Pacific Institute for Research and Evaluation

Results from the 2017 New Mexico Community Survey

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Executive Summary

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 in the core module included alcohol and prescription painkiller use and some of the contributing factors related to their misuse. Also included are modules on mental health and access to behavioral health services, tobacco, community support of alcohol prevention efforts (see Appendix F to review survey and modules).

Data collection took place in the spring of Fiscal Year 2017 using two methodologies; both relying upon convenience samples. The first approach was a time and venue-based data collection process. Questionnaires were administered via paper and pencil, or using Qualtrics 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 8,280 valid surveys representing 31 counties. The second approach involved two types of online recruitment of potential respondents: 1) via an ad campaign on Facebook targeting residents across the state who were 18 and older to take the survey on-line; and 2) via email invitations, QR codes, or friends and family members telling others about the on-line survey. On-line survey recruitment and data collection resulted in 2,461 valid surveys representing 31 NM counties. A total of 10,741 valid questionnaires representing all 33 counties were completed via the two different data collection strategies with about 70% coming from in-person data collection methods.

We weighted data to match NM Census 2016 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 three sources of funding were Substance Abuse Prevention and Treatment (SAPT) Block Grant funds, 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

- Women in target communities reported more past 30-day alcohol use, drinking and driving, and binge drinking and driving than in comparison communities.
- Latino/as in comparison communities reported significantly less current drinking, drinking and driving, and binge drinking and driving than their counterparts in target communities.
- Target communities reported significantly easier teen access to alcohol in stores and restaurants than comparison communities.
- Comparison communities reported significantly greater likelihood of police involvement when some alcohol laws were violated than in target communities.
- The main alcohol sources for underage youth were from parties and unrelated adults providing it to them. The survey results indicated that these sources contributed to recent access by 85% of respondents in target communities, which was a much higher rate than the estimate in FY2016.
- Survey responses indicated that a relatively small percentage of parents were aware of the "Parents Who Host Lose the Most" campaigns in their communities.
- The trends for the alcohol-related item estimates were less favorable in FY2017 than they had been in FY2016, but there were substantial changes between FY2016 and FY2017 in the communities funded to address alcohol across the state, and this was likely to have been a major influence on these trends.
- Target communities continue to have increased their perceived risk of legal consequences for breaking alcohol-related laws from FY2016, which in turn were higher than they had been in FY2015.

Prescription Painkillers

- There were higher rates of receiving prescription painkillers last year in target communities than in comparison communities.
- Men in comparison communities and women in target communities reported significantly higher rates of past 30-day painkiller use for any reason. Women in target communities also reported significantly higher rates of past year receiving prescription painkillers.
- Among the whole sample, non-Hispanic whites reported the lowest rate of past 30-day prescription painkiller use to get high (2.3%) and the highest prevalence of prescription painkiller use for any reason (14.6%).
- 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.

- A relatively small percentage of survey respondents indicated that pharmacy staff or medical providers had talked with them about the risks involved in using prescribed painkillers or how to store prescribed painkillers properly.
- In comparison to FY2016, target community respondents generally had lower levels of prescription painkiller abuse in FY2017, and indicated that they were more likely to store these drugs safely.

Mental Health

- There were observed increases on mental health measures reporting from 2016 to 2017. About 8.7% of New Mexican respondents met the WHO's critical threshold screening for severe mental illness.
- Almost 17.8% of the sample self-identified as having a mental health or drug or alcohol problem in the past year.
- About 4.9% of the sample reported suicidal ideation in the past year, and about 14.7% of the sample reported receiving professional help to address mental health or drug or alcohol problems over the past year.
- Young adults 18 to 20 years old most often met the threshold for severe mental illness (22.6%) and for suicidal ideation (12.3%). They were also most likely to report a mental health or drug or alcohol problem in the past year (30.9%), and to seek help on mental health or drug/alcohol problems in the past year (19.6%).

Prevention in New Mexico

The NM Office of Substance Abuse Prevention (OSAP) in FY 17 funded 27 prevention programs in 22 of the 33 counties in NM. Figure 1 below highlights the 22 counties receiving prevention funding in yellow and the 11 with no OSAP funding in orange.

Figure 1: OSAP funded counties (in yellow) in New Mexico in Fiscal Year 2017
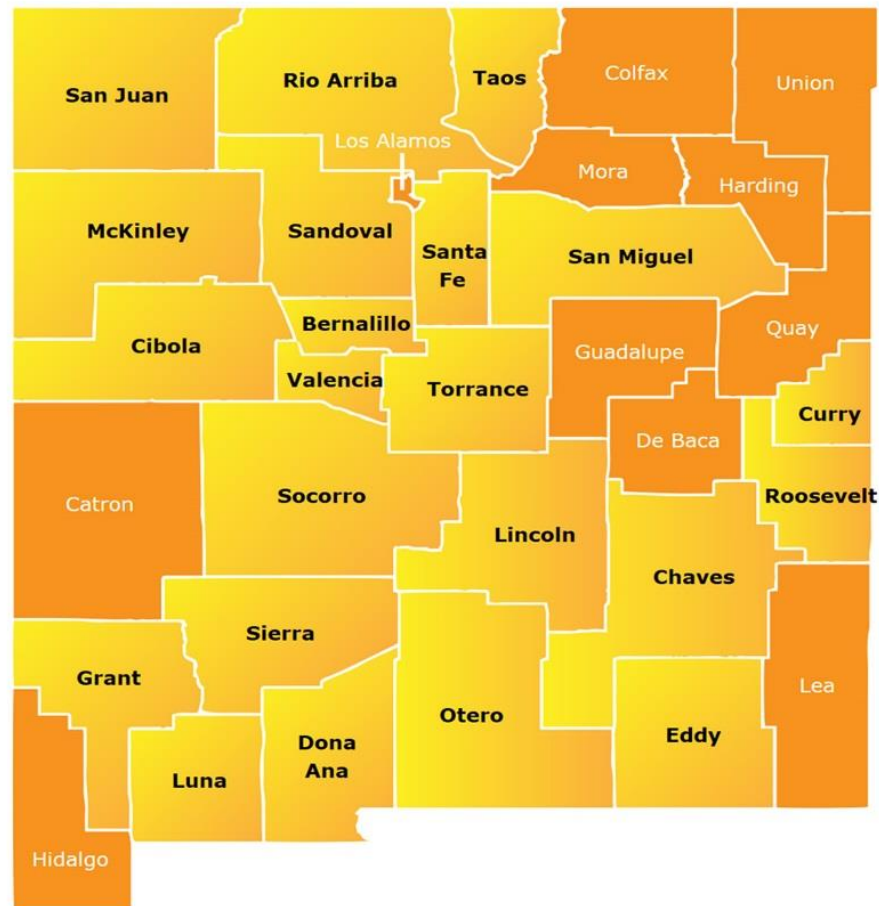
Programs receive funding to target several statewide prevention priorities including underage drinking, binge drinking among all youth and adults, driving while intoxicated among youth and adults, and prescription painkiller misuse and abuse among all ages. Depending on the original source of funding 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 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 2017, 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 is initially challenging for many, but over time, providers have come to regard this process as imperative to improving the quality of the services they provide.

Providers are 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 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 7,000 paper surveys (70% of the aggregated sample) and 788 surveys via iPad with Qualtrics (7% 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.

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 making such calculations possible.

Data Collection Approach # 2: On-line survey

The other data collection approach used in FY17 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 thereafter. We continued this methodology for FY17. This year, the on-line survey was 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 9 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, an invitation that not all respondents chose to accept. Each day, we gave away four $20 gas cards to randomly selected respondents from that day. Each week, a respondent was randomly selected to receive two $20 gas cards from the week's respondents, for a total of 30 gas cards given out each week for 9 weeks.

From February 26, 2017 to April 29, 2017 (63 days), the ads led to over 20,000 link clicks, with 307,179 people reached at the cost of approximately $0.25 per result and a result rate of 1.56%. Most website clicks resulted from the audience network (80%). A total of 670 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 groups or people and sending them directly to the on-line survey and circumventing the Facebook approach. An additional 1,791 surveys were collected on-line in these ways.

Data Collection Summary

Table 1 below provides a breakdown of the number of surveys collected for both methodologies, the percent of the total sample that each type constitutes, and the number of counties from which data were collected. Ideally, we want all 33 counties to be represented in the data collection process, and while all counties were represented by at least one survey, the eleven counties not receiving OSAP funding were underrepresented. Table 2 lists the number of surveys collected from each county and the weighted percentage contributed to the total sample.

Table 1. Summary of Survey methodologies

Survey Methodology	N	Percent	NM Counties Represented
PAPER- Convenience	7,492	69.8	31
Online - FACEBOOK (18+ yr. olds)	670	6.2	28
Qualtrics App	788	7.3	22
Online – Non-FACEBOOK	1,791	16.7	31
Total	10,741		

Table 2. Completed questionnaires by County compared to 2016

County	2017					2016				
	Qualtrics App	Online	Paper	Total	%	Qualtrics App	Online	Paper	Total	%
Bernalillo	320	206	617	**1143**	10.6	261	441	903	**1605**	12.7
Catron	0	2	1	**3**	0.0	1	7	296	**304**	2.4
Chaves	1	163	325	**489**	4.6	1	72	292	**365**	2.9
Cibola	7	5	307	**319**	3.0	2	17	359	**378**	3.0
Colfax	2	5	1	**8**	0.1	0	8	165	**173**	1.4
Curry	45	40	391	**476**	4.4	1	58	312	**371**	2.9
De Baca	0	0	2	**2**	0.0	0	4	152	**156**	1.2
Dona Ana	118	416	173	**707**	6.6	17	136	342	**495**	3.9
Eddy	3	159	290	**452**	4.2	0	25	283	**308**	2.4
Grant	0	135	192	**327**	3.0	3	98	222	**323**	2.6
Guadalupe	0	3	2	**5**	0.1	0	6	1	**7**	0.1
Harding	0	2	0	**2**	0.0	0	1	0	**1**	0.0
Hidalgo	0	93	327	**420**	3.9	6	73	238	**317**	2.5
Lea	0	14	7	**21**	0.2	0	27	2	**29**	0.2
Lincoln	1	6	4	**11**	0.1	0	21	2	**23**	0.2
Los Alamos	1	10	5	**16**	0.2	8	7	4	**19**	0.2
Luna	2	137	185	**324**	3.0	0	107	281	**388**	3.1
McKinley	1	12	592	**605**	5.6	6	19	645	**670**	5.3
Mora	1	0	6	**7**	0.1	0	3	3	**6**	0.0
Otero	0	15	3	**18**	0.2	1	39	260	**300**	2.4
Quay	0	4	1	**5**	0.1	0	3	1	**4**	0.0
Rio Arriba	4	20	301	**325**	3.0	3	36	611	**650**	5.1
Roosevelt	72	26	265	**363**	3.4	1	19	331	**351**	2.8
San Juan	8	131	682	**821**	7.6	25	426	640	**1091**	8.6
San Miguel	2	23	326	**351**	3.3	0	36	258	**294**	2.3
Sandoval	13	46	473	**532**	5.0	16	95	418	**529**	4.2
Santa Fe	27	363	762	**1152**	10.7	25	418	770	**1213**	9.6
Sierra	0	150	220	**370**	3.4	0	12	406	**418**	3.3
Socorro	114	236	253	**603**	5.6	37	30	543	**610**	4.8
Taos	32	6	350	**388**	3.6	31	47	311	**389**	3.1
Torrance	6	12	182	**200**	1.9	1	44	273	**318**	2.5
Union	0	2	0	**2**	0.0	2	8	2	**12**	0.1
Valencia	8	19	247	**274**	2.6	10	49	458	**517**	4.1
Total	788	2461	7492	**10741**	100%	458	2392	9784	**12634**	100%

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 2016 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 three funding streams: 1) the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant; 2) the NM Legislative funded Total Community Approach (TCA); and 3) the federal Partnerships for Success (PFS) 2015, which PFS 2015 programs are still in the "SPF" phase, not yet in implementation. 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/2016/SC-EST2016-ALLDATA6.html on August 2 2017.

sample was more educated than the general NM population; according to the US Census (2016 American Community Survey 1-Year Estimates), 27.2% of adults[2] in NM reported having a bachelor's degree compared to our weighted estimate of 31.6%. Approximately 5.6% of the sample reported having served or still serving in the military which, when weighted, increased to 7.6 %. The percentage of respondents in the sample who identified as LGBT was 7.9%, which when weighted decreased slightly to 6.5%.

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

Gender	n	Unweighted %	Weighted %
Men	4177	39.7	49.1
Women	6347	60.3	50.9
Age	n	Unweighted %	Weighted %
18-20	1656	15.4	5.4
21-25	1570	14.6	9.3
26-30	1196	11.1	8.9
31-40	1720	16.0	16.3
41-50	1464	13.6	14.9
51-60	1416	13.2	17.2
61-70	998	9.3	15.1
70+	721	6.7	12.7
Race/ethnicity	n	Unweighted %	Weighted %
Non-Hispanic White	3686	34.3	41.9
Hispanic or Latino	4815	44.8	44.9
Native American	1493	13.9	8.2
Other	747	7.0	5.0
Education	n	Unweighted %	Weighted %
Less than high school	640	6.0	6.3
High school graduate/GED	2249	21.2	22.2
Some college/Technical school	1988	18.8	21.9
College graduate or higher	2720	25.7	31.6
In college	2996	28.3	18.1
Military status	n	Unweighted %	Weighted %
Active military or veteran	602	5.6	7.6
Sexual orientation	N	Unweighted %	Weighted %
LGBT	836	7.9	6.5

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[2] Retrieved from
http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_16_1YR_S1501&prodType=table on March 2, 2018.

Demographics by Funding Stream

Results by funding stream are reported in this section. Table 4 provides a breakdown of the sample by funding stream and gender. We analyze three main funding streams: 1) the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant; 2) the federal Partnerships for Success (PFS) 2015; and 3) the NM Legislative-funded Total Community Approach (TCA). We also have data from communities receiving no prevention funding during FY2017 -- 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.

Funding stream	Total N	Men		Women	
		n	Weighted %	n	Weighted %
SAPT	5194	1937	47.5	3142	52.5
PFS 2015	3519	1486	50.7	1986	49.3
TCA	2237	938	51.7	1248	48.3

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.

Funding stream	Non-Hispanic White		Hispanic or Latino		Native American		Other	
	n	Weighted %	n	Weighted %	n	Weighted %	n	Weighted %
SAPT	1636	40.5	2136	42.1	1111	12.9	311	4.5
PFS 2015	1173	40.7	1573	44.4	461	8.1	312	6.8
TCA	879	45.2	1056	46.2	151	4.0	151	4.6

Demographics by Prevention Priority

All but one of the communities used OSAP funding to target alcohol-related outcomes, many communities targeted prescription painkiller misuse along with alcohol abuse. Therefore, analyses compare 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	8929		1812	
Gender	n	Weighted %	n	Weighted %
Men	3507	81.3	670	18.7
Women	5232	80.3	1115	19.7
Race/ethnicity	n	Weighted %	n	Weighted %
Non-Hispanic White	2953	79.3	733	20.7
Hispanic or Latino	3942	79.9	873	20.1
Native American	1405	93.6	88	6.4
Other	629	83.4	118	16.6

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

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

	Target Rx Painkillers		Comparison	
Total N	7860		2881	
Gender	n	Weighted %	n	Weighted %
Men	3009	68.8	1168	31.2
Women	4716	72.0	1631	28.0
Race/ethnicity	n	Weighted %	n	Weighted %
Non-Hispanic White	2656	69.9	1030	30.1
Hispanic or Latino	3455	69.4	1360	30.6
Native American	1197	77.6	296	22.4
Other	552	70.0	195	30.0

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 receive SAPT or TCA or PFS 2015 funding have 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=4742)	48.6	15.4	3.3	3.2	4.1
PFS 2015 (n=3519)	48.7	19.0	4.3	3.2	5.6
TCA (n=2237)	49.3	17.6	4.4	2.8	4.1

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

Alcohol use	Men			Women		
	SAPT (n=1780)	PFS 2015 (n=1486)	TCA (n=938)	SAPT (n=3852)	PFS 2015 (n=1986)	TCA (n=1248)
Past 30-day alcohol use	54.2	53.3	51.2	43.9	44.2	47.6
Past 30-day binge drinking	19.7	22.8	20.7	11.8	15.1	14.0
Past 30-day drinking & driving	3.9	5.0	5.5	2.7	3.4	3.1
Past 30-day binge drinking & driving	4.3	4.3	3.8	1.9	2.0	1.5
Past year purchased or provided alcohol for someone under 21	4.3	3.5	5.4	3.5	4.7	2.4

Next, we compared alcohol-related outcomes and intervening variables 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 2017. 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 issues than comparison communities. Comparisons across FY2014 - FY2017 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 narrowing or reversing. However, in 2017 these positive trends for the target communities had reversed, with the differences between the sets of communities being very similar to 2014. This pattern suggests that the effects of prevention efforts in the target communities may have fluctuated over time. However, it is important to consider other factors that may have influenced this trend change. Importantly, there were substantial changes in the communities funded to address alcohol issues (those analyzed as targeted communities) – ten of the communities remained the same across the years, but three 2016 communities were not funded for alcohol in 2017, eight new communities were added in 2017, and just UNM data, rather than all of Bernalillo County, were included in 2017.

Figure 2. Comparing target and comparison communities on alcohol consumption indicators from FY 2014 to FY 2017; weighted % reported
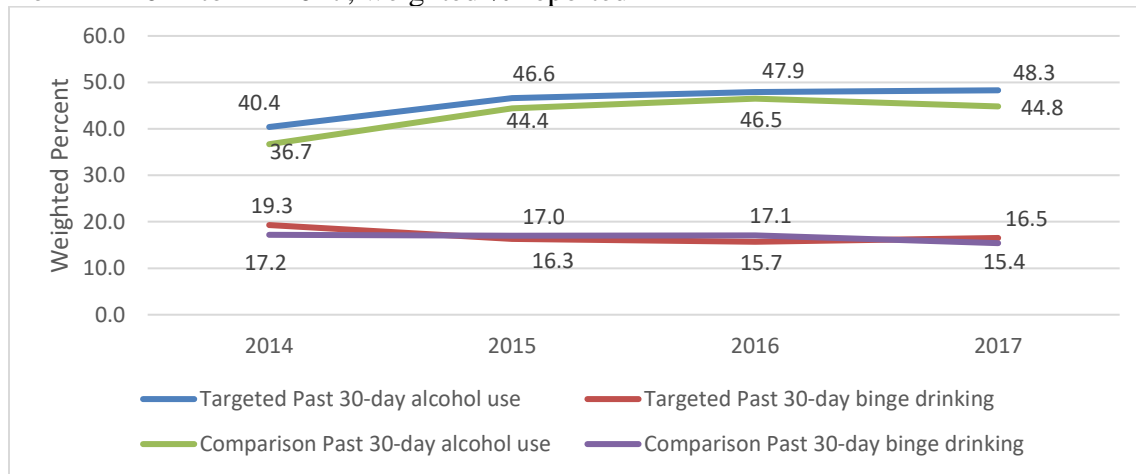

Figure 3. Comparing target and comparison communities on drinking and driving indicators from FY 2014 to FY 2017; weighted % reported.
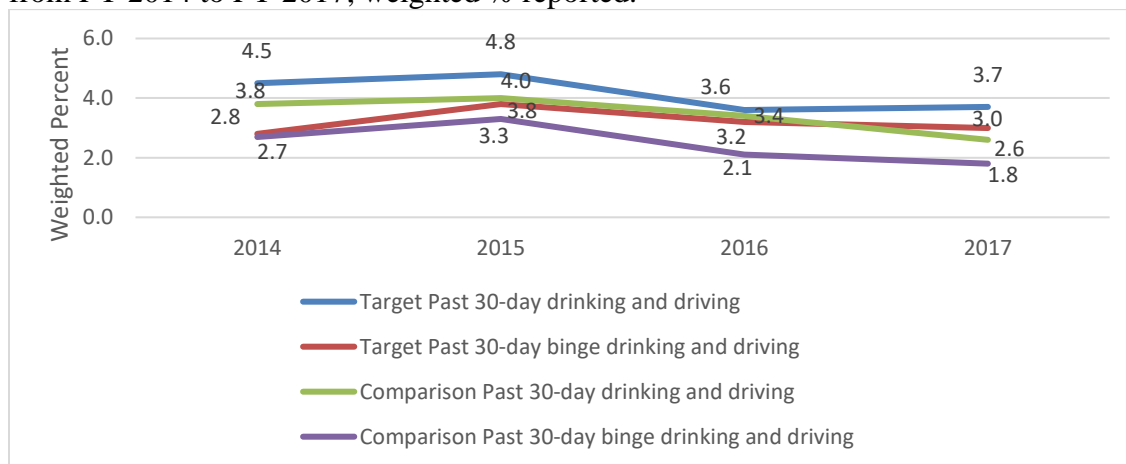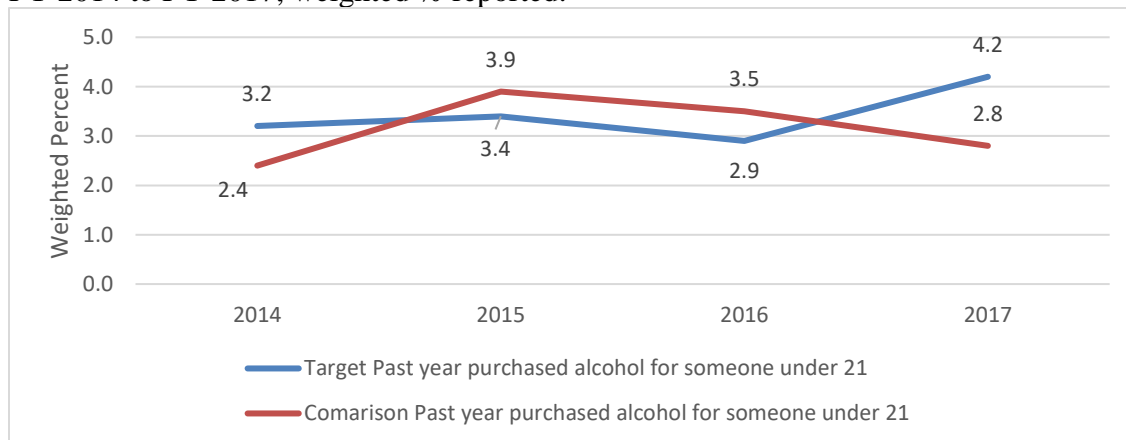

Figure 4. Comparing target and comparison communities on purchasing alcohol for minors from FY 2014 to FY 2017; weighted % reported.

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 seen in previous years, few adult respondents in the sample considered it to be even somewhat difficult for teens to get alcohol in their communities, and social access continues to be more influential than retail. Sixty percent of the respondents in target communities perceived that it was at least somewhat difficult for teens to purchase alcohol at stores or restaurants in the community, and a greater percentage of the population in comparison communities believed retail access was at least somewhat difficult (64%).

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 in 2017 the perceptions of risk in two categories were significantly lower in the target communities than in comparison communities, whereas in 2016 the perceptions in all five categories were significantly lower than in comparison communities. This indicates improvement in the target communities on the perceived risk for breaking alcohol-related laws, but also that there continues to be room for improvement relative to the comparison communities.

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	11.9 (898)	12.2 (181)
Ease of access to alcohol by teens from stores and restaurants**	59.6 (4310)	64.0 (908)
Perception of risk/legal consequences	**Very or Somewhat Likely**	
	Target	Comparison
Likelihood of police breaking up parties where teens are drinking ***	64.0 (4403)	69.3 (939)
Likelihood of police arresting an adult for giving alcohol to someone under 21 **	68.2 (4588)	72.6 (950)
Likelihood of someone being arrested if caught selling alcohol to a drunk or intoxicated person	62.0 (4458)	62.1 (906)
Likelihood of being stopped by police if driving after drinking too much	75.1 (5887)	77.2 (1237)
Likelihood of being convicted if stopped and charged with DWI	83.6 (6203)	83.9 (1257)

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

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. Forty-five percent of respondents indicated that they obtained it at a party. The second highest category was that an unrelated adult purchased it for them (40% in target communities). Finally, 23% of respondents in target communities 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=665)	Target	Comparison
Adult family member gave or bought it	23.1 (133)	16.9 (14)
Unrelated adult gave or bought it	40.4 (239)	33.8 (28)
Got it at a party	45.3 (268)	45.5 (38)
Parent/guardian gave or bought it	9.5 (56)	7.7 (6)
Took it from home	7.5 (43)	9.8 (7)
Bought it at a restaurant/bar/public place	5.6 (32)	5.2 (5)
Someone underage gave or bought it	10.0 (61)	13.5 (11)
Got it some other way*	5.0 (28)	11.3 (8)

*$p < .05$

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 receive SAPT, PFS 2015 or TCA funding had implemented prescription painkiller prevention programs. In Table 12 we can see that PFS 2015 communities have reported the highest prevalence rates on past 30-day prescription painkiller use for any reason (13.6%), past 30-day painkiller use to get high (3.4%) and past year receiving prescription painkillers (28.9%). A lower percentage of respondents in PFS 2015 communities than other communities were likely to lock or store prescription painkiller safely (38.4%). More respondents in SAPT communities (85.7%) perceived great or moderate risk of using prescription painkillers for non-medical reasons than other communities and fewer respondents in TCA communities were likely of giving or sharing prescription drugs (4.7%).

Prevalence of prescription painkiller use in SAPT and TCA communities are close. TCA communities have the lowest percentages of past 30-day painkiller use for any reason (12.1%) and past year receiving prescription painkillers (25.3%).

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=3236)	12.9	2.9	28.9	85.7	6.1	42.5
PFS 2015 (n=3519)	13.6	3.4	28.9	82.2	6.1	38.4
TCA (n=1524)	12.1	2.9	25.3	82.5	4.7	42.7

The following graph (Figure 5) displays the prevalence for the same indicators but instead of by funding stream, compares communities that target prescription drug abuse and those that do not. The only significant difference observed between target and comparison communities is the prevalence of receiving prescription painkillers last year (30.0% target vs. 25.7% comparison).

Figure 5. Comparing the prevalence of communities targeting prescription drugs to communities not targeting prescription drugs; weighted %.
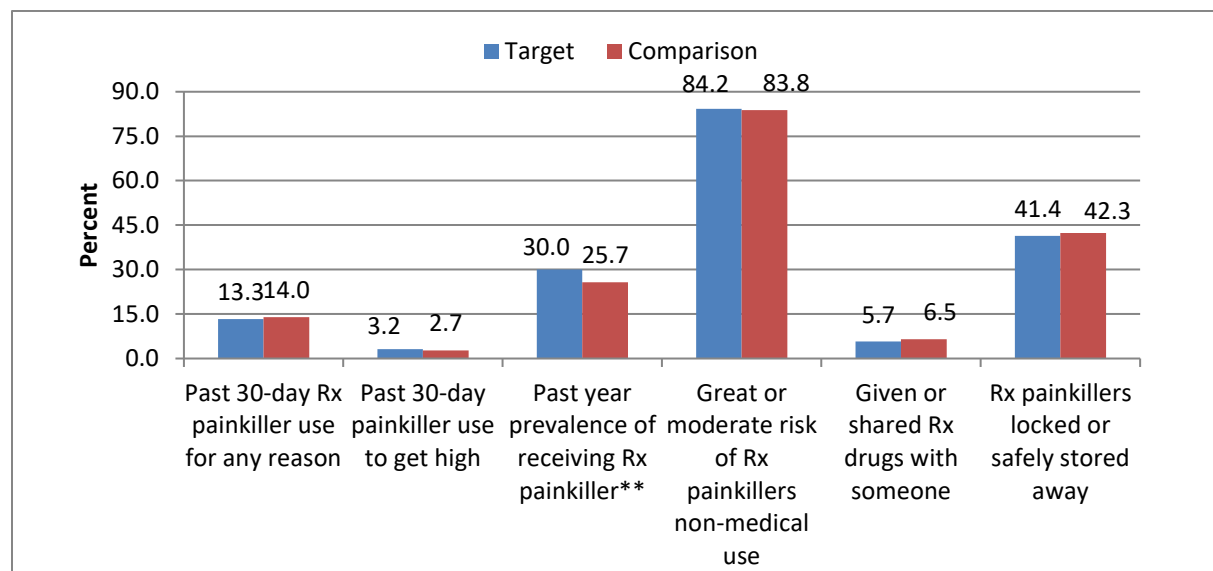
**p < .01

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.

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

Reasons of Prescription Drug Use (n=1316)	Target	Comparison
Treat pain identified by doctors/dentists	72.9 (661)	73.8 (254)
For pain not identified by doctors	12.8 (156)	11.2 (47)
Have fun with friends socially	1.9 (29)	2.1 (10)
Help me sleep	6.7 (76)	7.2 (31)
Get high, messed up or stoned	2.5 (30)	4.5 (22)
Cope with anxiety or stress	5.2 (66)	5.4 (27)
Another reason	5.7 (57)	7.5 (28)

Table 14 presents the various means by which respondents accessed the prescription painkillers used. The only statistically significant difference between target and comparison communities was that target communities had a smaller percentage of respondents taking prescription painkillers from someone without asking (1.1% vs. 2.9%). The majority of respondents reported having received a legitimate prescription for their painkillers. However, in both target and comparison communities, a noteworthy 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=1316)	Target	Comparison
A doctor/doctors prescribed	81.5 (747)	81.4 (277)
Family member shared	5.6 (82)	7.3 (37)
Friend shared	5.1 (54)	5.3 (26)
Bought from somebody	2.3 (25)	2.4 (18)
Taken from someone without asking*	1.1 (14)	2.9 (13)
Other places	2.5 (27)	1.8 (7)

*$p < .05$.

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 report significantly more cigarette and tobacco use than women on every measure.

Figure 6. Tobacco use prevalence for whole sample and stratified by gender; weighted %
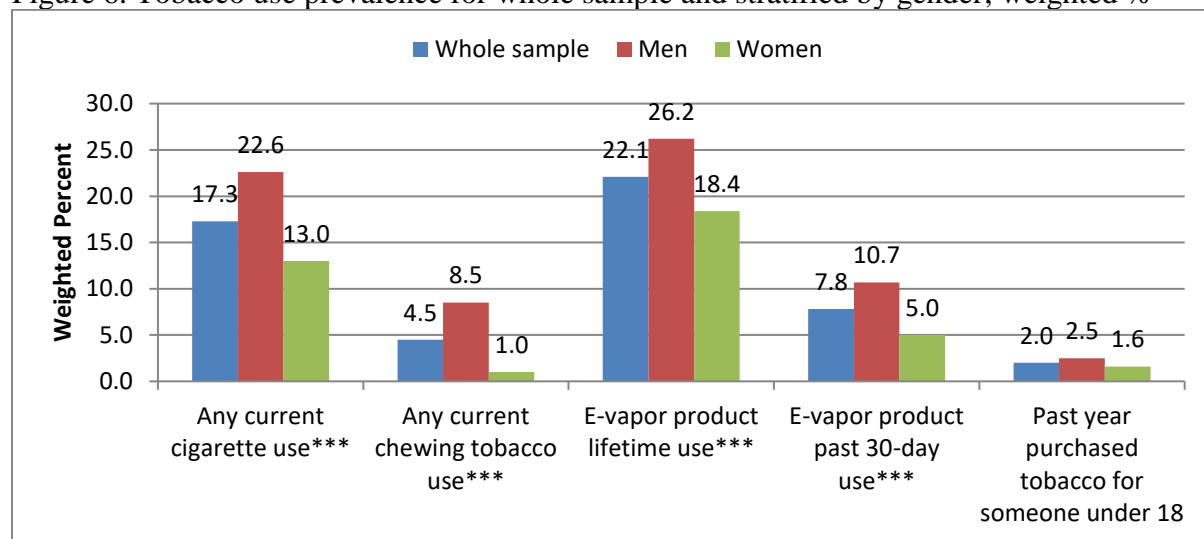
***p <.001

Mental Health

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

We selected six questions from the World Health Organization's (WHO) World Mental Health Surveys (WMHS). They are also included on the U.S. National Health Interview Survey (NHIS), self-administered version.[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 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.

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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.

Figure 7. The percent of respondents who reported they felt the following all or most of the time in the past 30 days; weighted %
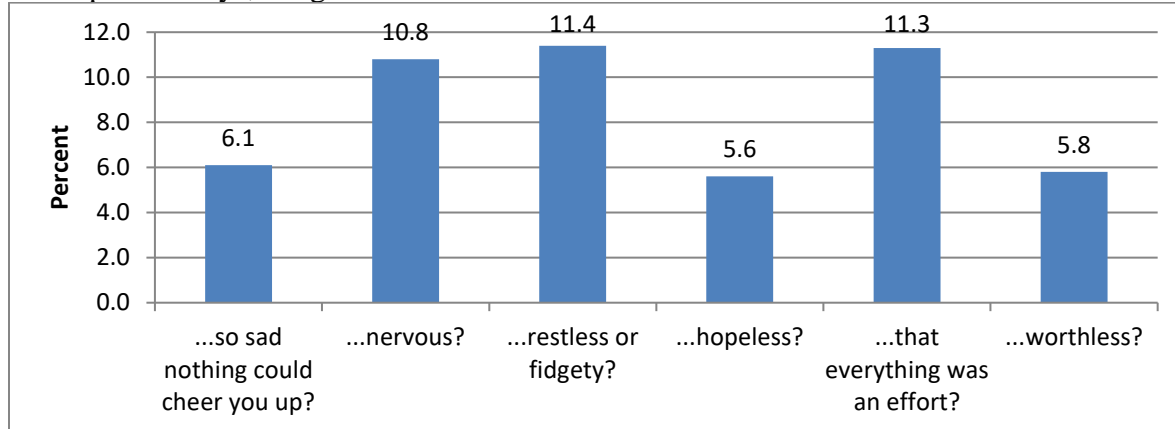
A total score across the six items of 13 or more suggests the presence of a serious mental illness (SMI), such as major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder, panic disorder, post-traumatic stress disorder (PTSD) and borderline personality disorder. As a symptom-screening tool, the scale does not actually diagnose or identify those respondents who may currently be successfully treated for a serious mental illness. Just under 9% 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. Figure 8 includes the prevalence of the combined score indicating severe mental illness and three additional measures, both for the entire sample and stratified by gender. The only significant difference found between men and women is that more women reported having mental health, drug, or alcohol problems in the past year (18.9% vs. 16.5%).

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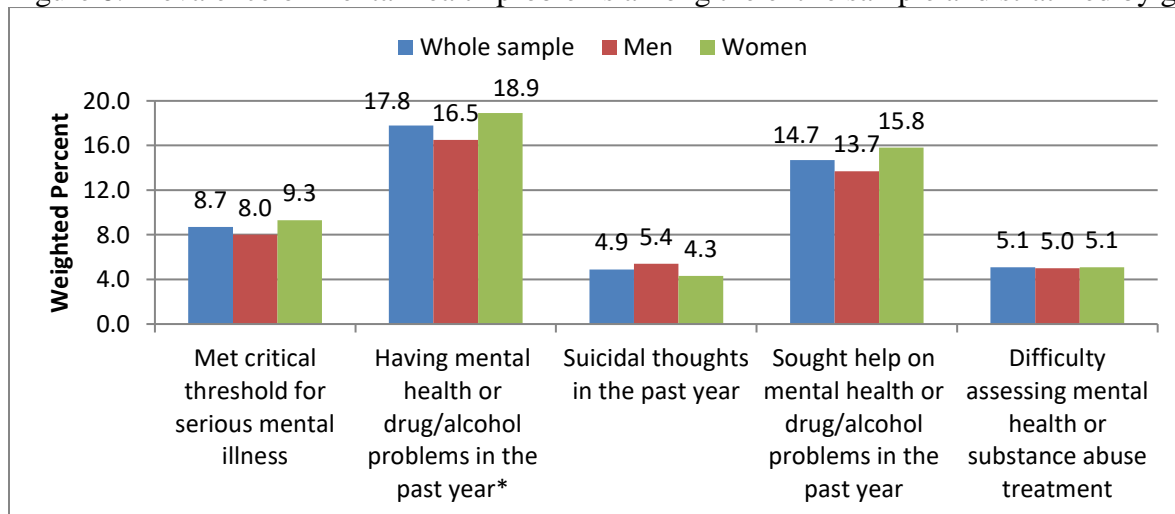
*p <.05.

Analysis by 2017 Prevention Strategies

To examine our intervening variable estimates in a different manner, we grouped our analyses around OSAP-approved prevention strategies that are designed to target particular intervening variables. Table 15 shows youth and adult alcohol and DWI prevention strategies (with their state codes) and the corresponding indicator estimates. Table 16 shows prescription painkiller abuse prevention strategies and their corresponding indicator estimates. Note that a small percentage of parents were aware of the "Parents Who Host Lose the Most" campaign (Table 15, 6.1%). Also, low percentages of respondents indicated that pharmacy staff or medical providers had talked with them about the risks involved in using prescribed painkillers or how to store prescribed painkillers properly. These results suggest a need to improve the reach of these strategies with their intended target populations.

Table 15. Alcohol and DWI prevention strategies and corresponding indicator estimates

2017 Strategies	Code	Indicators from NMCS 2017	Weighted %
Publicizing (law) enforcement efforts (saturation patrols, sobriety checkpoints, etc.)	A2a	Likelihood of police breaking up parties where teens are drinking: Very or somewhat Likely	65.0
		Likelihood of police arresting an adult for giving alcohol to someone under 21: Very or somewhat Likely	69.0
		Likelihood of someone being arrested if caught selling alcohol to a drunk or intoxicated person: Very or somewhat Likely	62.0
		Likelihood of being stopped by police if driving after drinking too much: Very or somewhat Likely	75.5
		Likelihood of being convicted if stopped and charged with DWI: Very or somewhat Likely	83.7
Responsible Beverage Service Model	A3a	Ease of access to alcohol by teens from stores and restaurants: Very or somewhat difficult	60.4
Developing and Coordinating a Parent Party Patrol	A4b	Access to alcohol at a party (among youth ages 18-20 who used alcohol last 30 days)	45.4
Parents Who Host Lose the Most	A4c	Parents or guardians provided alcohol (among youth ages 18-20 who used alcohol last 30 days)	9.3
		Aware of the campaign "Parents Who Host Lose the Most" (among parents)	6.1
Media to increase awareness of 4th degree felony and social host laws	A4d	Last year purchased or provided alcohol to underage youth	3.9

Table 16. Prescription painkiller abuse prevention strategies and corresponding indicator estimates

2017 Strategies		Indicators from NMCS 2017	Weighted %
Target **parents** to restrict youth social access to Rx pain-killers with by working directly with PTAs	R3a	Shared any prescription drugs with someone (parents only)	6.7
		Stored prescription drugs in a locked cabinet (parents only)	47.6
Target **parents** to restrict youth social access to Rx pain-killers by developing a culturally appropriate "parent handbook"	R3b	Same as R3a	
Target **parents** to restrict youth social access to Rx pain-killers by creating tools and promoting and implementing policies that insure that SBHCs & prescribers share information with parents	R3c	Same as R3a	
Restrict social access through the **elderly** (locking up meds, provide lock boxes, not sharing meds, etc.) with strategies that educate	R3d	Shared any prescription drugs with someone (ages 60 or above)	3.6
		Stored prescription drugs in a locked cabinet (ages 60 or above)	40.7
Work with **pharmacies** to always share information with customers about the dangers	R3e	Pharmacy staff talked about the risks involved in using prescribed painkillers.	12.5
		Pharmacy staff talked about storing prescribed painkillers safely.	10.0
Work directly with **medical providers** to create and implement policies such that medical providers educate patients	R3g	Medical providers talked about the risks involved in using prescribed painkillers.	18.6
		Medical providers talked about storing prescribed painkillers safely.	12.3
Work directly with **medical providers** so they can directly educate or encourage patients to reduce social access: develop and disseminate among providers a "provider guide"	R3h	Same as R3g	
Use media resources to increase awareness of Rx painkiller harm & potential for addiction	R4a	Perception of risks using Rx painkillers for a non-medical reason: moderate or great risk	84.1

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.

There were several items that were new to the 2017 survey that might have influenced the way that people responded to the final qualitative question. There were new alcohol-related 'community' and 'college community' modules that some communities added to the core questions. In addition, the inclusion of the mental health and opioid modules in Bernalillo County may have had an important impact on the nature of the responses, and the increased density of some of the comments may have been due to online recruitment through Facebook, Instagram, and direct email invitation.

Social Access
Respondents mentioned ease of social access to drugs and alcohol, especially at school, from family and friends, and at parties in the community. Multiple survey respondents spoke about access on college campuses and at parties. One respondent noted, "…when I was in high school alcohol was extremely accessible due to the college parties." Regarding access through families and at homes, one person noted, "Police are worried about drug dealers when the drug dealers are parents who don't lock away their medicine." Another respondent commented, "most kids learn from their families. There are a lot of people locally who offer drugs or alcohol to their children to be the 'cool' parent. Kids trust their parents." Another respondent cited ease of access in the community: "People can get just about anything if they just ask someone else in this town. It's too easy for minors to get anything they want to try or have done before. It's just a matter of asking and going through the grapevine to get it. All it is, is them simply asking an older person to get it for them."

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 for alcohol. Respondents noted over-prescribing: "Dr's. give out too many pills at one time! I was given an Rx for 30 painkillers, only needed 4." Another participant wrote, "Painkillers are the worst drug I have ever seen. Doctors give them away like candy. I have two close family members who have struggled with addiction because of oxi's and hydro's."

Respondents also commented on addiction, overdose and death: "I wish doctors would consider prescribing medication which would not harm or have individuals addicted to them." A few noted pharmaceutical industry practices: "I believe there is much fault in the pharmacological industry for promoting pain medications when they are not essential." One participant summed up these respondents' concerns about retail access of prescription opioids:

> "Prescription painkillers is a huge issue in the United States! And in New Mexico! It is easy to get addicted to pain killers and usually people move onto heroin. My dear friend has been in rehab the past 8 months because he got addicted to pain killers at a young age and ended up moving onto heroin. I think pain killers is a worse problem in my city here in New Mexico than alcohol, but… both are not taken as seriously by young people (and adults) as they should be and that is very sad."

Still others noted that advertising and corporate profit motive supports alcohol and drug abuse: "We need politicians to set a good example when it comes to positive behavior and the use of alcohol. Also, drug companies are to blame for the over-prescription and abuse of prescription drugs".

One participant noted policies that lead to more frequent prescribing of prescription painkillers:

> "I am an ER RN for 20 years, the association of our recent drug problems in our community and the government mandate and eacho (? Possibly ECHO?) to force ER to treat pain cannot be ignored. They like to say 'we never told you how you have to treat pain' but then they hold ERs and MDs to HCAPs (patient satisfaction scores) in order to get paid. Few people remember that Eacho (?) was passing out flyers in the waiting rooms stating 'you have a right to have your pain treated' Then they forced the Hospital to make pain a vital sign. At the same time no treatment programs were increased and instead many were shut down. Heroin use raising is a direct result of all of this. And mental health services in NM are sorely needed."

Some respondents support the legalization of marijuana and other drugs, noting its efficacy for pain relief, "Cannabis medicines should be taking the place of all this 'JUNK'! The doctors are PUSHING for pharmaceutical companies".

Regarding retail access to alcohol, respondents noted both national restaurant/bar and local establishments serving to minors or allowing for access to minors within the establishment: "San Juan County has a lot of underage drinking. This happens by people having fake ID's and by friends at restaurant giving them alcohol drinks. Buffalos, Applebee's, Texas, and Olive Garden to name some."

Low Enforcement

Low enforcement of drug and alcohol abuse was one of the most commonly discussed intervening variables. Many comments in this category were about poor enforcement of laws in

urban, rural, and tribal communities as well as in schools. Many respondents also commented on the need for stricter laws and sentencing (especially for those people with multiple DUIs). One respondent commented, "…Laws need to be enforced. DUI/DWI should NOT be a repeat-repeat offence. It needs to be stopped." Another also wondered about the lack of attention to prevention of repeat offending: "About law enforcement and seizure of vehicles; why are some people still driving and getting charged with their 8th or 9th DWI? When I read about this happening, I really think our legal system is not doing enough to stop drunk driving." Another noted, "I think the colleges should manage the fraternity and sorority places because that is where the most drinking gets done, plus have more check point stops on days that aren't the holidays to stop people who have possibly drunk to much before they ever get on the road." Another respondent stated, "New Mexico seems like a safe place for drunk drivers, countless DWI's and killings and they can still be out driving."

Several people commented on law enforcement funding and the need for additional police officers patrolling the streets, "We need to get money back into DWI programs all around. The budget cuts this year, especially during the holiday season, really hurt law enforcement's ability to keep drunk drivers off the road." One person questioned, "I have experienced fewer DWI checkpoints over the last year. Did SF stop funding check points?" Another noted, "Police need to patrol more to check drunk drivers."

Some respondents also spoke about the need for transportation options to reduce DUI, even while showing concern for low enforcement: "The lack of alternative transportation and the lack of police presence in my community is a huge problem in preventing DWI."

Many respondents spoke about biased enforcement among police, judges and school officials. "A lot of the students in my school are provided with alcohol and happen to get caught w/o punishment from the school all because of who they are. How is that fair?" A Santa Fe community member noted:

> "The unequal application of laws and consequences undermines the messages and prevention programs. DWI checkpoints target low income and immigrant communities on the southside, while tourists and hipsters openly drink and get drunk on the streets downtown and in the railyard. Youth on the southside are targeted by police, but not up in the hills and the parties the rich kids throw."

Another respondent noted, "I don't think the law enforcement or courts do enough to stop the problem. Also, it depends on who you are as if you would get arrested, etc."

While enforcement comments were primarily alcohol-related, some commented on drugs in the community and drug trafficking networks or gang involvement in the drug trade. As respondents often spoke only of "drugs," it was often unclear what substance(s) were considered the issue here: "the number of drug related incidents in our local schools begs the question of what school administration is doing." "Cops are called on drug activity at our small community and it does

not stop. Our cops rarely do anything to prevent our drug problems." "Street drug use/abuse needs as much if not more attention in my community". At times, illicit drugs were mentioned as a greater priority than the focus of the survey, alcohol and prescription opioids: "I believe that the problems of heroin and meth are a problem in our community. There should be a crackdown on these drugs much more often. It should be taken into consideration that these are the bigger problems other than alcohol abuse." A number of people commented specifically on the criminal aspects of drugs and drug use: "No one ever talks about the gangs and how drugs and gangs go hand in hand. The community, including the coalition for drugs and gangs, seems too afraid to mention this topic or to try to address the gang issue that has a lot to do with drug flow in our towns." Another suggested, "…prosecute dealers and users."

Perception of Risk of Legal Consequences

Perception of risk of getting caught is closely related to the above comments on enforcement and was commonly cited in terms of its absence: "I think young adults are drinking and driving more and more. Though they never get caught. I personally know many people who drink and drive on a daily basis. They never get caught." Many respondents commented on knowing people who drive under the influence without concern about the risks or consequences:

> "I think that drunk driving is the biggest issue among college students. Unfortunately, I have seen way too many people drive drunk or buzzed to and from parties and think that it's okay. I also know someone whose brother had died because of a drunk driver. It is truly heartbreaking and the amount of people that think it's okay to drive even slightly intoxicated is overwhelming."

The respondent below connected the idea of how highly visible enforcement might alter perception of risk:

> "I don't live on campus, so I don't know how much drinking occurs on campus; however, I've heard multiple people say that they drive after drinking, and I think this is intolerable because they're not only putting themselves at risk but others around them. Therefore, I would be open to more random checkpoints."

Others spoke directly to this intervening variable, "DWI continues to be a serious issue in my community and surrounding communities. People seem not to question the decision they make to drive while intoxicated because they do not think they'll be caught."

While highly visible enforcement increases the perception of risk, a common trope was that consequences are not sufficiently severe: "Honestly, the penalty of the use of drugs should be a lot greater. If you're caught at school all they do is suspend them. The police should get involved, so teenagers could have a bigger fear of using drugs."

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 comment, particularly about family, faith and individual responsibility. "Drinking is seen as a part of the culture in this community. It is hard to change the mindset of a teen whom has been raised in a community where it is routine and a part of life. To change the problems with addiction in this state, we must create a shift in cultural mentality." Another respondent noted:

> "Even if the whole community comes together to try and eliminate the alcohol abundance in our minor community, it will still be there. The consumption of alcohol is seen as cool or the only way to have fun in college, therefore, the minors still try to purchase it. It is up to the students and minors to decide enough is enough. If parents come out and tell their minors not to drink, it will only make them want to rebel and drink more. So it comes down to how do we change a norm in society that labels drinking alcohol as the only cool way to have fun?"

Many commented on substance use as a symptom of other societal/cultural problems or as self-treatment for trauma or mental health issues. For example, one respondent commented: "Substance abuse is not a "disease" it is a public health problem rooted in poverty and social inequality." Pointing to recent problems with Albuquerque Police Department, one respondent said:

> "I believe that Bernalillo county has a significant drug and alcohol abuse problem and that current law enforcement methodologies have proven unsuccessful in remediating that problem. I would like to see alternate approaches, rather than the continuation of draconian and expensive "tough on substances" policies. There is a greater overall social problem in my county that promotes a culture of abuse, homelessness, and helplessness. It must be addressed soon or the burgeoning property crime, homeless, and substance abuse rates will continue to grow. I hope that this survey encourages our judicial and legislative communities to investigate alternatives."

Some commented on larger cultural influences. "In relation to alcohol, the problem has always been in the way our culture celebrates alcohol. It is okay to use alcohol responsibly, but as long as advertisements, movies, and television shows celebrate alcohol and its effects, minors will continue to attempt to get alcohol and college students (as well as people in other groups) will develop drinking problems."

Respondents spoke about the need for better parenting and the importance of providing education and support for parents. "We put most of our efforts to reaching out to educate/inform our children. We need to put emphasis on educating the parents as well. Kids learn by example."

Other people commented critically on how society at large treats alcohol. The respondent below promoted a common notion that alcohol problems could be remedied by teaching young people to drink responsibly:

> "The taboo regarding drinking in the United States and in New Mexico is absurd. The reason communities have issues with underage drinking and binge drinking is the taboo that surrounds drinking. If we, as a society, would stop putting alcohol on a pedestal and teach kids at a younger age how to responsibly drink, we wouldn't have issues with underage drinking. It is ridiculous that we have an age limit as high as 21 to restrict drinking. If teenagers were introduced to liquor at younger ages, alcohol abuse would lower."

Faith was discussed as both prevention and treatment. "I have seen more people freed from addiction, mental health issues, and the other issues discussed today through connecting with churches than any other treatment." "If more people knew who God was there wouldn't be so many addicts."

Finally, numerous people commented on individual responsibility as it pertains to substance use and abuse, "cada quien es responsable por sus actos, ya que no somos unos niños." (Everyone is responsible for their own acts as we are no longer children).

Need for Services

The need for direct services to prevent and treat substance abuse was one of the most frequently noted responses by survey participants. Hundreds of comments focused on the need for behavioral health services, substance abuse treatment, youth-oriented services, housing, and other services. Many commented on the challenges of obtaining these services in local NM communities. For example, "We seriously lack services for addiction in our state and have very few options in our community," and "We need to invest more money into mental health care because persons who have been affected by drug addiction often are affected by a mental illness." Another respondent noted, "If there is a place to go when someone feels that they need mental help because of the stress/anxiety or depression, that doesn't require insurance, it would help prevent drug abuse. Both prescription and illegal." Another person commented, "Please fund more treatment, prevention and harm mitigation programs in our community! They are having a positive effect on our community."

People commented on the need for treatment in place of incarceration. "I believe that most of the people in jail & prisons are there because of alcohol or drugs. They need help not punishment." "The cure for most of these problems isn't legal, it's social, providing programs for addiction, health care, benefits to the poor, education. Law enforcement-based solutions target only individual offenders, and incarceration only leaves people and families more hopeless."

The need for prevention was also mentioned in hundreds of comments, including education, alternative activities, and programs and services targeted to youth. "Se necesita más información

en las escuelas para orientar a los jóvenes sobre el alcohol y drogas. No hay suficiente información para ellos" (more information is needed in schools in order to orient youth about alcohol and drugs). "More education in school and at home can stop drug abuse and prevent underage drinking."

Many commented on the need for alternative activities for children and youth, "the community needs to have healthy activities for adolescents to prevent them from drinking or using drugs at young ages. They need to invest in our kids." "Maybe if there were more things to do down here, teens wouldn't be drinking so much." "A mí me gustaría que hubiera programas a bajo costo para que los jóvenes tengan recreación y diversión saludable." (I would like for there to be low cost programs so that youth can have recreation and healthy fun). Another echoed this sentiment: "Our children would benefit from healthy fun options -- reduce desire for drugs & alcohol. Parents must set a good example! Educational Programs: self-esteem, self-worth, stress management."

Some spoke to increasing the perception of harm associated with substance misuse, "I love our small community and it is heartbreaking to see the devastation caused here by these issues. I wish there were more programs that helped the youth (and parents!) to know just how dangerous and detrimental underage drinking/providing alcohol to youth is. It would be beneficial to have guest speakers in the schools and other forums in the community."

And finally, many noted that lack of opportunities increases substance use and abuse at the local community level:

> "It is important to look at the root of a problem - providing treatment and looking at the factors that lead someone down a path to substance abuse are important. Can we provide more help to individuals and families to reduce the stressors that lead them towards drugs and alcohol? That money would be well spent. If we can help people and families to thrive in their daily lives, the risks of subsequent issues like drugs, alcohol, and getting involved in bad activities will be lowered as a result."

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 looked similar to comparison communities in 2016 (an improvement from other recent years), but in 2017 the positive trends appeared to have changed for some alcohol consumption behaviors (e.g., past 30-day alcohol use, binge drinking, and drinking and driving). The observed differences across the years may suggest that the effects of prevention efforts in the target communities have fluctuated over time, but there were substantial changes between 2016 and 2017 in the communities funded to address alcohol across the state, and this was likely to have been a major influence on these trends.

As in previous years, social access remains at the top of the list of intervening variables as a concern. Over 85% of underage adults in the target communities who drink got alcohol at parties or were given alcohol by unrelated adults. This was over 10 percentage points higher than the estimated rate in FY2016, so there appears to be a growing issue of how to address underage social access to alcohol, which is particularly difficult in a state that is highly rural, low in resources (as noted in many of the open-ended comments from survey respondents), and where evidence-based strategies to address social access are limited.

Target communities continue to have increased their perceived risk of legal consequences for breaking alcohol-related laws from FY2016, which in turn were higher than they had been in FY2015. This is likely attributable to the years of work in these communities to increase highly visible enforcement of alcohol-related laws, in spite of dwindling state resources for enforcement.

In comparison to FY2016, target community respondents generally had lower levels of prescription painkiller abuse in FY2017, and indicated that they were more likely to store these drugs safely. As in FY2016, many commented on excessive retail access to painkillers from medical providers, but social access to prescription painkillers seemed to be less mentioned. This suggests that public media campaigns and education needs to continue focusing on the dangers of social access.

All of the tobacco-related item estimates were more favorable in FY2017 than they had been in FY2016 (lifetime E-vapor use was up, but the trend seems positive because the recent 30-day use was down). For example, the rate of current cigarette use dropped from 22% in FY2016 to 17% in FY2017, the rate of current chewing tobacco use dropped from 6.5% to 4.5%, and the rate of purchasing tobacco from someone under 18 dropped from 3.5% to 2.0%

All of the mental health measure estimates were higher in FY2016 than they had been the previous year, and they remained at concerning levels in FY2017. For example, the percentage of respondents indicating that they had mental health or drug/alcohol problems in the past year increased slightly to 17.8% from 17.6% in 2016, and the estimated percentage of the population

that met the critical threshold for serious mental illness increased from 7.5% to 8.7%. As in 2016, the considerable survey respondent commentary about behavioral health problems in this state also supports this concern about the size of the issue.

Finally, the analyses on OSAP-approved prevention strategies that are designed to target intervening variables indicate that very few parents were aware of the "Parents Who Host Lose the Most" campaign and few pharmacy staff or medical providers had talked about the risks involved in using prescribed painkillers or how to store prescribed painkillers properly. These responses suggest a need for focusing on the reach and memorability of media campaigns and additional actions to increase the likelihood that medical/pharmacy personnel provide patients with timely education about prescription painkillers.

Appendix A: Alcohol

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

Alcohol use	Male		Female	
	SAPT	Non SAPT	SAPT	Non SAPT
Past 30-day alcohol use	54.2 (890)	51.3 (1235)	43.9 (1209)	42.7 (1534)
Past 30-day binge drinking	19.7 (377)	20.6 (553)	17.8 (391)	13.1 (521)
Past 30-day drinking & driving	3.9 (92)	4.6 (126)	2.7 (94)	2.6 (107)
Past 30-day binge drinking & driving	4.3 (96)	3.4 (107)	2.0 (68)	1.4 (59)*
Past year purchased or provided alcohol for someone under 21	4.3 (90)	4.6 (135)	3.5 (109)	2.9 (115)

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

Table A2. Alcohol use indicators comparing men and women in PFS 2015 and non-PFS 2015 communities; weighted % & unweighted (n)

Alcohol use	Male		Female	
	PFS 2015	Non PFS 2015	PFS 2015	Non PFS 2015
Past 30-day alcohol use	53.3 (784)	52.2 (1341)	44.2 (898)	42.9 (1845)
Past 30-day binge drinking	22.8 (366)	19.3 (564)**	15.1 (336)	11.6 (576)***
Past 30-day drinking & driving	5.0 (79)	4.1 (139)	3.4 (75)	2.4 (126)*
Past 30-day binge drinking & driving	4.3 (75)	3.6 (128)	2.0 (46)	1.5 (81)
Past year purchased or provided alcohol for someone under 21	6.3 (102)	3.8 (123)***	4.7 (101)	2.6 (123)***

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

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

Alcohol use	Male		Female	
	TCA	Non TCA	TCA	Non TCA
Past 30-day alcohol use	51.2 (491)	52.9 (1634)	47.6 (604)	42.0 (2139)**
Past 30-day binge drinking	20.7 (218)	20.1 (759)	14.0 (208)	12.1 (704)
Past 30-day drinking & driving	5.5 (58)	4.0 (160)	3.1 (47)	2.5 (154)
Past 30-day binge drinking & driving	3.8 (41)	3.7 (162)	1.5 (23)	1.7 (104)
Past year purchased or provided alcohol for someone under 21	5.4 (61)	4.2 (164)**	2.4 (39)	3.3 (185)

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

Table A4. 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	54.8 (738)	48.7 (1135)**	48.3 (898)	46.0 (1307)	34.3 (386)	36.6 (149)	44.7 (119)	46.7 (220)
Past 30-day binge drinking	11.6 (181)	13.4 (362)	18.1 (350)	20.6 (592)	18.3 (208)	17.3 (69)	12.3 (38)	14.7 (72)
Past 30-day drinking & driving	2.7 (46)	2.8 (75)	3.3 (70)	4.4 (130)	4.6 (55)	4.3 (17)	5.1 (18)	3.3 (17)
Past 30-day binge drinking & driving	2.0 (35)	2.0 (52)	3.7 (73)	2.8 (90)	4.1 (49)	2.7 (12)	5.4 (13)	3.8 (19)
Past year purchased or provided alcohol for someone under 21	3.5 (60)	3.2 (88)	4.4 (93)	4.2 (128)	4.1 (42)	4.5 (17)	6.4 (16)	4.4 (24)

**p ≤.01.

Table A5. 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	48.7 (596)	51.8 (1277)	50.0 (766)	45.8 (1439)*	39.3 (178)	33.4 (357)*	51.2 (161)	42.8 (178)
Past 30-day binge drinking	14.6 (210)	12.0 (333)*	22.8 (353)	18.5 (589)**	19.9 (87)	17.4 (190)	20.2 (60)	10.2 (50)***
Past 30-day drinking & driving	3.0 (45)	2.7 (76)	5.2 (75)	3.5 (125)*	5.7 (23)	4.1 (49)	4.4 (14)	3.8 (21)
Past 30-day binge drinking & driving	2.2 (30)	1.9 (57)	4.1 (67)	2.8 (96)*	3.6 (15)	3.8 (46)**	3.4 (12)	5.0 (20)
Past year purchased or provided alcohol for someone under 21	5.1 (71)	2.7 (77)***	6.7 (102)	3.4 (119)**	3.3 (16)	4.5 (43)	4.1 (17)	5.7 (23)

*p ≤.05, **p ≤.01, ***p ≤.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	53.8 (474)	50.2 (1399)	46.3 (510)	47.1 (1695)	36.1 (58)	34.8 (477)	48.6 (74)	45.2 (265)
Past 30-day binge drinking	14.3 (152)	12.1 (391)	21.5 (237)	19.0 (705)	15.4 (27)	18.4 (250)	11.6 (21)	14.4 (89)
Past 30-day drinking & driving	3.6 (36)	2.5 (85)	5.3 (63)	3.5 (137)*	2.0 (3)	4.8 (69)	4.0 (6)	4.0 (29)
Past 30-day binge drinking & driving	2.3 (23)	1.8 (64)	3.0 (34)	3.2 (129)	2.8 (4)	3.8 (57)	4.6 (7)	4.3 (25)
Past year purchased or provided alcohol for someone under 21	3.9 (39)	3.1 (109)	3.8 (46)	4.4 (175)	7.7 (10)	3.8 (49)*	6.6 (10)	4.7 (30)

*p ≤.05.

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	52.7 (1793)	51.4 (332)	44.1 (2296)	39.3 (447)**
Past 30-day binge drinking	20.3 (787)	19.8 (143)	12.8 (773)	11.4 (139)
Past 30-day drinking & driving	4.6 (192)	3.3 (26)	2.8 (176)	1.8 (25)*
Past 30-day binge drinking & driving	4.0 (173)	2.8 (30)	1.8 (114)	0.9 (13)*
Past year purchased or provided alcohol for someone under 21	4.8 (198)	3.0 (27)*	3.3 (195)	2.5 (29)

*p < .05, **p ≤ .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	52.6 (1549)	44.9 (324)	47.2 (1825)	45.7 (380)	34.4 (497)	43.3 (38)	47.8 (294)	36.2 (45)*
Past 30-day binge drinking	12.9 (451)	11.7 (92)	19.7 (775)	19.4 (167)	17.8 (259)	22.4 (18)	15.3 (101)	6.1 (9)**
Past 30-day drinking & driving	2.8 (99)	2.6 (22)	4.3 (175)	2.6 (25)*	4.5 (69)	4.0 (3)	4.6 (33)	0.9 (2)*
Past 30-day binge drinking & driving	2.1 (73)	1.5 (14)	3.4 (138)	2.1 (25)*	3.8 (59)	1.9 (2)	4.9 (29)	2.0 (3)
Past year purchased or provided alcohol for someone under 21	3.6 (126)	2.3 (22)	4.5 (191)	3.4 (30)	4.3 (57)	2.1 (2)	5.9 (37)	1.4 (3)**

*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	49.9 (258)	53.3 (44)	61.0 (429)	60.1 (64)
Past 30-day binge drinking	15.3 (90)	17.9 (15)	24.7 (195)	23.3 (26)
Past 30-day drinking and driving	2.6 (19)	2.9 (2)	8.2 (60)	7.3 (10)
Past 30-day binge drinking and driving	4.6 (30)	NA	8.8 (61)	9.3 (9)
Past year purchased alcohol for someone under 21	5.9 (33)	3.5 (3)	13.3 (90)	9.8 (7)

Appendix B: Prescription Drugs

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

Prescription drug use	Male		Female	
	SAPT	Non SAPT	SAPT	Non SAPT
Past 30-day Rx painkiller use for any reason	12.1 (118)	14.0 (378)	13.3 (264)	13.2 (517)
Past 30-day painkiller use to get high	2.9 (31)	3.2 (112)	2.6 (55)	2.8 (122)
Past year prevalence of receiving Rx painkiller	25.2 (249)	26.0 (686)	31.8 (597)	29.5 (1169)
Great or moderate risk of Rx painkiller non-medical use	83.4 (849)	80.7 (2251)	87.8 (1668)	86.7 (3428)
Given or shared Rx drugs with someone	5.1 (55)	5.4 (186)	6.9 (141)	6.0 (266)
Medication locked or safely stored away	39.2 (202)	39.6 (545)	44.6 (461)	43.1 (841)

Table B2. Prescription drug use indicators comparing men and women in PFS 2015 and non-PFS 2015 communities; weighted % & unweighted (n)

Prescription drug use	Male		Female	
	PFS 2015	Non PFS 2015	PFS 2015	Non PFS 2015
Past 30-day Rx painkiller use for any reason	12.8 (164)	13.8 (332)	14.1 (248)	12.9 (533)
Past 30-day painkiller use to get high	3.5 (54)	3.0 (89)	3.2 (57)	2.6 (120)
Past year prevalence of receiving Rx painkiller	26.4 (335)	25.5 (600)	33.0 (567)	29.9 (1199)
Great or moderate risk of Rx painkiller non-medical use	78.6 (1086)	82.4 (2014)**	85.8 (1575)	87.5 (3521)
Given or shared Rx drugs with someone	5.0 (81)	5.4 (160)	7.3 (150)	5.9 (257)
Medication locked or safely stored away	35.4 (238)	41.0 (509)*	41.6 (398)	44.3 (904)

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

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

Prescription drug use	Male		Female	
	TCA	Non TCA	TCA	Non TCA
Past 30-day Rx painkiller use for any reason	11.3 (67)	14.0 (429)	12.8 (98)	13.3 (683)
Past 30-day painkiller use to get high	3.0 (22)	3.2 (121)	2.6 (25)	2.8 (152)
Past year prevalence of receiving Rx painkiller	21.4 (116)	26.6 (819)	39.2 (233)	30.4 (1533)
Great or moderate risk of Rx painkiller non-medical use	79.3 (463)	81.9 (2637)	86.2 (710)	87.2 (4386)
Given or shared Rx drugs with someone	4.6 (33)	5.5 (208)	4.8 (43)	6.5 (364)
Medication locked or safely stored away	40.3 (87)	39.4 (660)	45.0 (168)	43.3 (1134)

Table B4. 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	14.1 (140)	14.8 (356)	12.6(144)	12.9 (422)	9.6 (82)	14.2 (83)*	18.4 (24)	12.6 (65)
Past 30-day painkiller use to get high	1.9 (22)	2.5 (73)	4.2 (42)	3.5 (131)	1.9 (21)	3.2 (18)	5.1 (6)	4.8 (26)
Past year prevalence of receiving Rx painkiller	31.5 (304)	32.3 (784)	28.3 (319)	23.7 (818) **	25.0 (205)	26.2 (155)	24.2 (30)	27.5 (139)
Great or moderate risk of Rx painkiller non-medical use	90.2 (835)	85.8 (2157)**	83.5 (929)	82.3 (2751)	80.3 (668)	79.1 (465)	84.8 (117)	78.6 (414)
Given or shared Rx drugs with someone	7.0 (75)	5.4 (164)	5.6 (68)	6.0 (223)	4.6 (44)	7.1 (46)*	7.4 (10)	7.6 (42)
Medication locked or safely stored away	30.3 (141)	33.4 (397)	49.0 (279)	46.6 (757)	51.1 (220)	56.1 (164)	58.0 (35)	41.8 (105)

*p ≤.05, **p ≤.01.

Table B5. 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	14.5 (146)	14.7 (350)	13.3 (195)	12.6 (371)	11.3 (47)	11.8 (118)	12.5 (33)	14.4 (56)
Past 30-day painkiller use to get high	2.7 (28)	2.2 (67)	4.3 (69)	3.4 (104)	2.2 (8)	2.6 (31)	3.1 (10)	5.9 (22)
Past year prevalence of receiving Rx painkiller	32.7 (347)	31.8 (741)	26.4 (386)	24.2 (751)	25.2 (115)	25.6 (245)	27.0 (37)	26.8 (96)
Great or moderate risk of Rx painkiller non-medical use	84.9 (932)	87.7 (2060)*	80.5 (1177)	83.3 (2503)*	81.2 (364)	79.2 (769)	78.3 (225)	80.7 (306)
Given or shared Rx drugs with someone	5.6 (80)	5.9 (159)	6.9 (109)	5.5 (182)	5.0 (27)	6.0 (63)	5.7 (18)	8.6 (34)
Medication locked or safely stored away	33.2 (174)	32.3 (364)	41.4 (318)	49.3 (718)**	47.4 (98)	55.0 (286)	37.3 (53)	49.4 (87)*

*p ≤.05, **p ≤.01.

Table B6. 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	14.1 (80)	14.7 (416)	10.2 (67)	13.3 (499)*	11.7 (10)	11.7 (155)	11.3 (12)	14.1 (77)
Past 30-day painkiller use to get high	2.1 (17)	2.4 (78)	3.6 (26)	3.7 (147)	3.2 (2)	2.4 (37)	4.9 (5)	4.9 (27)
Past year prevalence of receiving Rx painkiller	29.3 (162)	32.6 (926)	21.6 (152)	25.4 (985)	30.1 (25)	25.2 (335)	18.1 (19)	28.3 (150)
Great or moderate risk of Rx painkiller non-medical use	82.3 (493)	87.9 (2499)***	83.7 (555)	82.4 (3125)	78.8 (73)	79.8 (1060)	73.4 (75)	80.9 (456)
Given or shared Rx drugs with someone	4.8 (30)	6.1 (209)	4.4 (33)	6.2 (258)	5.5 (6)	5.7 (84)	6.2 (8)	7.7 (44)
Medication locked or safely stored away	37.2 (91)	31.7 (447)	47.1 (135)	47.3 (901)	66.8 (24)	52.4 (360)	34.1 (13)	46.6 (127)

***$p < .001$.

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

Prescription drug use	Men		Women	
	Target	Comparison	Target	Comparison
Past 30-day Rx painkiller use for any reason	12.6 (334)	15.6 (162)*	13.8 (602)	11.8 (179)
Past 30-day painkiller use to get high	3.3 (103)	2.8 (40)	2.9 (137)	2.3 (40)
Past year prevalence of receiving Rx painkiller	26.0 (674)	25.4 (261)	31.6 (1364)	26.6 (402)***
Great or moderate risk of Rx painkillers non-medical use	81.2 (2234)	81.8 (866)	87.2 (3793)	86.7 (1303)
Given or shared Rx drugs with someone	5.0 (162)	6.0 (79)	6.3 (307)	6.1 (100)
Rx painkillers locked or safely stored away	38.6 (505)	41.5 (242)	43.9 (966)	42.6 (316)

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

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

Prescription drug use	Non-Hispanic White		Hispanic		Native American		Other	
	Target	Comparison	Target	Comparison	Target	Comparison	Target	Comparison
Past 30-day Rx painkiller use for any reason	14.5 (358)	15.0 (138)	12.7 (411)	13.0 (155)	11.0 (127)	14.0 (38)	12.7 (61)	16.0 (28)
Past 30-day painkiller use to get high	2.3 (65)	2.5 (30)	4.2 (139)	2.4 (34)**	2.1 (28)	3.8 (11)	4.3 (20)	6.4 (12)
Past year prevalence of receiving Rx painkiller	32.6 (808)	30.7 (280)	26.6 (865)	20.7 (272)***	25.8 (289)	24.7 (71)	25.1 (116)	31.1 (53)
Great or moderate risk of Rx painkillers non-medical use	86.9 (2160)	87.3 (832)	83.2 (2659)	81.3 (1021)	79.3 (905)	81.4 (228)	79.7 (395)	80.1 (136)
Given or shared Rx drugs with someone	5.8 (171)	6.0 (68)	5.8 (206)	6.1 (85)	4.7 (64)	9.2 (26)**	5.9 (33)	11.4 (19)*
Rx painkillers locked or safely stored away	32.5 (392)	32.7 (146)	46.9 (736)	48.0 (300)	52.1 (294)	57.0 (90)	44.0 (97)	47.2 (43)

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

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

Prescription drug use	Veteran		LGBT	
	Target	Comparison	Target	Comparison
Past 30-day Rx painkiller use for any reason	16.9 (71)	20.3 (30)	19.0 (109)	22.7 (45)
Past 30-day painkiller use to get high	3.4 (16)	3.8 (7)	5.7 (57)	8.6 (17)
Past year prevalence of receiving Rx painkiller	34.6 (147)	30.8 (44)	33.5 (183)	43.3 (76)*
Great or moderate risk of Rx painkillers non-medical use	79.7 (438)	78.6 (330)	77.8 (466)	70.4 (143)
Given or shared Rx drugs with someone	3.5 (20)	13.8 (24)***	10.6 (70)	18.9 (39)**
Rx painkillers locked or safely stored away	45.6 (106)	40.1 (34)	40.0 (120)	43.0 (52)

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	17.8 (89)	3.9 (20)	43.2 (215)	19.5 (94)	4.1 (19)
21-25	19.0 (65)	5.5 (17)	43.3 (157)	16.2 (57)	2.2 (9)
26-30	22.8 (32)	6.1 (8)	39.0 (56)	12.3 (18)	1.6 (3)
31-40	26.9 (56)	6.6 (12)	24.8 (55)	6.3 (12)	1.5 (3)
41-50	20.9 (29)	7.0 (8)	11.9 (19)	1.5 (3)	2.3 (3)
51-60	12.8 (19)	3.8 (5)	6.7 (11)	1.9 (3)	2.3 (3)
61-70	9.0 (9)	2.5 (2)	3.7 (4)	2.1 (2)	2.0 (2)
70+	7.5 (6)	0.0 (0)	1.2 (1)	1.2 (1)	0.0 (0)

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	17.9 (108)	17.9 (149)	12.8 (28)	13.2 (20)
Any current chewing tobacco use	3.8 (19)	4.9 (35)	7.1 (12)	3.0 (6)
E-vapor product lifetime use	22.5 (169)	21.7 (250)	24.6 (58)	21.5 (41)
E-vapor product past 30-day use	8.0 (63)	7.4 (89)	10.6 (24)	6.5 (14)
Past year purchased tobacco for someone under 18	1.1 (9)	2.6 (22)	2.3 (7)	2.3 (4)

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

Tobacco Use	Military	LGBT
Any current cigarette use	16.4 (11)	27.6 (36)
Any current chewing tobacco use	13.4 (9)	7.6 (10)
E-vapor product lifetime use	18.2 (18)	39.2 (66)
E-vapor product past 30-day use	4.2 (6)	16.5 (28)
Past year purchased tobacco for someone under 18	1.8 (2)	3.4 (8)

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	22.6 (194)	30.9 (262)	12.3 (102)	19.6 (173)	7.3 (64)
21-25	13.3 (101)	28.2 (222)	7.5 (60)	18.7 (145)	7.3 (58)
26-30	9.5 (47)	20.5 (108)	5.4 (25)	15.8 (84)	5.8 (29)
31-40	9.3 (69)	18.7 (149)	6.3 (44)	17.7 (140)	7.2 (53)
41-50	7.8 (49)	20.8 (126)	5.5 (31)	17.9 (110)	6.2 (42)
51-60	5.8 (32)	13.8 (83)	3.3 (20)	11.5 (69)	4.1 (26)
61-70	5.3 (21)	10.9 (46)	0.7 (3)	11.3 (45)	2.5 (10)
70+	3.4 (11)	7.0 (22)	2.0 (6)	7.6 (21)	1.2 (3)

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	7.4 (141)	9.5 (239)	8.4 (97)	11.1 (47)
Having mental health, drug or alcohol problems in the past year	18.1 (328)	17.2 (414)	18.5 (195)	18.5 (81)
Suicidal thoughts in the past year	4.9 (93)	5.0 (125)	4.6 (51)	4.1 (22)
Sought help on mental health or drug/alcohol problems in the past year	14.1 (236)	15.1 (329)	16.3 (170)	12.7 (52)
Difficulty assessing mental health or substance abuse treatment	4.5 (76)	5.1 (113)	6.2 (67)	7.3 (29)

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	4.1 (17)	18.0 (83)
Having mental health, drug or alcohol problems in the past year	14.2 (51)	44.6 (179)
Suicidal thoughts in the past year	4.2 (16)	16.4 (68)
Sought help on mental health or drug/alcohol problems in the past year	12.8 (45)	34.6 (125)
Difficulty assessing mental health or substance abuse treatment	4.8 (16)	17.5 (63)

Appendix E: Facebook Ads

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

New Mexico Community Survey 2017

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

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.
- There is a very slight risk that your responses will be seen by the data collectors, however we have taken precautions to prevent this by providing a closed container to place your completed survey. Do NOT put your name or any identifying information on the survey.
- There is also a slight risk that you may feel upset or have a negative emotional reaction when responding to some questions. You do not have to answer any question you don't want to answer.
- 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 (Name your coalition or agency here) 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 ☐ I choose not to identify

3. 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

4. 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]

_____

5. 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

6. Are you currently an undergraduate in college?

☐ Yes ☐ No (*go to question 8*)

7. What college/university do you currently attend?

_____

8. 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

9. Do you identify as Lesbian, Gay, Bisexual, Transgender, Queer, or Questioning?

☐ Yes ☐ No

10. What is your zip code? _____ *(for geographic sorting purposes only)*

11. Are you a parent or caretaker of someone <u>under 21</u> currently living in your household?

☐ Yes ☐ No

12. For the <u>past 30 days,</u> have you had a permanent and stable place to live?

☐ Yes ☐ No

The next questions are about your personal perceptions of the community where you are *currently* living. Please remember that your responses are anonymous.

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13. 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

14. 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

15. 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

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

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

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

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

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

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

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

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

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

☐ None
_____ Drinks a week (1 or more)

21. Think specifically about the past <u>30 days</u>. During the past <u>30 days</u>, on how many days did you drink <u>one or more drinks</u> 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

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

☐ None
_____ Times in past 30 days

23. During the past <u>30 days</u>, how many times have you driven when you've had perhaps too much to drink?

☐ None
_____ Times in past 30 days

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

☐ Yes ☐ No

25. *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]:*
_____

26. 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

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

☐ Yes ☐ No ☐ Don't know

The following questions have to do with prescription painkillers such as Vicodin, OxyContin (also called Oxy or OC), or Percocet (also called Percs).

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

☐ Yes ☐ No *(if no, go to question 32.)*

29. When you were prescribed painkillers, were you also prescribed naloxone or Narcan, at the same time?

☐ Yes ☐ No ☐ I don't know

30. When you were prescribed painkillers, did anyone talk to you about the risks involved in using them? *(check all the apply)*

☐ Health care provider ☐ Pharmacy Staff

☐ No one talked with me ☐ Not sure

31. When you were prescribed painkillers, did anyone talk to you about storing them safely? *(check all the apply)*

☐ Health care provider ☐ Pharmacy Staff

☐ No one talked with me ☐ Not sure

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 39*

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 used a painkiller or other opioid to get high, did you have access to naloxone or Narcan?

☐ Yes ☐ No

36. 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)

37. 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]:*

_____

38. If you used **painkillers** in the last 30 days 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 describe]:* _____

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

☐ Yes ☐ No

40. Are all your prescription painkillers 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 last questions ask for your thoughts about media campaigns going on in our state.

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

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

42. What do you think is the main prevention message of the campaign "A Dose of R$_x$eality"? *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.

You are almost done! Just one last question!

43. 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.]*

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!**

College Community Module

Please think about the community you live in as you answer these questions.

How much do you agree or disagree with the following statements? *(Circle the number of your response)*		Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	Underage drinking among college students is a problem in my community.	0	1	2	3	4
2	Binge drinking by college students is a problem in my community.	0	1	2	3	4
3	Drinking and driving by college students is a problem in my community.	0	1	2	3	4
4	My local college or university needs to do more to stop underage drinking and binge drinking among college students.	0	1	2	3	4
5	Local law enforcement needs to do more to stop underage drinking and binge drinking among college students.	0	1	2	3	4
6	College student drinking contributes to drinking among teens in my community.	0	1	2	3	4
7	College drinking harms the personal safety and well-being of my community members.	0	1	2	3	4
8	Stores, bars and restaurants in my community do not do enough to discourage sales to intoxicated customers.	0	1	2	3	4
9	Stores, bars and restaurants in my community do not do enough to discourage sales to minors.	0	1	2	3	4
10	Problems due to drinking hurts my community financially (such as costs associated with property damage, use of criminal justice system and public services).	0	1	2	3	4
11	In the past year, I have experienced problems associated with alcohol misuse in my community (such as litter, property damage, personal safety, noise, assault, etc.).	0	1	2	3	4
11.a	*Please describe:*					

Tobacco Module

The next questions are about tobacco use. Please remember that your responses are anonymous.

1. 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

2. 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

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

4. Have you ever used an electronic vapor product?

    ☐ Yes   ☐ No

5. 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

Mental Health Module

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

1. During the past 4 weeks (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

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

   ☐ Yes   ☐ No

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

   ☐ Yes   ☐ No

4. In the past year, 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

5. During the past year, have you had difficulty accessing treatment for a mental health or substance abuse problem?

   ☐ Yes   ☐ No

6. In the past year, have you been screened by a health care provider for alcohol or drug problems?
   ☐ Yes   ☐ No

7. In the past year, have you been screened by a health care provider for depression?
   ☐ Yes   ☐ No

8. In the past year, have you been screened by a health care provider for suicidal ideation?
   ☐ Yes   ☐ No

Community Module

Please think about the community you live in as you answer these questions.

How much do you agree or disagree with the following statements? *(Circle the number of your response)*	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1	Underage drinking is a problem in my community.	0	1	2	3	4
2	I support local law enforcement efforts to prevent underage drinking.	0	1	2	3	4
3	Heavy drinking is a problem in my community.	0	1	2	3	4
4	I support local efforts to prevent heavy drinking.	0	1	2	3	4
5	Drinking and driving is a problem in my community.	0	1	2	3	4
6	I support local law enforcement efforts to prevent drinking and driving.	0	1	2	3	4
7	I support the enforcement of laws prohibiting serving the intoxicated.	0	1	2	3	4
8	The overuse of alcohol harms the personal safety and well-being of members of my community.	0	1	2	3	4
9	Problems due to drinking hurts my community financially (such as costs associated with property damage, use of criminal justice system and public services).	0	1	2	3	4
10	In the past year, I have experienced problems associated with alcohol misuse in my community (such as litter, property damage, personal safety, noise, assault, etc.).	0	1	2	3	4
10.a	*Please describe:*					