Pacific Institute for Research and Evaluation

Results from the 2018 New Mexico Community Survey

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Executive Summary

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

Data collection took place in the spring of Fiscal Year 2018 using two methodologies; both methodologies relied on convenience samples. The first approach was a time and venue based data collection process in-person or via Qualtrics app. 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 in person or via Qualtrics resulted in 8,280 valid surveys representing 32 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; 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 were completed via the two different data collection strategies with about 70% coming from in-person data collection methods.

We analyzed the data in several ways. First, 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. Next, 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.

Major findings include:

Alcohol

- Men in target and comparison communities reported similarly on the majority of alcohol consumption measures except for past 30-day alcohol use that target communities reported more than comparison communities. And women in target communities significantly reported more on past 30-day binge drinking and driving than their counterpart in comparison communities.
- Non-Hispanic Whites in comparison communities reported significantly less current drinking, binge drinking, and drinking and driving than their counterparts in target communities. And they were less likely to provide alcohol to minors in the past year.
- Target and comparison communities reported similarly with regard to ease of teen access to alcohol in communities or in stores and restaurants.
- Target communities reported significantly greater likelihood of police involvement when some alcohol laws were violated than in comparison communities.
- The main alcohol sources for underage youth were from parties and unrelated adults providing it to them.

Prescription Painkillers

- Target and comparison communities reported similarly on all prescription painkiller consumption measures. But more people in comparison communities reported perceiving great or moderate risk of prescription painkiller non-medical use and safely storing away prescription painkiller.
- The only difference between target and comparison communities by sex was that men and women in comparison communities reported significantly higher rates of perceiving great or moderate risk of prescription painkiller non-medical use.
- 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 (13.5%).
- Young adults 18 to 20 reported the highest prevalence of prescription painkiller use to get high (3.8%) and sharing prescription painkillers with others (7.1%). They also were less likely to perceive that there was great risk of harm associated with using prescription painkillers for non-medical reasons (78.5%).

Opioid

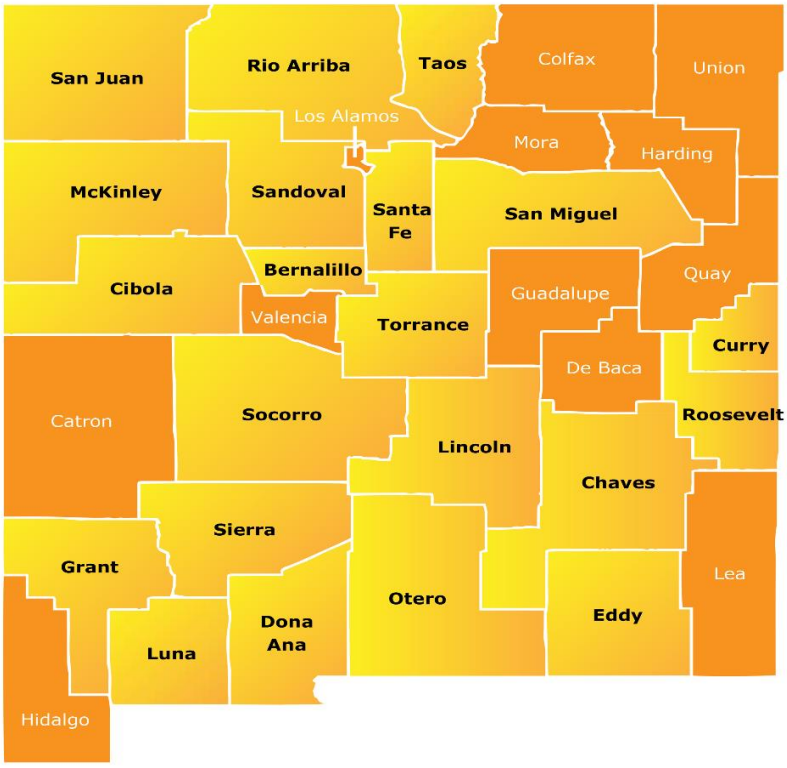
- Among the communities that have collected opioid-related data, about 23% respondents reported having family members or friends who often use prescription painkillers. And among these respondents, a little over half (52%) thought that those prescription painkiller users are at risk of overdose.

- Similarly, about 9% respondents reported having family members or friends who often use heroin. The majority of these respondents (87%) thought that those heroin users are at risk of overdose.
- Among the whole sample, the majority (64%) endorsed the statement that “it is never ok to share a prescription painkiller with another person”.

Prevention in New Mexico

The NM Office of Substance Abuse Prevention (OSAP) in FY18 funded 25 prevention programs in 21 of the 33 counties in NM. Figure 1 below highlights the 21 counties receiving prevention funding in yellow and the 12 with no OSAP funding in orange.

Figure 1: OSAP funded counties (in yellow) in New Mexico in Fiscal Year 2018



Programs receive funding to target several statewide prevention priorities including underage drinking, binge drinking among all youth and adults, driving while intoxicated among youth and adults, and prescription painkiller misuse and abuse among all ages. Depending on the original source of funding and needs assessment results, communities focus on two or more of these priorities (only Eddy County prioritizes illicit drug use, which is not mentioned in the NMCS, so this priority is not otherwise mentioned). Also depending on the original funding source and the community needs assessment, communities may be implementing environmental-level prevention strategies, direct services prevention strategies, or both. All communities are expected to collect Community Survey data, and those communities implementing direct services also implement the Strategies for Success, which is reported on elsewhere.

More projects beyond OSAP funded prevention programs are using the NMCS to obtain timely community-based data. These include local DWI programs, Drug Free Community grantees, as

well as other community-based initiatives that partner with an OSAP-funded program in order to make community-wide impact.

Methodology

The NM Community Survey

The New Mexico Community Survey (NMCS) has been implemented in 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 the NM Office of Substance Abuse Prevention (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 2018, we implemented two data collection methodologies.

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

The first approach taken to collect data is the now routinized time and venue-based sampling within funded communities. This convenience sampling approach has been used by funded communities since 2008 and involves 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.

Members of the State Epidemiological Outcomes Workgroup (SEOW) review community-level data collection protocols to ensure the capture of a reasonably representative sample of adults. PIRE instructs community providers and local evaluators in appropriate data collection methodology and how to maintain respondents' confidentiality while completing the survey.

This approach draws from CBPR, Community Based Participatory Research 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. 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 as last year. This 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 FY2018, 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 6,294 paper surveys (about 50% of the aggregated sample) and 562 surveys via iPad with Qualtrics (about 4.5% of the total sample). These data came from the 29 counties where OSAP funded prevention services in FY2018 or in previous fiscal years.

This approach to data collection has worked well for most communities in NM but not all; for particularly larger communities, such as Bernalillo County, a time and venue-based approach is

problematic. The geographic and socio-demographic diversity is much greater than in rural areas, making it challenging to identify locations that attract large number of diverse people.

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

As new sub-recipients are funded, we have seen increased coverage across the state, particularly in more rural communities. Local DWI programs and others are starting to conduct the NMCS data as well, which has helped increase the number of counties across the state collecting data so that comparisons can be made between OSAP prevention funded communities and those without.

We currently do not calculate response rate for this approach, due to the community-based and diverse nature of this process (from community to site to individual data collector) and the considerable additional resources it would require making such calculations possible. Calculating response rate and developing means to increase it would require communities to sacrifice leadership in data collection, and would require considerably more resources in order to rigorously align data collection across the state.

Data Collection Approach # 2: On-line survey

The other data collection approach used in FY18 was the on-line recruitment and implementation of the NMCS. Ads for the survey were placed on Facebook and Instagram targeting NM residents 18 and older. (Appendix D shows the ads themselves.) We piloted this methodology in FY14 among 18 to 25 year-olds and expanded to include all NM residents 18 and older since then. 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 25, 2018 to April 28, 2018 (63 days), the ads led to over 5,070 link clicks, with 113,604 people reached at the cost of approximately $2.30 per result and a result rate of 1.91%. A total of 3,060 surveys were collected recruiting directly through the Facebook ads or via Facebook group sharing.

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. Additional 2,669 surveys were collected directly via email invitations, QR codes, or friends and family members telling others about the on-line survey.

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	6,294	50.0	29
Online - FACEBOOK (18+ yr. olds)	3,060	24.3	33
Qualtrics App	562	4.5	24
Online – Non-FACEBOOK	2,669	21.2	31
Total	12,589		

Table 2. Completed questionnaires by County compared to 2017

County	2018						2017				
	Qualtrics App	Online	QR code	Paper	Total	%	Qualtrics App	Online	Paper	Total	%
Bernalillo	266	846	1	563	1676	13.3	320	206	617	1143	10.6
Catron	0	6		0	6	0.1		2	1	3	0.0
Chaves	3	102		382	487	3.9	1	163	325	489	4.6
Cibola	2	96		342	440	3.5	7	5	307	319	3.0
Colfax	1	27		4	32	0.3	2	5	1	8	0.1
Curry	0	85	1	478	564	4.5	45	40	391	476	4.4
De Baca	0	2		0	2	0.0	0	0	2	2	0.0
Dona Ana	13	678	8	75	774	6.2	118	416	173	707	6.6
Eddy	7	390	1	4	402	3.2	3	159	290	452	4.2
Grant	37	162	10	187	396	3.2	0	135	192	327	3.0
Guadalupe	0	4		1	5	0.0	0	3	2	5	0.1
Harding	0	4		2	6	0.1	0	2	0	2	0.0
Hidalgo	1	72		118	191	1.5	0	93	327	420	3.9
Lea	1	63		1	65	0.5	0	14	7	21	0.2
Lincoln	0	43		15	58	0.5	1	6	4	11	0.1
Los Alamos	2	23		2	27	0.2	1	10	5	16	0.2
Luna	7	178	4	151	340	2.7	2	137	185	324	3.0
McKinley	11	61	1	471	544	4.3	1	12	592	605	5.6
Mora	0	9		17	26	0.2	1		6	7	0.1
Otero	3	118		223	344	2.7	0	15	3	18	0.2
Quay	0	31		1	32	0.3	0	4	1	5	0.1
Rio Arriba	1	73		174	248	2.0	4	20	301	325	3.0
Roosevelt	1	61	3	371	436	3.5	72	26	265	363	3.4
San Juan	2	675	2	345	1024	8.1	8	131	682	821	7.6
San Miguel	1	60		257	318	2.5	2	23	326	351	3.3
Sandoval	15	191		531	737	5.9	13	46	473	532	5.0
Santa Fe	115	859		262	1236	9.8	27	363	762	1152	10.7
Sierra	54	183		178	415	3.3	0	150	220	370	3.4
Socorro	1	385	2	277	665	5.3	114	236	253	603	5.6
Taos	4	60		341	405	3.2	32	6	350	388	3.6
Torrance	4	37		255	296	2.4	6	12	182	200	1.9
Union	1	9		0	10	0.1	0	2	0	2	0.0
Valencia	9	107		266	382	3.0	8	19	247	274	2.6
Total	562	5700	33	6294	12589	100	788	2461	7492	10741	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); 3) the federal Partnerships for Success (PFS) 2015. We compared prevalence estimates across funding streams and un-funded communities. Then we examined outcomes by comparing communities that targeted a specific substance with those that did not, regardless of funding sources. In all analyses, SAS Survey procedures were used to account for survey design and weights.

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 despite the actual number of respondents, thus the discrepancies between the number and the weighted percent reported. Weighted estimates show the sample to be evenly split between men and women although more women completed the survey than men. Efforts were made in some communities to oversample 18 to 25 year olds although they reflect a relatively small portion of the actual state population. This over-sampling was advantageous to programs targeting prevention strategies towards this young adult population. Native Americans were also more prevalent in the sample than in the population as a whole and thus, weighted percentages have de-emphasized their influence to approach a more representative state estimate. Our survey sample was more educated than the general NM population; according to the US

[1] Retrieved from http://www.census.gov/popest/data/state/asrh/2016/SC-EST2016-ALLDATA6.html on August 2 2018.

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 6.5% of the sample reported having served or still serving in the military which, when weighted, increased to 8.8%. The percentage of respondents in the sample who identified as LGBT was 8.7%, which when weighted decreased slightly to 7.4%.

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

Gender	n	Unweighted %	Weighted %
Men	4,560	37.0	49.1
Women	7,747	63.0	50.9
Age	**n**	**Unweighted %**	**Weighted %**
18-20	1452	11.5	5.4
21-25	1528	12.1	9.1
26-30	1235	9.8	8.9
31-40	2140	17.0	16.6
41-50	1807	14.4	14.6
51-60	2090	16.6	16.9
61-70	1583	12.6	15.4
70+	754	6.0	12.9
Race/ethnicity	**n**	**Unweighted %**	**Weighted %**
Non-Hispanic White	4,938	39.2	41.2
Hispanic or Latino	5,021	39.9	45.1
Native American	1,829	14.5	8.6
Other	801	6.4	5.1
Education	**n**	**Unweighted %**	**Weighted %**
Less than high school	628	5.1	5.8
High school graduate/GED	2,491	20.1	21.2
Some college/Technical school	2,771	22.4	24.0
College graduate or higher	3,619	29.2	32.0
In college	2,891	23.3	17.0
Military status	**n**	**Unweighted %**	**Weighted %**
Active military or veteran	819	6.5	8.8
Sexual orientation	**N**	**Unweighted %**	**Weighted %**
LGBT	106	8.7	7.4

Demographics by Funding Stream

Results by funding stream are reported in this section. Table 4 provides a breakdown of the sample by funding stream and gender. We analyze three main funding streams: 1) the federal

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

Substance Abuse Prevention and Treatment (SAPT) Block Grant; 2) the federal Partnerships for Success (PFS) 2015; 3) the NM Legislative-funded Total Community Approach (TCA). We also have data from communities receiving no prevention funding during FY2018 -- these communities also serve as comparisons when we examine data by target outcome later in the report. Table 5 breaks the sample down by funding stream and race/ethnicity.

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

		Men		Women	
Funding stream	Total N	n	Weighted %	n	Weighted %
SAPT	5687	1919	46.8	3656	53.2
PFS 2015	3529	1475	53.4	2004	46.6
TCA	2347	902	51.2	1353	48.8

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

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

	Non-Hispanic White		Hispanic or Latino		Native American		Other	
Funding stream	n	Weighted %	n	Weighted %	N	Weighted %	n	Weighted %
SAPT	2093	41.5	1949	40.0	1399	14.9	246	3.6
PFS 2015	1293	37.7	1445	47.1	448	7.4	343	7.7
TCA	991	51.7	1022	48.3	138	3.6	196	6.4

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				
Gender	N	Weighted %	n	Weighted %
Men	3553	50.2	1007	45.9
Women	5703	49.8	2044	54.1
Race/ethnicity	N	Weighted %	n	Weighted %
Non-Hispanic White	3611	40.8	1327	42.3
Hispanic or Latino	3661	44.1	1360	48.0
Native American	1575	9.8	254	5.1
Other	638	5.3	163	4.6

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

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

	Target Rx Painkillers		Comparison	
Total N				
Gender	N	Weighted %	n	Weighted %
Men	2811	48.0	1749	50.7
Women	4862	52.0	2885	49.3
Race/ethnicity	N	Weighted %	n	Weighted %
Non-Hispanic White	3062	41.2	1876	41.2
Hispanic or Latino	3007	44.1	2014	46.7
Native American	1232	9.2	597	7.6
Other	548	5.5	253	4.6

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

Analysis by Survey Topic

Alcohol

We begin by providing a breakdown by funding stream of the prevalence of alcohol use items and related risk behaviors. In Table 8, the weighted prevalence estimate for each indicator is given as is the corresponding number of unweighted respondents. In Table 9, we examine the same information stratified by gender. In Appendix A, we provide a table of alcohol indicators broken down by funding stream and sociodemographic indicators. All communities that receive SAPT or TCA or PFS 2015 funding have implemented underage drinking and/or alcohol abuse prevention programs.

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

	Weighted Percent				
Funding stream	Past 30-day alcohol use	Past 30-day binge drinking	Past 30-day drinking & driving	Past 30-day binge drinking & driving	Past year purchased/provided alcohol for someone under 21
SAPT (n=4951)	48.7	13.7	3.2	2.7	2.7
PFS 2015 (n=3529)	45.5	17.3	4.5	3.7	5.0
TCA (n=2347)	48.5	15.1	4.4	2.8	2.9

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

Alcohol use	Men			Women		
	SAPT (n=1700)	PFS 2015 (n=1475)	TCA (n=902)	SAPT (n=3152)	PFS 2015 (n=2004)	TCA (n=1353)
Past 30-day alcohol use	53.2	49.8	52.5	45.4	40.8	44.6
Past 30-day binge drinking	17.3	21.3	18.6	10.3	12.4	11.3
Past 30-day drinking & driving	4.2	5.4	5.9	2.2	3.3	2.8
Past 30-day binge drinking & driving	3.5	3.9	3.7	1.8	3.3	1.5
Past year purchased or provided alcohol for someone under 21	2.8	4.9	3.4	2.5	5.3	2.3

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 2018. 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. Target communities tend to report higher prevalence of alcohol consumption and binge drinking as well as drinking and driving than comparison communities. Comparisons across FY2014 - FY2018 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. Yet in 2017 and 2018 regarding drinking and driving, the difference between target and comparison communities appeared wider than the difference in 2016. And in contrast to 2017, the percentage of respondents who provided alcohol to minors have decreased to the 2016 level in target communities in 2018 (Figure 4). This pattern may suggest that the effects of prevention efforts in those target communities may have fluctuated over time.

Figure 2. Comparing target and comparison communities on alcohol consumption indicators from FY 2014 to FY 2018; weighted % reported

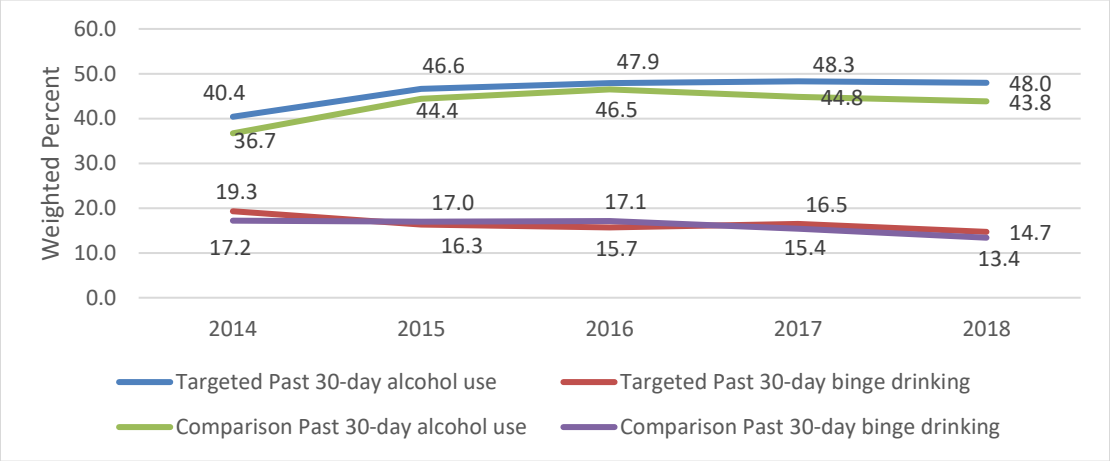


Figure 3. Comparing target and comparison communities on drinking and driving indicators from FY 2014 to FY 2018; weighted % reported.

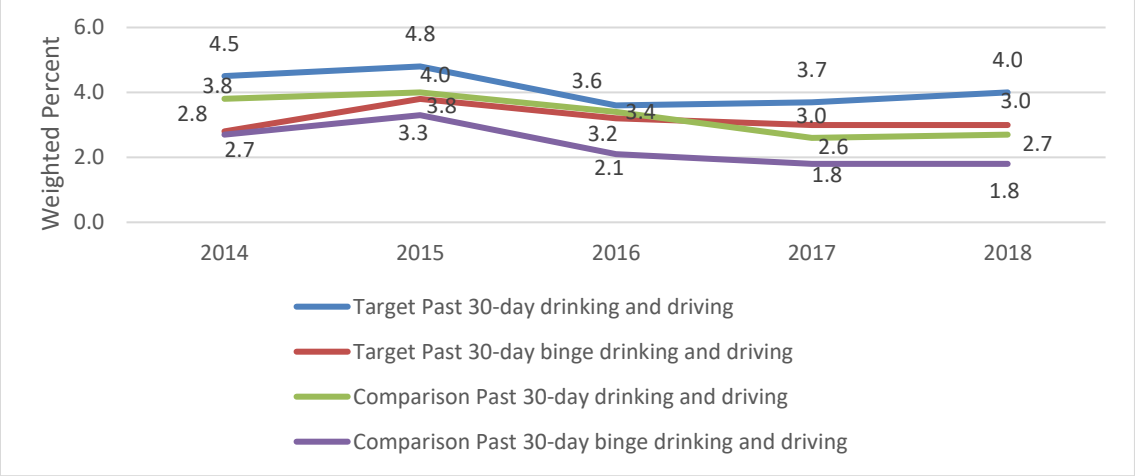
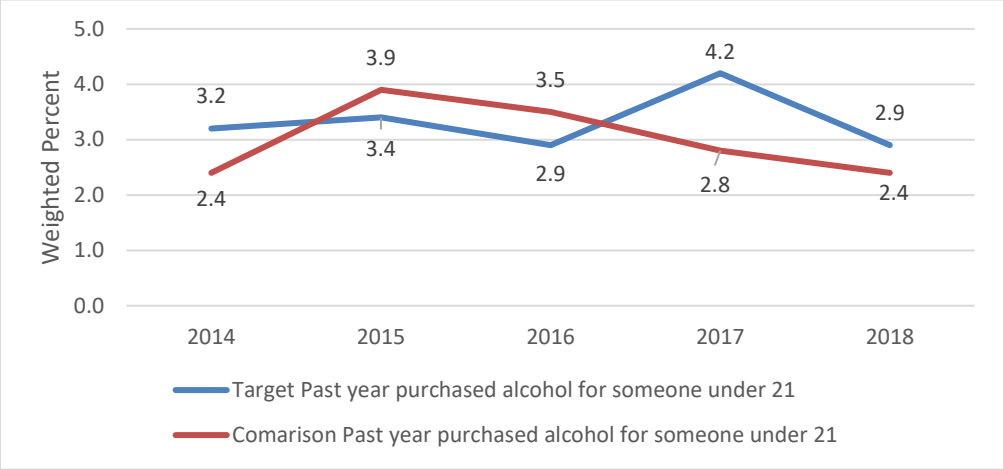


Figure 4. Comparing target and comparison communities on purchasing alcohol for minors from FY 2014 to FY 2018; weighted % reported.



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 very or even somewhat difficult for teens to get alcohol in their communities in general. On the other hand, almost 60% of the respondents in target communities perceived that it was very or somewhat difficult for teens to purchase alcohol at stores or restaurants in the community (retail access). Social access continues to be more influential than retail overall. There are significantly more people in comparison communities than in target communities who thought that retail access is very or somewhat difficult.

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 2018 target and comparison communities were very similar regarding such perceptions of risk, and target communities reported significantly higher percentage of likelihood of police breaking up parties where teens are drinking than comparison communities (64.1% vs. 61.3%). This suggests a small improvement regarding prevention efforts on the perceived risk of legal consequences for breaking alcohol-related laws. It also indicates the importance of continuously consistent prevention efforts. Generally speaking, higher estimates suggest that more people in communities perceive that they will face legal consequences if they break the law; therefore, there is more of a deterrent for engaging in illegal alcohol-related behavior. Facing cuts in enforcement funding in NM, the need is ever greater for communities to work closely and creatively with law enforcement to address the perception of risk.

Table 10. Comparing target and comparison communities on alcohol intervening variables; weighted % & unweighted (n)

Access to alcohol	Very or Somewhat Difficult	
	Target	Comparison
Ease of access to alcohol by teens in the community	12.3 (950)	13.0 (329)
Ease of access to alcohol by teens from stores and restaurants	59.5 (4415)	58.5 (1464)
Perception of risk/legal consequences	**Very or Somewhat Likely**	
	Target	**Comparison**
Likelihood of police breaking up parties where teens are drinking *	64.1 (4536)	61.3 (1449)
Likelihood of police arresting an adult for giving alcohol to someone under 21	66.8 (4656)	65.4 (1542)
Perception of risk/legal consequences	**Very or Somewhat Likely**	
	Target	**Comparison**
Likelihood of being stopped by police if driving after drinking too much	72.0 (5800)	73.1 (1906)

*$p \leq .05$

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. Over 41% of respondents indicated that they obtained it at a party. The second highest category is that an unrelated adult purchased it for them (36.9% in target communities), then next comes that an adult family member provided the alcohol to the minor. Finally, significantly more respondents in target communities indicated that their parents or guardians gave or bought alcohol for them (8.2% vs. 2.1%).

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

Access to Alcohol (n=531)	Target	Comparison
Got it at a party	41.7 (187)	41.1 (31)
Unrelated adult gave or bought it	36.9 (170)	29.3 (22)
Adult family member gave or bought it	14.8 (69)	19.6 (14)
Took it from home	9.3 (40)	11.8 (9)
Parent/guardian gave or bought it*	8.2 (36)	2.1 (2)
Someone underage gave or bought it	7.7 (34)	5.1 (5)
Bought it at a restaurant/bar/public place	5.4 (25)	1.2 (1)
Got it some other way	4.6 (23)	5.5 (4)

*$p < .05$

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 except three that receive SAPT, PFS 2015 or TCA funding have implemented prescription painkiller prevention programs. In Table 12 we can see that TCA communities have reported the highest prevalence rates on past 30-day prescription painkiller use for any reason (12.3%), past 30-day painkiller use to get high (3.9%) and past year receiving prescription painkillers (26.8%). Slightly more respondents in PFS 2015 communities than other communities were likely to give or share prescription drugs with someone else (5.6%) or to lock or store prescription painkiller safely (39.7%). Fewer respondents in PFS 2015 communities (83.8%) perceived great or moderate risk of using prescription painkillers for non-medical reasons than other communities.

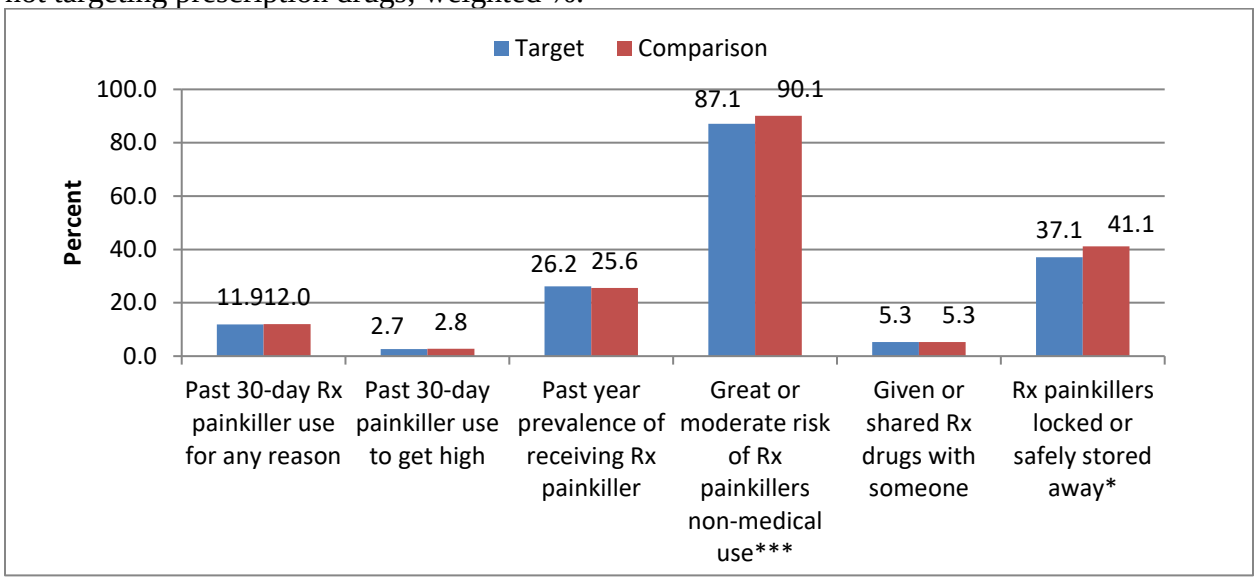
Prevalences of prescription painkiller use in SAPT and PFS 2015 communities are the same or close in FY2018 regarding past 30-day painkiller use for any reason and painkiller use to get high. PFS 2015 communities have the lowest percentage of past year receiving prescription painkillers (23.7%).

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=4950)	10.9	2.3	25.0	89.8	5.5	35.0
PFS 2015 (n=3529)	10.9	2.5	23.7	83.8	5.6	39.7
TCA (n=1694)	12.3	3.9	26.8	86.8	4.9	36.8

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 significant differences observed between target and comparison communities are on these two measures: perceived great or moderate risk of harm using Rx painkillers for a non-medical reason (87.1% vs. 90.1%) and medication locked or safely stored away (37.1% vs. 41.1%).

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



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

Table 13 below provides a breakdown by target and comparison groups of respondents' reasons for using prescription painkillers. Only those who had used prescription painkillers in the past 30 days were asked to respond to the question, and respondents could select all options that applied to them. Not surprisingly, the majority of respondents in both target and comparison communities were almost equally likely to indicate that their recent use of prescription painkillers was for a legitimate pain identified by a health care provider. It appears that comparison communities tended to report less use on most of these measures than target communities in FY2018 although these differences were not statistically significant.

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

Reasons of Prescription Drug Use (n=1398)	Target	Comparison
Treat pain identified by doctors/dentists	72.3 (606)	76.7 (400)
For pain not identified by doctors	15.1 (137)	12.7 (74)
Have fun with friends socially	2.7 (28)	1.5 (10)
Help me sleep	7.8 (74)	8.0 (42)
Get high, messed up or stoned	3.8 (38)	2.5 (14)
Cope with anxiety or stress	6.5 (63)	5.5 (34)
Another reason	6.5 (62)	6.4 (37)

Table 14 presents the various means by which respondents accessed the prescription painkillers used. No significant differences were found between target and comparison communities. The majority of respondents report having received a legitimate prescription for their painkillers. However, in both target and comparison communities, about 10% of the respondents reported

accessing painkillers 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=1398)	Target	Comparison
A doctor/doctors prescribed	83.3 (696)	83.3 (436)
Family member shared	6.1 (64)	4.2 (28)
Friend shared	4.8 (47)	5.1 (32)
Bought from somebody	3.9 (36)	3.4 (21)
Taken from someone without asking	2.0 (20)	1.2 (7)
Other places	2.2 (24)	1.4 (8)

Opioid-Related outcomes

In FY2018, the Community Survey added a new Opioid module to assess respondents' knowledge about whether or not their family members or friends use prescription painkillers or heroin and their knowledge about Naloxone. Table 15 and Table 16 summarize these results. Note that about 23% respondents reported having family members or friends who often use prescription painkillers. And among these respondents, a little over half (52%) thought that those prescription painkiller users are at risk of overdose. Similarly, about 9% respondents reported having family members or friends who often use heroin. The majority of these respondents (87%) thought that those heroin users are at risk of overdose. Finally, the survey also asked respondents' attitude towards sharing prescription painkillers or opioids, the majority of respondents (63.6%) agreed that it was never OK to share prescription painkillers with others (Figure 6).

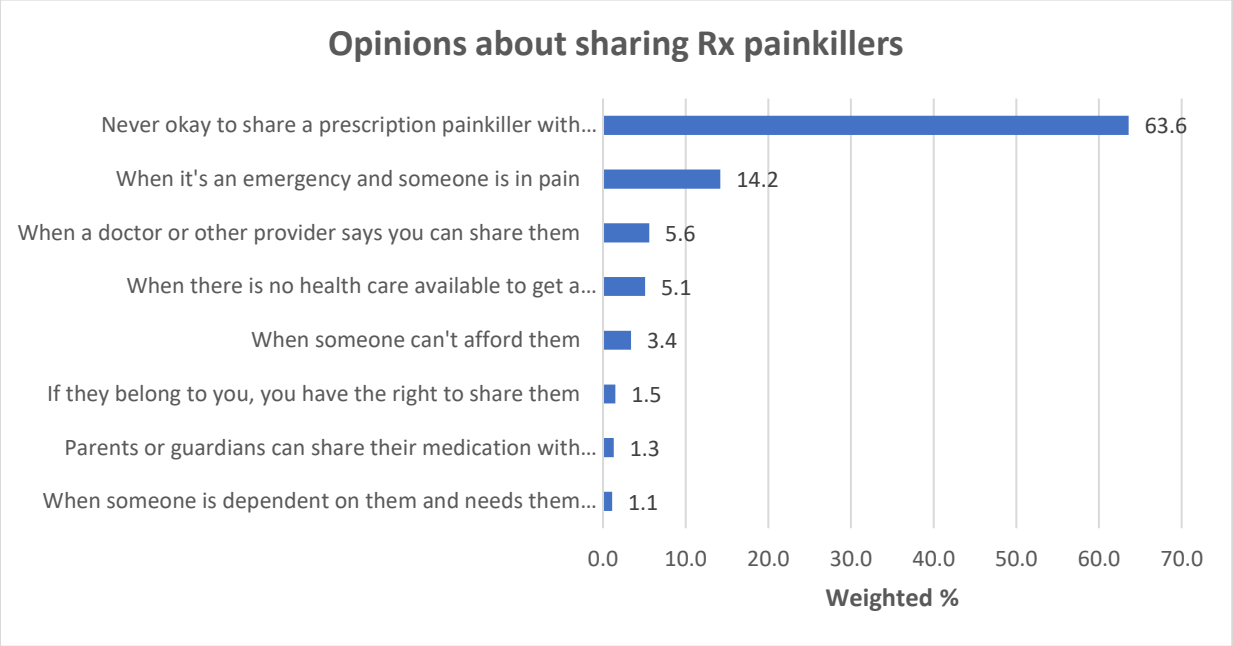
Table 15. Knowledges about family members/friends who use prescription painkillers or heroin

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

Table 16. Access to and knowledge about Naloxone/Narcan

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

Figure 6: Opinions about sharing Rx painkillers with others (n=8,848)



Analysis of the Indicators Associated with Each 2018 Prevention Strategies

To help monitor progress in addressing the targeted indicators across the state, Tables 17 and 18 show the statewide estimates for the indicators associated with the OSAP-approved prevention strategies. Table 17 shows youth and adult alcohol and DWI prevention strategies (with their codes, e.g., A2a) and their corresponding statewide indicator estimates, and Table 18 shows prescription painkiller abuse prevention strategies and their corresponding indicator estimates. Note that very few parents statewide were aware of the "Parents Who Host Lose the Most" campaign (Table 17, 7.6%). Also, there were low percentages of pharmacy staff or medical providers who had talked about the risks involved in using prescribed painkillers or how to store prescribed painkillers properly. These suggest a great need of improving the outreach and effect of media campaign and providing patients timely education about prescription painkillers.

Table 17. Alcohol and DWI prevention strategies and corresponding statewide indicator estimates

Intervening variable	2018 Strategies		Indicators from NMCS 2018	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	63.4

Intervening variable	2018 Strategies		Indicators from NMCS 2018	Weighted %
Perception of Risk of getting caught			Likelihood of police arresting an adult for giving alcohol to someone under 21: Very or somewhat Likely	66.4
			Likelihood of being stopped by police if driving after drinking too much: Very or somewhat Likely	72.3
Retail Access	Responsible Beverage Service Model	A3a	Ease of access to alcohol by teens from stores and restaurants: very or somewhat difficult	59.2
			Bought alcohol at a store, a restaurant or public place (among youth ages 18-20 who used alcohol last 30 days)	4.7
	Restrictions on alcohol placement in stores	A3b	Same as A3a	
	Restrictions on alcohol sales (days, hours)	A3d	Same as A3a	
	Restrictions on alcohol outlet density	A3e	Same as A3a	
	Prevention of alcohol license transfers or new licenses	A3f	Same as A3a	
	Restrictions on local alcohol discounts and sales	A3g	Same as A3a	
Social Access	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)	41.6
Social Access	Parents Who Host Lose the Most	A4c	Parents or guardians provided alcohol (among youth ages 18-20 who used alcohol last 30 days)	7.2
			Took alcohol from home or someone else's home (among youth ages 18-20 who used alcohol last 30 days)	9.7
			Aware of the campaign "Parents Who Host Lose the Most" (among parents)	7.6
Social Access	Media to increase awareness of 4th degree felony and social host laws	A4d	Access to alcohol at a party (among youth ages 18-20 who used alcohol last 30 days)	41.6
			Last year purchased or provided alcohol to underage youth	2.9

Intervening variable	2018 Strategies		Indicators from NMCS 2018	Weighted %
Community Concern or Awareness	Education about the benefits of reducing the cost of alcohol-related problems to the community.	A6a	Problems due to drinking hurts my community financially: Agree or strongly agree	68.2

Table 18. Prescription painkiller abuse prevention strategies and corresponding statewide indicator estimates

Intervening variable	2018 Strategies		Indicators from NMCS 2018	Weighted %
Social Access	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)	5.5
			Stored prescription drugs in a locked cabinet (parents only)	45.9
Social Access	Target **parents** to restrict youth social access to Rx pain-killers by developing a culturally appropriate "parent handbook"	R3b	Same as R3a	
Social Access	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	
Social Access	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+ only)	3.8
			Stored prescription drugs in a locked cabinet (ages 60+ only)	35.2
Social access	Work with **pharmacies** to always share information with customers about the dangers of prescription opioid use and addiction	R3e	Pharmacy staff talked the risks involved in using prescribed painkillers (among people who were prescribed painkillers)	33.7
			Pharmacy staff talked about storing prescribed painkillers safely (among people who were prescribed painkillers).	26.1

Intervening variable	2018 Strategies		Indicators from NMCS 2018	Weighted %
Social Access	Work directly with **medical providers** to create and implement policies such that medical providers educate patients	R3g	Medical providers talked the risks involved in using prescribed painkillers (among people who were prescribed painkillers).	51.8
			Medical providers talked about storing prescribed painkillers safely (among people who were prescribed painkillers).	32.1
			Shared any prescription drugs with someone (whole sample)	5.3
			Stored prescription drugs in a locked cabinet (whole sample)	38.5
Social Access	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	
Perception of Harm	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	88.3
			self-reported 30-day use of prescription painkillers for any reason	11.9
			Shared any prescription drugs with someone (whole sample)	5.3
			Stored prescription drugs in a locked cabinet (whole sample)	38.5
			Among binge-drinker, self-reported 30-day use of prescription painkillers for any reason	12.8
			Among people who reported 30-day use of prescription painkillers, percentage of doing binge drinking past 30 days	15.6

Summary

The Community Survey continues to be an essential part of local and statewide monitoring and evaluation of OSAP's substance abuse prevention services, as well as efforts to collaboratively plan for and address ATOD prevention and mental health promotion, and building community readiness and capacity for data-driven substance abuse prevention. Important intervening variable data collected through the Community Survey help communities identify their progress and issues with regard to perception of risk, access, and perception of harm. New sites have been added to conduct the Community Survey and with each implementation, improvements are made to planning and collection methodology in order to achieve consistency across years although the nature of the Community Survey data remains non-probability sample.

With regard to the alcohol-related outcomes of underage drinking, binge drinking, and DWI prevention, target communities looked similar to comparison communities in 2017 and in 2018 they did differ significantly from each other on some alcohol consumption behaviors (i.e., past 30-day alcohol use and past 30-day binge drinking and driving). The observed differences suggest that the effects of prevention efforts in those target communities may have fluctuated over time.

As in previous years, social access remains at the top of the list of intervening variables as a concern. Over 77% of underage adults who drink got alcohol at parties or were given alcohol by unrelated adults. Our open-ended responses suggest that most New Mexicans perceive this to be concerning as well as socially ingrained, particularly for special events such as holidays and graduations. Our findings suggest a continued need to address youth social access to alcohol in a state that is highly rural, low in resources (especially for enforcement), and where evidence-based strategies to address social access are limited.

Target communities look similar in FY2018 to FY2017 regarding perceived risk of legal consequences for breaking alcohol-related laws. Open-ended responses suggest that the perception of inconsistent police presence, primarily related to DWI checkpoints, but also associated with underage drinking at parties and public drunkenness, limits the effectiveness of substance use-related laws. More optimistically, respondents used the open-fields to voice support for law enforcement generally and their willingness to help protect their neighborhoods if given direction.

Regarding prescription painkiller prevention, the differences between target and comparison communities are narrowing. Target and comparison communities look similar in 2018 on majority of prescription painkiller measures except for (1) perceptions of risk of using prescription painkiller for non-medical purpose and (2) storing away prescription painkillers. As in FY2017, many commented on excessive retail access to painkillers from medical providers, yet social access to prescription painkillers seemed to be less mentioned. It suggests that public media campaign and education need to continue focusing on the dangers of social access.

Finally, analyses of the intervening variable indicators associated with the OSAP-approved prevention strategies suggested that very few parents statewide were aware of the "Parents Who Host Lose the Most" campaign and that pharmacy staff or medical providers very often had not talked with their clients about the risks involved in using prescribed painkillers or how to store prescribed painkillers properly. Together they suggest a great need of improving the outreach and effect of media campaign and providing patients timely education about prescription painkillers.

Appendix A: Alcohol

Table A1. Alcohol use indicators comparing men and women in SAPT and non-SAPT communities; weighted %

	Male		Female	
Alcohol use	SAPT	Non SAPT	SAPT	Non SAPT
Past 30-day alcohol use	53.2	50.1	45.4	41.7**
Past 30-day binge drinking	17.3	19.0	10.5	10.3
Past 30-day drinking & driving	4.2	5.3	2.2	2.5
Past 30-day binge drinking & driving	3.5	3.4	1.8	2.1
Past year purchased or provided alcohol for someone under 21	2.8	3.3	2.5	2.8

**$p \leq .01$

Table A2. Alcohol use indicators comparing men and women in PFS 2015 and non-PFS 2015 communities; weighted %

	Male		Female	
Alcohol use	PFS 2015	Non PFS 2015	PFS 2015	Non PFS 2015
Past 30-day alcohol use	49.8	51.8	40.8	43.8*
Past 30-day binge drinking	21.3	17.3**	12.4	9.8**
Past 30-day drinking & driving	5.4	4.7	3.3	2.1***
Past 30-day binge drinking & driving	3.9	3.3	3.3	1.6***
Past year purchased or provided alcohol for someone under 21	4.9	2.4***	5.3	1.9***

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

Table A3. Alcohol use indicators comparing men and women in TCA and non-TCA communities; weighted %

	Male		Female	
Alcohol use	TCA	Non TCA	TCA	Non TCA
Past 30-day alcohol use	52.5	50.9	44.6	42.8
Past 30-day binge drinking	18.6	18.4	11.3	10.2
Past 30-day drinking & driving	5.9	4.7	2.8	2.3
Past 30-day binge drinking & driving	3.7	3.4	1.5	2.1
Past year purchased or provided alcohol for someone under 21	3.4	3.0	2.3	2.8

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

	Non-Hispanic White		Hispanic		Native American		Other	
Indicator	SAPT	Non SAPT	SAPT	Non SAPT	SAPT	Non SAPT	SAPT	Non SAPT
Past 30-day alcohol use	56.3	50.5***	47.8	42.5**	34.5	33.3	43.8	47.5
Past 30-day binge drinking	10.6	12.3	15.7	17.1	16.7	13.1	11.5	14.0
Past 30-day drinking & driving	2.9	3.4	3.2	4.3	4.2	3.2	1.5	4.9
Past 30-day binge drinking & driving	2.3	2.3	2.8	3.1	3.2	2.9	3.3	3.6
Past year purchased or provided alcohol for someone under 21	2.3	2.7	3.4	3.4	1.7	1.7	4.5	2.9

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

Table A5. Alcohol use indicators comparing race/ethnic groups in PFS 2015 and non-PFS 2015 communities; weighted %

	Non-Hispanic White		Hispanic		Native American		Other	
Indicator	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	50.9	53.1	43.2	44.6	27.9	35.0**	49.9	44.4
Past 30-day binge drinking	15.6	10.4***	19.4	15.7***	11.4	17.0***	18.9	9.8***
Past 30-day drinking & driving	3.8	3.0	5.2	3.6**	2.6	4.3	5.0	3.4
Past 30-day binge drinking & driving	2.9	2.1	4.4	2.5***	2.5	3.3	4.4	2.9
Past year purchased or provided alcohol for someone under 21	5.2	1.8***	6.0	2.7***	2.1	1.6	4.4	2.6

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

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

	Non-Hispanic White		Hispanic		Native American		Other	
Indicator	TCA	Non TCA	TCA	Non TCA	TCA	Non TCA	TCA	Non TCA
Past 30-day alcohol use	52.7	52.7	45.6	43.8	42.4	33.6	47.0	46.5
Past 30-day binge drinking	13.9	11.2*	16.5	16.7	12.6	16.0	14.0	13.2
Past 30-day drinking & driving	4.3	2.9*	4.2	3.9	5.1	3.8	6.3	3.3
Past 30-day binge drinking & driving	2.2	2.3	2.9	3.0	5.0	2.9	4.6	3.2
Past year purchased or provided alcohol for someone under 21	2.4	2.6	3.7	3.4	1.4	1.8	1.4	3.9

*$p \leq .05$.

Table A9. Alcohol use indicators comparing men and women in target and comparison communities; weighted %

Alcohol use	Male		Female	
	Target	Comparison	Target	Comparison
Past 30-day alcohol use	52.8	46.4**	43.7	41.6
Past 30-day binge drinking	18.7	17.4	10.5	10.0
Past 30-day drinking & driving	5.2	4.0	2.7	1.7**
Past 30-day binge drinking & driving	3.7	2.8	1.9	2.0
Past year purchased or provided alcohol for someone under 21	3.3	2.6	2.9	2.3

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

Table A10. Alcohol use indicators comparing race/ethnic groups in target and comparison communities; weighted %

Alcohol use	Non-Hispanic White		Hispanic		Native American		Other	
	Target	Comparison	Target	Comparison	Target	Comparison	Target	Comparison
Past 30-day alcohol use	54.3	47.8 ***	45.2	41.6 *	35.2	28.5	46.5	47.0
Past 30-day binge drinking	12.6	9.0 **	16.4	17.4	16.2	13.6	14.0	11.4
Past 30-day drinking & driving	3.7	1.7***	4.2	3.5	4.2	2.6	4.4	2.7
Past 30-day binge drinking & driving	2.4	2.0	3.1	2.7	3.3	1.8	3.7	2.9
Past year purchased or provided alcohol for someone under 21	2.9	1.6***	3.5	3.3	1.8	1.2	3.7	2.2

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

Table A11. Alcohol use indicators comparing military and LGBT in target and comparison communities; weighted %

Alcohol use	Military		LGBT	
	Target	Comparison	Target	Comparison
Past 30-day alcohol use	52.0	50.0	59.8	59.4
Past 30-day binge drinking	15.2	12.2	22.1	22.4
Past 30-day drinking and driving	4.5	2.4	7.3	3.7
Past 30-day binge drinking and driving	2.5	5.6	5.0	5.5
Past year purchased alcohol for someone under 21	3.4	3.1	6.9	4.4

Appendix B: Prescription Drugs

Table B1. Prescription drug use indicators comparing men and women in SAPT and non-SAPT communities; weighted %

Prescription drug use	Male		Female	
	SAPT	Non SAPT	SAPT	Non SAPT
Past 30-day Rx painkiller use for any reason	9.0	12.1**	12.6	12.9
Past 30-day painkiller use to get high	2.6	3.1	2.1	2.5
Past year prevalence of receiving Rx painkiller	22.4	24.6	27.4	28.3
Great or moderate risk of Rx painkiller non-medical use	88.3	85.8*	91.2	89.4*
Given or shared Rx drugs with someone	4.5	4.7	6.1	5.5
Medication locked or safely stored away	31.3	39.0**	37.9	42.2*

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

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

Prescription drug use	Male		Female	
	PFS 2015	Non PFS 2015	PFS 2015	Non PFS 2015
Past 30-day Rx painkiller use for any reason	10.7	11.1	11.4	13.2*
Past 30-day painkiller use to get high	2.4	3.1	2.5	2.3
Past year prevalence of receiving Rx painkiller	21.8	24.6**	26.0	28.6*
Great or moderate risk of Rx painkiller non-medical use	81.7	88.6***	86.2	91.3***
Given or shared Rx drugs with someone	4.3	4.8	7.0	5.3**
Medication locked or safely stored away	39.5	35.3	40.2	40.7

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

Table B3. Prescription drug use indicators comparing men and women in TCA and non-TCA communities; weighted %

Prescription drug use	Male		Female	
	TCA	Non TCA	TCA	Non TCA
Past 30-day Rx painkiller use for any reason	11.6	10.9	12.4	12.8
Past 30-day painkiller use to get high	3.5	2.8	3.0	2.3
Past year prevalence of receiving Rx painkiller	24.6	23.7	28.8	27.9
Great or moderate risk of Rx painkiller non-medical use	85.2	86.9	89.4	90.2
Given or shared Rx drugs with someone	3.7	4.8	4.8	5.9
Medication locked or safely stored away	37.1	36.4	38.4	40.9

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

	Non-Hispanic White		Hispanic		Native American		Other	
Prescription drug use	SAPT	Non SAPT	SAPT	Non SAPT	SAPT	Non SAPT	SAPT	Non SAPT
Past 30-day Rx painkiller use for any reason	12.1	14.3*	10.4	11.3	8.6	9.6	12.8	12.3
Past 30-day painkiller use to get high	1.8	2.6	2.8	3.2	2.2	3.9	3.4	4.0
Past year prevalence of receiving Rx painkiller	28.5	29.2	22.9	24.8	22.3	22.5	19.2	24.4
Great or moderate risk of Rx painkiller non-medical use	93.7	89.5***	87.8	86.6	85.7	83.1	83.3	83.6
Given or shared Rx drugs with someone	7.1	5.2**	3.9	5.3	5.5	3.5	3.8	6.6
Medication locked or safely stored away	26.8	32.8	40.2	45.5*	42.8	49.1	32.5	42.9

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

Table B5. Prescription drug use indicators comparing race/ethnic groups in PFS 2015 and non-PFS 2015 communities; weighted %

	Non-Hispanic White		Hispanic		Native American		Other	
Prescription drug use	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	12.0	13.9	10.0	11.4	8.1	9.3	13.7	11.6
Past 30-day painkiller use to get high	2.4	2.3	2.6	3.2	1.8	3.2	3.6	4.1
Past year prevalence of receiving Rx painkiller	25.9	29.9*	21.9	25.0*	21.4	22.7	26.3	21.0
Great or moderate risk of Rx painkiller non-medical use	86.9	92.3***	82.9	88.4***	79.7	86.0**	78.3	87.0**
Given or shared Rx drugs with someone	5.2	6.1	5.7	4.5	4.8	4.7	7.0	5.1
Medication locked or safely stored away	36.5	29.0**	38.9	45.8***	52.9	43.1*	47.5	35.5*

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

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

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	13.6	13.4	11.6	10.9	10.2	9.0	9.4	13.1
Past 30-day painkiller use to get high	3.0	2.2	3.9	2.9	9.0	2.5**	6.4	3.3
Past year prevalence of receiving Rx painkiller	29.9	28.8	25.8	23.9	22.7	22.4	15.6	24.8*
Great or moderate risk of Rx painkiller non-medical use	87.8	91.6**	86.5	87.0	82.8	84.8	85.1	83.1
Given or shared Rx drugs with someone	4.1	6.2*	5.8	4.7	3.7	4.8	3.6	6.4
Medication locked or safely stored away	33.5	30.2	40.4	44.4	32.6	45.8	31.3	42.6

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

Table B7. Prescription drug use indicators comparing men and women in target and comparison communities; weighted %

Prescription drug use	Male		Female	
	Target	Comparison	Target	Comparison
Past 30-day Rx painkiller use for any reason	11.2	10.7	12.6	13.0
Past 30-day painkiller use to get high	2.7	3.3	2.5	2.2
Past year prevalence of receiving Rx painkiller	23.5	24.3	28.7	26.9
Great or moderate risk of Rx painkillers non-medical use	85.4	88.5**	88.9	92.1***
Given or shared Rx drugs with someone	4.3	5.1	6.0	5.4
Rx painkillers locked or safely stored away	35.3	38.6	39.4	42.7

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

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

	Non-Hispanic White		Hispanic		Native American		Other	
Prescription drug use	Target	Comparison	Target	Comparison	Target	Comparison	Target	Comparison
Past 30-day Rx painkiller use for any reason	13.9	12.8	10.8	11.3	8.2	10.6	12.3	12.7
Past 30-day painkiller use to get high	2.5	2.1	2.8	3.3	2.4	3.6	4.4	3.0
Past year prevalence of receiving Rx painkiller	29.4	28.2	24.4	23.8	21.5	24.1	23.4	22.5
Great or moderate risk of Rx painkillers non-medical use	89.4	93.5***	86.1	88.2	84.5	84.9	81.1	87.8*
Given or shared Rx drugs with someone	5.7	6.1	5.0	4.6	4.5	5.2	5.9	5.8
Rx painkillers locked or safely stored away	32.6	27.4	39.2	52.2***	43.6	48.1	41.2	38.9

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

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

	Veteran		LGBT	
Prescription drug use	Target	Comparison	Target	Comparison
Past 30-day Rx painkiller use for any reason	13.5	13.6	14.7	13.2
Past 30-day painkiller use to get high	2.0	3.8	5.4	3.8
Past year prevalence of receiving Rx painkiller	30.9	31.7	30.5	28.6
Great or moderate risk of Rx painkillers non-medical use	82.4	90.0**	85.8	89.1
Given or shared Rx drugs with someone	3.5	6.9*	11.1	13.1
Rx painkillers locked or safely stored away	34.9	45.4	38.4	25.8**

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

Appendix C: Qualitative Response Analysis NMCS 2018

The last question of the 2018 New Mexico Community Survey asks, "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.]"* All responses are captured exactly from the online or app version of the survey or transcribed verbatim if completed on paper. After transcription, qualitative responses were uploaded into QSR NVivo 12Pro coding software. Direct email and social media-related advertising (e.g. Facebook, Instagram) grew the percentage of online responses as compared to previous years. We have noted longer and more detailed comments as a result. This gives us rounded picture of salient topics for respondents.

These data are provided with caveats. It is important to note that while everyone completed the "core" module, community providers had the option to select additional modules. For example, one community might choose to add the gambling and adverse child events (ACE) modules to the core while a different county could choose the core questions and a college/university-focused module. This means that respondents from different communities received a different set of questions. The questions asked likely primed the scope of the free response answers. In addition to the responses, not all participants chose to write a free response and many of the free responses were limited to "thank you" or suggestions for additional survey questions. Although numerical counts are provided to indicate prevalence of certain themes, this is not indicative of the strength of response. Instead, these comments can be considered a snapshot in time, wherein respondents can tell us what is on their mind in the moment.

Data analysis was conducted using best practices in qualitative methodology. A mixed deductive and inductive approach was used to identify and explore themes common in previous surveys as well as identify new themes. An example of a common intervening variable across survey years is "social access" to alcohol for underage drinkers. As this coding followed a theory of change based upon intervening variables, we coded deductively. Inductive reasoning facilitated examination of emerging concepts and response categories such as the legalization of marijuana.

The most frequently mentioned themes are discussed below. Themes are organized by intervening variable (community concern and awareness of the issue, access, individual factors, community needs, and perceptions of law enforcement/judicial involvement). Exemplary quotes are used to illustrate the aspects of a particular finding and the perspectives of our participants. Quotations are edited for readability, punctuation, and spelling, and when necessary, were translated from Spanish. Quotes also include the name of the county associated with the response. Wherever possible, alcohol and prescription drugs are discussed separately.

Community Concern and Awareness of Issues

Prevalent Drug and Alcohol Use

Survey respondents were deeply aware of the drug and alcohol abuse in New Mexico. Respondents indicated a general feeling that drug and alcohol use was higher in their state than other, nearby states. One respondent from Eddy county described her community this way: "for being a small community, it's unreal seeing how much drug addiction/use is prevalent here." Many respondents indicated how personal the issues were to them. One Lincoln County woman told us that "I am a recovering person with 9 years sobriety…My husband is also a recovering alcoholic. However, he has recently struggled with drinking and gambling…We have three casinos within twenty minutes of home. Many of my fellow New Mexicans struggle and the situation with alcohol, drug abuse, and gambling needs swift attention and care." Another respondent told us "I was hit by a drunk driver my senior year of high school. I have family members that are or have been addicted to pain killers. I feel it is a real issue in Albuquerque that affects most families."

Increased Crime

Respondents perceived a relationship between drugs and alcohol abuse and increased crime risk. Many cited that the shadow economy of drug use was driving crime up to intolerable levels. One Torrance County respondent described the community context this way: "It's worrisome how many people are being victimized in their homes by drug addicted burglars who are desperate. This community is in serious need of help. It's enough to make you want to move to a safer place. Sadly."

Alcohol Taxes

Degree of concern about alcohol-related problems can be reflected in people's support of increases in alcohol taxes. Perhaps in reaction to a specific additional question from a community about this matter, a few respondents commented on alcohol taxation; with equal numbers against and in support. Those supporting cited that the additional funds could be used for substance use prevention.

Legalizing Marijuana

Many respondents considered the he legalization of drugs, primarily marijuana. Marijuana is legally available in neighboring Colorado. During the time of the survey, the legalization of marijuana was being debated in the New Mexico legislature. A number (n=38) of respondents were in favor of legalizing marijuana. Reasoning for this primarily fell into two categories. Respondents either favored legalizing marijuana as a treatment for pain instead of opioids or as a way that currently addicted individuals could get off opioids. "I think that people should be permitted to grow and produce (so you don't have) to take painkillers and physicians who overprescribe legal painkillers should go to jail." (Santa Fe) Other respondents believed that marijuana should be legalized for reasons related to personal freedoms or crime reduction. Drug

use was seen as inevitable and the unintended consequences of criminalizing drugs led desperate people to crime. The solution, then, was to legalize drugs starting with marijuana. As one Socorro-based respondent told us, “May we legalize marijuana? I think all the crimes and everything else will go down.”

Access to Alcohol

Retail access for excessive drinking

Aware of the illicit nature of most drug use, many also cited concerns with the pervasive availability of alcohol, a legal drug. Alcohol problems were described most frequently in terms of imbibing too much and too often. In this space where respondents were able to respond freely to whatever topic they chose, thirty-two respondents frequently described how easy alcohol was to get. One Sierra County resident stated, “If there is an issue with substance use in this area, why is alcohol so readily available in stores? Displays of liquor are absorbed by the minds of children as a normal part of shopping for fairy products at the local Walmart. Now alcohol is available at a local convenient store off an I-25 exit that gives further access to drivers with substance use issues to make wrong choices and get back on the highway.”

Many cited frustrations with lack of laws and regulations on the retail availability of alcohol for problem drinking. For example, respondents were critical of the new regulations about the sales times for alcohol. One McKinley County respondent told us “Alcohol sales should be at least 1pm. Only drunks drink at 10am. Responsible adults drink after work.” A few respondents believed that alcohol should be outlawed entirely. “No alcohol=no harm. Simple.” (San Juan)

Retail access to alcohol for minors

Most respondents acknowledged laws addressing the selling or serving of alcohol to underaged minors but were skeptical that those laws were enough to prevent access. One former food service employee from San Juan County told us, “I think it is extremely hard to buy alcohol under age at a bar or restaurant. I used to serve tables and we had to put up with multiple BS stings trying to incriminate someone (me) just trying to feed their toddler. Never have I witnessed any server in the establishment I used to belong to even to this day serve to a minor.” Respondents that did mention underage access to alcohol noted that bootlegging and theft were much more problematic. Another San Juan County respondent provided this suggestion: “in order to best combat underage drinking in New Mexico, it should be illegal to purchase hard liquor at gas stations or supermarkets. A lot of time the underage individual will just steal the product, because the security at markets and gas stations is extremely lax. Require liquor sales to take place inside an actual liquor store and not grocery chains and gas stations.”

Social access for underage alcohol consumption

Several respondents noted social ways in which underage children obtained alcohol. For example, they cited that families intentionally provided alcohol for teen parties. One Grant

County respondent told us: “I believe that the majority of underage drinkers in my area receive the alcohol or have it bought for them by family. Family makes plans for graduation and birthday parties and provide alcohol for these parties.” Four respondents mentioned the relative ease with which underage drinkers could access alcohol at parties. One described the difficulty of limiting these parties this way: “The parties in this community are not very well known and are hidden well. Though I have not been to a high school party with alcohol in it, I know students that have went to parties and drank a lot. I am not sure how the transportation here is when students are out drinking.” (San Juan)

Access to Opioids

Retail or Regulated Access to Rx Opioids

Many respondents expressed anger towards doctors overprescribing opioids. Physicians’ lack of accountability frustrated many respondents who described medical doctors as the gatekeeper to opioid abuse. They reported frustration with what they saw as too brief interactions with doctors who did not take the time to evaluate each individual’s pain and addiction history. Some respondents suspected a profit motive such as this respondent who told us “Doctors are over-prescribing opiates and all pharmaceuticals for their own profit. Until doctors are held accountable for their part in the NM opioid crisis, it will never end.” (Chaves) Instead of higher regulation of opiates through mistrusted doctors, several respondents favored legalizing marijuana. Noting the pain and anxiety reduction common with marijuana use, respondents saw marijuana as an alternative to opioid misuse telling us “legalize pot to lower opioid deaths in the state of New Mexico!!!” (Bernalillo) It is interesting to note that respondents did not refer to “medical marijuana,” which suggests that their support of legalization as an alternative to opiates was valuable in centering the locus of pain control back to the patient instead of relying on physicians as gatekeepers.

No other set of comments in our open field generated as many strong words as the feeling of anger and despair reflected by those with chronic pain. Respondents told us personal stories about how awareness of the opioid crisis has negatively impacted their ability to get the drugs that they need to control their pain. They were frustrated at the barriers to access and were concerned that painkillers might be outlawed all together. “I think the people like myself whose had 32 major surgeries shouldn't have to pay for the idiots who abuse painkillers! Start making the patients PROVE that they need them such as x-rays, MRIs, ultrasounds! I'm having to bend over backwards to get my meds because of all the people that are overdosing and that's not right!” (Doña Ana)

Respondents were also aggravated by what they considered a lack of follow-up from prescribers, which could lead to misuse or diversion. One Rio Arriba respondent suggested “doctors should periodically test people to check if they are actually taking the meds they prescribe to them. I

know of four family members who get prescription opioids from two or more different doctors. And sell them."

This frustration extended to large pharmaceutical conglomerates, which seventeen respondents described as responsible for the opioid crisis. Here, a Santa Fe respondent told us "We should be concentrated on taking down 'big pharma', which I believe is at the root of our alcohol/prescription drug problem."

Social access to Rx Opioids

Strikingly few respondents noted opiate availability outside of regulated access. Only two respondents cited theft and both did so in a very general way that reflected stereotypes versus experience. For example: "Those who want painkillers have so many ways to get them! In Mora county that will trade their SNAP benefits for drug money!! There are scores of drug dealers and users!! They will lie and steal to acquire drugs!" Similarly, only two respondents noted teen access to opioids through family members. Both respondents gave personal attribution. One respondent said "I know doctors are not held responsible for prescription of painkillers that result in overdose or death. Also. Parents are also not held responsible for giving their children medical cannabis." (Santa Fe) No respondents noted opioid access through schools, friends, or at a party.

Individual Factors

Personal

Although we know that risk factors from drug and alcohol use vary greatly by individual and community, most survey respondents attributed misuse to individual factors, referring to addiction as an individual choice. While the social norm of pervasive drug use was acknowledged as influencing use among others, a lack of personal accountability was seen as the primary motivation for drug use among participants. One participant from Bernalillo County advised, "drugs can be tempting to consume, especially when the ones around you are also doing them. Be your own person. And make your own decisions." The lack of nuanced perception of risk suggests a fertile ground for drug and alcohol misuse-related stigma.

Many participants (n=43) reflected a sense of personal accountability and responsibility, referencing beliefs that substance abuse is a matter of personal choice. Although some participants reflected a "live and let live" philosophy, participants were genuinely concerned about the growing impact of drugs and alcohol in the State of New Mexico.

For many survey participants, taking the survey gave them a moment to reflect on their own personal stories related to drug dependence. Twenty-seven respondents elected to mention that they were in drug/alcohol recovery themselves, with 51 describing having close friends or family with drug/alcohol related problems. When referring to causal factors for their own misuse, the overwhelming majority of respondents pointed to poor choices. Recovery was reliant on their own gumption and faith.

Faith

Some cited their Christian faith as providing the support that they needed to get off drugs, but the usefulness of faith was limited in scope. As one Taos respondent told us "Jesus saved me from drug addiction and alcoholism." Another respondent from Chaves County told us "I was abandoned as a child which led me into a life of drugs. I was looking (for) love and longing to be satisfied. I gave my hear(t) to Jesus at the age of 26 and he has restored me and has given me a life of hope and satisfaction. I've been clean over 9 years." It is noteworthy that no respondents referred to faiths other than Christianity, nor did any respondent refer to a more general sense of spirituality or indigenous faith beliefs. In addition, respondents did not note the usefulness of faith in drug prevention or providing alternate places of belonging for those at high-risk for addiction.

Parenting

Quite a few respondents blamed a lack of effective parenting for youth substance abuse. One respondent from Luna County described it this way: "I think as an educator, we have become a babysitting program. Parents are not focused on raising their children and instilling respect, morals, values, because they are too busy with their own lives. This is why we have such a high number of teens using substance and using prescription drugs; abusing alcohol. It has become a huge problem in our community." Again, lax parenting was viewed as an individual, rather than sociocultural problem. Respondents largely blamed parents for youth substance abuse. One McKinley County respondent advised us that "parents must constantly be checking their children's rooms, drawers, for drugs and watching for behavior changes." There was a notable lack of sophistication in respondent comments about youth drug and alcohol availability. Common prevention strategies like locking up drugs and alcohol and proper disposal of unused medicines were not referenced. Rather, respondents saw youth drug use as simply under the control of parents. An Otero-based respondent poignantly told us that "kids are so dumb and parents just let it happen and nobody stops it."

One respondent from Valencia provided a different perspective. She discussed multiple run-ins with the police and her difficulty ensuring the safety of her grandchildren without consistent police enforcement and intervention by the New Mexico Children, Youth, and Families Department (CYFD). In her eyes, parents (and adults serving in a parenting role) need more state support. Her story is tragic. "I have adult child alcoholic and drug abuser. I have called CYFD many times about her. Nothing happened until she rolled her truck with her kids. Lost kids for a year. She has them back and she's still drinking & drugs. Other son in law is extremely violent. I have called CYFD, no action. He leaves the kids at his parents' house. I believe his dad sexually abuses the kids. No action. CYFD is a joke. We can't break the cycles hear because the state isn't doing their job."

Community Concerns and Needs

While this survey is intended to fulfill the needs of evaluation for primary prevention, respondents commonly argued for the need for treatment services and spoke for greater access to community resources in general. Knowledge of existing services and education were considered

key. Participants reflected that they wanted to know more about available resources so that they could share that information with others. Providing alternate activities, especially for youth as a pro-social diversion from drugs and alcohol was commonly mentioned. For adults, participants called for jobs with a living wage. Many respondents noted a lack of substance abuse and mental health treatment options, particularly in more rural areas. Finally, perhaps responding to queries in the Opioid module, some respondents mentioned being unfamiliar with Naloxone/Narcan as a life-saving remedy to overdose and were generally curious and wanted to know more.

Prevention Education

Many respondents (n=111) mentioned their overwhelming support of continued substance use prevention and education, particularly for youth, as a pathway to address the state's growing drug and alcohol crisis. Participants were aware that prevention education was widely available in New Mexico schools. Some even mentioned specific prevention education programs by name (e.g. DARE, Don't Meth with Us) Several respondents called for substance use prevention education at the latter grade levels such as "our schools need more classes of drug prevention up to 12th grade, not just at elementary schools." (Eddy)

Alterative Activities

Twenty-nine respondents specifically stated support for state and private-led efforts to increase the number of alternate activities available, particularly for youth. These respondents associated boredom, often described as "nothing to do," with people's drug and alcohol use. Although most respondents mentioned youth specifically, several also noted the lack of alternative activities for adults as well. Almost a dozen New Mexicans related the poor economy and lack of employment with drug use and alcoholism in adults. One McKinley resident poignantly reflected "(I) believe if people had good jobs, we'd see a decrease in use of alcohol and drugs. People need to have a reason to live."

Substance Use Treatment

Many respondents (n=65) mentioned the need for locally-available substance use treatment options. Many mentioned that there were no substance use treatment options available in their county. "There are no programs for heroin addicts in Las Cruces and the entire state lacks in rehab facilities and facilities that work. Incarcerating drug addicts in New Mexico is NOT a solution to the problem with addicts in New Mexico and their families who suffer from it!" Others mentioned that the number of in-patient beds was far too low for the population. A few others were concerned about the lack of follow-up once someone graduated from inpatient care and transferred back to their communities. Of note, several participants called for culturally-nuanced substance abuse treatment for Native Americans saying "there needs to be Long Term Native Recovery Houses here in Gallup, Farmington, Bloomfield etc., so Native families can visit their relatives. Run by recovering Natives mainly. There also needs to be recovery houses for long term patients that can take Natives and Non-Natives. (McKinley)

Other Mental Health Assistance

Almost as many participants that requested substance use treatment also requested increased mental health services. Most recognized the link between poor mental health and drug/alcohol addiction saying "I believe that using alcohol and drugs is used to mask underlying issues. It only helps the pain but not the issue." (Grant) Many respondents emphasized this need for teens with hopes that the investment of early interventions with mental health would be drug prevention. One respondent characterized it this way: "counseling early…especially with high school and middle school students before they become hard core." (McKinley)

Naloxone/Narcan Availability

Most respondents who mentioned Narcan/Naloxone were supportive of its use and hoped that the State of New Mexico would make it more widely available and at low-cost or free. Six respondents had never heard of Narcan/Naloxone and wanted increased education. Two respondents were offended by our questions citing the mixed prevention/harm reduction messages that Narcan/Naloxone sends: "Why would someone be prescribed naloxone, w/ prescription painkillers? Dumb question! Naloxone would not be prescribed w/ a painkiller unless the Dr. expected the patient to overdose or have a problem (hence don't prescribe)." (Taos)

Perceptions of Risk of Legal Consequences (Low Enforcement)

Perception of Risk

Community support is important for ideal law enforcement; enforcement as prevention for future drug and alcohol misuse in the community. Respondent comments can reflect a degree of high perception of risk. When community members believe that drug and alcohol enforcement is occurring, if not inconsistently applied (i.e., only doing DWI checkpoints in poor neighborhoods), it matches well with the perception of risk as people believe there will be consequences. Otherwise, this might suggest poor community support for law enforcement.

New Mexicans called for social and structural supports to aid individual efforts towards recovery. In the meantime, many also called for reduction of harms to innocent bystanders. Study participants often recommended limiting the impact of drugs and alcohol through judicial involvement, and other kinds of legal or criminal justice efforts. However, respondents largely viewed perceptions of risk in terms of driving while impaired. Respondents pointed to low perception of risk in terms of inconsistency the consequences, as well as a lack of community trust. Respondents recognized a state-wide problem with DWIs and strongly favored increased consequences for offenders. They called for increased police presence and more severe consequences of getting caught. Many New Mexicans are frustrated by the lack of patrolling and poor sentencing of DWIs. Respondents expressed frustration that offenders with multiple DWIs were still driving while impaired.

Perceptions of Law Enforcement

The general perception of the police and justice system were poor. However, it should be noted that respondents were not explicitly asked to comment on police or any other aspect of the judicial system and therefore those with more negative experiences may have been more likely to report them in an "open" field. Interestingly, quite a few respondents explicitly asked for increased police presence, even while criticizing police enforcement. One Eddy County respondent told us, "we need more police officers. I have called to report community nuisances and no one shows up. With the growth of our community, they ignore the minor issues…which could be a teen party or lead to a larger problem."

Several other respondents mentioned experiences where they called the police and police did not arrive. Respondents largely viewed enforcement in punitive terms, rather than as a method of prevention. Law Enforcement was discussed in terms of removing community threats and judicial fairness rather than deterring bad behavior through visible consequences.

Fortunately, there was little comment on biased police enforcement. Although a few respondents alleged a lack of patrolling in Indian Country, the claims of bias generally refer to a perceived cozy relationship between police and criminals. One Rio Arriba participant characterized it this way "the cops are usually in agreement with drug lords and don't help." Other complaints included bias towards arresting for marijuana and under-age drinking, rather than arrests for drugs the respondent deemed more dangerous.

Inconsistent/Ineffective Laws and Sentencing

While some respondents complained about poor police enforcement, many of these things lie out of direct police control such as a lack of legal consequences of drunk driving offenses. Of all of the legal-related complaints, anger at multiple DWI charges was most prevalent. Twenty-nine participants echoed concerns about alcohol abuse and multiple DWIs. These ranged from calls for stricter laws, to more prison time for repeat offenders, to greater access of alcohol treatment options while incarcerated. Most respondents acknowledged a social norm of DWIs as described by this respondent: "I don't understand why DUI is so accepted here. I don't understand why there are so many people who have been arrested several times for DUIs who are still driving instead of being in jail." (Santa Fe) Many respondents mentioned the lack of judicial support for police and a general sense that DWI offenders are in and out of the courtroom with few meaningful consequences. One respondent put it this way "I feel the biggest problem is the lack of judicial support for our law enforcement when responding to problems in these areas. They have a 'why bother' attitude about it because they know the courts will just throw it out anyway." (San Juan) Another respondent was frustrated enough to suggest a shaming technique "Why aren't drunk drivers prosecuted? The police can do only so much. Why aren't judges held accountable? Ask the newspapers to print names of judges and their prosecution numbers for drunk drivers, distracted drivers." (Santa Fe)

One Curry-based respondent described a tragic experience and his resulting anger at the larger judicial system: "The drunk drivers in Clovis sucks, the DA's office don't do their job on it or drugs. My son was hit by a drunk 8th [offense with] no license. Nothing happened to her cause

she didn't get a speedy trial, which is bullshit. She had lots of felonies that night... How in the hell did this one guy keep his license? After the first he had 10 [more] when they finally kept him in jail. My son suffers to this day, and I also it's all about money in this town. It's bullshit."

Legal consequences for providing alcohol to a minor

One final theme emerged concerning the necessity to confer consequences of under-age drinking onto parents, particularly parents who provide alcohol or knowingly host parties including alcohol. This is similar to the calls for personal responsibility mentioned earlier. Adults can and should stop themselves. Kids need to be taught and have limited or no access. These comments echo earlier respondent calls for individual-level interventions.

Conclusions

Free-response questions at the end of a survey provide a "voice" for respondents to tell us what was on their mind. The quantitative constructs reported here more appropriately address questions of prevalence and change over time. However, optional, qualitative, write-in responses give a barometer of themes salient to our respondents primed to think about substance use generally through their survey participation. Many of the respondent comments referred to the intervening variables in the OSAP conceptual model.

Thirteen respondents reflected gains in knowledge and awareness just by completing the survey. This phenomenon could be partially explained by the tendency for research participants to interpret personal benefits from their participation rather than societal ones. However, the survey reminded some people of existing community resources or provided the impetus to do more research on available prevention and treatment. This is aligned with participant calls for increased knowledge about available resources. One Santa Fe respondent told us: "After taking this survey I feel that there may be more resources available to the community than we may know about. It also seems that some sort of general public education may be valuable." Taken in total, our qualitative findings suggest that New Mexicans see value in drug prevention opportunities and are willing to learn more, particularly information about existing community prevention and treatment resources so that they can help others.