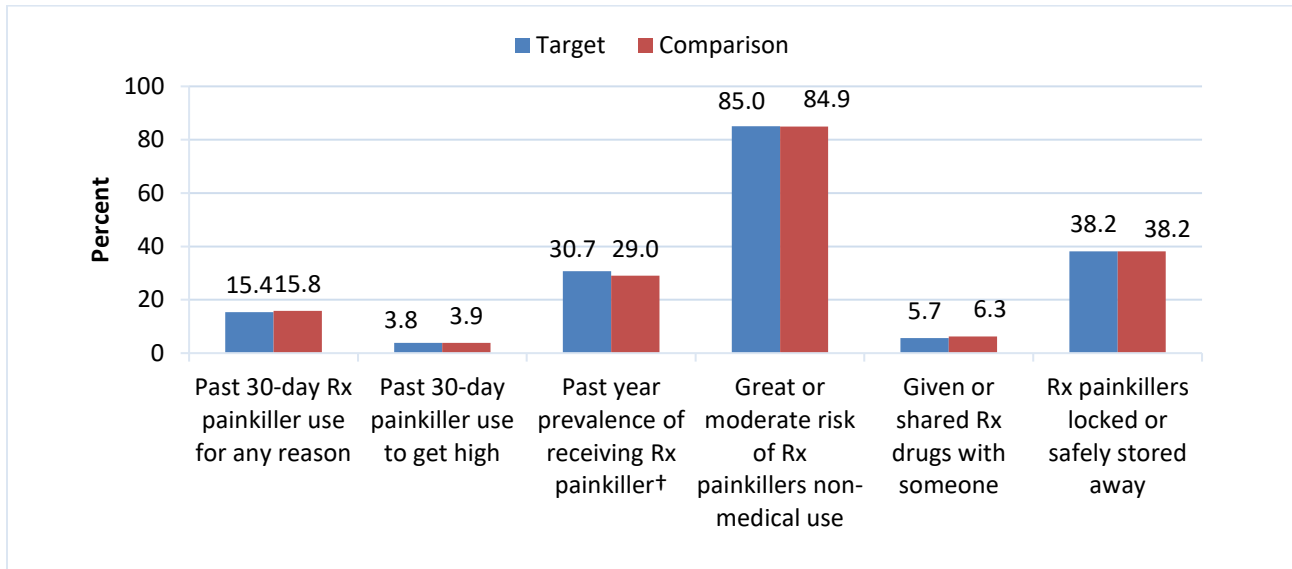
†*p* < .10

Table 13 below provides a breakdown by target and comparison communities 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. As in FY2015, 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 were respondents in target communities.

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

Reasons of Prescription Drug Use (n=1801)	Target	Comparison
Treat pain identified by doctors/dentists	76.6 (707)	76.7 (636)
For pain not identified by doctors***	13.2 (133)	11.2 (102)
Have fun with friends socially	1.7 (25)	2.8 (30)
Help me sleep	6.4 (74)	6.3 (58)
Get high, messed up or stoned	2.3 (30)	3.7 (36)
Cope with anxiety or stress†	3.7 (48)	4.8 (44)
Another reason	5.2 (54)	2.7 (20)

†*p* < .10, ***p* <.001.

Table 14 presents the various means by which respondents accessed the prescription painkillers used. No significant differences were found between target and comparison communities except more respondents in target communities obtained their prescription painkillers from doctors (83.2% vs. 79.9%, marginally significant). Although the majority of respondents reported having received a legitimate prescription for their painkillers, in both target and comparison communities a substantial percentage reported 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 % & unweighted (n)

Sources of Prescription Drug Use (n=1801)	Target	Comparison
A doctor/doctors prescribed†	83.2 (773)	79.9 (648)
Family member shared	6.0 (66)	4.7 (48)
Friend shared	4.2 (51)	5.4 (59)
Bought from somebody	2.9 (31)	3.2 (30)
Taken from someone without asking	1.5 (18)	0.9 (14)
Other places	1.6 (21)	2.4 (22)

†$p < .10$.

Tobacco

Figure 6 below presents the prevalence of tobacco 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. Men reported 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 %
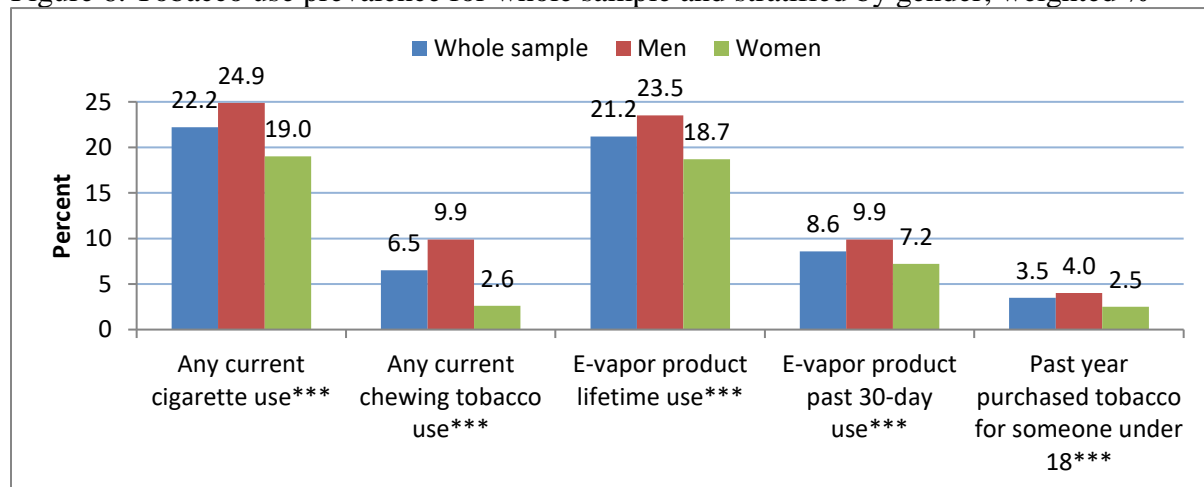
***$p < .001$.

Mental Health

Questions on the status of respondents' mental health were included in the Community Survey for the purposes of tracking both current need for 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.[3] 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 7 shows the prevalence of respondents who responded either "all of the time" or "most of the time" for the six items. There was a low prevalence of respondents indicating that 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.

Figure 7. The percent of respondents who reported they felt the following all or most of the time in the past 30 days; weighted %
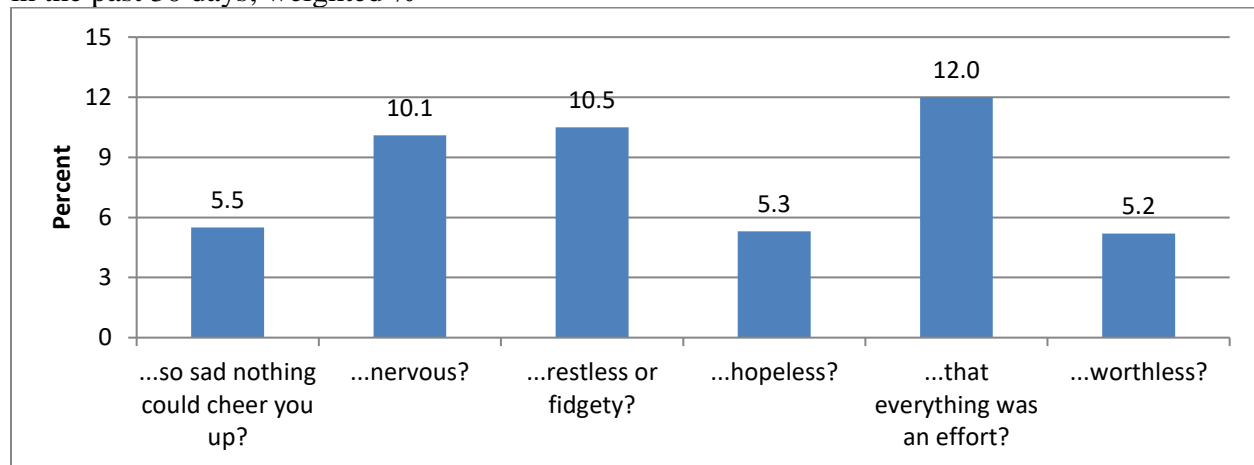
A total score across the six items of 13 or more suggests the presence of a serious mental illness (SMI), such as major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder, panic disorder, post-traumatic stress disorder (PTSD) and borderline personality disorder. However, as a 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 7.5% 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. The alpha coefficient for this scale was .89, a respectable score of reliability. Figure 8 includes the

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[3] 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.

prevalence of the combined score indicating severe mental illness and four 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 (5.7% vs. 5.0%). Little difference was found between men and women on SMI or having difficulty accessing treatment for mental health/substance problems.

Figure 8. Prevalence of mental health problems among the entire sample and stratified by gender.
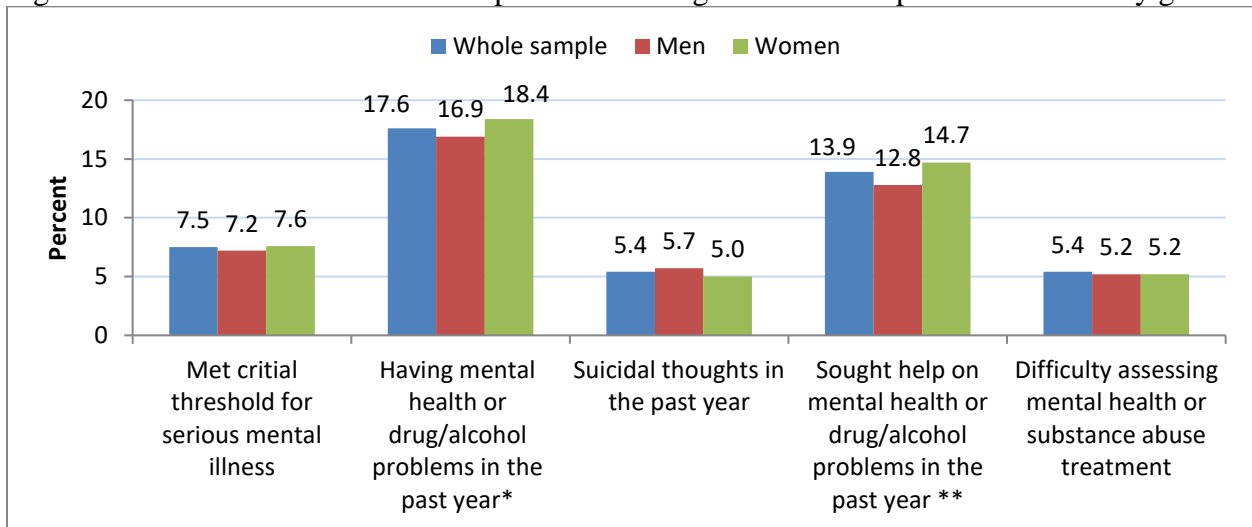
*$p <.05$, **$p <.01$.

Qualitative Analysis Results

Responses to the final, open-ended question – "Is there anything else you'd like to tell us or add about the issues we have asked about today?" – were uploaded into QSR NVivo 11 coding software. Data analysis began first by constructing a coding tree that included parent nodes, under which child nodes were created and aggregated under the relevant parent node theme. Nodes were organized by intervening variable (social access, retail access, low enforcement, perceived risk of legal consequences, social norms, and individual characteristics) as well as other themes, such as comments about the experience of taking the survey. Below is a summary of the respondent comments, with representative quotations that were edited for readability, and some were translated from Spanish.

Social Access
Respondents mentioned ease of social access to drugs and alcohol at school, from family and friends, and at parties in the community. "It is really easy for minors to drink when they are at a party…" A respondent stated "Drugs and alcohol are available to kids in our community. Schools, law enforcement, and even parents just pretend it is not a problem. Few activities for

kids except high school sports. After graduating, our kids either wander around town without jobs or move away permanently." A young adult noted, "…I am a GHS student and there are too many alcoholic parties!" Another respondent opined, "Kids can get any drugs or alcohol they want. In some cases, they can just use with their parents. Or steal from them." Another respondent opined "I think it is important to continue targeting adults of all ages and backgrounds to lock up all pills because the kids are taking anything they can find".

A small number of respondents noted sharing prescription painkillers. "I'm very concerned about people with acute chronic pain who can't get help from our health care system. I did supply painkillers to such a friend whose pain issues were not being addressed at all by his doctor and I would do it again if necessary."

Retail Access

Respondents noted retail access themes of inappropriate or excessive prescriptions, serving or selling alcohol to minors, and theft. Ease of retail access to prescription drugs was cited much more frequently than alcohol access. "Can someone please review how doctors are prescribing narcotics in our state? I hear from so many people how easily they got narcotics from doctors for a simple procedure. I believe doctors also prescribe too many pills per procedure". Another respondent noted, "Doctors prescribe pain killers for everything and anything! :(Too easy to access those addictive pain pills." Another respondent stated, "I am a family nurse practitioner who worked at the local clinic. I quickly learned that there is a serious prescription narcotics problem here with many prescriptions given inappropriately and diversion of narcotics to those for whom the narcotics were not prescribed." One respondent noted, "Doctors prescribe pain killers like candy, they are easy to get, easy to get addicted to, and eventually turn into heroin addicts. The drug problem in NM is scary and there is no hope for those on drugs as jail is not the answer. They need to be FORCED into treatment."

Another respondent commented on excessive prescriptions, addiction and the need to focus on monitoring and enforcement of prescribers:

> "I am aware of a few people who do or did have an addiction, and the problem was always doctor related...in other words the doctor aided the person's addiction by continually writing Rx's for the people long after the normal period the medication was intended for or needed. Enforcement of ethical medical practices, meaning legally holding doctors responsible for their abetment, should be part of any social campaign effort."

Respondents mentioned fake ID use, specific types of local retailers who sell alcohol to under-age customers (gas stations, sports bars), and the prevalence of under-age drinkers asking adults to buy alcohol for them. One respondent noted, "I have a teenage daughter and a lot of her friends have fake ID's. Alcohol is easy to obtain by kids now." Another stated, "I have worked in stores and I've seen how easy it is for kids to get beer…"

A small number of respondents noted theft as an issue.

> "I work in a local grocery store and we constantly have problems with minors stealing bottles of alcohol, Delsym, and Robitussin at all times of the day. I don't think adults buying alcohol or drugs for kids is as big of an issue as kids stealing it is. I feel like our laws are not strong enough to teach these kids a lesson when they are caught. To them the laws are just a joke especially when they just receive a ticket to appear in court at a later date and are allowed to walk out of the store after being caught."

Low Enforcement

Low enforcement of drug and alcohol abuse was the most commonly discussed intervening variable by a significant margin. Many comments in this category were about poor enforcement of laws in urban, rural, and tribal communities as well as in schools. Respondents also commented on the need for stricter laws and sentencing (especially for those people with multiple DUIs). It is noteworthy how many survey respondents either referenced driving under the influence themselves or knowing other people who drive under the influence.

One respondent commented "I've seen teen drinking by people I know who are not of age. I've seen more people drive drunk taking the back roads. I would like to see more police surveillance in back roads and rural communities." Another noted:

> "…DWI/DUI seems to be commonly accepted in this community. I have heard many people, including teens, say they think it is ok to drive after drinking, and rarely hear reports of negative consequences or convictions, even after major accidents. Two houses on my block have had drunk drivers crash into their yard and the side of their house in the past three years. These should have had more news coverage with the reports that the driver was intoxicated and charged with DUI or provided with treatment services..."

A tribal community member opined, "Living in the rez, police never ever charge adults who provide alcohol to underage people. I once tried to do this and it's been 2 years since I heard anything from the courts. And the parent I pressed charges against, still does this…" A northern NM community member noted, "There are not DWI Checkpoints in Taos, ever, yet most people I know drive drunk weekly. Some daily. It's so common here, unbelievable. Enforce!"

Many respondents commented on low enforcement while also noting the need for treatment for those with addictions and mental health issues.

> "New Mexico needs to get serious about the problems we have with addictions and get some detox facilities and rehabs for these addicts. We are burying them instead of helping them! And we need to revamp and enforce DWI laws. I see hundreds of DWI cases every few months and nobody is being punished unless they kill someone and then it is too late!! We need harsher laws and we need more treatment centers. I can't say enough about how NM is failing its citizens by not having facilities to address these

issues! We need to quit making criminals out of addicts and build rehabs instead of more prisons! AND we need to get away from private run prisons!! We won't need them if we will start putting the money used to house our addicts into rehabs instead of prisons!"

Participants in urban and rural areas of the state noted limited resources for police. One respondent noted, "Albuquerque does not have enough police to do anything...600 officers, when they should have over 1,500." Another respondent stated, "Need more money for rural areas for Law Enforcement". A respondent from the northwest part of NM noted, "Have police in Shiprock NM not enough to patrol when help needed. More training for law enforcement, San Juan County population wise."

Some participants commented on law enforcement bias, including profiling of community members based on race, skin color, or class.

> "Where I live, the probability of getting pulled over for drinking and driving or even any other reason feels like it is based on the color of your skin. The probability of a conviction for those offenses seems to be determined by the color of your skin whether you're an alcoholic or drug addict or even if you've never tried either in your life. If you're not the 'right' ethnicity, you're screwed either way. No prevention program will ever solve that!"

Respondents also commented on local police officers lack of respect for the law. One respondent stated, "Cops drink and drive, text and drive, don't follow driving rules."

Perception of Risk of Legal Consequences

Perception of risk was not widely commented on by respondents but was most commonly cited for its absence.

> "We are sending the wrong message to the youth of our communities when we keep letting multiple offenders of DWI, DUI, etc. get off over and over again. It is the common opinion that the only way someone really will get punished is when they finally kill someone. Over and over again we see someone arrested then let go for 6, 7, 8 times and yet they are back out on the streets doing the same behavior. The message is wrong, and the cycle will not stop until our laws are enforced."

One respondent noted, "Driving while intoxicated kills innocent people. The law is too lenient to people with DWI's. I have seen it myself being caught for driving more than 5x's and just merely getting a slap on the wrist. Which means nothing is done to them at all." Another opined, Kids under 18 yrs. old know that there is nothing that is going to happen to them. Just a ride home is the way they see it. No JPO or Teen Court follow through. Just talk."

Social Norms

While our programs do not directly address social norms as an intervening variable for alcohol-related prevention strategies, appreciation of New Mexico cultural values and beliefs is essential to help us create strong and effective programs. Additionally, the NM Community Survey asks just a few questions regarding social norms, so many respondents take this opportunity to speak their minds about this area, particularly about family, faith and individual responsibility.

Participants commented on the relationship of family values to substance abuse, problems associated with poor parenting, or the need for support for parents. Some commented on teaching "responsible drinking" as purportedly done in other countries.

Numerous comments were made about children's behavior: ideas that kids will drink and drug no matter what interventions occur, the need for improved supervision of children, and the need to talk to children. "Pues muchas veces nosotros los padres somos culpables que anden en vicios por que no platicamos con nuestros hijos o tenemos tiempo." (Often we the parents are to blame as we have our own vices and we don't talk to our own children or we don't have time for them). Another respondent noted that, "Parents need to be active in making sure their children don't have access to illegal drugs and alcohol but unfortunately some parents are the problem."

Some respondents noted intergenerational issues facing New Mexico communities.

> "I hope that the state really takes this epidemic seriously and helps not only the addict but the family members. Luckily for me, I watched the behavior of addicts, visited many prisons, felt the impact, disappointment and heartache that addiction causes so I was strong enough to say I will break this cycle, I can do this, I will not be another statistic. I did this without any support from schools or community members. No one ever knew what my life was like, I was embarrassed, ashamed and full of guilt. Children of drug addicts aren't usually told don't tell anyone mommy and daddy do this, they just know. The behavior is learned without saying a word. Luckily for me I saw the way out."

Regarding faith, we saw three predominant themes: faith (and Christian moral values) as prevention, faith as essential to recovery, and lack of faith as the root cause of substance abuse. Quite a few individuals espoused how faith to them was the answer to prevent substance abuse. For example, a resident from a rural community stated that Christian values helped them mitigate the lack of resources for other kinds of prevention: "We are rural so have little police presence and not all day. We have an obvious drug operation here. Everyone knows about it but nothing is done about it. My family is very active in church and we teach our children to stay away from drugs and alcohol."

Some used the lack of faith as what promoted substance abuse itself.

> "When people have no hope then they turn to things that will, they feel, either take the pain away or fill the void. With the absence of God in our communities, schools, and

homes it is no wonder that hopelessness abounds… In the end hope comes from faith and faith comes from believing in something greater than yourself and the only thing greater than myself is Jesus. So, I believe that if the educational programs can be based on principles of the word of God then those programs will have a better chance of success."

Others reported that faith in a higher power helped them stop drinking: "I became a Christian, and that is what helped me to stop drinking alcohol many years ago."

Many respondents focused on the need for people to take responsibility for their own actions, while others noted that their (and others) ability to quit or not abuse drugs and alcohol was due to resources not sufficiently available in NM: "A person needs to take responsibility for their own actions and face the consequences for them." A respondent shared:

"I abused opiates and amphetamines for many, many years. My use nearly killed me but, thankfully I had the resources, support, and willingness to seek help and I was able to get treatment. The process of finding good, affordable, and quality treatment was incredibly difficult and stressful. I had to go to treatment outside of the state and I currently attend weekly meetings and groups. I work very hard to be my own advocate for my health and recovery."

Others noted that use of drugs and alcohol are either an attempt at self-medication, evidence of another deficit in an individual's life or symptomatic of larger societal problems: "Substance abuse happens (when you) don't find out what works for you. Exercise, art, gardening, animal care, fun without enhancement. Find your passion."   Another respondent noted, "When people's hope and dreams are taken away from them due to financial matters what else is there but to self-medicate. Happy people don't need drugs of any kind other than physical pain." A respondent stated, "Society's problems are not about drugs and alcohol. Drug and alcohol issues are a symptom of society's ills."

Some respondents called out community norms that drive alcohol abuse in NM, "College turns many people into binge drinkers. It's the ugly truth." A respondent stated "A huge problem we have to contend with is generations of people having normalized alcohol abuse, and drinking and driving." Another respondent commented that:

"I think alcohol in this state is somewhat culturally accepted, long generations abuse of alcohol and a sense that it is acceptable, 'the norm.' How to reach those kids that are brought up thinking it's normal for mom/dad to drink 6-packs or more after working all day because they 'deserve it' after working all day, or even the parents, large families that drink like that every weekend…"

Other Themes

People noted that lack of opportunities increases substance use and abuse at the local community level: "The substance abuse issue in NM as well as in other parts of the country is a reflection of

the lack of opportunities provided. The economy and conditions in NM are very poor and many individuals suffer from inertia and depression. Generational substance use and abuse have caused families to be in a constant state of crisis." Another respondent noted that: "I think one thing that turns people and/or kids to drink and do drugs is because there is nothing for people to do here for fun. Kids need more positive and fun things to do."

Others noted that advertising and the corporate profit motive support alcohol and drug abuse:

> "We live in a culture heavily immersed in drugs, especially alcohol. We are constantly being bombarded with advertising telling us to buy drugs and alcohol yet harshly criminalize it when people use it 'irresponsibly.' If you want to stop drug abuse, stop the opportunities for relentless advertising, like billboards on NM highways. You cannot continue to send out these mixed messages. For example, billboards tell me to buy beer and liquor at the next exit followed by a mean-looking cop threatening to bust me for DWI. Drugs and alcohol are a medical problem and should be treated as such. Instead of trying to counteract the overwhelming persuasion of advertising for these substances, take a stand and stop giving them the freedom to market wherever and whenever they want."

Some respondents supported the legalization of marijuana and other drugs, noting its efficacy for pain relief and its revenue-generating potential: "We should consider the legalization of marijuana to cut down on prescription drug overdoses and use the tax money to increase safe rides to and from places that serve alcohol." A respondent stated, "Legalize all drugs, then use the tax gained from that to open drug rehabilitation centers across NM." Another opined, "Criminalizing drug use doesn't work. Legalize it all and put the money in rehab when it is wanted."

Respondent comments on a possible 25 cent alcohol tax increase were varied and demonstrated opportunity for education around how an alcohol tax would impact underage drinking. "How is a tax going to change the situation of underage drinking? You need to change where they are getting it from and whose providing it to them. A tax isn't going to do that!!" A respondent stated: "I don't think increasing the taxes on alcohol is going to reduce underage drinking. I believe if we want our youth to refrain from alcohol & drugs we need to build a better community for them."

Some people suggested a variety of alternatives to an alcohol tax increase: "We do not need to be taxed more. Enforce the laws in place at this time." Another stated, "Increased taxes will not solve drug and alcohol abuse. Treatment facilities are very much needed in the state of NM. Parents need to be responsible and teach kids at all times- give emotional support, teach morals and teach the children they are important to everyone every day."

Respondents commented about the lack of perception of harm, as well as the challenges associated with youth being surrounded by parents and community whose use and abuse

normalizes drinking and drugging. Prevention/Education about the dangers of use was noted as an important component as were behavioral health services.

> "Alcohol is the most abused drug that we have. I see more domestic violence, more violent crime on a day-to-day basis than if the individual was on illegal controlled substances. When I ask what they were doing when they did the act/crime, almost 95% say that they were drinking. Drinking and prescription drugs are a horrendous problem in our communities."

Another stated, "The reality of how it affects family units, siblings, and close friends is rarely mentioned! Where it all ends up, the circular drain to death, jail, or poor health."

Need for Services

Direct service provision is NOT a strategy supported through these prevention program funding streams, but it is the most frequently noted response by survey participants. Over 700 comments were focused on the need for behavioral health services, substance abuse treatment, youth-oriented services, housing and homelessness, and other services. Many commented on the need to seek supportive services outside of NM.

A respondent noted, "I work in mental health with young people. They need more resources! They need help at all levels of care including prevention, outpatient, and inpatient. I'm sure we could say the same for adults." Another commented "More money needs to be put into facilities that help youth with drug or alcohol addictions." Another noted, "Mental health services are too difficult to obtain. Too many wait lists even for outpatient, not enough inpatient facilities. It is especially hard to find services for Medicaid recipients. The providers working with Medicaid clients cannot afford budget cuts."

"I lost my son 5 years ago to a heroin overdose. What we went through for a few years prior to that was hell on earth and my experience educated me in ways I never dreamed. We desperately need long term treatment and transitional living in order to help save our kids."

A community member stated that:

> "If it was difficult for me to navigate my way through treatment and now recovery, I can't imagine how difficult it would be for someone who didn't have the resources or support! What can be done to facilitate this process for others? For example, New Mexicans need more sober living communities, employers willing to work with people in early recovery, and patient advocates."

Many respondents commented on the need for treatment and services in communities versus incarceration: "It is extremely important for people who have substance abuse issues to be seen by professional therapists. Therapists are exactly what these people need, rehabilitation, NOT jail! More money should be allocated to help. The money should not be saved for them to be

incarcerated." Another respondent stated: "Start treating drug abuse as a mental health issue rather than a criminal issue. Juvenile system lacks rehab for teens. Advice given by probation officer: smoke cigarettes to replace marijuana." Another noted, "If someone wants help, there is too long of a wait time to get them help, but if they commit a crime to feed a drug habit... Always room in jail. We can't incarcerate ourselves out of what is happening... Addiction is and should be treated as a health issue, not a moral failure."

Respondents also commented on effective programs and the best use of limited resources:

> "Public health campaigns without funding for behavioral health treatment is not an effective strategy for public health, nor is it efficient use of taxpayer dollars. There is no REAL help for the drug and booze addicted, unless sentenced to by the court, or if one has unlimited money or insurance. Sentencing people to mandatory AA meetings is the most common 'solution' and that's ridiculous. Tangible help for the addicted does not seem to be a priority--just repeatedly incarcerating them-which creates a larger problem. Then the parole/probation system sets them up to fail yet again, and back they go, having NO support system. All the prevention slogans in the world are not going to work--going WAY back to 'Just say no to drugs', and red ribbon week. Didn't help, did it."

The need for prevention was also mentioned in hundreds of comments. Specific areas included: education, alternative activities, employment, and education and services targeted to youth. "We need more people talking to and sharing their personal stories with middle school children and need more community events to raise awareness that drug addiction does not discriminate. Doesn't matter what zip code you live in, the drugs are readily available."

Some connected lack of alternatives and economic opportunity to drug and alcohol abuse: "We need a place for younger people that can get help and education, so they don't have to choose drugs/alcohol as a lifestyle. They need to be influenced before they get out of high school. Some kind job assistance, education or medical intervention before they become users of these things. They need to feel they are someone that can contribute to society." A respondent noted, "New Mexico needs more youth activities and MORE JOBS." Another stated, "The substance abuse issue in NM, as well as in other parts of the country, is a reflection of the lack of opportunities provided. The economic conditions in NM are very poor and many individuals suffer from inertia and depression. Generational substance use and abuse have caused families to be in a constant state of crisis."

Respondents also commented on the broad root causes of substance abuse, "I feel poverty, lack of jobs and genetic mental health issues are the root of abuse. Regulation of substances can only go so far. There are larger social systemic issues that need to be addressed as well."

Discussion

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 plan collaboratively 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 regarding 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 to achieve greater utility and consistency across years.

For the alcohol-related outcomes of underage drinking, binge drinking, and DWI prevention, target communities remain similar to comparison communities and did not differ significantly from each other on alcohol consumption behaviors. Given that target communities were originally identified for prevention funding by their high alcohol-related consequences and that these differences have been reduced, and in some cases reversed, since 2014, there is a positive trend in outcomes in these communities that suggests their alcohol-related prevention activities are making a difference.

As in previous years, social access remains at the top of the list of intervening variables as a concern. Almost 75% of underage young adults in target communities who drink got alcohol at parties or were given alcohol by unrelated adults. Our 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/frontier, low in resources (especially for enforcement), and where evidence-based strategies to address social access are limited.

Target communities have increased their perceived risk of legal consequences for breaking alcohol-related laws from FY2015 (four of the five questions concerning risk indicated increased perception of risk, with the one exception being the likelihood of being convicted if charged with DWI). It is a continuation of the years of work in these communities 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. And that the 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, the differences between target and comparison communities are narrowing. Target communities continue to show greater awareness of risks associated with using prescription painkillers for non-medical reasons (the perceived risk increased quite a bit from 2015 to 2016 in both target and comparison

communities) and had fewer people sharing prescription drugs in FY2016 than FY2015 (down from 7% to under 6% in target communities, while remaining just over 6% in 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.

The mental health item responses were also noteworthy, especially in relation to other survey responses. Compared to FY2015, we see an uptick on every mental health measure in FY2016, especially the measure of having mental health or drug/alcohol problems in the past year increasing to 17.6% from 13.4% in 2015. The considerable commentary about behavioral health problems in this state also supports this assessment. And while the social indicators of health or resources are not a focus of this survey *per se*, it is important to note how many open-ended responses draw attention to these issues. In identifying the lack of resources for activities and services (including enforcement) to help address interdependent behavioral health and other community concerns, respondents acknowledged the challenges that our state faces as it attempts to prevent substance abuse.

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	50.8 (1012)	52.3 (1357)	46.1 (1408)	41.3 (1692)***
Past 30-day binge drinking	18.8 (400)	22.7 (627)**	9.9 (331)	12.7 (574)***
Past 30-day drinking & driving	4.7 (103)	4.2 (135)	2.4 (82)	2.5 (114)
Past 30-day binge drinking & driving	4.1 (104)	3.5 (113)	1.9 (64)	1.6 (77)
Past year purchased or provided alcohol for someone under 21	2.6 (65)	4.1 (127)**	2.5 (77)	2.8 (120)

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

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	51.4 (285)	51.6 (2084)	41.1 (463)	43.9 (2637)
Past 30-day binge drinking	25.3 (145)	20.3 (882)**	13.2 (168)	11.1 (737)*
Past 30-day drinking & driving	4.1 (27)	4.5 (211)	2.4 (31)	2.4 (165)
Past 30-day binge drinking & driving	4.0 (28)	3.7 (189)	2.3 (31)	1.6 (110)
Past year purchased or provided alcohol for someone under 21	2.9 (19)	3.5 (173)	1.8 (22)	2.8 (175)*

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

Table A3. Alcohol use indicators comparing men 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	48.7 (364)	52.2 (2005)	38.0 (404)	44.5 (2696)***
Past 30-day binge drinking	19.2 (161)	21.3 (866)	11.6 (131)	11.4 (774)
Past 30-day drinking & driving	4.7 (47)	4.4 (191)	2.7 (31)	2.4 (165)
Past 30-day binge drinking & driving	3.9 (38)	3.7 (179)	1.6 (20)	1.8 (121)
Past year purchased or provided alcohol for someone under 21	3.5 (33)	3.4 (159)	2.9 (34)	2.6 (163)

***$p \leq .001$.

Table A4. Alcohol use indicators comparing men and women in PFS 2015 and non-PFS 2015 communities; weighted % & unweighted (n)

Alcohol use	Men		Women	
	PFS 2015	Non PFS 2015	PFS 2015	Non PFS 2015
Past 30-day alcohol use	54.2 (582)	51.0 (1787)†	43.3 (664)	43.5 (2436)
Past 30-day binge drinking	24.6 (274)	20.1 (753)**	13.3 (228)	11.0 (677)*
Past 30-day drinking & driving	5.7 (68)	4.2 (170)*	2.8 (51)	2.4 (145)
Past 30-day binge drinking & driving	4.3 (54)	3.7 (163)	1.6 (29)	1.8 (112)
Past year purchased or provided alcohol for someone under 21	6.4 (74)	2.7 (118)***	4.2 (62)	2.3 (135)***

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

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

Alcohol use	Non-Hispanic White		Hispanic		Native American		Other	
	SAPT	Non SAPT	SAPT	Non SAPT	SAPT	Non SAPT	SAPT	Non SAPT
Past 30-day alcohol use	50.9 (957)	49.7 (1257)	47.6 (1166)	47.4 (1340)	38.7 (237)	31.0 (329)**	50.9 (184)	42.7 (205)*
Past 30-day binge drinking	11.1 (215)	13.8 (378)*	17.1 (409)	22.2 (618)***	15.7 (94)	15.0 (160)	12.1 (46)	17.2 (83)*
Past 30-day drinking & driving	3.6 (68)	2.6 (76)	3.6 (91)	4.1 (125)	3.8 (23)	3.9 (38)	3.3 (14)	3.9 (22)
Past 30-day binge drinking & driving	1.9 (37)	1.5 (47)	3.3 (82)	3.5 (105)	4.6 (28)	2.9 (27)	8.8 (34)	3.9 (23)**
Past year purchased or provided alcohol for someone under 21	2.6 (56)	3.6 (109)	2.5 (64)	3.4 (101)	3.3 (18)	1.9 (20)	6.3 (21)	3.5 (20)

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

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

Alcohol use	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 (215)	50.1 (1999)	49.4 (384)	47.2 (2122)	27.7 (147)	36.9 (419)***	37.2 (29)	47.6 (360)
Past 30-day binge drinking	10.0 (46)	12.9 (547)	24.7 (177)	18.9 (850)***	15.9 (86)	15.0 (168)	18.6 (14)	14.4 (115)
Past 30-day drinking & driving	1.3 (7)	3.2 (137)*	3.9 (31)	3.9 (185)	4.9 (22)	3.3 (39)	1.0 (1)	3.9 (35)
Past 30-day binge drinking & driving	0.7 (5)	1.8 (79)*	4.2 (35)	3.3 (152)	3.6 (16)	3.6 (39)	6.9 (6)	6.1 (51)
Past year purchased or provided alcohol for someone under 21	2.2 (10)	3.3 (155)	2.6 (23)	3.0 (142)	1.5 (8)	2.9 (30)	0.9 (1)	5.3 (40)*

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

Table A7. Alcohol use indicators comparing race/ethnic groups in TCA and non-TCA communities; weighted % & unweighted (n)

Alcohol use	Non-Hispanic White		Hispanic		Native American		Other	
	TCA	Non TCA	TCA	Non TCA	TCA	Non TCA	TCA	Non TCA
Past 30-day alcohol use	42.4 (328)	52.0 (1886)***	44.9 (397)	48.1 (2109)	48.6 (49)	32.9 (517)**	46.3 (44)	46.6 (345)
Past 30-day binge drinking	9.4 (82)	13.3 (511)**	21.9 (195)	19.3 (832)	20.3 (20)	14.9 (234)	18.0 (19)	14.4 (110)
Past 30-day drinking & driving	2.4 (22)	3.2 (122)	4.5 (43)	3.7 (173)	10.4 (10)	3.4 (51)***	8.5 (10)	2.9 (26)**
Past 30-day binge drinking & driving	1.4 (14)	1.8 (70)	4.1 (38)	3.3 (149)	11.4 (9)	3.0 (46)***	5.6 (7)	6.3 (50)
Past year purchased or provided alcohol for someone under 21	2.0 (18)	3.4 (147)*	3.7 (36)	2.8 (129)	10.3 (8)	1.9 (30)***	8.8 (9)	4.3 (32)*

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

Table A8. Alcohol use indicators comparing race/ethnic groups in PFS 2015 and non-PFS 2015 communities; weighted % & unweighted (n)

Alcohol use	Non-Hispanic White		Hispanic		Native American		Other	
	PFS 2015	Non PFS 2015	PFS 2015	Non PFS 2015	PFS 2015	Non PFS 2015	PFS 2015	Non PFS 2015
Past 30-day alcohol use	53.1 (516)	49.6 (1698)	48.8 (485)	47.3 (2021)	33.2 (143)	34.2 (423)	44.2 (116)	47.4 (273)
Past 30-day binge drinking	19.0 (190)	11.1 (403)***	20.1 (212)	19.7 (815)	14.4 (62)	15.5 (192)	17.6 (46)	13.8 (83)
Past 30-day drinking & driving	3.7 (39)	2.9 (105)	5.5 (58)	3.6 (158)**	2.6 (13)	4.2 (48)	4.0 (13)	3.4 (23)
Past 30-day binge drinking & driving	2.3 (25)	1.5 (59)	4.1 (42)	3.3 (145)	1.4 (7)	4.2 (48)**	3.5 (12)	7.1 (45)*
Past year purchased or provided alcohol for someone under 21	7.0 (74)	2.3 (91)***	4.4 (43)	2.7 (122)**	2.1 (9)	2.5 (29)	3.6 (11)	5.2 (30)

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

Table A9. 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	51.3 (1558)	52.1 (811)	44.7 (2189)	40.7 (911)**
Past 30-day binge drinking	20.8 (670)	21.3 (357)	11.0 (603)	12.3 (302)
Past 30-day drinking & driving	4.7 (162)	4.0 (76)	2.5 (136)	2.4 (60)
Past 30-day binge drinking & driving	4.3 (165)	2.7 (52)**	2.0 (108)	1.3 (33)*
Past year purchased or provided alcohol for someone under 21	3.2 (119)	3.9 (73)	2.4 (123)	3.2 (74)†

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

Table A10. Alcohol use indicators comparing race/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	50.9 (1377)	49.2 (837)	48.5 (1792)	45.1 (714)*	34.4 (481)	31.9 (85)	48.1 (260)	43.6 (129)
Past 30-day binge drinking	11.6 (333)	14.2 (260)*	19.2 (689)	21.0 (338)	16.0 (222)	11.2 (32)†	13.9 (77)	16.6 (52)
Past 30-day drinking & driving	3.1 (88)	2.9 (56)	3.9 (152)	3.7 (64)	4.1 (54)	2.5 (7)	2.9 (19)	4.9 (17)
Past 30-day binge drinking & driving	1.8 (56)	1.4 (28)	3.7 (141)	2.8 (46)	3.8 (49)	2.4 (6)	7.8 (45)	3.2 (12)**
Past year purchased or provided alcohol for someone under 21	2.8 (90)	3.7 (75)	2.8 (111)	3.2 (54)	2.5 (32)	2.4 (6)	5.1 (28)	4.2 (13)

*p ≤ .05, **p ≤.01.

Table A11. Alcohol use indicators comparing military and LGBT in target and comparison communities; weighted % & unweighted (n)

Alcohol use	Military		LGBT	
	Target	Comparison	Target	Comparison
Past 30-day alcohol use	49.5 (221)	56.3 (211)	58.8 (327)	58.7 (128)
Past 30-day binge drinking	15.2 (65)	20.3 (74)	20.7 (123)	23.3 (58)
Past 30-day drinking and driving	4.8 (294)	3.9 (17)	8.1 (46)	6.7 (16)
Past 30-day binge drinking and driving	7.9 (38)	2.9 (13)**	8.0 (48)	5.3 (13)
Past year purchased alcohol for someone under 21	7.2 (35)	2.4 (12)***	8.9 (47)	9.5 (22)

**p ≤.01, ***p ≤.001.

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**
Past 30-day Rx painkiller use for any reason	13.5 (108)	15.4 (553)	16.7 (193)	15.6 (869)
Past 30-day painkiller use to get high	3.4 (32)	4.4 (180)	3.6 (48)	3.1 (185)
Past year prevalence of receiving Rx painkiller	27.8 (218)	27.8 (963)	34.4 (402)	31.6 (1770)
Great or moderate risk of Rx painkiller non-medical use	82.5 (644)	84.5 (3055)	86.6 (1060)	86.8 (4913)
Given or shared Rx drugs with someone	4.7 (44)	5.3 (220)	5.5 (71)	6.6 (397)
Medication locked or safely stored away	41.7 (154)	35.2 (649)*	42.2 (246)	39.7 (1162)

*$p < .05$.

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**
Past 30-day Rx painkiller use for any reason	14.1 (83)	15.1 (578)	16.4 (167)	15.7 (895)
Past 30-day painkiller use to get high	3.4 (23)	4.3 (189)	4.6 (44)	2.9 (189)*
Past year prevalence of receiving Rx painkiller	27.5 (152)	27.9 (1029)	32.9 (356)	23.0 (1816)
Great or moderate risk of Rx painkiller non-medical use	85.0 (467)	84.0 (3232)	83.4 (939)	87.4 (5034)***
Given or shared Rx drugs with someone	4.4 (31)	5.3 (233)	6.5 (75)	6.3 (393)
Medication locked or safely stored away	38.0 (119)	36.1 (684)	42.7 (269)	39.6 (1139)

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

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

	Men		Women	
Prescription drug use	**TCA**	**Non TCA**	**TCA**	**Non TCA**
Past 30-day Rx painkiller use for any reason	17.3 (90)	14.7 (571)	19.9 (136)	15.3 (926)**
Past 30-day painkiller use to get high	4.5 (26)	4.2 (186)	4.9 (38)	3.0 (195)**
Past year prevalence of receiving Rx painkiller	30.9 (159)	27.3 (1022)	33.8 (227)	31.9 (1945)
Great or moderate risk of Rx painkiller non-medical use	88.2 (458)	83.5 (3241)**	89.9 (597)	86.4 (5376)*
Given or shared Rx drugs with someone	5.2 (33)	5.2 (231)	4.7 (35)	6.6 (433)
Medication locked or safely stored away	31.2 (89)	37.2 (714)	41.7 (147)	40.0 (1261)

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

Table B4. Prescription drug use indicators comparing men and women in PFS 2015 and non-PFS 2015 communities; weighted % & unweighted (n)

Prescription drug use	Men		Women	
	PFS 2015	Non PFS 2015	PFS 2015	Non PFS 2015
Past 30-day Rx painkiller use for any reason	13.4 (135)	15.4 (526)	17.3 (247)	15.5 (815)
Past 30-day painkiller use to get high	3.3 (37)	4.4 (175)	3.0 (46)	3.3 (187)
Past year prevalence of receiving Rx painkiller	26.7 (258)	28.1 (923)	34.7 (499)	31.5 (1673)*
Great or moderate risk of Rx painkiller non-medical use	79.4 (830)	85.2 (2869)***	84.7 (1251)	87.2 (4722)**
Given or shared Rx drugs with someone	5.4 (64)	5.1 (200)	7.3 (115)	6.1 (353)
Medication locked or safely stored away	36.6 (195)	36.3 (608)	39.3 (319)	40.3 (1089)

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

Prescription drug use	Non-Hispanic White		Hispanic		Native American		Other	
	SAPT	Non SAPT	SAPT	Non SAPT	SAPT	Non SAPT	SAPT	Non SAPT
Past 30-day Rx painkiller use for any reason	14.4 (130)	16.5 (553)	16.4 (110)	15.0 (651)	11.3 (38)	14.1 (177)	17.0 (30)	17.9 (112)
Past 30-day painkiller use to get high	1.8 (17)	2.9 (106)	4.9 (36)	4.5 (198)	5.2 (17)	4.4 (53)	8.2 (15)	5.9 (39)
Past year prevalence of receiving Rx painkiller	33.3 (288)	32.0 (1079)	27.9 (198)	28.0 (1218)	27.6 (85)	27.4 (356)	34.1 (61)	29.4 (181)
Great or moderate risk of Rx painkiller non-medical use	86.5 (742)	88.2 (2986)	82.6 (610)	84.0 (3697)	82.8 (258)	78.9 (1029)	81.4 (142)	80.2 (506)
Given or shared Rx drugs with someone	5.4 (50)	6.3 (238)	4.0 (33)	6.0 (294)*	3.5 (12)	5.6 (72)	11.6 (23)	8.0 (58)
Medication locked or safely stored away	37.8 (141)	30.5 (506)**	46.4 (165)	42.6 (932)	45.3 (72)	41.4 (313)	31.9 (32)	38.0 (139)

*p ≤.05, **p ≤.01.

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

Prescription drug use	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 Rx painkiller use for any reason	16.5 (67)	16.0 (616)	15.5 (116)	15.2 (645)	12.8 (62)	14.0 (153)	19.3 (15)	17.5 (127)
Past 30-day painkiller use to get high	3.3 (15)	2.6 (108)	4.9 (34)	4.5 (200)	4.0 (20)	4.8 (50)	2.4 (2)	6.9 (52)
Past year prevalence of receiving Rx painkiller	34.3 (142)	32.2 (1225)	30.0 (229)	27.6 (1187)	24.5 (128)	28.8 (313)	36.9 (28)	29.8 (214)
Great or moderate risk of Rx painkiller non-medical use	90.4 (357)	87.6 (3371)	82.9 (646)	83.9 (3661)	76.3 (393)	81.2 (894)*	72.4 (54)	81.1 (594)
Given or shared Rx drugs with someone	6.1 (31)	6.1 (257)	5.8 (50)	5.7 (277)	5.0 (25)	5.3 (59)	7.0 (7)	9.0 (74)
Medication locked or safely stored away	28.0 (54)	32.3 (593)	46.1 (189)	42.7 (908)	41.0 (133)	42.8 (252)	45.2 (24)	35.5 (147)

*p ≤.05.

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

Prescription drug use	Non-Hispanic White		Hispanic		Native American		Other	
	TCA	Non TCA	TCA	Non TCA	TCA	Non TCA	TCA	Non TCA
Past 30-day Rx painkiller use for any reason	21.3 (125)	15.2 (558)***	13.8 (75)	15.4 (686)	28.2 (17)	12.9 (198)***	22.6 (16)	17.2 (126)
Past 30-day painkiller use to get high	3.8 (25)	2.5 (98)	5.2 (30)	4.5 (204)	3.5 (3)	4.6 (67)	10.0 (8)	6.1 (46)
Past year prevalence of receiving Rx painkiller	35.5 (198)	31.9 (1169)	27.2 (155)	28.0 (1261)	53.8 (29)	26.3 (412)***	30.5 (20)	30.5 (222)
Great or moderate risk of Rx painkiller non-medical use	89.9 (515)	87.5 (3213)	86.4 (464)	83.4 (3843)	85.8 (48)	79.4 (1239)	88.2 (64)	79.4 (584)
Given or shared Rx drugs with someone	5.2 (34)	6.2 (254)	4.9 (28)	5.8 (299)	8.3 (6)	5.0 (78)	5.0 (5)	9.2 (76)
Medication locked or safely stored away	33.2 (108)	31.6 (539)	39.5 (115)	43.7 (982)	30.1 (9)	42.6 (376)	31.0 (12)	37.4 (159)

***p <.001.

Table B8. Prescription drug use indicators comparing race/ethnic groups in PFS 2015 and non-PFS 2015 communities; weighted % & unweighted (n)

Prescription drug use	Non-Hispanic White		Hispanic		Native American		Other	
	PFS 2015	Non PFS 2015	PFS 2015	Non PFS 2015	PFS 2015	Non PFS 2015	PFS 2015	Non PFS 2015
Past 30-day Rx painkiller use for any reason	16.2 (145)	16.0 (538)	15.8 (159)	15.1 (602)	12.8 (52)	13.8 (163)	14.4 (34)	18.8 (108)
Past 30-day painkiller use to get high	2.8 (29)	2.7 (94)	4.0 (41)	4.7 (193)	2.4 (9)	5.1 (61)*	3.7 (8)	7.4 (46)
Past year prevalence of receiving Rx painkiller	32.5 (293)	32.4 (1074)	3.5 (24)	2.8 (99)	2.3 (13)	2.9 (32)	6.8 (10)	8.8 (30)
Great or moderate risk of Rx painkiller non-medical use	19.7 (105)	15.3 (401)*	30.3 (292)	27.5 (1124)	24.6 (106)	28.3 (335)	33.0 (76)	29.7 (166)
Given or shared Rx drugs with someone	83.2 (781)	88.9 (2947)***	81.6 (802)	84.2 (3505)	80.1 (331)	79.5 (956)	77.9 (189)	81.0 (459)
Medication locked or safely stored away	7.5 (73)	5.8 (215)	5.7 (70)	5.7 (257)	5.4 (23)	5.1 (61)	6.1 (18)	9.7 (63)

*p ≤.05, ***p <.001.

Table B9. 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 30-day Rx painkiller use for any reason	14.0 (338)	16.1 (323)	16.8 (594)	14.7 (468)*
Past 30-day painkiller use to get high	3.5 (98)	5.0 (114)*	4.0 (150)	2.3 (83)***
Past year prevalence of receiving Rx painkiller	28.0 (656)	27.6 (525)	33.6 (1214)	30.4 (958)**
Great or moderate risk of Rx painkillers non-medical use	84.3 (2018)	84.0 (1681)	87.1 (3240)	86.5 (2733)
Given or shared Rx drugs with someone	5.0 (146)	5.3 (118)	6.2 (248)	6.6 (220)
Rx painkillers locked or safely stored away	35.9 (446)	36.9 (357)	41.1 (795)	38.9 (613)

*p <.05, **p ≤.01, ***p ≤.001.

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

	Non-Hispanic White		Hispanic		Native American		Other	
Prescription drug use	**Target**	**Comparison**	**Target**	**Comparison**	**Target**	**Comparison**	**Target**	**Comparison**
Past 30-day Rx painkiller use for any reason	16.2 (382)	15.8 (301)	15.0 (356)	15.4 (405)	12.9 (148)	15.1 (67)	16.1 (70)	19.5 (72)
Past 30-day painkiller use to get high	2.6 (69)	2.8 (54)	4.7 (115)	4.4 (119)	4.3 (48)	5.1 (22)	6.0 (27)	7.0 (27)
Past year prevalence of receiving Rx painkiller	33.7 (771)	30.8 (596)	28.3 (700)	27.6 (716)	27.3 (313)	27.9 (128)	31.2 (134)	29.7 (108)
Great or moderate risk of Rx painkillers non-medical use	88.2 (2053)	87.4 (1675)	83.7 (2083)	83.8 (2224)	79.9 (914)	79.1 (373)	78.6 (345)	82.0 (303)
Given or shared Rx drugs with someone	6.1 (162)	6.1 (126)	5.1 (143)	6.3 (184)	4.9 (59)	5.9 (25)	8.7 (45)	9.0 (36)
Rx painkillers locked or safely stored away	32.3 (367)	31.3 (280)	43.9 (548)	42.6 (549)	41.1 (266)	44.7 (119)	35.3 (92)	38.4 (79)

*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	Veteran		LGBT	
	Target	**Comparison**	**Target**	**Comparison**
Past 30-day Rx painkiller use for any reason	23.2 (74)	21.7 (103)	22.3 (91)	22.8 (80)
Past 30-day painkiller use to get high	5.6 (23)	7.7 (37)	9.0 (38)	8.0 (29)
Past year prevalence of receiving Rx painkiller	38.6 (121)	36.1 (168)	37.0 (149)	34.0 (113)
Great or moderate risk of Rx painkillers non-medical use	84.9 (256)	78.6 (351)	82.1 (341)	79.1 (265)
Given or shared Rx drugs with someone	9.2 (30)	7.9 (40)	12.9 (58)	14.7 (50)
Rx painkillers locked or safely stored away	36.5 (64)	37.8 (94)	40.8 (87)	42.0 (77)

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	22.8 (338)	11.3 (160)	45.0 (707)	19.9 (310)	9.7 (130)
21-25	24.5 (384)	10.1 (151)	39.9 (628)	15.3 (237)	5.2 (79)
26-30	30.0 (378)	10.8 (125)	32.7 (396)	14.3 (175)	5.3 (66)
31-40	27.8 (530)	7.5 (124)	26.4 (496)	10.4 (188)	3.3 (62)
41-50	24.3 (409)	6.7 (109)	18.1 (307)	7.8 (133)	3.6 (63)
51-60	19.7 (377)	4.3 (72)	13.5 (257)	5.8 (111)	2.1 (44)
61-70	17.5 (233)	3.3 (43)	9.6 (128)	3.2 (43)	1.7 (21)
70+	13.4 (107)	3.8 (32)	8.7 (73)	3.2 (28)	2.2 (18)

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

Tobacco Use	Non-Hispanic White	Hispanic	Native American	Other
Any current cigarette use	20.8 (958)	23.5 (1241)	21.2 (351)	24.7 (206)
Any current chewing tobacco use	5.4 (239)	6.7 (339)	8.9 (142)	11.3 (96)
E-vapor product lifetime use	19.2 (968)	23.6 (1475)	17.5 (330)	23.6 (219)
E-vapor product past 30-day use	7.3 (375)	9.9 (613)	6.8 (128)	12.0 (109)
Past year purchased tobacco for someone under 18	2.4 (128)	3.9 (214)	5.3 (87)	6.7 (54)

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

Tobacco Use	Military	LGBT
Any current cigarette use	26.8 (233)	38.6 (308)
Any current chewing tobacco use	14.0 (131)	12.8 (102)
E-vapor product lifetime use	24.2 (222)	40.8 (353)
E-vapor product past 30-day use	10.4 (102)	20.2 (178)
Past year purchased tobacco for someone under 18	6.0 (60)	10.5 (80)

Appendix D: Mental Health

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

Age group	Mental Health Indicators				
	Met critical threshold for serious mental illness	Having mental health, drug or alcohol problems in the past year	Suicidal thoughts in the past year	Sought help on mental health or drug/alcohol problems in the past year	Difficulty assessing mental health or substance abuse treatment
18-20	15.8 (230)	22.4 (363)	11.5 (178)	16.7 (265)	7.3 (104)
21-25	11.2 (170)	25.2 (403)	8.2 (133)	19.1 (304)	7.5 (118)
26-30	8.9 (103)	22.5 (280)	7.5 (86)	16.4 (208)	7.3 (90)
31-40	8.2 (142)	21.4 (419)	5.4 (104)	16.9 (334)	6.8 (131)
41-50	7.7 (119)	17.7 (300)	4.9 (83)	14.1 (242)	6.1 (103)
51-60	5.1 (86)	14.8 (270)	3.8 (72)	12.0 (227)	4.2 (79)
61-70	4.0 (49)	12.4 (165)	3.3 (45)	11.7 (157)	3.0 (44)
70+	5.5 (34)	9.9 (75)	4.3 (30)	6.8 (56)	3.0 (21)

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

Mental Health Indicators	Non-Hispanic White	Hispanic	Native American	Other
Met critical threshold for serious mental illness	6.4 (302)	8.1 (414)	8.5 9126)	11.0 (91)
Having mental health, drug or alcohol problems in the past year	18.8 (893)	16.6 (933)	17.2 (302)	17.0 (147)
Suicidal thoughts in the past year	5.7 (275)	4.9 (278)	6.2 (112)	6.8 (66)
Sought help on mental health or drug/alcohol problems in the past year	14.6 (686)	12.7 (706)	15.3 (265)	16.0 (136)
Difficulty assessing mental health or substance abuse treatment	5.3 (241)	5.1 (284)	5.6 (92)	9.1 (73)

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

Mental Health Indicators	Military	LGBT
Met critical threshold for serious mental illness	10.1 (76)	16.3 (131)
Having mental health, drug or alcohol problems in the past year	20.1 (162)	40.3 (321)
Suicidal thoughts in the past year	9.3 (80)	18.6 (156)
Sought help on mental health or drug/alcohol problems in the past year	16.3 (133)	32.2 (257)
Difficulty assessing mental health or substance abuse treatment	8.0 (69)	17.8 (130)

Appendix E: Facebook Ads

Appendix F: FY2016 New Mexico Community Survey

Site ID:_____ Location:_____ Surveyor Initials:_____   Survey #:_____

Date:_____ Actual Time: ____:____ AM/PM (please circle)

New Mexico Community Survey 2016

<u>You must be 18 or older and currently live in New Mexico to take this survey.</u>

The purpose of the study:
- This survey is sponsored by the NM Office of Substance Abuse Prevention (NM OSAP) and administered by the Pacific Institute for Research and Evaluation (www.pire.org).
- NM OSAP will use the findings from this survey to determine substance abuse prevention and treatment needs across the state of New Mexico.
- The more New Mexico residents who complete the survey, the better NM OSAP can respond to the problems and areas of most concern.

What you can expect:
- **Your participation in this survey is completely voluntary**. You may choose not to answer a question and you may quit the survey at any time.
- The survey should take you approximately 15-20 minutes to complete.
- Your responses are completely anonymous.
- The only risk of participating in this study is that you may feel upset or have a negative emotional reaction when responding to some questions.
- When you have completed the survey, please fold it and place in the box provided by the data collectors.

IMPORTANT:
- **You must be 18 or older and currently live in New Mexico to take this survey.**
- There are no right or wrong answers.
- Your answers are anonymous.
- Please answer the questions as honestly as possible.

This survey is conducted by the Santa Fe Prevention Alliance on behalf of the NM Office of Substance Abuse Prevention. If you have questions about the purpose of this study please contact Dr. Martha Waller at: **mwaller@pire.org or toll-free at 1-855-346-2631**. If you have questions or concerns about this procedure or your rights as a survey participant in the study please contact Elysia Oudemans toll-free at 1-866-PIRE-ORG x 2757 **or oudemans@pire.org** Please refer to the "New Mexico Community Survey" when you call.

Directions: Please think about where you <u>currently live</u> in New Mexico as you answer the following questions. Provide <u>only 1</u> answer for each question unless otherwise specified.

1. 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

2. Are you: ☐ Male ☐ Female

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

   _____

4. 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

5. 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]

   _____

6. Are you on active duty in the U.S. Armed Forces, military Reserves, or National Guard or a veteran of the U.S. Armed Forces?

   ☐ Yes ☐ No

7. What is the highest grade or year of school you completed to date?

   ☐ Less than high school
   ☐ High school graduate or GED
   ☐ Some college or technical school
   ☐ College graduate, graduate or professional school graduate
   ☐ Currently in college. What year? ____

8. Do you identify as Lesbian, Gay, Bisexual, or Transgender?

   ☐ Yes ☐ No

9. Are you a parent or caretaker of someone under 21 currently living in your household?

   ☐ Yes ☐ No

10. What is your zip code? _____

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

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11. Do you now smoke cigarettes every day, some days, or not at all? *(not including tobacco used for ceremonial or religious purposes)*

    ☐ Every day
    ☐ Some days
    ☐ Not at all

12. Do you currently use chewing tobacco or snuff, every day, some days, or not at all? *(not including tobacco used for ceremonial or religious purposes)*

    ☐ Every day
    ☐ Some days
    ☐ Not at all

13. In the past year, 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 ceremonial or religious purposes)*

    ☐ Yes ☐ No ☐ Don't know

The next 2 questions ask about electronic vapor products, such as blu, NJOY, or Starbuzz. Electronic vapor products include e-cigarettes, e-cigars, e-pipes, vape pipes, vaping pens, e-hookahs, and hookah pens.

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14. Have you ever used an electronic vapor product?
    ☐ Yes ☐ No

15. During the past 30 days, on how many days did you use an electronic vapor product?
    ☐ 0 days
    ☐ 1 or 2 days
    ☐ 3 to 5 days
    ☐ 6 to 9 days
    ☐ 10 to 19 days
    ☐ 20 to 29 days
    ☐ All 30 days

16. 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

17. 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

18. 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

19. How likely are police in your community to arrest an adult for giving alcohol to someone under 21?

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

20. In your opinion, if someone was caught selling alcohol to a drunk or intoxicated 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

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

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

22. 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 convicted?

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

As you answer the next few questions, please define one drink as equivalent to a 12-ounce beer, a 5-ounce glass of wine, or a drink with one shot of liquor. A 40-ounce beer would count as 3 drinks, or a cocktail drink with 2 shots of liquor would count as 2 drinks.

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23. In general, how many alcoholic drinks do you typically consume in a week (including weekends)?

☐ None
_____ Drinks a week (1 or more)

24. 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)?

☐ 0 days
☐ 1 or 2 days
☐ 3 to 5 days
☐ 6 to 9 days
☐ 10 to 19 days
☐ 20 to 29 days
☐ All 30 days

25. 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)?

☐ None
_____ Times in past 30 days

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

☐ None
_____ Times in past 30 days

27. During the past 30 days, have you driven a vehicle after drinking 5 or more alcoholic beverages?

☐ Yes   ☐ No

28. *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.

☐ Adult 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.

☐ I got it at a party.

☐ My parent or guardian gave it or bought it for me.

☐ I took it from my home or someone else's home.

☐ I bought it at a store, restaurant, bar or public place

☐ Someone under age 21 bought or gave it to me.

☐ I got it some other way. *[Please describe]:*

_____

29. In your opinion, when is it okay for someone to provide alcohol to minors (i.e., under 21) *(not for religious purposes)*. Check all that apply.

☐ If parents give their permission

☐ If they are supervised by an adult

☐ If they are drinking at home

☐ If they are responsible (mature for their age, a good student, etc.)

☐ If there is a celebration (e.g., wedding, quinceañera, graduation)

☐ As long as they are not driving and are safe

☐ If they are in the military

☐ Other   *[Please describe]:*_____

☐ Never

30. In the past year, 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

The following questions have to do with prescription painkillers.

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

☐ Yes   ☐ No

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

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

33. In the last 30 days, did you use **prescription painkillers** for any reason *(even if you were not prescribed them)?*

☐ Yes   ☐ No   *– If you answer no, please skip to question 38 on the following page.*

34. During the past 30 days, how many times did you use a **painkiller** 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

35. If you've taken **prescription painkillers** in the last 30 days, on how many days did you take them?

_____ days in the last 30 days (1-30)

36. 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

☐ Another reason *[Please describe]:*

_____

37. 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 somebody (e.g., friend, dealer, family member)

☐ They were taken from someone (including friends or relatives) without asking

☐ Other place (e.g., Mexico, internet):

_____

Please answer the next two questions:

38. 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

39. Are <u>all your prescription painkillers</u> stored in a locked cabinet or box so that others cannot get to them *(including youth and family)?*

☐ Yes   ☐ No

☐ I do not have any prescription painkillers

These next questions are about your mental and emotional health. Please recall that all your responses are anonymous.

40. 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

41. <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

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

☐ Yes   ☐ No

43. <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

44. <u>During the past year</u>, have you had difficulty accessing treatment for a mental health or substance abuse problem?

☐ Yes   ☐ No

These last questions ask for your thoughts about campaigns going on in our state.

45. The following is a list of different drug prevention media campaigns. Please check the box next to those you recognize or have heard of:

☐ Be the Solution
☐ Suck It Up!
☐ Good Drugs Gone Bad
☐ Parents Who Host Lose the Most
☐ A Dose of Reality
☐ Up and Away and Out of Sight
☐ Wake Up Now
☐ I've never heard of any of these.

46. What do you think is the main prevention message of the campaign "A Dose of Reality"? *Check only one option.*

☐ Stay in school if you want to be successful.
☐ Prescription drugs can be dangerous if not used as intended.
☐ Reality is harsh, but medication can help.
☐ Daily exercise is good for your health.
☐ Take your medication as directed by your doctor.
☐ Vaccinate your kids.

47. Is there anything else you'd like to tell us or add about the issues we have asked about today? *[Please write your comments in the box below.]*

The Santa Fe Prevention Alliance has twelve more questions it would like to ask you in order to help them improve their specific county services.

1. In the past 12 months, how much have you heard or seen about activities in your community to discourage stores, bars, & restaurants from selling alcohol to drunk or intoxicated patrons?

☐ None
☐ A little bit
☐ A lot   ☐ Don't know

2. In the past 12 months, how much have you heard or seen about police arresting drunk drivers in your community?

☐ None
☐ A little bit
☐ A lot   ☐ Don't know

3. In the past 12 months, how much have you heard or seen about the Cab Ride Home Program?

☐ None
☐ A little bit
☐ A lot   ☐ Don't know

4. Are you aware that in Santa Fe County vehicle forfeiture is a consequence of one DWI conviction with 1 subsequent DWI arrest?

☐ Yes   ☐ No

5. Are you aware that in NM it is a 4th degree felony to provide alcohol to a minor?

☐ Yes   ☐ No

6. Are you aware that under the City of Santa Fe's Nuisance Abatement Ordinance, a property owner can be cited for underage drinking that occurs on their property?

☐ Yes   ☐ No

7. Treatment can help people with mental illness lead normal lives.

☐ Strongly Agree
☐ Slightly Agree
☐ Neither Agree or Disagree
☐ Slightly Disagree
☐ Strongly Disagree

8. People are generally caring and sympathetic to people with mental illness.

☐ Strongly Agree
☐ Slightly Agree
☐ Neither Agree or Disagree
☐ Slightly Disagree
☐ Strongly Disagree

9. Treatment for substance abuse has been shown to decrease crime, improve family and community situations, lower health care costs and save lives.

☐ Strongly Agree
☐ Slightly Agree
☐ Neither Agree or Disagree
☐ Slightly Disagree
☐ Strongly Disagree

10. Which of the following comes closest to your view?

☐ Substance abuse is a disease
☐ Substance abuse is NOT a disease
☐ Not Sure

11. In your opinion, are the police creating cooperative **partnerships** with the community?

☐ Yes   ☐ No   ☐ Not sure

12. Some people say that the best way to deal with substance abuse is to recognize it as a health problem and to provide those who abuse drugs and alcohol access to healthcare, social services and treatment. They say that the money currently spent on keeping substance abusers in prison could be better used providing them with these kinds of services. Do you agree or disagree with this point of view?

☐ Agree   ☐ Disagree   ☐ Not sure

13. Would you support a 25 cents per drink tax on alcohol to reduce underage drinking and provide more health care?

☐ Yes   ☐ No   ☐ Not Sure

Thank you for your participation. The information YOU provide is helping the State of New Mexico improve its substance abuse prevention and mental health services by better understanding what is needed and where it is needed.

In case you have personal concerns that were raised while taking this survey and you would like information on substance use and/or mental health treatment available in your area, please contact the **New Mexico Crisis and Access Line (NMCAL)**. NMCAL is staffed by mental health professionals who can respond to a crisis 24 hours per day and 7 days per week. The line is available statewide and toll free at 1-855-NMCRISIS (1-855-662-7474). In addition, consumers and families/caregivers who have questions or need help finding behavioral health services can call **Optum New Mexico** toll-free at 1-866-660-7185.

If you have questions or concerns about the survey procedure or your rights as a participant please contact Elysia Oudemans toll-free at 1-866-PIRE-ORG x 2757 or at oudemans@pire.org. If you have questions about the purpose of this study, please contact Dr. Martha Waller toll-free at 1-855-346-2631 or at mwaller@pire.org. Please refer to the "New Mexico Community Survey" when you call. **Please take one of the "Take Home" documents with you that provides all of this information in case you want it later! THANKS AGAIN!**