Pacific Institute for Research and Evaluation

Results from the 2019 New Mexico Community Survey

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Acknowledgements

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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, prescription drug use, and some of the contributing factors related to their misuse.

Data collection took place in the spring of Fiscal Year 2019 using two methodologies; both methodologies relied on convenience samples. The first approach was a time and venue-based data collection process that either via paper and pencil, or using a Qualtrics app on iPads, tablets, and smartphones or directly online via laptops. Potential respondents were solicited in strategically identified venues in communities across the state. This time and venue-based data collection resulted in 5,840 valid surveys representing 29 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 6,249 valid surveys representing 33 NM counties. A total of 12,089 valid questionnaires were completed via the two different data collection strategies with about 40% coming from in-person data collection methods.

We analyzed the data in several ways. First, we weighted data to match NM Census 2018 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), and prescription painkillers (using painkillers to get high). We also examined data by outcomes comparing communities that targeted a specific substance with those that did not.

Noteworthy findings include:

Alcohol

- Target and comparison community estimates were similar for alcohol use and misuse variables, with misuse rates trending downward across time and the two-year trend for most of these variables being more favorable for target than comparison communities.
- Target communities reported significantly greater likelihood of police breaking up parties where teens were drinking than in comparison communities.
- The main alcohol sources for underage youth were from parties and unrelated adults providing it to them.

Prescription Painkillers

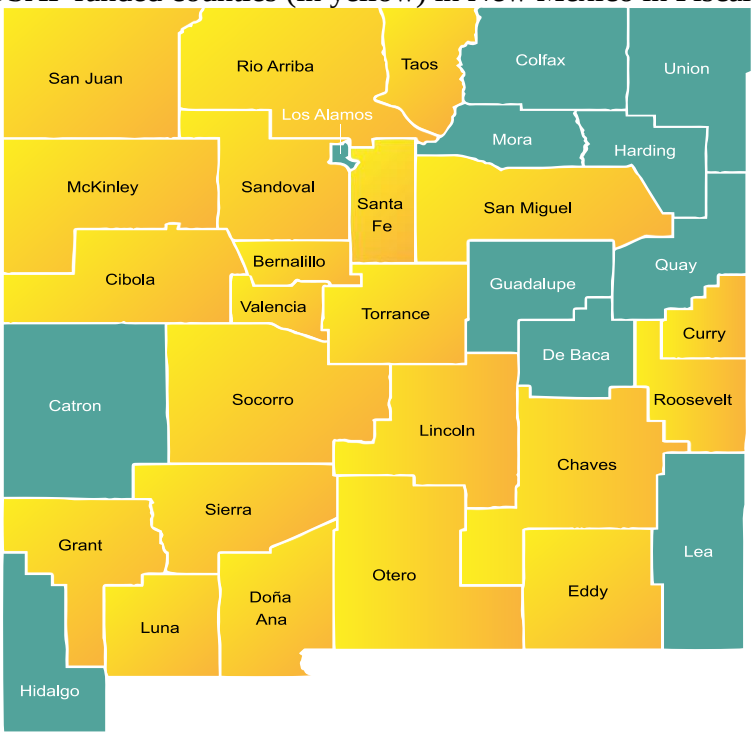
- As with alcohol, target and comparison communities tended to have similar estimates for most of the core survey prescription painkiller measures.
- The estimated past 30-day use rate of prescription painkillers was significantly lower for target than comparison communities, but a higher percentage in comparison communities reported perceiving great or moderate risk of prescription painkiller non-medical use.
- Almost 20% of respondents who used prescription painkillers indicated that their source was not their own prescription.
- Among the communities that administered the survey with additional opioid-related questions, about 15% of respondents reported having family members or friends who often use prescription painkillers. And among these respondents, a little over half (59%) thought that those prescription painkiller users were at risk of overdose.
- Similarly, about 8% of respondents reported having family members or friends who often use heroin. The majority of these respondents (88%) thought that those heroin users are at risk of overdose.
- About 25% of respondents indicated that they have Naloxone/Narcan, and about 20% indicated that they know how to get and how to use Naloxone/Narcan.
- A slight majority (52%) of respondents endorsed the statement that “it is never ok to share a prescription painkiller with another person”.

The qualitative analyses of responses to the final survey item asking for additional, open-ended input indicated that New Mexico communities would like to have better drug treatment options and more effective prevention efforts. The often-expressed perception that most alcohol and drug law offenders have a low risk of (a) getting caught and (b) experiencing negative consequences if caught indicates that there is support for more effective collaboration between prevention efforts and law enforcement.

Prevention in New Mexico

The NM Office of Substance Abuse Prevention (OSAP) in FY19 funded 27 prevention programs in 22 of the 33 counties in NM. Figure 1 below highlights the 22 counties receiving prevention funding in gold and the 11 with no OSAP funding in aqua.

Figure 1: OSAP funded counties (in yellow) in New Mexico in Fiscal Year 2019



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. 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 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 2019, 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 Community Based Participatory Research (CBPR) using 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. The purpose of this was to compare the originally proposed approach in the data collection protocol to actual data collection in order to improve the planning process the following year. For example, if some locations originally expected to be good places to collect data actually turned out not to be, then this information would help inform future planning. This also helps future data collection planners know where to start in the case of staff turnover, a common event in NM. The next year's protocol will be a composite of the previous year's data collection log and planned protocol, helping providers make data collection more efficient and more representative of their communities.

In FY2019, 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. Most combined it with traditional paper and pencil data collection. Communities collected 5,108 paper surveys (about 42.3% of the aggregated sample) and 732 surveys via iPad with Qualtrics (about 6.1% of the total sample). These data came from 29 New Mexico counties.

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, manage data collection itself.

Data Collection Approach # 2: On-line survey

The other data collection approach used in FY19 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. 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 social media ads.

Ads ran for a total of 9 weeks. Nine ads were created in both English and in Spanish, featuring photos, slide shows and animation. Ads ran on Facebook and Instagram which used internal algorithms to determine which ads were shown most often on each platform and influenced the location of the ads. In addition, a Facebook page provided daily engagement with New Mexicans about the survey and winners of the weekly drawings to increase visibility and provide legitimacy to the survey. We offered 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. Every week we gave away three $100 cash gift cards to randomly selected respondents from that week. At the end of the data collection, we randomly selected one respondent and gave away one $500 cash gift card. Weekly gift card winners were not eligible for the final gift card.

From February 24, 2019 to April 27, 2019 (63 days), the ads led to over 5,625 link clicks, with 94,664 people reached at the cost of approximately $1.91 per result and a result rate of 0.61%. A total of 3,644 surveys were collected recruiting directly through the Facebook ads or via Facebook group sharing.

Some communities used posters advertising the survey, and that included the QR code and weblink for the survey, in heavily trafficked areas such as MVD offices 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. Finally, some communities sent email invitations to groups or listservs directing them to the on-line survey. These were reviewed by the SEOW prior to granting permission to recruit this way. An

additional 2,605 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	5,108	42.3	29
Online - FACEBOOK (18+ yr. olds)	3,644	30.1	33
Qualtrics App	732	6.1	23
Online – Non-FACEBOOK	2,605	21.5	32
Total	12,089		

Table 2. Completed questionnaires by County compared to 2018

County	2019					2018				
	Qualtrics App	Online	Paper	Total	%	Qualtrics App	Online	Paper	Total	%
Bernalillo	255	1314	249	1818	15.0	266	847	563	1676	13.3
Catron	1	11	0	12	0.1	0	6	0	6	0.1
Chaves	3	231	235	469	3.9	3	102	382	487	3.9
Cibola	4	66	309	379	3.1	2	96	342	440	3.5
Colfax	1	40	0	41	0.3	1	27	4	32	0.3
Curry	1	244	262	507	4.2	0	86	478	564	4.5
De Baca	0	4	1	5	0.0	0	2	0	2	0.0
Dona Ana	55	827	214	1096	9.1	13	686	75	774	6.2
Eddy	1	391	9	401	3.3	7	391	4	402	3.2
Grant	0	71	201	272	2.3	37	172	187	396	3.2
Guadalupe	0	7	2	9	0.1	0	4	1	5	0.0
Harding	0	2	2	2	0.0	0	4	2	6	0.1
Hidalgo	0	8	0	10	0.1	1	72	118	191	1.5
Lea	0	79	2	81	0.7	1	63	1	65	0.5
Lincoln	1	41	21	63	0.5	0	43	15	58	0.5
Los Alamos	2	23	1	26	0.2	2	23	2	27	0.2
Luna	0	135	321	456	3.8	7	182	151	340	2.7
McKinley	2	79	519	600	5.0	11	62	471	544	4.3
Mora	0	13	4	17	0.1	0	9	17	26	0.2
Otero	4	126	234	364	3.0	3	118	223	344	2.7
Quay	0	23	2	25	0.2	0	31	1	32	0.3
Rio Arriba	1	289	144	434	3.6	1	73	174	248	2.0
Roosevelt	72	182	156	410	3.4	1	64	371	436	3.5
San Juan	1	421	537	959	7.9	2	677	345	1024	8.1
San Miguel	1	51	264	316	2.6	1	60	257	318	2.5
Sandoval	20	208	520	748	6.2	15	191	531	737	5.9
Santa Fe	11	391	346	748	6.2	115	859	262	1236	9.8
Sierra	5	184	133	322	2.7	54	183	178	415	3.3
Socorro	187	339	2	528	4.4	1	387	277	665	5.3
Taos	93	132	165	390	3.2	4	60	341	405	3.2
Torrance	1	165	125	291	2.4	4	37	255	296	2.4
Union	0	9	0	9	0.1	1	9	0	10	0.1
Valencia	10	143	128	281	2.3	9	107	266	382	3.0
Total	732	6,249	5,108	12,089	100	562	5,733	6,294	12,589	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 2018 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.

Quantitative Results

Demographics- Whole Sample

Table 3 presents the unweighted n and percent, 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. For example, a disproportionate number of women completed the survey than men, but the weighting generates estimates that adjust for the nearly equal distribution of men and women in the full population. 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 full population and thus, weighted percentages have de-emphasized their influence to approach a more representative state estimate. Our weighted survey sample was more educated than the general NM population;

[1] Retrieved from https://www.census.gov/data/tables/time-series/demo/popest/2010s-state-detail.html on August 2 2019.

according to the US Census (2017 American Community Survey 1-Year Estimates), 27.1% of adults[2] in NM reported having a bachelor's degree compared to our weighted estimate of 31.1%. Approximately 5.3% of the sample reported having served or to be still serving in the military which, when weighted, increased to 7.5%. The percentage of respondents in the sample who identified as LGBT was 9.4%, which when weighted decreased slightly to 8.1%.

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

Gender	n	Unweighted %	Weighted %
Men	4,215	35.8	49.1
Women	7,575	64.3	50.9
Age	**n**	**Unweighted %**	**Weighted %**
18-20	1231	10.2	5.3
21-25	1275	10.6	8.9
26-30	1180	9.8	9.0
31-40	2240	18.5	16.6
41-50	1953	16.2	14.6
51-60	2019	16.7	16.4
61-70	1469	12.2	15.6
70+	722	6.0	13.6
Race/ethnicity	**n**	**Unweighted %**	**Weighted %**
Non-Hispanic White	4,223	34.9	40.7
Hispanic or Latino	5,342	44.2	45.7
Native American	1,868	15.5	8.5
Other	656	5.4	5.1
Education	**n**	**Unweighted %**	**Weighted %**
Less than high school	651	5.5	5.8
High school graduate/GED	2,522	21.3	21.9
Some college/Technical school	2,830	23.9	25.5
College graduate or higher	3,368	28.4	31.1
In college	2,484	21.0	15.8
Military status	**n**	**Unweighted %**	**Weighted %**
Active military or veteran	636	5.3	7.5
Sexual orientation	**n**	**Unweighted %**	**Weighted %**
LGBT	1109	9.4	8.1

Demographics by Funding Stream

Table 4 provides a breakdown of the sample by funding stream and gender. We analyze three main funding streams: 1) the federal Substance Abuse Prevention and Treatment (SAPT) Block

[2] Retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_16_1YR_S1501&prodType=table on November 11, 2019.

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 FY2019 -- 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 numbers and weighted percent of sample stratified by funding stream and gender.

		Men		Women	
Funding stream	Total n	n	Weighted %	n	Weighted %
SAPT	4330	1485	46.9	2771	53.1
PFS 2015	3234	1256	52.6	1905	47.4
TCA	1847	696	50.3	1109	49.7

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

Table 5. Unweighted numbers 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	1323	39.1	1490	38.7	1342	17.9	175	4.3
PFS 2015	1213	42.2	1369	43.5	408	7.3	244	7.0
TCA	773	45.9	855	46.0	113	3.5	106	4.7

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 numbers 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	2878	49.1	1337	49.0
Women	4927	50.9	2648	51.0
Race/ethnicity	n	Weighted %	n	Weighted %
Non-Hispanic White	2748	41.1	1475	39.9
Hispanic or Latino	3145	42.2	2197	52.0
Native American	1624	11.6	244	3.1
Other	443	5.1	213	5.0

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 numbers 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	2725	49.8	1490	48.0
Women	4610	50.2	2965	52.0
Race/ethnicity	n	Weighted %	n	Weighted %
Non-Hispanic White	2588	41.1	1635	40.1
Hispanic or Latino	2941	42.0	2401	51.1
Native American	1515	11.5	353	4.2
Other	427	5.3	229	4.7

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=4330)	43.0	14.6	2.6	2.2	1.9
PFS 2015 (n=3234)	49.8	18.9	3.9	4.0	4.4
TCA (n=1847)	49.6	16.4	4.2	2.6	3.3

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

Alcohol use	Men			Women		
	SAPT (n=1485)	PFS 2015 (n=1256)	TCA (n=696)	SAPT (n=2771)	PFS 2015 (n=1905)	TCA (n=1109)
Past 30-day alcohol use	48.4	53.3	51.2	38.1	46.0	48.4
Past 30-day binge drinking	19.6	22.4	19.1	10.0	15.1	14.2
Past 30-day drinking & driving	3.8	4.6	5.8	1.4	2.9	2.7
Past 30-day binge drinking & driving	3.4	5.6	3.0	1.1	2.1	1.9
Past year purchased or provided alcohol for someone under 21	2.0	5.0	3.6	1.7	3.6	2.8

Next we compared alcohol-related outcomes and intervening variables to examine whether communities targeting alcohol appeared to have more positive trends 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 2019. 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 - FY2019 showed that, in FY2014 target communities reported more on past 30-day alcohol use, binge drinking, drinking and driving, and purchasing alcohol for a minor; and these differences remained relatively stable across the following five years. However, for all of the items other than purchasing alcohol for a minor, the most recent trend was favorable for the targeted communities relative to the comparison communities, with the most recent estimated levels of 30-day use and binge drinking lower in the target than the comparison communities. Overall, too, the estimated levels of binge drinking, drinking and driving, and purchasing alcohol for a minor have gradually decreased across the six-year period, with only 30-day use rising during that period.

Figure 2. Comparing target and comparison communities on alcohol consumption indicators from FY 2014 to FY 2019; weighted % reported

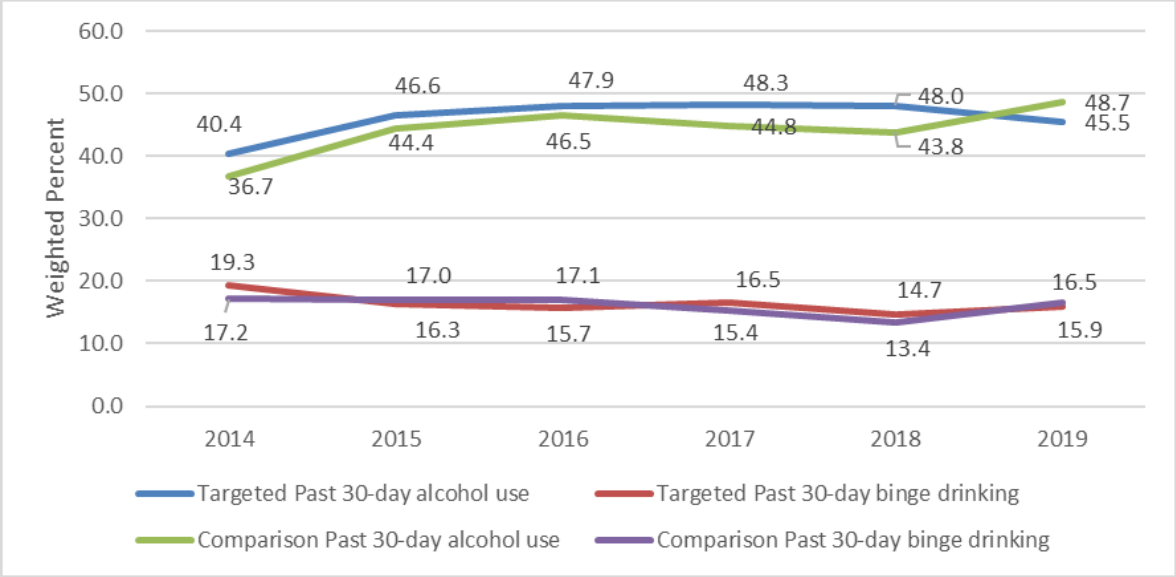


Figure 3. Comparing target and comparison communities on drinking and driving indicators from FY 2014 to FY 2019; weighted % reported.

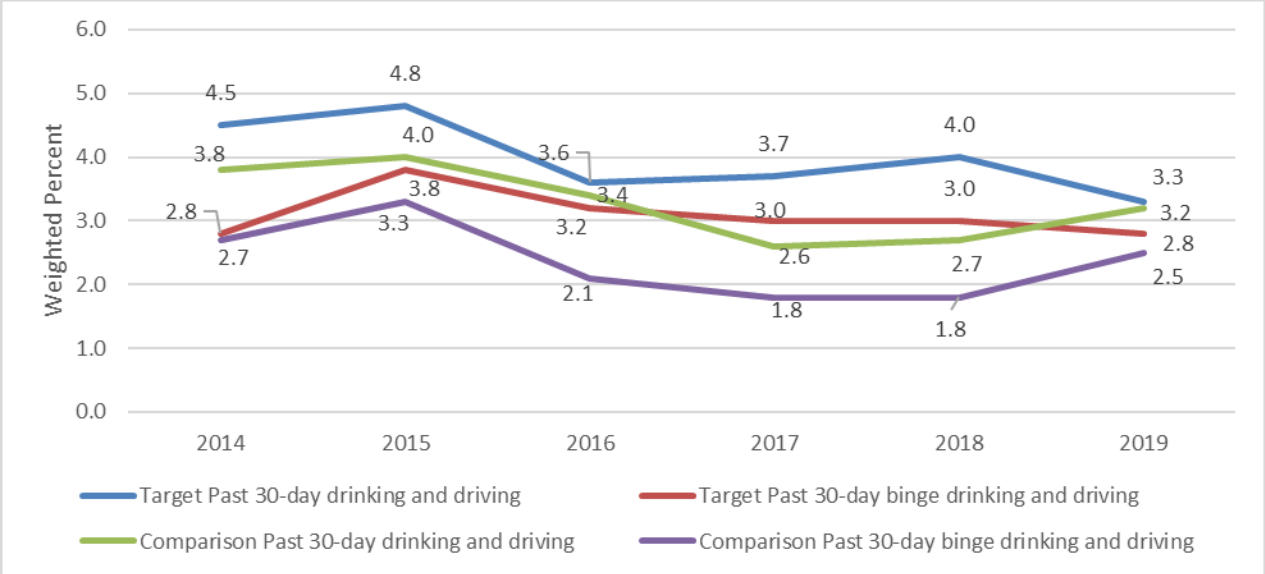
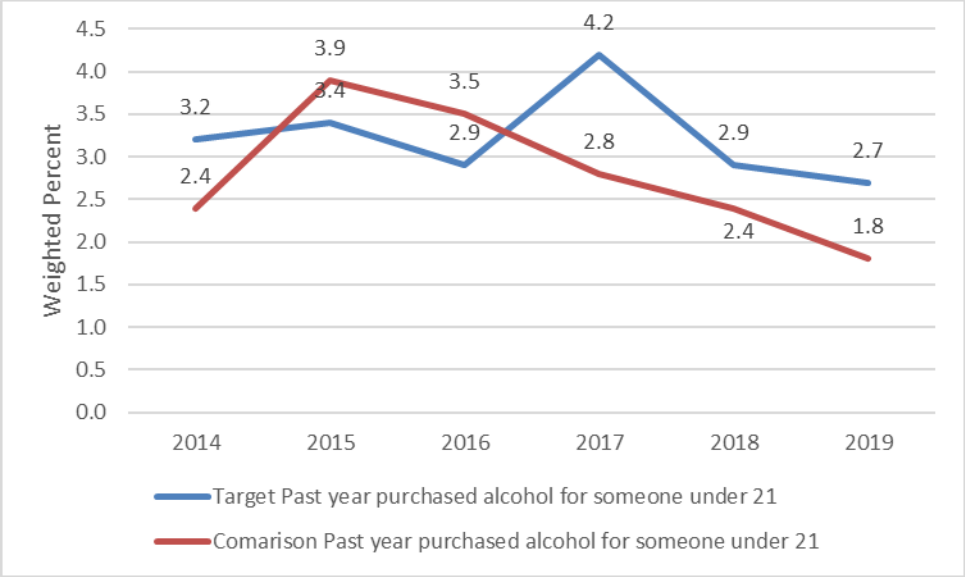


Figure 4. Comparing target and comparison communities on purchasing alcohol for minors from FY 2014 to FY 2019; weighted % reported.



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, about 61% of the respondents in both target and comparison 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.

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 target and comparison communities were similar regarding such perceptions of risk, but that target communities reported a significantly higher percentage of likelihood of police breaking up parties where teens are drinking than comparison communities (64.3% vs. 58.8%). This suggests prevention efforts have been influencing 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. With inconsistent funding for enforcement in NM communities, 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	13.0 (829)	13.7 (440)
Ease of access to alcohol by teens from stores and restaurants	61.3 (3860)	61.5 (1958)
Perception of risk/legal consequences	**Very or Somewhat Likely**	
	Target	**Comparison**
Likelihood of police breaking up parties where teens are drinking ***	64.3 (3824)	58.8 (1792)
Likelihood of police arresting an adult for giving alcohol to someone under 21	67.1 (3930)	65.8 (2045)
Perception of risk/legal consequences	**Very or Somewhat Likely**	
	Target	**Comparison**
Likelihood of being stopped by police if driving after drinking too much	72.5 (4775)	72.7 (2571)

****p* < .001

The Community Survey asked underage adults (18 to 20 years old) who reported current drinking how they obtained their alcohol in the past 30 days. Respondents could select multiple options. Table 11 displays where these young adults indicated that they obtained their alcohol. About 26% of target community respondents indicated that they obtained it at a college party and about 19% got it at some other type of party. Over a third of respondents said that an unrelated adult purchased it for them (42.0% in target communities), and 20% indicated that an adult family member provided the alcohol to the minor.

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

Access to Alcohol (n=488)	Target	Comparison
Unrelated adult gave or bought it	42.0 (165)	35.6 (33)
Got it at a college party	25.9 (102)	17.8 (17)
Adult family member gave or bought it	20.1 (77)	17.0 (15)
Got it at some other type of party	18.7 (73)	26.8 (24)
Got it some other way *	9.7 (37)	3.2 (3)
Someone underage gave or bought it	8.5 (33)	8.8 (9)
Parent/guardian gave or bought it	7.3 (28)	5.1 (5)
Took it from home	6.4 (26)	7.9 (8)
Bought it at a restaurant/bar/public place	5.5 (20)	7.7 (7)

**p* ≤..05

Prescription Painkillers

Table 12 below displays the weighted prevalence estimate 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 one that receive SAPT, PFS 2015 or TCA funding have implemented prescription painkiller prevention programs. Table 12 indicates that SAPT communities reported the highest prevalence rates on past 30-day prescription painkiller use for any reason (11.3%), but TCA communities reported the highest levels of past 30-day painkiller use to get high (2.5%). A higher percentage of respondents in PFS 2015 communities than other communities had given or shared prescription drugs with someone else (5.4%), and a lower percentage indicated storing prescription painkillers safely (38.2%). In addition, a lower percentage of respondents in PFS 2015 communities (75%) perceived great or moderate risk of using prescription painkillers for non-medical reasons than other communities.

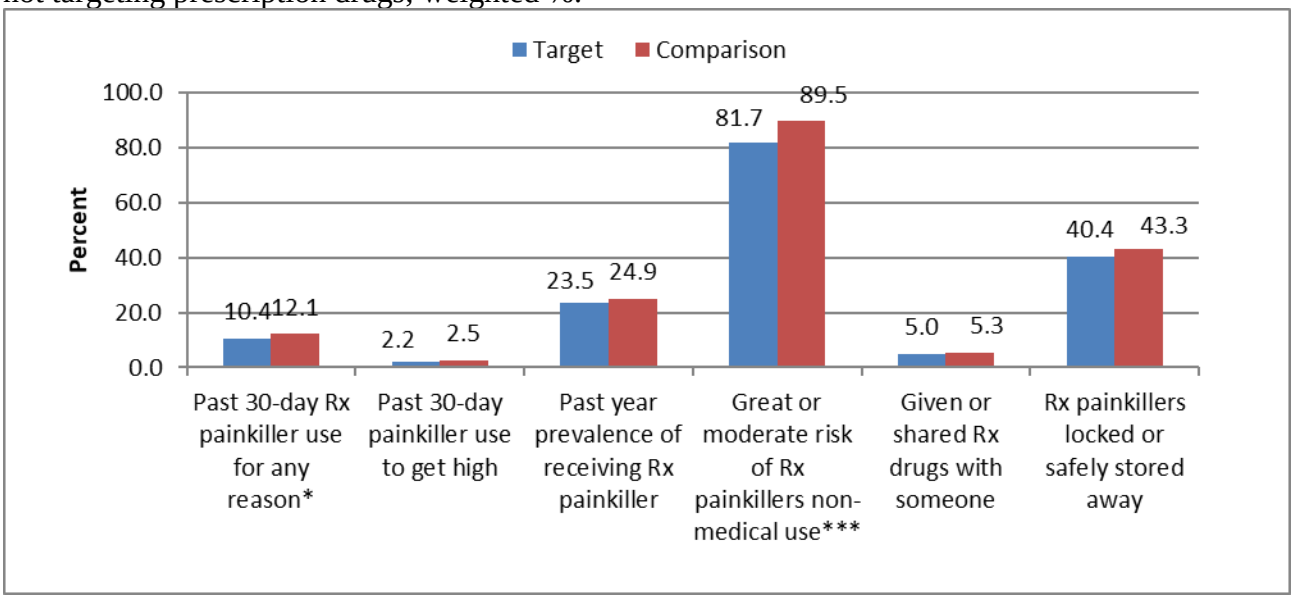
Table 12. Prevalence of prescription painkiller use by funding stream; weighted % & (unweighted n)

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=3798)	11.3	2.1	23.4	85.4	4.8	41.2
PFS 2015 (n=3234)	8.8***	2.0	23.6	75.0***	5.4	38.2*
TCA (n=1457)	10.3	2.5	22.0	87.3*	4.9	40.4

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

Figure 5 displays the prevalence for the same indicators but, instead of by funding stream, it compares communities that target prescription drug abuse and those that do not. The significant differences observed between target and comparison communities are for past 30-day painkiller use for any reason (lower in target communities -- 10.4% vs. 12.1%) and perceived great or moderate risk of harm using Rx painkillers for a non-medical reason (lower in target communities -- 81.7% vs. 89.5%).

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



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

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 likely to indicate that their recent use of prescription painkillers was for a legitimate pain identified by a health care provider. Respondents in target communities were more likely to report use for pain not identified by doctors (17.0% vs. 11.9%), but the other measures of reasons for use were not significantly different in target versus comparison communities.

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

Reasons of Prescription Drug Use (n=1222)	Target	Comparison
Treat pain identified by doctors/dentists	73.8 (513)	76.1 (385)
For pain not identified by doctors*	17.0 (133)	11.9 (66)
Have fun with friends socially	2.3 (16)	1.1 (8)
Help me sleep	6.8 (54)	7.0 (35)
Get high, messed up or stoned	2.5 (2)	2.5 (15)
Cope with anxiety or stress	5.6 (49)	5.2 (31)
Another reason	5.0 (36)	5.9 (31)

*$p \leq .05$.

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 reported having received a legitimate prescription for their painkillers. However, in both target and comparison communities, at least 5% of the respondents reported accessing painkillers from family members and from 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=1222)	Target	Comparison
A doctor/doctors prescribed	81.0 (559)	82.9 (420)
Family member shared	7.5 (63)	4.9 (25)
Friend shared	5.0 (41)	5.0 (24)
Bought from somebody	2.9 (23)	2.7 (14)
Taken from someone without asking	1.2 (9)	1.1 (6)
Other places	1.6 (16)	2.8 (12)

In the prior year (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. It is important to note, though, that the sample responding to these items was much smaller in FY2019 than it had been the prior year. Table 15 and Table 16 summarize this year's results. About 15% of respondents reported having family members or friends who often use prescription painkillers. Among these respondents, over half (59%) thought that those prescription painkiller users were at risk of overdose. Similarly, about 8% of respondents reported having family members or friends who often use heroin, and the majority of these respondents (88%) thought that those heroin users are at risk of overdose. Finally, the survey asked respondents' attitude towards sharing prescription painkillers or opioids. The majority of respondents to the Opioid module (51.7%) agreed that it was never OK to share prescription painkillers with others (Figure 6).

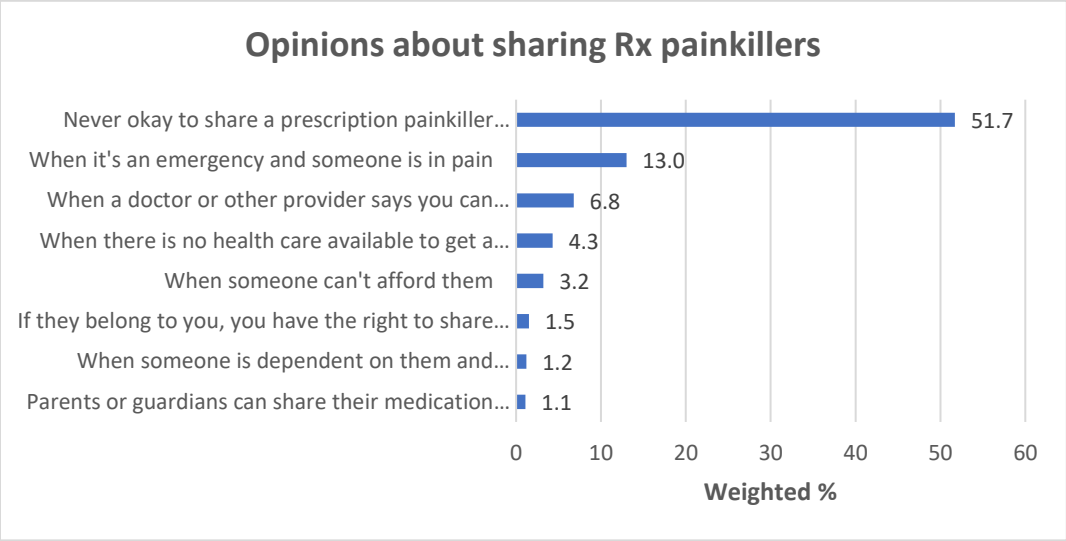
Table 15**.** Knowledge about family members/friends who use prescription painkillers or heroin

Outcomes	% of Yes
Having family members or friends who often use Rx painkillers (n=2,330)	14.9
These Rx painkiller users are at risk of overdose (n=318)	58.9
Some of these Rx painkiller users live with you (n=293)	15.7
Having family members or friends who often use heroin (n=2,330)	8.1
These heroin users are at risk of overdose (n=167)	88.1
Some of these heroin users live with you (n=162)	7.9

Table 16. Access to and knowledge about Naloxone/Narcan

Outcomes	% of Agree or Strongly Agree
Have Naloxone/Narcan (n=1,528)	25.6
Know how to get Naloxone/Narcan (n=1,543)	20.6
Know how to use Naloxone/Narcan (n=1,538)	21.6

Figure 6. Opinions about sharing Rx painkillers with others (n=2,330)



Analysis of the Indicators Associated with Each 2019 Prevention Strategy

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 the 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.

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

Intervening variable	2019 Strategies		Indicators from NMCS 2019	Weighted %
Perception of Risk of getting caught	Publicizing (law) enforcement efforts (saturation patrols, sobriety checkpoints, etc.)	A2a	Likelihood of police breaking up parties where teens are drinking: Very or somewhat Likely	62.3
			Likelihood of police arresting an adult for giving alcohol to someone under 21: Very or somewhat Likely	66.6
			Likelihood of being stopped by police if driving after drinking too much: Very or somewhat Likely	72.6
Retail Access	Responsible Beverage Service Model	A3a	Ease of access to alcohol by teens from stores and restaurants: very or somewhat difficult	61.3
			Bought alcohol at a store, a restaurant or public place (among youth ages 18-20 who used alcohol last 30 days)	6.3
	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)	22.3
			Access to alcohol at a college party (among youth ages 18-20 who used alcohol last 30 days)	27.0
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)	7.7
			Took alcohol from home or someone else's home (among youth ages 18-20 who used alcohol last 30 days)	7.4

Intervening variable	2019 Strategies		Indicators from NMCS 2019	Weighted %
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)	22.3
			Last year purchased or provided alcohol to underage youth	2.4
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	67.2

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)	5.3
			Stored prescription drugs in a locked cabinet (parents only)	50.4
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)	4.0
			Stored prescription drugs in a locked cabinet (ages 60+ only)	40.1
Social access	Work with **pharmacies** to always share information with customers about the dangers of prescription opioid use and addiction	R3e	Pharmacy staff talked about the risks involved in using prescribed painkillers (among people who were prescribed painkillers)	32.0

Intervening variable	2018 Strategies		Indicators from NMCS 2018	Weighted %
			Pharmacy staff talked about storing prescribed painkillers safely (among people who were prescribed painkillers).	24.6
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).	50.8
			Medical providers talked about storing prescribed painkillers safely (among people who were prescribed painkillers).	33.2
			Shared any prescription drugs with someone (whole sample)	5.1
			Stored prescription drugs in a locked cabinet (whole sample)	41.5
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	84.9
			self-reported 30-day use of prescription painkillers for any reason	11.1
			Shared any prescription drugs with someone (whole sample)	5.1
			Stored prescription drugs in a locked cabinet (whole sample)	41.5
			Among binge-drinker, self-reported 30-day use of prescription painkillers for any reason	10.8
			Among people who reported 30-day use of prescription painkillers, percentage of doing binge drinking past 30 days	16.0

Qualitative Results

The last question of the 2019 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.]"* A total of 3034 of Community Survey respondents opted to write a comment. After subtracting "empty" comments such as "no," "nada," "not at this time," "n/a," "thanks," and "good luck" as well as uninterpretable comments such as drawings of smiling and frowning faces and dashes, 1993 comments remained.

All responses were 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) helped to increase the percentage of online responses as compared to previous years, and there have been longer and more detailed comments as a result. These open-ended responses give us rich information about the concerns and thoughts that this survey evoked in participants.

As with quantitative data, qualitative data in a convenience sample are not generalizable to the full population. In addition, 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 different sets of questions in the survey. The questions asked in the survey likely primed the scope of the free response answers.

In the description of the results below, sometimes numerical counts are provided to indicate prevalence of certain themes. However, this should not be interpreted as a frequency count *per se*, but as a general indication of the spread of a concern. Despite its limitations, qualitative data provides a window through which respondents can tell us what is on their mind in the moment. It is a democratizing process wherein the State of New Mexico can get a sense of some substance-related concerns of the people that they serve.

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 a concern over judicial lenience for repeat DUI/DWI offenders. As this coding followed a theory of change model based upon intervening variables, the data were coded deductively. Inductive reasoning facilitated examination of emerging concepts such as anger directed at opioid-producing pharmaceutical advertisers.

The most frequently mentioned themes are discussed below. Themes are organized by intervening variable (community concern and awareness of the issues, access to alcohol and opioids, individual factors, community concerns and needs, and perceptions of risk related to legal consequences). Exemplary quotes are used to illustrate the aspects of a finding and the perspectives of 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.

Community Concern and Awareness of Issues

Prevalent Drug and Alcohol Use

Of all the free response comments in the Community Survey, the prevalence of drugs and alcohol in local New Mexico communities was the most prevalent and emotional. Many posts were in ALL CAPS or punctuated by a long series of exclamation points. There was a common sense of despair and hopelessness as evidenced by this Rio Arriba resident and others "Espanola Valley has [had] a real drug and alcohol problem for years now, and I'm not too sure if it'll ever be fixed."

Several respondents juxtaposed the prevalent and very visible drug and alcohol problem with the natural beauty in New Mexico including this respondent: "Sad statement of the locals in our little community when there [are] so many people with money moving to Taos for its beauty. It's under side is dismal. How can we turn this life-threatening trend around?"

Drug and alcohol use in New Mexico was widely characterized as an epidemic. "I believe there is a great problem among our youth with alcohol and drugs. They might arrest the drug dealers but they are out in a few days causing havoc again. It's not only the youth, I guess, it's everywhere. Alcohol and Meth seem to have its hold in this community." (Cibola) A Lincoln County resident made these observations: "Alcohol and drug use/addiction are a very real issue in the community in which I live and work. These are a real issue on Native reservations in New Mexico."

Survey respondents were looking for New Mexico to address drug and alcohol abuse within the context of related social issues. One respondent told us: "Albuquerque is obviously a center for significant drug & alcohol abuse problems but the underlying problems of classism, racism, LGBT phobia, homelessness, mental health, etc. continue to go undressed. Policing rather than aiding effected populations will only continue to perpetrate drug abuse issues." (Bernalillo)
In sum, concerns about drug and alcohol abuse are very real to New Mexicans. While respondents may pinpoint different causes and populations of concern, data reveal a deep awareness and apprehension about the future of their state.

Increased Crime

For the second survey year in a row, respondents noted the close connection between widespread substance use and increased crime in New Mexico neighborhoods. Citizen pleas were strong such as this Luna county resident who wrote “Please help with this problem. It is all over Deming. It has led to other drug abuse problems (meth). I believe it is out of control in our community. There is no safe neighborhood anymore.” Respondents also told us about how public drunkenness led to concerns about safety, even when they had not witnessed a crime. “We have a serious problem with alcoholism among the Navajo people in Thoreau. They wander the streets, panhandling for money & food. I don't feel safe when I go out by myself.” (McKinley)

Generally, survey respondents viewed crime reduction as inseparable from addressing substance abuse. A Taos County resident echoed this concern and called for drug treatment to reduce crime in the community: “I feel alcohol and drugs are a big problem in Taos County which promotes more crime in the community especially burglary and physical abuse/harm to others. I feel we really need detox programs in our community because that is lacking.”

Legalizing Marijuana

Twenty-five respondents used their comment space to continue a national dialogue about legalizing marijuana. Marijuana is legally available in neighboring Colorado and increasingly throughout the United States. Nineteen respondents were in favor of legalizing marijuana, while 6 were against such measures. The passion was equally fervent in favor and against legalization. As with the 2018 survey, respondents favored legalizing marijuana as a treatment for pain instead of opioids or as a way that currently addicted individuals could get pain relief as they eased off opioid use. A Santa Fe County resident told us: “Providers are prescribing less opioid pain killers to patients who have been on a high fixed dose for years. I believe that tapering of pain meds must be done gradually and with empathic providers offering some alternatives, e.g. medical cannabis.” Marijuana was seen as “natural” and was contrasted with synthetic opioids. One respondent characterized it this way: “While I feel that alcohol and pharmaceuticals are generally harmful and should be considered drugs, I believe cannabis is a natural medicine we can use responsibly without most of the social ills associated with the former.” (Santa Fe) Those against legalizing marijuana cited the “mixed messages” that marijuana legalization would give to kids who are taught that drugs are bad. Other residents opined that legalized marijuana would just add to New Mexico’s drug problem, rather than divert existing opioid addicted persons to a potentially safer drug. “Roswell is full of alcohol and drug related activities. I see many people abusing alcohol or drugs. If they legalize marijuana, it's going to be way worse!” (Chaves)

Access to Alcohol

Retail access for minors

Only a handful of respondents discussed retail access for minors, indicating that this was not the most pressing issue in the minds of the respondents. Of these, two respondents called for a total ban on alcohol sales, while seven requested more retailer accountability such as greater ID checks. Border towns and reservations were both cited as places where alcohol was relatively more accessible to underage drinkers. One respondent told us in a straight-forward way that social access was a bigger issue than retail access: "You do realize that most the alcohol isn't being provided to the children They're stealing it either at home or stealing whole bottles from the store…whole cases of beer." (Bernalillo)

Social access for underage alcohol consumption

All 30 respondents who chose to write about this topic cited how easily alcohol was obtained for underage drinkers through their social networks. An underage respondent from (Dona Ana County) told us, "pretty much everyone I know that is my age or close to my age drinks regularly." One respondent cited middle-schoolers using water bottles to store and drink vodka during the school day.

Parents were seen as the primary provider for underage drinking while in middle/high school. Fourteen respondents reported that their own children or the child of a close friend or family member was provided alcohol by another parent at a teen party. This caused outrage, as exhibited by a respondent who told us "many parents of other children have given my underage child alcohol and I am very upset about it. I believe that parents need to be more educated on what can happen to them for allowing this behavior and what can happen to our children."

A younger respondent discussed her own experience drinking underage: "usually minors ask older people to buy it for them, or either attend a party where alcohol is provided. Police do little to investigate underage drinking unless there's a complaint. [I] lived in Clovis for 3.5 years and cops searched one party for underage drinking I attended due to noise complaint." (Curry)

Providing alcohol to people 18 years and older was deemed more acceptable than to people under 18. Five respondents wondered at the misalignment of military service at age 18 with the "right" to alcohol delayed until age 21. Other respondents nuanced social access like this Dona Ana resident: "drinking with friends (not a party) seems harmless to me when the people are over 18."

In sum, respondents indicated stronger feelings related to social than retail access for underage drinking. Parents, whether wittingly or not, were thought to be a primary source of alcohol.

Access to Opioids

Retail or Regulated Access to Rx Opioids

Respondents perceived a current and future lack of access to prescribed opioid pain relief for diagnosed medical conditions. This perceived lack of access to the many for the sins of the few garnered the second most common free response in the Community Survey. Forty-four respondents addressed these concerns in the free response section, most citing their own experiences or the experiences of a close friend or family member whom they believe was denied opioids unfairly. Below are two quotes which characterize respondents' concerns. The first respondent refers to "government" intervention within the doctor/patient relationship. "I've had a chronic deteriorating spinal problem and was using opioids to really help me perform daily work and household chores till my doctor was forced to cut my pain medication due to the big cut down. Now I'm off all pain medications and still in terrible pain daily. But doctors refuse to help due to fear of retaliation by the government. Many doctors have to go against their oath to help people in my situation due to the "opioid crisis." The real problem is street drugs. Not doctors helping their patients." (Bernalillo) A Rio Arriba respondent personalized her experience to New Mexico specifically: "I'm not originally from New Mexico, but I've noticed here, it's very hard for anyone, such as myself, to get any type of pain medication even though I'm not an addict and don't abuse my medicines because of all the other people that were born here and that do abuse. It's not fair to all the people who are responsible and do take their meds as directed and really need them but can't get them such as myself. I have a lot of chronic pain issues that I've gone to the doctors for and have had multiple procedures done in which none of them fixed my problem and the doctors STILL won't prescribe me pain pills because of the epidemic here. It's not right or fair."

Respondents linked very negative physical and mental health outcomes with the reduction of opioid availability. Some even specified or alluded to friends or family who had committed suicide related to chronic, unabated pain. A respondent even went as far as this plea within the survey: "Since you're (the survey) interested in prescription meds, make use of these surveys to get our pain meds back and stop this genocide!! (Luna)

Frustration often outpaced empathy for those addicted. This frustration for one resident was so prevalent and serious that she told us that the "best cure for an opioid addict is overdose & death." (Socorro) It is important to note that this anger could boil over into even greater stigma for substance abusers as noted in this participant's response: "The opioid hysteria hurts patients with chronic and terminal illnesses. It's nothing more than propaganda. Let the damn addicts die. Their choice. The problem is street drugs not prescription drugs. The whole thing is bullshit. F*** the addicts." (Sandoval)

Yet frustration about the opioid epidemic was not unique to substance abusers. The qualitative analysis revealed a similar amount of frustration about doctors who overprescribe: “Doctors should be answering to how much opioids they prescribe to patients and be held more accountable. These issues should NOT be handled at the pharmacy, they need to be behind closed doors with their doctors. The drama at the pharmacy due to opioid addiction and doctors not taking fault is ridiculous.” (Bernalillo) One respondent suggested that the problem of doctors overprescribing was so severe that it warranted its own hotline: “There needs to be a hotline number or someone to call when someone knows that a doctor is enabling a patient and continues to prescribe painkillers even after the patient has admitted to the doctor that they are taking them for recreational use.” (San Juan)

Social access to Rx Opioids

As in 2018, very few respondents noted opiate availability outside of regulated access within the free response comments. Two of these respondents disclosed a cultural pattern of sharing such as: “I think my family has a habit of offering each other prescription meds (not just painkillers) because so much of my family is really sick and it’s easier to share than keep going to the doctor.” (Bernalillo)

Yet this sharing could be unintentionally seeping beyond familial boundaries. “Our schools (high and middle) seem to have easy access to drugs and alcohol. I have heard from kids there (who) have also been asked for prescription drugs from relatives if I have any. So it's out there and we have it in our community.” (San Juan)

Tensions around “the opioid crisis” are very high and prevalent in New Mexico. Those individuals with problematic use are blamed for a current or perceived future lack of access to opioids needed and prescribed for pain. Given the intensity with which respondents self-reported, this is a trend to watch in future NMCS surveys.

Individual Factors

Personal

Personal attributions, or the tendency to blame addiction on the moral failings or character flaws of individuals was a strong undercurrent in the qualitative data. Quotes like: “I think we should hold young adults and teenagers more accountable” (San Juan) and “Some think drinking is a disease but it is only a habit people get into out of stupidity” (Luna) suggest that frustration over misuse is widespread. In contrast, a minority of respondents saw alcohol and drug use more structurally oriented as one (Sierra County) told us, “Don’t blame the addict or the alcoholic.

People drink and use drugs for all kinds of reasons and it's a health issue, not a criminal issue. We need to educate ourselves more on childhood trauma and stop criminalizing those who abuse substances to cope with the harsh realities of life."

Parenting

Similar to personal attributions, thirty respondents cited poor or lazy parenting for substance use among children and adults. "Bad (substance using) parents create bad kids" (Torrance) was a prominent theme. The love and attention from at least one parent in the household was cited as a prominent protective factor against substance use. "Being more involved with the children in the family. Give them love and attention and genuine attention. Prevention, prevention, prevention." (Cibola) Some respondents blamed parents for continuing a cycle of substance use "From what I have seen in my community, it's the parents and family who show their children, grandchildren, or cousins how to use. They don't care how this affects everyone else as long as they have another person to get high with. Not to mention the older family members that enable. Some people are in denial up till the overdosed body is put in a body bag. Very sad long-term situation in our community." (Rio Arriba)

Faith

Likewise, other survey participants believed that individuals could become addicted, and then rely on God to become sober. The faith mentioned was exclusively Christian faith and placed the locus of responsibility on the shoulders of the addicted to ask for God's help in sobriety. This blaming language is characterized by this respondent who told us that "All problems are most likely solved if one would only follow and abide by the word of GOD (Jesus still saving)" (McKinley)

Other respondents cited a cultural shift away from Christian faith as responsible for the prevalent substance use in America. "Here in the United States we need to know more about God and his power and that he died for us so that we would have a better life but here the parents do not teach children a good education (to) respect their elders greet people and respect thoughts and actions of others." (Bernalillo)

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, particularly infrastructure for youth and young adult activities. Notably, there was far less emphasis on the economy in 2019 comments than there had been in 2018. Instead, respondents associated the lack of infrastructure in New Mexico with boredom and thrill seeking with the excitement of drugs and alcohol.

Prevention Education

Education about the consequences of drug and excessive alcohol use, particularly for school-aged children remains popular in New Mexico. Many respondents (n=58) mentioned their support for these efforts as key to the future of New Mexico. These comments were more general and did not support specific school-based substance use curricula or strategies. This could suggest a general acknowledgement of the importance of early prevention, but less familiarity with current, ongoing efforts. Here is an example from a Luna County resident: “When it comes to substance abuse and speaking to the younger crowd for prevention, it needs to be done several times a year. I would say at least 12. Retention is important and if these speakers come once or twice a year kids in high school will already forget and not take the message or information with them.”

Alterative Activities

Thirty-seven respondents called for alternate activities for New Mexican youth believing that idle teenage bodies are more likely to turn to drugs and alcohol. "It's such a small town with nothing to do! Many people turn to drugs and alcohol." (Chaves)
A youth from Curry County provided perspective on the void in transition between youth and adulthood. She highlighted the role that drugs and alcohol play as a rite of passage into adulthood. “More adult entertainment are not the issues in Curry County. The issues are with youth who are left behind... after they graduate/turn 18 they are left on their own. They are still kids! They all of a sudden don’t have band, sports, art, choir, cheer, etc. They lose their ambition; not everyone can afford college to keep those things up. They turn to drugs... they ruin their lives.”

Several respondents mentioned concerns about the downward shifting age demographics of drug use, such as this respondent from Eddy County: “I’m noticing that majority of users are 23-30, making them teenagers at the beginning of the opioid epidemic. Users my age started later, whereas those trying these drugs are getting younger and younger. I've met several teens already shooting heroin or meth who don't even have a diploma or driver’s license.”

Substance Use Treatment

Respondents (n=67) strongly advocated for substance use treatment options in their New Mexico Community Survey comments. Quotes like: “Anything re alcohol/drug etc. rehab is pretty much non-existent!!!! If exists in area, (it is) unaffordable.” (San Juan) and “It would be extremely helpful to those living here and in the surrounding area to have a treatment center. I had to travel out of town for treatment.” (San Miguel) reflect a perceived lack of treatment infrastructure.

Other Mental Health Assistance

Data suggest that New Mexicans understand the link between mental illness and substance abuse. One respondent described substance use prevention and treatment efforts as addressing the symptoms rather than the cause of the problem.

"The issues that plague the abq (Albuquerque) community at large are systemic. It's not just about drugs and police action. It's about fixing the problem that leads to addiction: why are people trying to escape their reality? That woman is on heroin because her parents made her feel inhuman growing up, so she numbs the pain. Or the group of homeless men at the bus stop are homeless because they have a mental illness from a war and no one will take a chance on them. We need to educate our community, set up programs for those in need and maybe even penalize those who try to stigmatize mental illness. We can't be better if no one honestly lends a helping hand." (Bernalillo)

Youth with mental health issues are particularly at risk. Several professionals that work with teenagers and young adults begged for more help to address what they believe is the root of many social ills including substance use. One respondent characterized it this way: "I work in a high school (where) it seems the vast majority of my students have suffered something that seriously traumatized them. Schools need to do more trauma-informed teaching and professional development." (Valencia)

Funding for mental health was particularly mentioned among racially marginalized communities such as Native Americans. One respondent told us "Family gets drugs so easily on reservation. Not enough Police, resources for alcohol/drugs and mental health/suicide prevention is not enough for our suicide rate on the reservation." (Otero)

In sum, support to build New Mexico's infrastructure regarding mental health and substance use is strong. Prevention is uniformly, if vaguely, supported.

Naloxone/Narcan Availability

Encouragingly, ten of twelve respondents who mentioned Narcan/Naloxone favored its use. Recognizing its importance, two participants asked specifically to be trained. Yet, two other participants voiced concerns about the underlying philosophy of life-saving drug intervention. "I do not like the drug that brings people back from overdose. The Good Samaritan law seems like an incorrect way to deal with an overwhelming amount of people who are hooked on drugs. Instead of not prosecuting at all, the penalty for drug use should be addiction treatment that actually works... Bringing people back from overdose does not benefit our society or our planet. If people want to kill themselves with drugs then let them." (Bernalillo) In both cases, respondents indicated stigma by their opinions using phrases like "no offense but." (Santa Fe) Yet their willingness to write comments of this nature unprompted suggests that providing Narcan/Naloxone is not uniformly supported.

Perceptions of Risk of Legal Consequences

Most respondents reflected a concern for the citizens of New Mexico, yet the tone suggested a difficult context in which to conduct prevention work. Although participants differed in who shouldered the blame (e.g. uninvolved parents, ineffective police, judges that allow repeat DUI offenders, doctors who overprescribe, etc.), hope and satisfaction was noticeably missing from the qualitative responses. One Bernalillo respondent suggested that the growing availability of alcohol was feeding the pro-alcohol culture in New Mexico "How as a community are we supposed to value health and mitigate this crisis when there's a new brewery or distillery opening on every other corner in Albuquerque, New Mexico?" Others blamed outsiders: "I know a lot about the Opioid Epidemic. The Sachler Family, Purdue [Pharma] & others who have benefited from the opioid sales should be behind bars. They knew from day one that these drugs were very addictive." (Grant) Still others blamed a lack of structural support, particularly for communities already marginalized: "There is a raging alcohol epidemic in San Juan county amongst the Navajo people. There is not, to my knowledge, a public intoxication law in our cities, mainly Farmington where the epidemic is the worst. Officials need to address this if they want to make our community safe." (San Juan) The low perception of risk, or put another way, the risk of one suffering publicly-oriented consequences for their drug and alcohol use is described below.

Perception of Risk of DUIs

Respondents clearly expressed frustration over multiple infractions from driving under the influence of alcohol (DUI). Uniformly, respondents blamed judges rather than law enforcement officers on the street. Specifically, the failure to revoke offender's licenses or provide more serious consequences to repeat offenders was frustrating for respondents. One Bernalillo County resident told us "DWI is not taken seriously. There is a chart that has to be displayed at establishments that serve alcohol, but it lists up to 8 offenses. It's ridiculous to give someone that many chances." Survey participants also discussed the culture surrounding drunk driving in New Mexico. The lackadaisical attitude of judges was reflected among the citizens. One respondent told us "I have lived in Taos for greater than 10 years. I find the culture here does not discourage underage drinking nor does it discourage DWI driving. To me it is disappointing that the issue of drinking is 'no big deal'. It's almost as if it's an acceptable way of life to have at least one DWI."

General Perceptions of Law Enforcement

Law enforcement (police in particular) were largely described in benevolent ways. When participants discussed police, they largely called for greater public financial support. Participants from urban, suburban, and rural counties alike noted that police officers were spread too thin and chronically underfunded. A few respondents discussed confusion over jurisdiction between local and tribal governments. This was compounded by racism as noted by this McKinley County

participant: “I just feel that a lot of issues relating to alcohol or drugs in the area I reside in, on the Navajo reservation go unnoticed, or are "not important" to law enforcement (tribal police) because some of them feel like there are more important calls or situations to respond to.”

Others cited the challenges of rural locations “The reason I said the police were unlikely to break up a party, stop DWI etc., is because in our area there is hardly a police presence. We're an unincorporated town, so no town police, so rely on county and state police, and it can take them up to 45 minutes to get to our community and are hardly ever here.” (Taos)
Finally, a few respondents (n=5) cited lack of enforcement by law enforcement. Although this number is small, it is noteworthy, particularly as attitudes towards law enforcement were not the focus of the survey. “Cops in our area have 2 things against them: familiar relationships, as most everyone is related to one another or friends growing up, and judges and prosecutors constantly drop charges or let offenders off with easy please deals for alcohol and domestic violence related offenses. A cop in the area can bust his ass to keep the community safe, but prosecutors and judges just let the people back out on the streets, no matter how many previous offenses. It's sickening.” (Rio Arriba)

Summary

The Community Survey continues to be an essential part of local and statewide monitoring and evaluation of OSAP’s substance abuse prevention services. The survey also contributes to collaborative efforts to plan for and address ATOD prevention and mental health promotion, and build community readiness and capacity for data-driven substance abuse prevention. Important intervening variable data collected through the Community Survey continue to help communities identify their progress and issues about perception of risk, access, and perception of harm. With each year of survey implementation, improvements are made to the planning and collection methodology in order to generate estimates that are as accurate and comparable across years as possible, given the limitations of the convenience sampling approach.

As noted earlier in the document, the multi-year trends for alcohol-related indicators concerning underage drinking, binge drinking, and DWI prevention have looked similar for target and comparison communities, with all except the alcohol use rate trending down across time. It is noteworthy, though, that the most recent data looks more promising for target than comparison communities, which suggests that the effects of prevention efforts may be starting to be evident in the indicators.

Social access continued to be the intervening variables of most concern related to underage drinking. Close to 50% of underage adults who drink got alcohol at parties, and over 40% indicated that they were given alcohol by unrelated adults. In addition, all of the respondents

who wrote about social access commented about how easy it was for minors to obtain alcohol through their social networks.

Given that access by minors at parties is a problem, it is good news for preventionists that in both FY2018 and FY2019, the survey estimates indicated greater perceived risk of police breaking up parties where teens are drinking in target than in comparison communities. The difference between target and comparison communities was greater this year than in the prior year (5.5 percentage point difference in FY2019 vs. 2.8 in FY2018). This likely reflects the years of work in these communities to increase highly visible enforcement of alcohol-related laws, despite inconsistent resources for enforcement in communities.

Regarding prescription painkiller prevention, the most encouraging difference between target and comparison communities was that past 30-day use was lower in target than in comparison communities. There had been little difference between target and comparison communities in FY2018 (use rates of about 12%), and the comparison communities estimate remained at that level this year while the target community estimate dropped below 10.5%. While this is good news for preventionists, it was also the case that there was significantly lower perception in target vs. comparison communities that there was at least moderate risk associated with using prescription painkillers for non-medical uses (this had also been the case in FY2018). Clearly, prescription drug misuse prevention should remain a high priority in the targeted communities, with an important goal being to increase the perception of risk associated with misuse so that it is (at least) no lower than the estimates in other NM communities.

The New Mexico Community Survey provides an opportunity for New Mexicans to pause and reflect on the most important ATOD-related issues that are on their minds each year. The quantitative items provide insight on issues such as risk factor prevalence and community-level changes over time, while the optional, qualitative, write-in responses give a barometer of themes salient to survey participants primed to think about substance use generally. The qualitative findings in this report indicate significant community desire for better drug treatment options and more effective prevention efforts. The perception of risk of getting caught (relatively low) and bearing consequences if caught (even lower) demonstrate the need for even greater collaboration between prevention efforts and law enforcement. They also represent one potentially changeable aspect within OSAP-funded communities. A paramedic/firefighter in San Juan County summed his feelings this way: “Most of our calls are related to alcohol/substance abuse. But most of us feel that there is nothing we can do to help. Until people want to stop, I'm unsure that [we will be able to] help. And I'm not sure how to stop this, so if you can help, many kudos to you!”

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	48.4	52.4*	38.1	45.2***
Past 30-day binge drinking	19.6	19.9*	10.0	14.3***
Past 30-day drinking & driving	3.8	4.7	1.4	2.5**
Past 30-day binge drinking & driving	3.4	4.0	1.1	1.9*
Past year purchased or provided alcohol for someone under 21	2.0	3.2*	1.7	2.0

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

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	53.3	50.4	46.0	41.7**
Past 30-day binge drinking	22.4	18.9*	15.1	12.2**
Past 30-day drinking & driving	4.6	4.3	2.9	1.9**
Past 30-day binge drinking & driving	5.6	3.2***	2.1	1.5
Past year purchased or provided alcohol for someone under 21	5.0	2.0***	3.6	1.4***

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

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	51.2	51.1	48.4	41.6***
Past 30-day binge drinking	19.1	20.0	14.2	12.5
Past 30-day drinking & driving	5.8	4.1	2.7	2.0
Past 30-day binge drinking & driving	3.0	4.0	1.9	1.6
Past year purchased or provided alcohol for someone under 21	3.6	2.6	2.8	1.8*

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

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	47.9	51.6	42.7	47.2 *	33.2	40.0*	42.1	42.9
Past 30-day binge drinking	13.0	14.7	15.6	19.5 **	16.0	13.8	14.0	12.9
Past 30-day drinking & driving	1.7	3.2 **	2.6	3.9 *	3.8	3.6	5.8	2.7
Past 30-day binge drinking & driving	1.4	2.1	2.4	3.6	2.8	5.0 *	4.7	3.1
Past year purchased or provided alcohol for someone under 21	1.7	2.4	2.3	2.8	1.4	2.1	1.3	3.6

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

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	51.3	50.1	51.4	44.3 ***	36.6	34.8	45.8	41.1
Past 30-day binge drinking	17.2	13.2 **	22.4	17.3 ***	13.9	15.7	13.8	12.9
Past 30-day drinking & driving	4.0	2.3 **	4.2	3.4	2.3	4.2	3.1	3.9
Past 30-day binge drinking & driving	2.8	1.6 *	5.5	2.6 ***	3.5	3.4	2.9	3.9
Past year purchased or provided alcohol for someone under 21	4.0	1.6 ***	5.6	1.8 ***	1.2	1.8	2.7	3.0

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

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	52.0	50.0	49.8	45.1 *	34.5	35.2	33.9	44.2
Past 30-day binge drinking	14.3	14.1	19.5	18.2	15.5	15.3	7.9	14.2
Past 30-day drinking & driving	4.3	2.3 **	4.3	3.4	3.7	3.8	2.7	3.8
Past 30-day binge drinking & driving	2.2	1.8	2.7	3.3	2.7	3.5	4.8	3.3
Past year purchased or provided alcohol for someone under 21	2.6	2.1	3.7	2.5 *	1.8	1.6	7.3	2.1 **

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

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	49.8	53.5 *	41.4	45.0 **
Past 30-day binge drinking	20.0	19.5	12.1	14.1 *
Past 30-day drinking & driving	4.4	4.3	2.1	2.2
Past 30-day binge drinking & driving	4.0	3.4	1.5	1.8
Past year purchased or provided alcohol for someone under 21	3.0	2.4	2.4	1.1 ***

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

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	49.1	52.7 *	45.9	45.9	33.0	49.2 ***	41.9	44.2
Past 30-day binge drinking	14.2	14.1	18.3	18.6	15.1	16.9	12.4	14.8
Past 30-day drinking & driving	2.8	2.5	3.5	3.6	3.7	4.1	4.1	2.7
Past 30-day binge drinking & driving	2.0	1.8	3.5	2.9	3.0	6.4 *	4.0	2.7
Past year purchased or provided alcohol for someone under 21	2.2	2.2	3.6	1.4 ***	1.4	3.1	3.4	1.9

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

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	47.4	56.8	59.2	61.0
Past 30-day binge drinking	15.5	18.7	23.6	23.4
Past 30-day drinking and driving	2.6	3.2	5.9	5.9
Past 30-day binge drinking and driving	3.1	1.1	5.6	2.9
Past year purchased alcohol for someone under 21	1.7	1.5	6.1	1.3 **

**$p \leq .01$.

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	11.2	9.9	11.6	12.2
Past 30-day painkiller use to get high	2.6	2.8	1.7	2.2
Past year prevalence of receiving Rx painkiller	21.4	23.3	25.4	25.6
Great or moderate risk of Rx painkiller non-medical use	82.8	83.2	88.1	86.2
Given or shared Rx drugs with someone	4.1	4.4	5.4	6.1
Medication locked or safely stored away	38.3	37.2	43.1	45.6

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	7.7	11.1 **	10.0	12.6 **
Past 30-day painkiller use to get high	2.6	2.8	1.4	2.2 *
Past year prevalence of receiving Rx painkiller	21.4	23.2	25.9	25.5
Great or moderate risk of Rx painkiller non-medical use	71.7	87.2 ***	78.4	89.2 ***
Given or shared Rx drugs with someone	4.2	4.4	6.2	5.8
Medication locked or safely stored away	35.0	38.4	41.3	45.8 *

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

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	11.2	10.1	9.3	12.4 *
Past 30-day painkiller use to get high	2.7	2.7	2.5	2.0
Past year prevalence of receiving Rx painkiller	24.0	22.6	19.7	26.4 ***
Great or moderate risk of Rx painkiller non-medical use	85.2	82.8	89.4	86.4 *
Given or shared Rx drugs with someone	4.7	4.3	5.3	6.0
Medication locked or safely stored away	36.6	37.7	46.1	44.7

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

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	12.5	12.3	12.1	9.9	7.7	11.9 *	11.4	10.3
Past 30-day painkiller use to get high	2.1	2.4	2.0	2.5	1.5	2.1	5.0	3.6
Past year prevalence of receiving Rx painkiller	25.6	27.5	23.8	21.8	19.2	24.5 *	20.7	22.5
Great or moderate risk of Rx painkiller non-medical use	88.8	88.8	84.1	82.5	82.5	68.0 ***	78.2	84.2
Given or shared Rx drugs with someone	4.9	5.9	5.5	4.9	3.4	5.6 *	3.8	4.1
Medication locked or safely stored away	31.6	32.9	47.1	48.5	48.3	43.7	32.4	41.8

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

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	9.4	13.4 **	8.9	10.8	6.1	9.9 *	6.6	12.5 *
Past 30-day painkiller use to get high	1.5	2.5	2.8	2.3	0.7	2.0	2.5	4.6
Past year prevalence of receiving Rx painkiller	26.5	27.2	22.6	22.1	19.1	21.4	15.9	25.2 *
Great or moderate risk of Rx painkiller non-medical use	81.1	91.3 ***	72.3	86.1 ***	58.0	83.0 ***	72.5	88.2 ***
Given or shared Rx drugs with someone	5.6	5.6	5.5	4.9	4.7	4.0	3.4	4.3
Medication locked or safely stored away	33.6	32.2	39.6	50.9 ***	54.1	45.1	38.6	39.4

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

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	12.8	12.3	8.4	10.7	6.8	9.1	8.0	10.9
Past 30-day painkiller use to get high	2.9	2.2	2.1	2.4	0.0	1.8	4.4	3.8
Past year prevalence of receiving Rx painkiller	23.9	27.5	20.4	22.5	22.7	20.9	18.5	22.7
Great or moderate risk of Rx painkiller non-medical use	90.0	88.6	84.3	82.6	91.1	77.2 *	91.0	81.6 *
Given or shared Rx drugs with someone	4.7	5.8	5.1	5.0	3.7	4.1	5.2	3.9
Medication locked or safely stored away	38.9	31.6	40.7	49.4 *	48.8	46.7	47.1	38.3

*p <.05.

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	10.1	10.6	10.8	13.7 **
Past 30-day painkiller use to get high	2.7	2.8	1.8	2.3
Past year prevalence of receiving Rx painkiller	22.3	23.5	24.7	26.7
Great or moderate risk of Rx painkillers non-medical use	78.9	89.6 ***	84.6	89.9 ***
Given or shared Rx drugs with someone	4.3	4.3	5.6	6.3
Rx painkillers locked or safely stored away	37.1	38.2	43.4	46.8

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

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	11.7	13.4	10.2	10.6	7.1	16.9 ***	8.9	13.4
Past 30-day painkiller use to get high	2.1	2.5	2.4	2.3	1.3	3.5 *	3.9	3.9
Past year prevalence of receiving Rx painkiller	25.9	28.7	22.9	21.5	19.5	26.5 *	18.5	28.4 **
Great or moderate risk of Rx painkillers non-medical use	86.2	92.7 ***	79.2	87.2 ***	75.7	85.1 ***	78.1	90.8 ***
Given or shared Rx drugs with someone	5.1	6.4	5.5	4.5	3.7	5.7	4.3	3.5
Rx painkillers locked or safely stored away	33.9	30.4	43.9	53.9 ***	49.2	37.8 *	36.9	42.9

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

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

	Veteran		LGBT	
Prescription drug use	Target	Comparison	Target	Comparison
Past 30-day Rx painkiller use for any reason	12.1	12.1	13.1	11.2
Past 30-day painkiller use to get high	1.6	2.3	4.0	3.8
Past year prevalence of receiving Rx painkiller	29.2	33.6	27.7	25.9
Great or moderate risk of Rx painkillers non-medical use	80.2	90.9 **	79.7	90.0 ***
Given or shared Rx drugs with someone	4.2	3.9	10.4	12.4
Rx painkillers locked or safely stored away	32.4	34.7	32.0	38.8

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