



Results from the 2013 New Mexico Community Survey

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Table of Contents

Acknowledgements.....	6
Executive Summary	7
The New Mexico Community Survey	9
Methodology.....	9
Results.....	12
<i>Demographics</i>	12
Tobacco Use.....	12
<i>Summary</i>	14
Alcohol Perceptions of Risk and Consumption Behaviors.....	14
<i>Comparing NMCS 2013 to 2012</i>	16
<i>2013 NMCS consumption results for men and women</i>	18
<i>Veteran and current military personnel</i>	21
<i>Underage access to alcohol</i>	22
<i>Summary</i>	23
Prescription Pain-killers.....	24
<i>Binge drinking and prescription drug use</i>	28
<i>Summary</i>	30
Mental Health.....	30
<i>Mental health by prevention funding subgroup</i>	31
<i>Mental health by gender</i>	32
County Level Estimates	40
Community Survey Conclusions	42

Table of Tables

Table 1: Counties, major metropolitan areas, and Native American communities grouped within two funding subgroups.....	10
Table 2: Perception of the ease of retail access to alcohol and likelihood of legal consequences of illegal alcohol-related behaviors.	15
Table 3: Percent of respondents reporting positively to questions on tobacco & alcohol use by “community” (defined by the geographic area where respondent lives).....	41
Table 4: Percent of respondents reporting positively to Rx drug use and mental health questions by “community” (defined by the geographic area where respondent lives).....	41

Table of Figures

Figure 1: Race/ethnicity distribution in 2013 NM Community Survey.	12
Figure 2: Percentage of respondents who reported currently smoking cigarettes or using tobacco products.....	13
Figure 3: Percentage of respondents who reported providing cigarettes, chew, snuff or other tobacco products to minors in the past year.....	14
Figure 4: Percent of respondents who think it is very likely police would break up parties where teens are drinking in 2012 and 2013.	16
Figure 5: Percent of respondents who think it is very likely police in their community would arrest an adult for giving alcohol to someone under 21 in 2012 and 2013.....	17
Figure 6: Percent of respondents who think it is very likely one would be arrested if caught selling alcohol to a drunk or intoxicated person in 2012 and 2013.....	17
Figure 7: Percent of respondents who think it is very likely one would be stopped by police if driving after drinking too much in 2012 and 2013.	17
Figure 8: Percent of respondents who think it is very likely one would be convicted if stopped and charged with DWI in 2012 and 2013.....	18
Figure 9: Percent of male and female respondents reporting alcohol use behaviors.....	18
Figure 10: Prevalence of current alcohol consumption and related risk behaviors by race/ethnicity.	19
Figure 11: Percent of respondents who reported past 30-day alcohol use.....	20
Figure 12: Percent of respondents who reported drinking five or more drinks on at least one occasion in past 30 days.....	20
Figure 13: Percent of respondents who reported driving after having too much to drink in past 30 days.	20
Figure 14: Percent of respondents who reported driving after having 5 or more drinks in past 30 days.	21
Figure 15: Prevalence of past 30-day binge drinking among veterans or active duty respondents compared to non-veteran respondents.	21
Figure 16: Percentage of underage current drinkers who identified each of the listed means of accessing alcohol in the past 30 days.....	22
Figure 17: Percent of respondents who reported receiving prescription painkiller prescriptions in past year, using prescription painkillers in past 30-days, sharing prescription drugs in the past year, and currently safely storing prescription pain-killers by funding subgroup.....	25
Figure 18: Percent of respondents who reported prescriptions for and use, sharing, and storage of prescription pain-killers by gender.	25
Figure 19: Past 30-day prescription pain-killer use by race/ethnicity.	26
Figure 20: Past 30-day prescription pain-killer use by age group.	26
Figure 21: Prevalence of prescriptions for and use of prescription pain-killers by military status.....	27
Figure 22: Past 30-day prescription pain-killer use by current binge drinking behavior	28

Figure 23: Reasons for current prescription pain-killer use.....	29
Figure 24: Sources of prescription pain-killers.....	29
Figure 25: The percent of respondents who reported they felt the following all or most of the time in the past 30 days.....	31
Figure 26: Prevalence of mental health problems by three funding subgroups.....	32
Figure 27: Prevalence of mental health problems by gender.....	33
Figure 28: Prevalence of mental health problems by race/ethnicity.....	33
Figure 29: Prevalence of serious mental illness and drug or alcohol problem by age groups.....	34
Figure 30: Prevalence of suicidal thoughts and receiving professional help by age groups.	34
Figure 31: Prevalence of mental health problems by military service status.	35
Figure 32: Prevalence of receiving professional help dependent on whether one has experienced mental health problems in the past year.....	36
Figure 33: Prevalence of mental health problems by past 30-day binge drinking.....	36
Figure 34: Prevalence of where respondents went to receive professional help for mental health problems in the past year.	37
Figure 35: Prevalence of types of help provided by mental health professionals.	38

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Executive Summary

Funding from the Centers for Substance Abuse Prevention 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, the 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 in substance abuse. To aid in statewide to community-level efforts to address these indicators, SPE partners developed a community survey referred to as the New Mexico Community Survey (NMCS). This survey's methodology and questions were based upon community surveys collected under the SPF SIG funding. Topic areas included alcohol, tobacco, prescription drug use and some of the contributing factors related to their misuse. Also included are questions on mental health and access to help for behavioral health issues.

Data collection guidelines were provided to participating communities, and protocols were reviewed by the SEOW workgroup. Only a paper and pencil version was offered. As a result of limited evaluation funding for FY13, surveys were collected in 9 of 33 counties in New Mexico. Findings were analyzed according to two principal groups: OSAP Community Based Processes (CBP) communities (all former SPF SIG and focusing on alcohol prevention) and comparison communities, which include 2 direct services programs, 1 prescription drug prevention county, and one county not conducting OSAP-supervised prevention. Also implemented were gender and cross-sectional analyses.

Major findings include:

- The perception of risk that one will be caught and face legal consequences because of providing/selling alcohol to minors or intoxicated patrons, and/or drinking and driving has generally decreased in OSAP-funded communities since the end of the SPF SIG in 2010.
- Males remain more likely than females to report current engagement in alcohol-related risk behavior such as binge drinking and drinking and driving, as well as providing alcohol to minors.
- Prevalence of alcohol-related risk behaviors including binge drinking and drinking and driving have decreased among males since 2012.
- Females reported a higher prevalence of drinking and driving compared to 2012 estimates.
- Social routes remain the most common way underage adults are accessing alcohol.
- On average, 22% of respondents reported receiving at least one prescription from a doctor for an opioid pain-killer in the past year.
- Approximately 12% reported past 30-day use of prescription pain-killers.
- Almost 6 % indicated sharing their prescription pain-killers with another person.
- African Americans, Asian/Pacific Islanders and "Others" are most likely to report past 30-day prescription pain-killer use.
- Young adults 18-20 reported the highest prevalence of past 30-day prescription pain-killer use.

- Veterans and active duty military personnel are more likely to have been prescribed and to report current use of a prescription pain-killer.
- Current binge drinkers reported more current prescription drug use than non-binge drinkers.
- A mental health screening tool identified about 6.5% of respondents as possibly having a serious mental illness.
- Few differences by gender were found for mental health items.
- African Americans, Asian/Pacific Islanders and “Others” reported the highest prevalence of mental health problems followed by Hispanic/Latino.
- Adults ages 31 to 40 report the greatest prevalence of mental health, drug, or alcohol problems in the past year; 18 to 20 year olds report more presence of serious mental illness in the past 30 days and suicidal ideation in the past year.
- Almost 57% of respondents who reported having a mental health, drug, or alcohol problem in the past year received professional help to address the problem.
- Binge drinkers were more likely to report mental health problems than non-binge drinkers.

Statewide and community-level results will aid in evaluating current prevention programming, assessment for new and evolving programs, as baseline measures for the Partnerships for Success II evaluation, and in general to assist in state-level alignment of data collection and evaluation for prevention.

The New Mexico Community Survey

In the spring of 2012, New Mexico prevention providers and community leaders implemented the New Mexico Community Survey (NMCS). Based upon a successful community survey approach developed during the SPF SIG, the 2013 NMCS included questions about alcohol, tobacco, and prescription drug consumption in addition to perception of risk and mental health items. The majority of the questions in the 2013 NMCS remained the same as the 2012 NMCS. Minor revisions were applied as a result of the feedback received from the 2012 NMCS. Due to funding constraints, communities could choose whether or not to conduct the 2013 NMCS and they were allowed to select and administer questions they regarded as aligning with and evaluating their community prevention goals. Therefore the number of participants varied across questions to a great degree. As in previous years, a Spanish language survey was provided.

Methodology

The survey content and data collection methodology was based upon the community survey protocol developed during the NM SPF SIG and SPE, which was reviewed and approved by PIRE's Institutional Review Board prior to implementation. All communities/organizations were trained on how to complete and follow the data collection protocol and enter data using a standard format.

These community-level organizations conducted the survey among a convenience sample of community residents 18 and older, representing their own community across the state. Paper and pencil questionnaires were administered in both Spanish and English. Participating organizations had 4 weeks in which to collect surveys. Each organization developed a community-specific data collection protocol that identified, who, when, where and how surveys would be collected in the community. Data were entered by community members or evaluators and data files were sent to PIRE where cleaning took place. Table 1 provides a summary of the communities with data.

Table 1: Counties, major metropolitan areas, and Native American communities grouped within two funding subgroups

Funding Subgroup	County, major metropolitan & NA areas	N
Current OSAP CBP Sites (all are former SPF SIG communities)	San Juan County	399
	Taos County	411
	(Northern) Rio Arriba County	230
	Albuquerque	339
	Laguna Pueblo	206
	Total	1585
Comparison Sites (sites not conducting CBP- alcohol programming but other strategies and substances)	Catron County (Rx drug – Emerging trends)	300
	Hidalgo County (TCA and Rx drug – Emerging trends)	315
	Chaves County (direct services)	457
	Zia Pueblo (direct services)	101
	Total	1173

For the purpose of simplifying the results, we grouped respondents based on where they lived into 2 funding subgroups (see

Table 1 for a listing of communities in each subgroup). These two groups were: 1) FY13 OSAP communities funded for CBP- alcohol prevention, called “OSAP Current Sites” in the tables following, and 2) comparison communities, including direct services communities, “Emerging Trends” prescription drug programs, and Total Community Approach prevention and treatment programming. This group was chosen as the comparison group because none of the comparison communities were working on plans that had originally been developed as part of the SPF SIG.

Data were analyzed by age, organized into eight distinct categories: 18-20, 21-25, 26-30, 31-40, 41-50, 51-60, 61-70 and 71 and older. Age was of specific interest to the evaluators in order to determine use of and access to alcohol by underage adults, and age differences among prescription pain-killers use, specifically among young adults and the “mature” respondents. We were also interested in mental health and access to mental health services across the lifespan.

Respondents were allowed to select multiple race/ethnicities to describe themselves. Race/ethnicity was then coded hierarchically. All respondents identifying as Hispanic regardless of other classifications were classified as Hispanic, followed by all non-Hispanic Native Americans, all non-Hispanic whites, and all other categories of race/ethnicity including African Americans/blacks and Asian/Pacific Islanders.

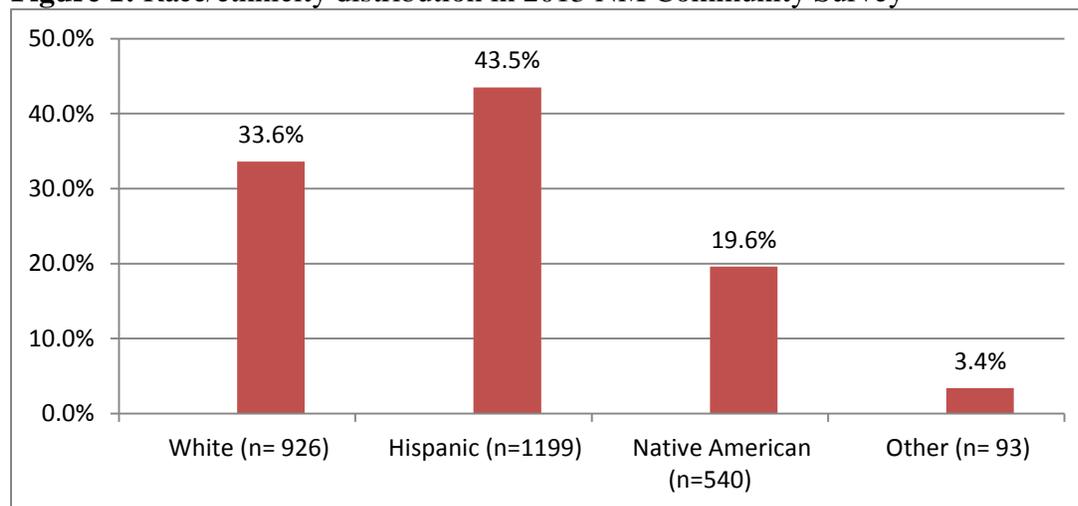
We chose not to weight the data collected for the FY13 survey because limited number of communities participated the 2013 NMCS, and weighting in previous years had little effects changing the results yet created confusion among local evaluators and providers.

Results

Demographics

There were 2,868 surveys completed. All respondents missing data for age were removed from the sample. Those who indicated living outside of the state were also removed from the sample. The final valid sample size was 2,758. The age groups (no specific ages were collected in 2013) ranged from ages 18-20 to ages 71 or above; 8.5% (n=234) were less than 21 years old. The sample was 63.8% female and 36.2% male. Figure 1 provides the breakdown of race/ethnicity in the community survey sample. Similarly as in 2012, the 2013 NMCS sample is under-representative of non-Hispanic whites and over-representative of Native Americans. The percentage of Hispanics in the NMCS 2013 sample is close to the percentage in the 2010 U.S. Census. Finally, approximately 8% of the 2013 NMCS sample identified as a veteran of or currently on active duty in the U.S. Armed Forces.

Figure 1: Race/ethnicity distribution in 2013 NM Community Survey



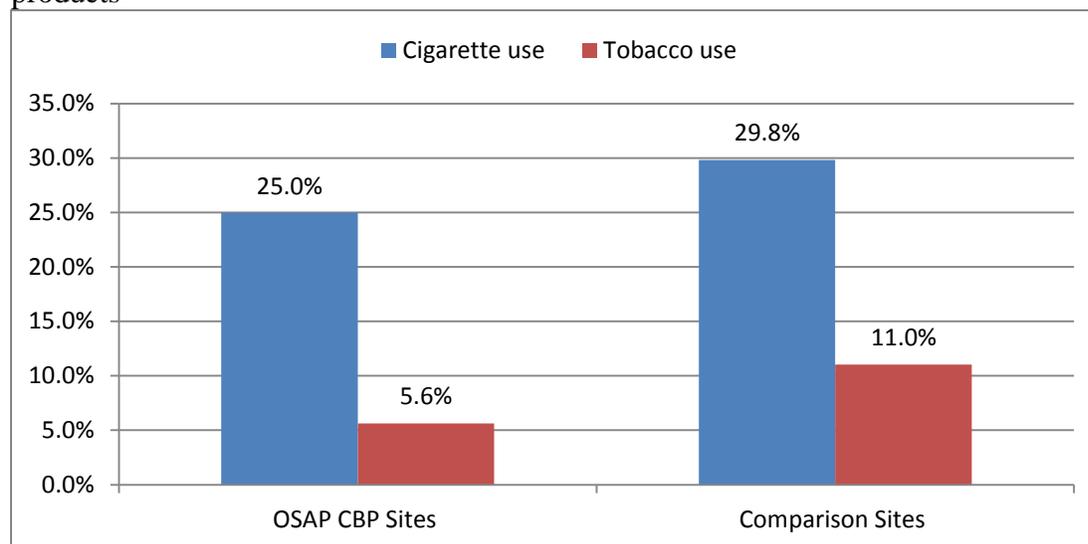
Tobacco Use

Smoking and use of tobacco products remains an important public health problem among New Mexico's youth and adults alike. In recent years, New Mexico's OSAP has worked hard through its SYNAR program to reduce youth initiation of smoking and current cigarette smoking and has been largely effective in doing so based on yearly evaluations that reveal that sales to minors in the state are well under the 20% recommended by the Federal Government. Yet there remains incredible variability among counties across the state with some counties at close to twice the rate for the state as a whole. Furthermore, 30-day smoking prevalence among NM youth remains higher than the U.S. as a whole.

The 2013 NMCS included three items related to tobacco use: current smoking of cigarettes; use of other tobacco products; and because the sample for the NMCS was of legal age to purchase tobacco products, providing cigarettes and/or other tobacco products to minors.

Figure 2 illustrates the prevalence of self-reported current cigarette and other tobacco use by each funding subgroup. Current cigarette use is higher among comparison communities than among FY13 OSAP CBP communities, while in FY12 OSAP CBP communities were higher (29.1%) than comparison communities (26.4%) (2012 estimates not shown in Figure 1).¹

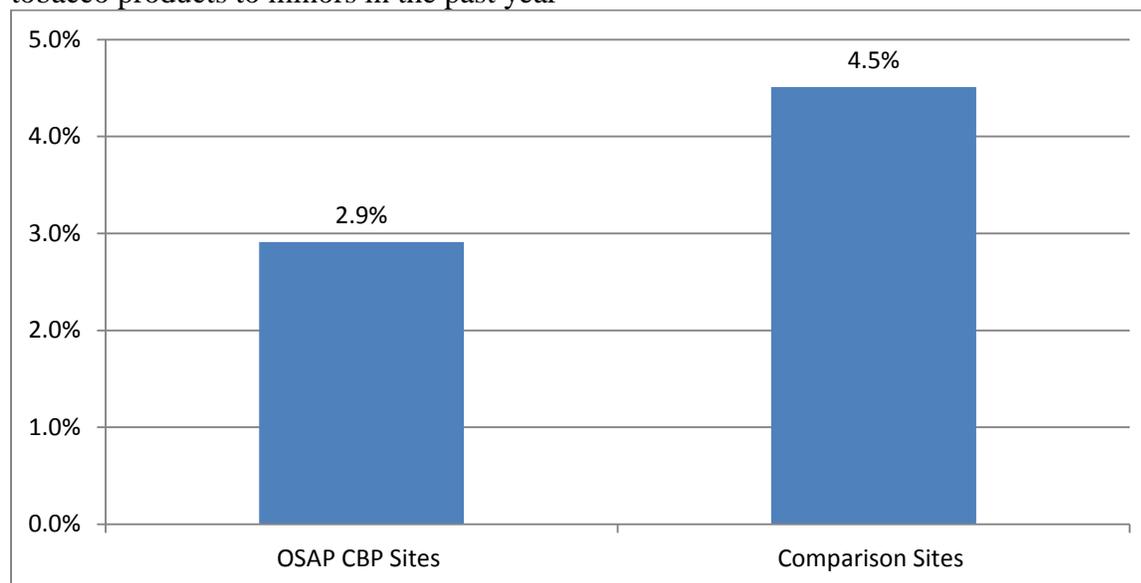
Figure 2: Percentage of respondents who reported currently smoking cigarettes or using tobacco products



Similarly, FY13 OSAP CBP community respondents reported providing minors with cigarettes and/or tobacco products less often than comparison communities (see Figure 3), while in FY12, this was reversed and OSAP CBP respondents reported a higher prevalence of providing minors with cigarettes and/or tobacco product.

¹ The comparison was made only among sites that have both 2012 and 2013 data.

Figure 3: Percentage of respondents who reported providing cigarettes, chew, snuff or other tobacco products to minors in the past year



Summary

Our estimates of current smoking are almost identical to the estimates in 2012 (whole sample 26.8% in 2013 vs. 26.7% in 2012), which both are higher than the statewide estimate of 19.3% from the 2012 NM BRFSS for the same question: “Do you now smoke cigarettes every day, some days, or not at all?” As in the BRFSS, we included as current smokers or tobacco users those who reported using every day or some days. One possible explanation in interpreting the different estimates is that sample compositions in NMCS and NM BRFSS are different. NMCS is a convenient sample, whereas NM BRFSS is a probability sample.

Alcohol Perceptions of Risk and Consumption Behaviors

Factors contributing to alcohol use being targeted by prevention programs included: (1) reducing retail access to minors, (2) reducing social access to minors, and (3) increasing the perceived risk of legal consequences. These three were assessed with several questions on the retail access to alcohol by teens, a question assessing overall alcohol accessibility for teens in one’s community, and perception of risk of getting caught if engaging in illegal alcohol-related risk behaviors (increased law enforcement efforts could be assessed by other methods). For those 18-20 who had drunk in the last 30 days, one additional question on social access was asked. Table 2 displays the percent of respondents who reported the ideal response to the 7 questions by the 2 funding subgroups.

Generally, OSAP CBP FY13 communities did better on four out of five measures of perception of risk than comparison communities, showing slightly higher perceptions of risk of police involvement if one violates the drinking laws. However a rather large difference on alcohol accessibility measures separated the two groups. It appears that it was perceived to be much easier for teens in OSAP CBP FY13 communities to access alcohol than in comparison communities. It should be noted that not every community collected data on each of the measures in 2013 and that the question asking overall alcohol accessibility was not added until 2013.

One way to understand the difference on the retail access measure is to compare individual communities that have both 2012 and 2013 data on this measure. There are four OASP CBP communities and four comparison communities that have both year's data available. In 2012, 9% of respondents in OASP-funded communities reported it to be very difficult for teens to get alcohol from retail outlets, whereas 19% in 2013 indicated that it was very difficult for underage youth to access alcohol through retail outlets, a considerable improvement. Similarly, 22% in comparison communities reported it was very difficult in 2012 for youth in their community to access alcohol, versus 40% in 2013. It appears that across the board, NM is doing a better job of decreasing retail access to alcohol among minors, or at least respondents think so, which is important. However, OSAP CBP communities still need to work on reducing retail and social access because they remain considerably behind the comparison communities.

Table 2: Perception of the ease of retail access to alcohol and likelihood of legal consequences of illegal alcohol-related behaviors

	OSAP CBP Current Sites	Comparison Sites
Alcohol accessibility	Very difficult	Very difficult
Teens in the community to get alcohol	3.0%	10.4%
Teens in the community to get alcohol from stores and restaurants	18.8%	39.7%
Perception of risk/legal consequences	Very likely	Very likely
Likelihood of police breaking up parties where teens are drinking	19.2%	18.7%
Likelihood of police arresting an adult for giving alcohol to someone under 21	30.9%	27.9%
Likelihood of someone being arrested if caught selling alcohol to a drunk or intoxicated person	24.4%	21.8%
Likelihood of being stopped by police if driving after drinking too much	30.2%	28.3%
Likelihood of being convicted if stopped and charged with DWI	52.4%	55.2%

Comparing NMCS 2013 to 2012

We wanted to compare 2013 NMCS estimates with the 2012 NMCS on the same measures to assess any change over time in perceived risk of legal consequences. An ideal change should be directed upward (i.e., increase from 2012 to 2013). Figures 4-8 graph this comparison by funding subgroups. Again, this comparison was made only among communities that have data in both years. Within OSAP CBP communities from 2012 to it appears that for every measure there was observable, although not considerable declines in perceived risk indicators, while in comparison communities there were slight increases on most of measures between 2012 and 2013, except for the measure assessing the likelihood of police breaking up parties where teens are drinking. Yet OSAP CBP respondents were consistently more likely to report higher perceptions of risk on the four measures in 2012 and 2013 than comparison communities, with the exception of likelihood of being convicted due to DWI where both groups are comparable in their estimates (see Figure 4 - Figure 8).

Comparison communities have maintained similar levels of perceived risks in 2012 and 2013, whereas OSAP CBP communities decline slightly more on some indicators. It is uncertain what factors are linked to the decline in the perceptions of risk in OSAP CBP communities. Given that OSAP has worked diligently to encourage all funded programs to link highly visible enforcement with increasing the perception of risk of arrest for those enforcement efforts, communities need to examine changes in community-level perceived risk indicators and actual law enforcement efforts and publicizing of efforts. Further assessment efforts are required to determine where lapses have occurred in perception of risk.

Figure 4: Percent of respondents who think it is very likely police would break up parties where teens are drinking in 2012 and 2013

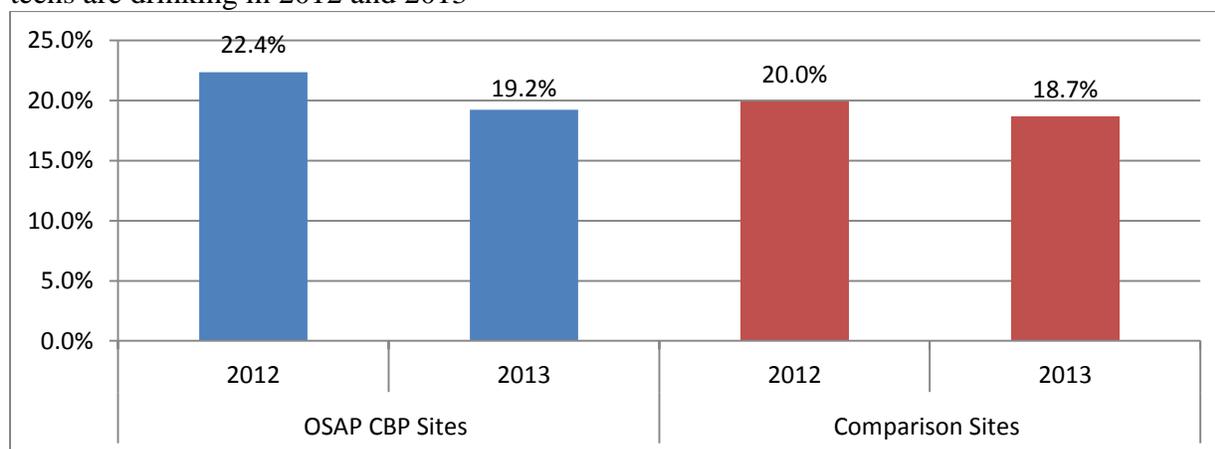


Figure 5: Percent of respondents who think it is very likely police in their community would arrest an adult for giving alcohol to someone under 21 in 2012 and 2013

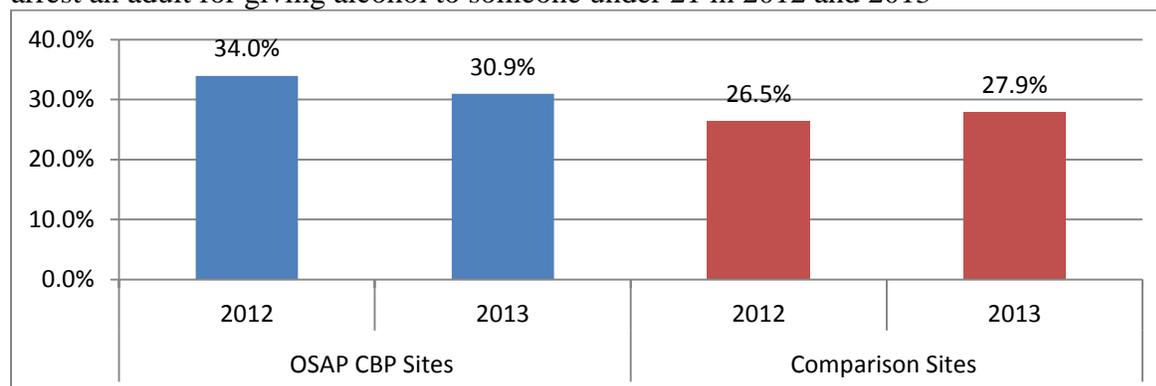


Figure 6: Percent of respondents who think it is very likely one would be arrested if caught selling alcohol to a drunk or intoxicated person in 2012 and 2013

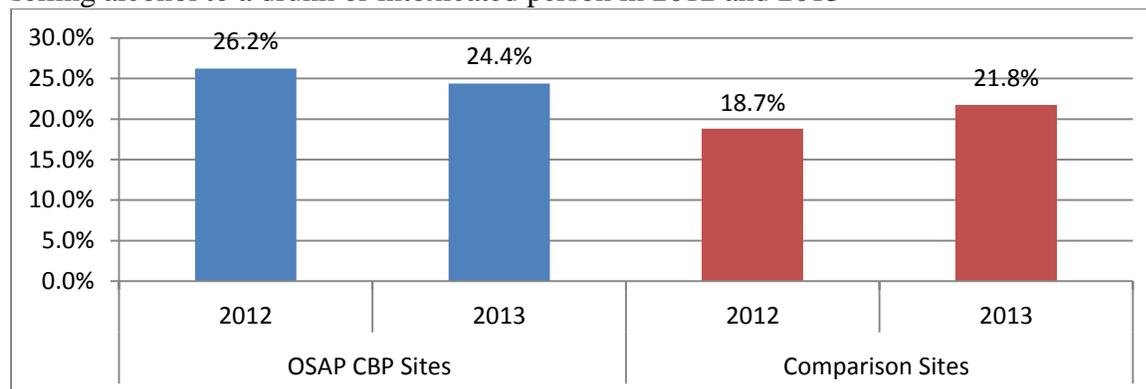


Figure 7: Percent of respondents who think it is very likely one would be stopped by police if driving after drinking too much in 2012 and 2013

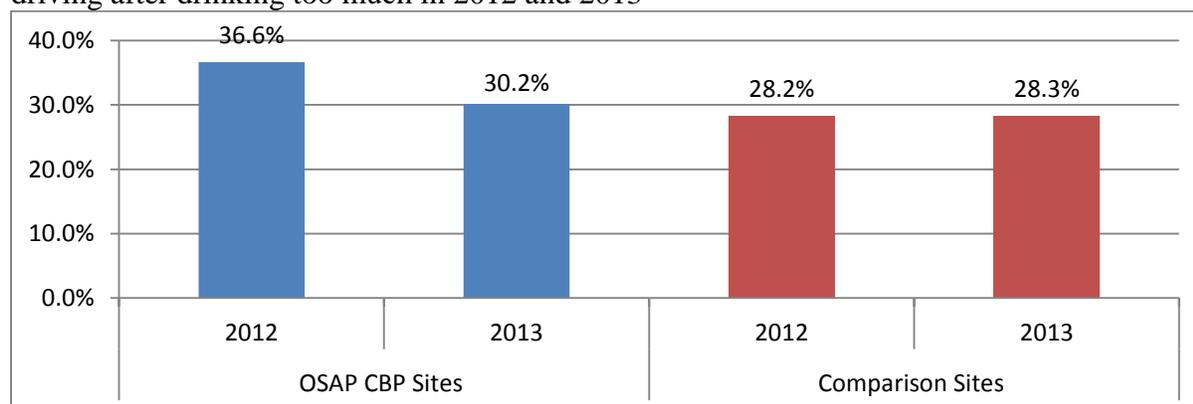
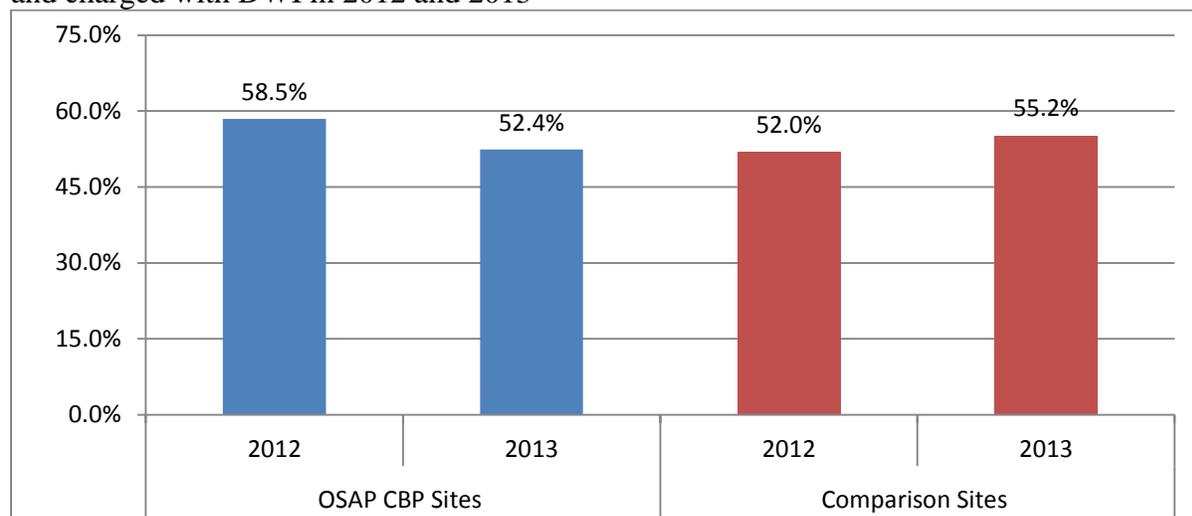


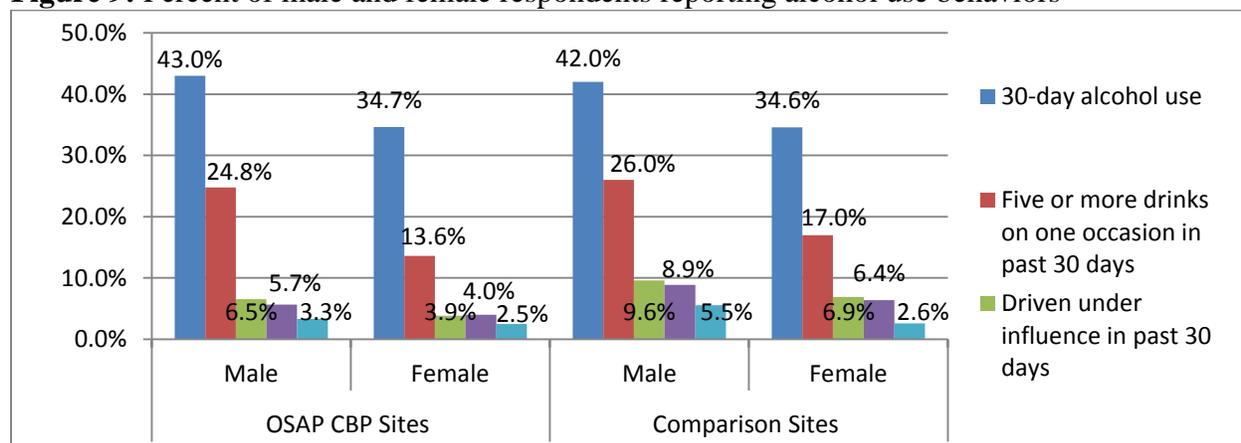
Figure 8: Percent of respondents who think it is very likely one would be convicted if stopped and charged with DWI in 2012 and 2013



2013 NMCS consumption results for men and women

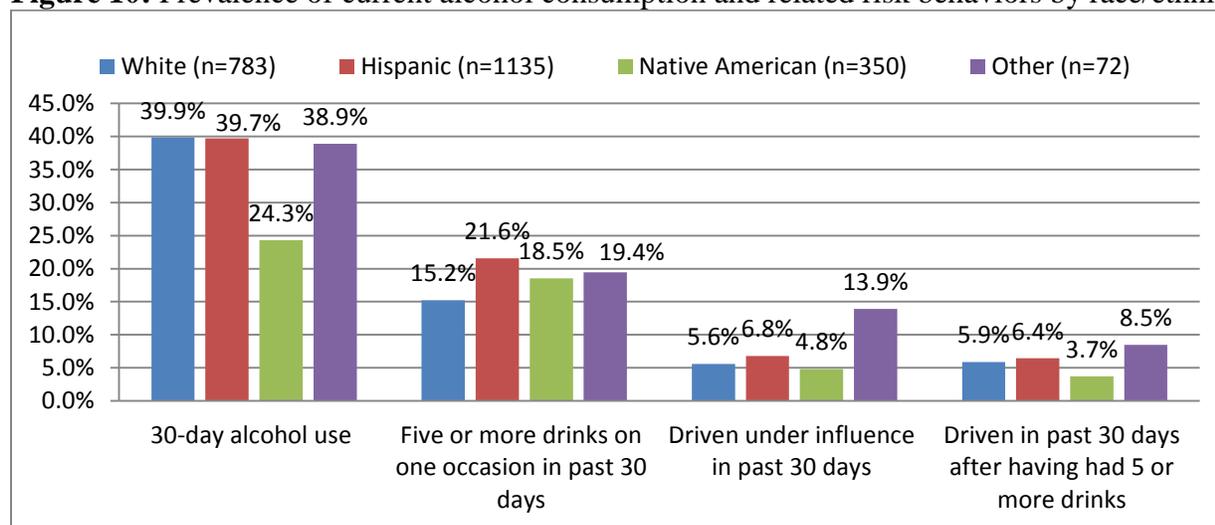
We assessed the 2013 NMCS alcohol consumption and related risk behaviors and examined these responses by gender. For every alcohol consumption measure with the exception of past 30-day alcohol use, males in OSAP CBP communities reported lower prevalence compared to males in comparison communities. Males in comparison communities were slightly more likely to have driven under the influence, driven after having 5 or more drinks, and binge drinking. Males in comparison communities were also slightly more likely to report having provided alcohol to minors in the past year compared to 2013 OSAP CBP communities. Similarly, females in the OSAP CBP communities reported less binge drinking, drinking and driving, and binge drinking and driving compared with females in comparison communities. With regard to past 30-day alcohol use and having provided alcohol to minors in the past year, there was virtually no difference between these two groups of females (see Figure 9). These findings suggest that the prevention efforts to reduce problem alcohol use have made a difference among males and females in targeted communities.

Figure 9: Percent of male and female respondents reporting alcohol use behaviors



When examined by race/ethnicity, we find that non-Hispanic whites and Hispanics are equally likely to report drinking any alcohol in the past 30 days, but non-Hispanic whites are the least likely to report binge drinking (five or more drinks at one sitting) among all ethnic groups. Hispanics are most likely to report current binge drinking and other racial/ethnic groups are more likely to report driving under the influence and drinking and driving after having had five or more drinks. Non-Hispanic Native Americans are least likely to report any 30-day drinking, but those who did were more likely than non-Hispanic whites to report binge drinking. Figure 10 breaks down these estimates.

Figure 10: Prevalence of current alcohol consumption and related risk behaviors by race/ethnicity



When comparing 2012 NMCS data with the 2013 NMCS on the same measures by programming type², there are patterns suggest a decrease in alcohol consumption and drinking and driving in 2013 (see Figures 11-14). Within each group, there was a decrease from 2012 to 2013 for males on the four alcohol measures. There was also an observable decrease for females in OSAP-CBP communities except driving after having too much to drink. Females in comparison communities either increased or remained unchanged on most of measures except for 30-day alcohol use. OSAP communities fared better for males and females than comparison communities in 2012 and 2013 except for 30-day alcohol use.

² The comparison only includes communities that have both 2012 and 2013 data.

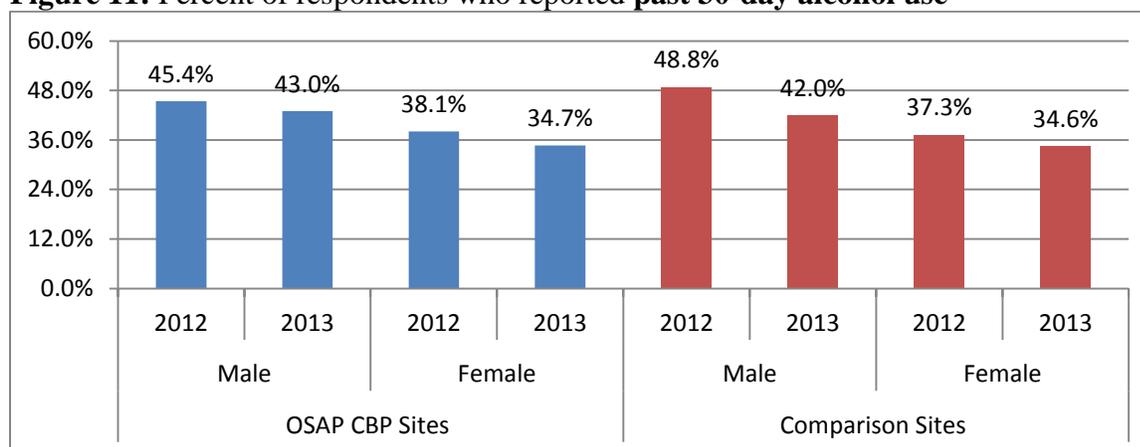
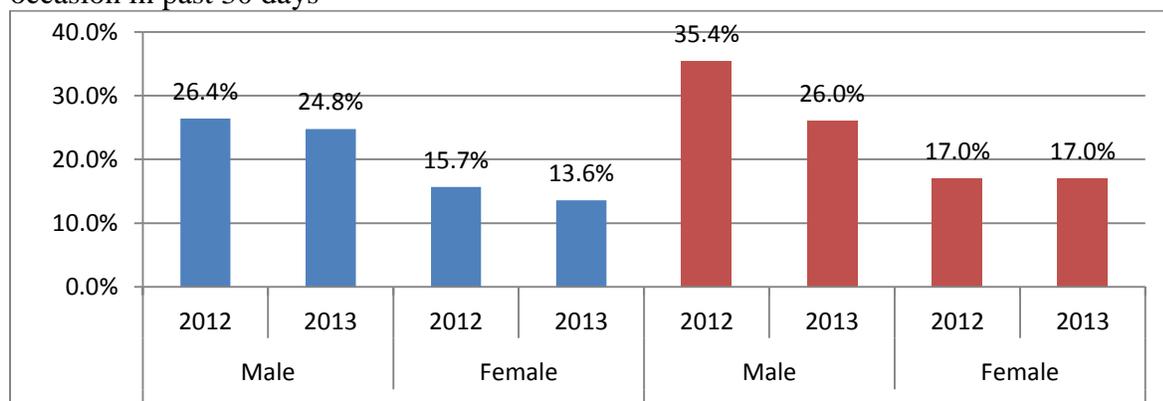
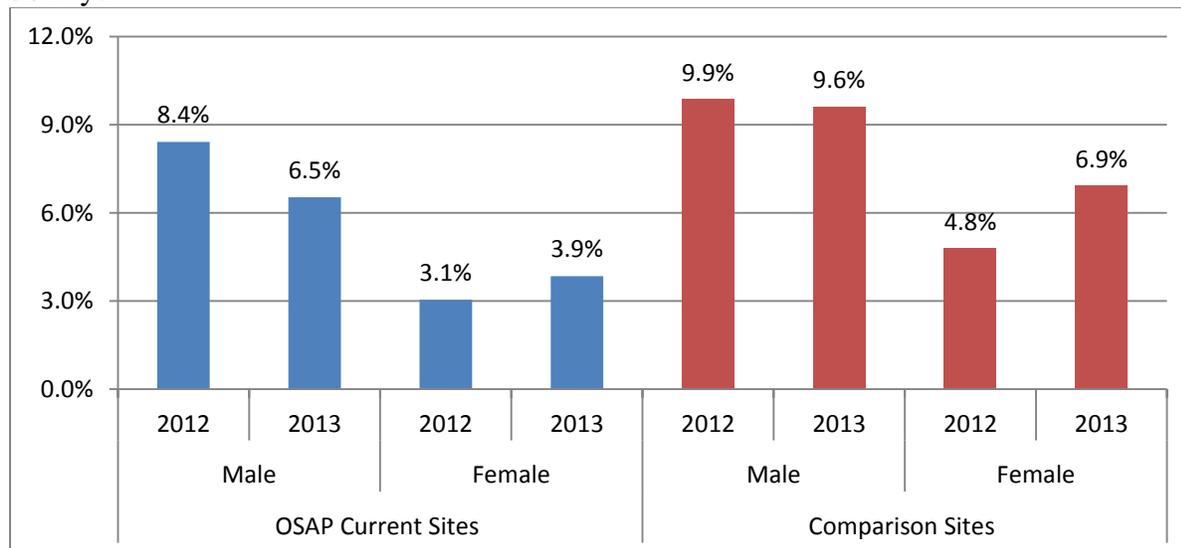
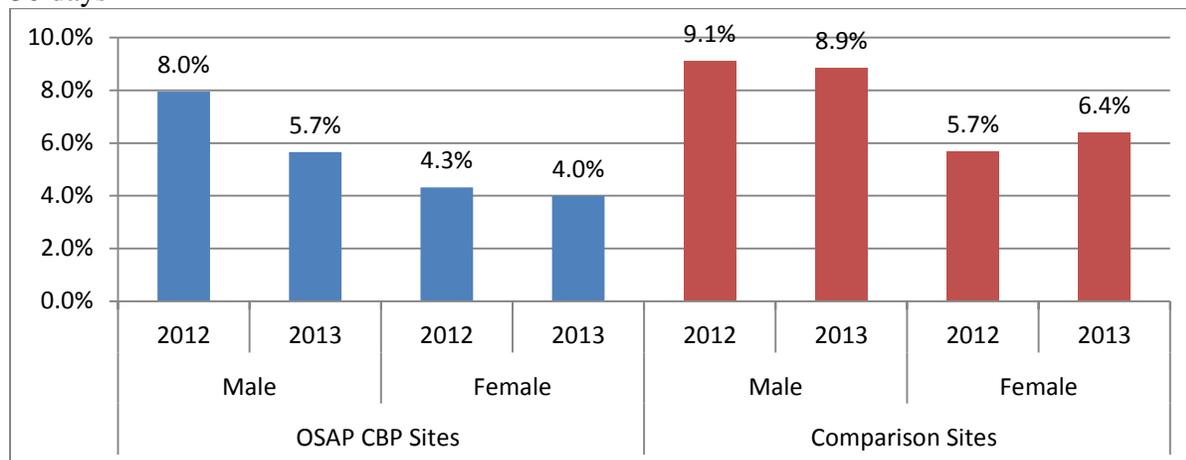
Figure 11: Percent of respondents who reported past 30-day alcohol use**Figure 12: Percent of respondents who reported drinking five or more drinks on at least one occasion in past 30 days****Figure 13: Percent of respondents who reported driving after having too much to drink in past 30 days**

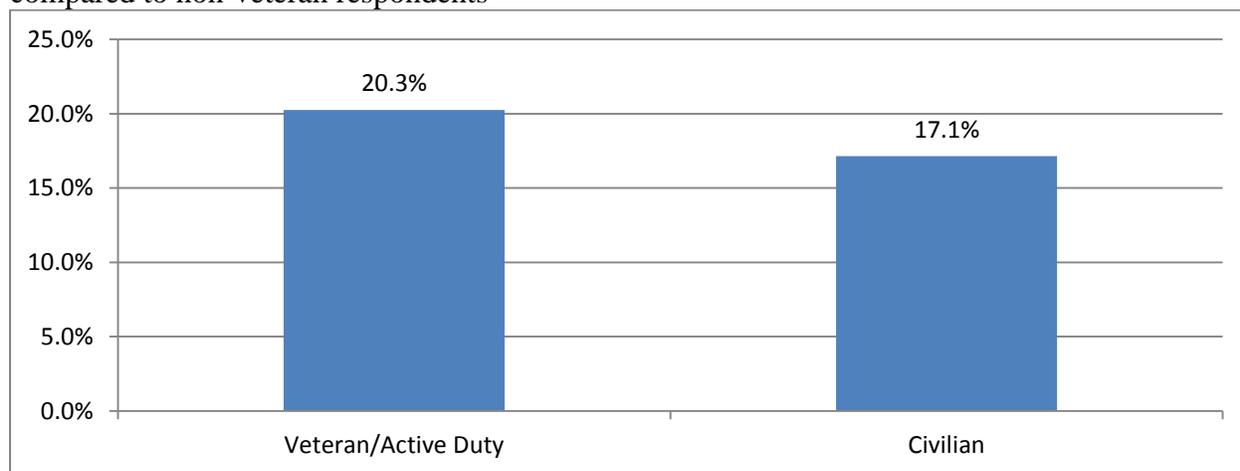
Figure 14: Percent of respondents who reported **driving after having 5 or more drinks** in past 30 days



Veteran and current military personnel

The 2013 NMCS continued to ask respondents if they were currently on active duty in the U.S. Armed Forces or a veteran of the U.S. Armed Forces. We examined this subgroup on several of the risk behaviors assessed. **Error! Reference source not found.** is the percent of binge drinking among veterans or active duty respondents compared to non-veterans. As seen in 2012, there are no meaningful differences between these two groups of respondents on past 30-day binge drinking.

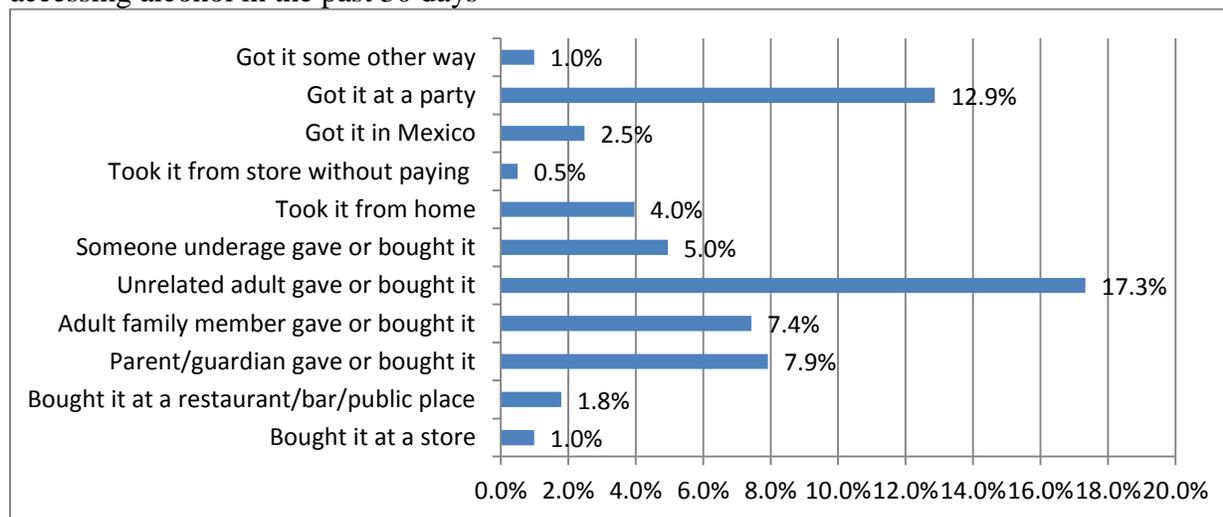
Figure 15: Prevalence of past 30-day binge drinking among veterans or active duty respondents compared to non-veteran respondents



Underage access to alcohol

There is considerable interest in understanding how underage drinkers access alcohol. The NMCS includes a question specifically on this topic for 18 to 20 year olds. Figure 16 displays the responses to the question, “During the past 30 days, how did you get your alcohol?” This question was only completed by underage respondents who reported drinking alcohol in the past 30 days, so the overall sample of respondents for this question is considerably smaller than for other questions. Respondents were allowed to select as many options as applied³. Not surprisingly, social access is by far the most common means of accessing alcohol as a minor. As in 2012, having a legal adult purchase alcohol to give to the minor (17%), drinking at a party (13%), or having parent or guardian provide it (8%) were the most common methods by which respondents indicated they accessed alcohol as minors in 2013. There is a considerable decrease (from 17% in 2012 to 8% in 2013) of underage respondents who indicated either obtaining alcohol by purchasing it at a store or restaurant, or having someone else under 21 purchase alcohol for them. This suggests that communities that have effectively addressed reducing retail access of alcohol to minors appear to be making good progress. Addressing social access continues to lag behind as it is more challenging to address, involving deeply held social norms. However, these findings again point to the considerable need to start to develop environmental strategies to address this key indicator. Figure 16 displays the percent of each place where underage drinking adults obtained alcohol in the last 30 days.

Figure 16: Percentage of underage current drinkers who identified each of the listed means of accessing alcohol in the past 30 days



³ There is a similar question about access to alcohol in the Youth Risk and Resiliency Survey that could match this question, but we consider inadequate to capture the access issue at its heart: the YRRS survey requests a singular response to the most accessed source. The NMCS question instead provides the breadth of possible responses, as it is important to understand all possible sources of alcohol in order to address the full spectrum of access for evaluation purposes. For example, the YRRS question lacks the ‘at a party’ option, which has always gained a significant response in our survey.

Summary

Alcohol remains a persistent public health problem in NM. Decreasing trends were found for males in OSAP-funded and comparison communities and slight increases were present mainly for females in comparison communities, which may indicate that prevention programs are having positive effects. Perceptions of risk are decreasing mainly in OSAP-funded communities. This is of considerable concern given OSAP has strongly encouraged all funded programs to link highly visible enforcement with increasing the perception of risk of arrest for those enforcement efforts. It suggests there is a continuous need for a comprehensive campaign that coordinates federal, State, and local law enforcement agencies and judicial systems, local prevention providers and coalitions, school administrators and educators, as well as state and local media outlets and state government to address perception of risk of legal consequences for breaking alcohol-related laws. In addition, a broad NM approach to decreasing social access remains elusive, yet a consistent and concentrated effort must be a focus of future prevention efforts to prevent underage drinking if there are to be noticeable reductions.

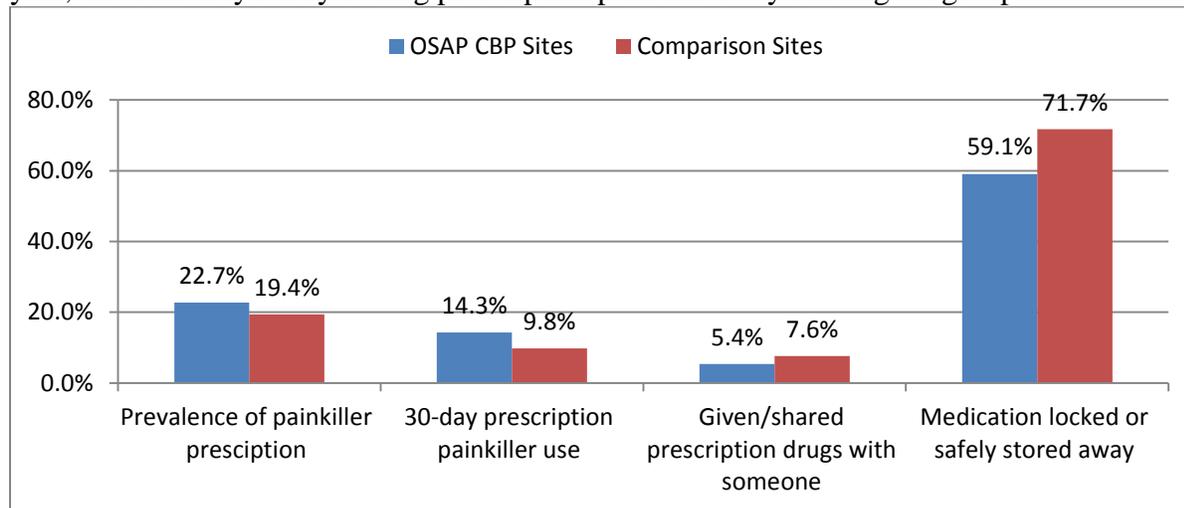
Prescription Pain-killers

Between 2007 and 2011, almost 50% of drug overdose deaths were attributable to prescription drugs and of those, 50% were attributed to prescription opioids or pain-killers. New Mexico's average drug-induced death rate from 2007 to 2011 was 24.3 per 100,000 population compared to 12.3 for the U.S. as a whole. Within NM, the prescription drug death rate by county varies dramatically, suggesting that access to prescription painkillers may be correlated.

Seven NMCS prescription pain-killer questions assessed the prevalence of prescriptions issued for opioids and current opioid use, as well as risk factors such as reasons for use, sharing of prescription opioids, and storage of prescription medications. Figure 17 below provides a breakdown of four of these topic areas across funding groups. Specifically, comparison sites reported a lower prevalence of prescription pain-killer use in the past year as well as 30-day prescription pain-killer use than OSAP CBP communities. OSAP CBP communities reported considerably less past 30-day use than comparison communities and were less likely to store medications safely to reduce access. On the other hand, OSAP CBP communities were slightly less likely to report sharing prescription medications with someone else.

Comparing 2013 to 2012, there is a slight decrease in the prevalence of receiving prescription pain-killers for a medically-identified problem in the past year across both OSAP CBP and comparison communities. In 2012, approximately 26% of both comparison and OSAP CBP communities reported receiving a prescription for painkillers, whereas in 2013 only 19% of comparison communities and 23% of OSAP CBP communities reported receiving a prescription for pain medications in the past year. The prevalence of having used a prescription pain-killer for any reason in the past 30 days ranged from 10% in comparison communities to 14% in OSAP CBP communities in 2013. What is encouraging is that there are two comparison communities specifically targeting prescription pain killer use in their prevention efforts and that comparison communities are performing better than OSAP CBP communities is very supportive of their efforts in those communities.

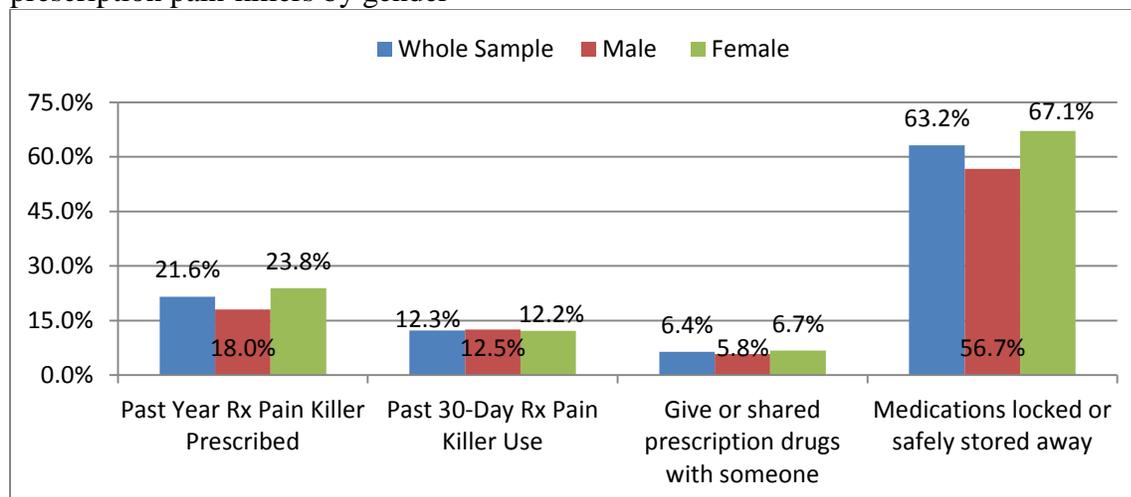
Figure 17: Percent of respondents who reported receiving prescription painkiller prescriptions in past year, using prescription painkillers in past 30-days, sharing prescription drugs in the past year, and currently safely storing prescription pain-killers by funding subgroup



Pain-killer use by gender, race/ethnicity and age group

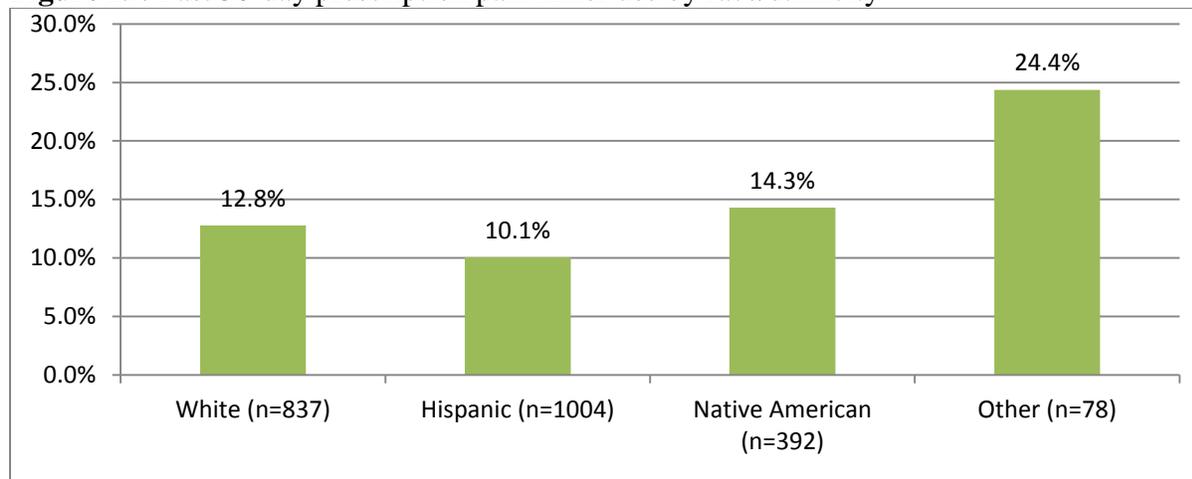
Examining these same indicators stratified by gender, we see a similar pattern in 2013 as in 2012 that females report receiving prescriptions for pain-killers only slightly more frequently than males although past 30-day use does not really differ. Women are also slightly more likely to share their medication with others. Finally, women are more likely to report storing their prescription medications properly. See Figure 18.

Figure 18: Percent of respondents who reported prescriptions for and use, sharing, and storage of prescription pain-killers by gender



Other race/ethnicities report the highest prevalence of current use of prescription pain medications followed by Native Americans, Non-Hispanic whites and Hispanics. **Error! Reference source not found.** displays past 30-day prescription pain-killer use by race/ethnicity.

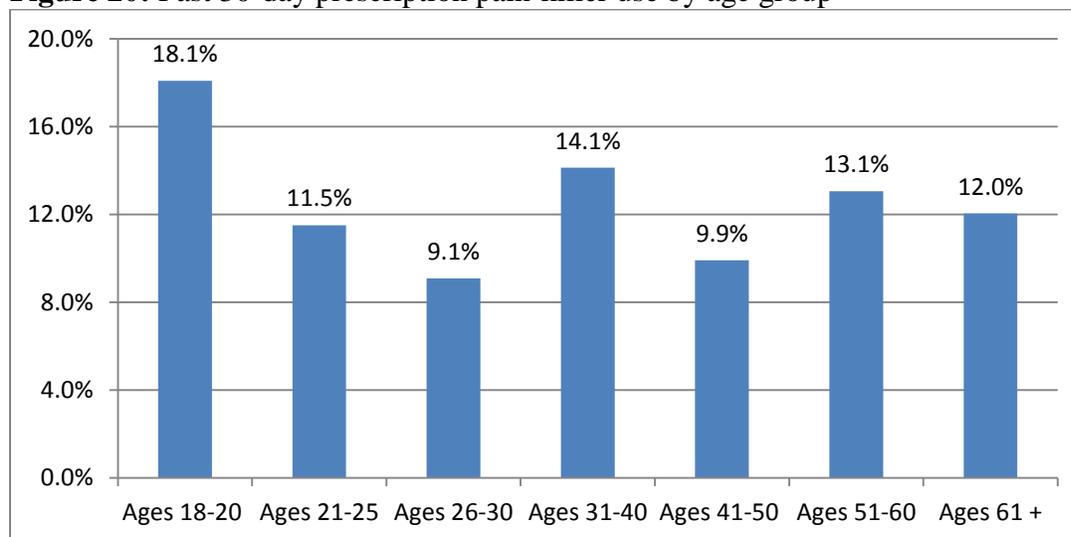
Figure 19: Past 30-day prescription pain-killer use by race/ethnicity



Prescription pain-killer use in 2013 exhibits an unusual pattern. In the past, prescription pain-killer use typically increased as age increased, yet this was not the case in 2013. The highest percentage of users concentrated in the age group 18-20. They reported more use than any other age groups.

Figure 20 displays current use by age group.

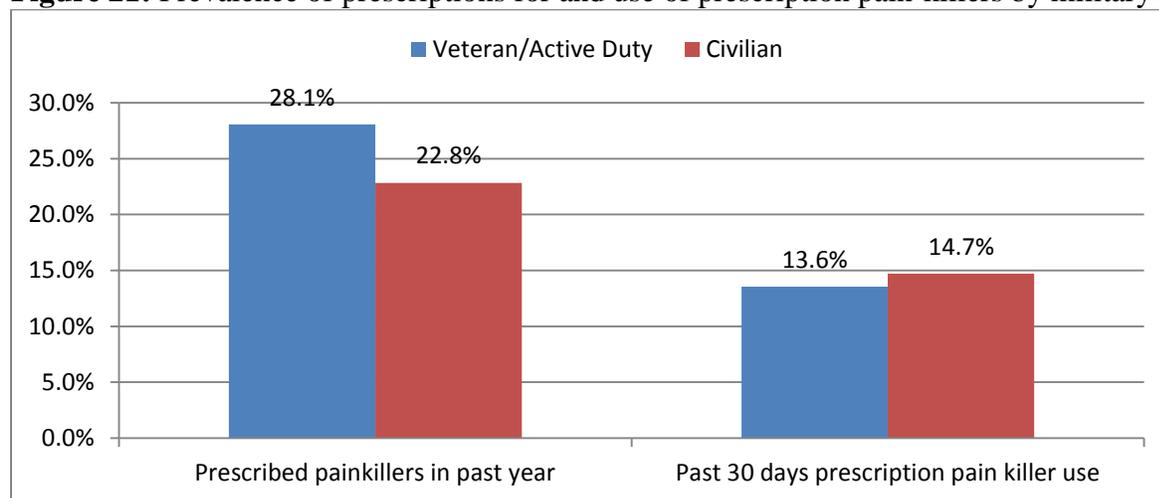
Figure 20: Past 30-day prescription pain-killer use by age group



Military personnel and prescription pain-killers

Veterans and active duty military personnel are more likely than civilians to report having been given at least one prescription for pain-killers in the past year (28.1% vs. 22.8%) in 2013. The same was true in 2012. They differ only slightly in current prescription pain-killer use (13.6% veteran/active duty vs. 14.7% civilian). Given a consistently greater prevalence of pain-killers being prescribed in the last year among veteran and active duty respondents, it is reasonable to assume this may be attributable in part to injuries sustained while in the military (see Figure 21).

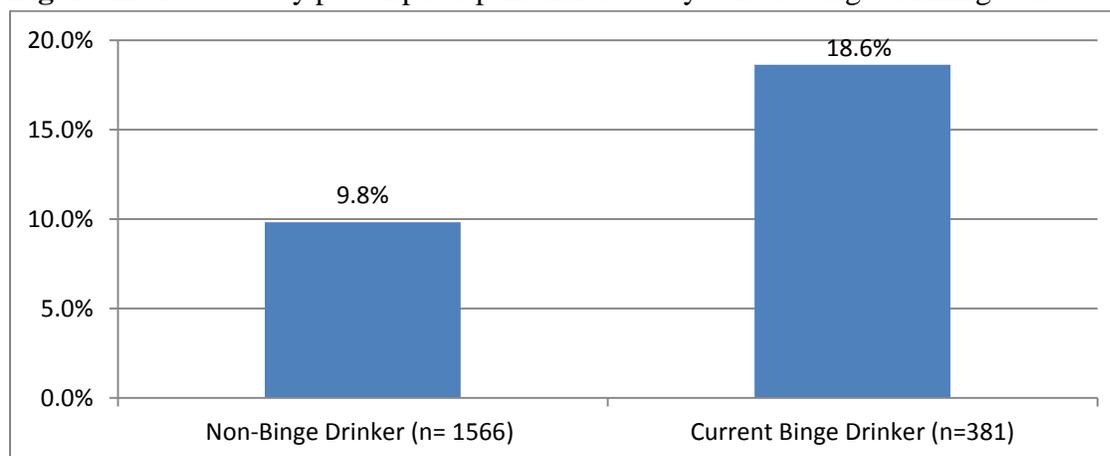
Figure 21: Prevalence of prescriptions for and use of prescription pain-killers by military status



Binge drinking and prescription drug use

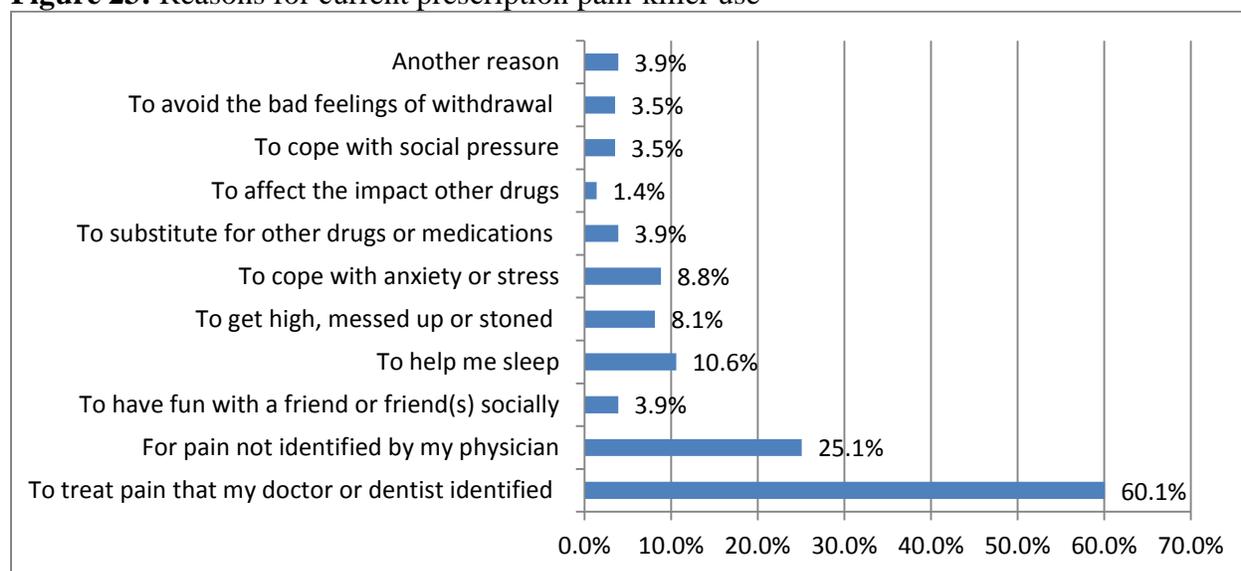
We examined the possible co-occurring risk behaviors of binge drinking and prescription drug use. Figure 22 graphs this relationship. Current binge drinkers were more likely to report current prescription pain-killer use (18.6%) as compared to non-binge drinkers (9.8%). Although it is impossible to determine if the drinking occurred concurrently with prescription drug use, the potential for this to occur exists. The ‘legal’ nature of both drugs often allow for their users to imagine that their use, as well as their combination is harmless; and binge drinking and painkiller use cause decreases in judgment that make it easier for individuals to combine their use. Prescription drug use with heavy alcohol use is a recipe for accidental overdose or poisoning.

Figure 22: Past 30-day prescription pain-killer use by current binge drinking behavior

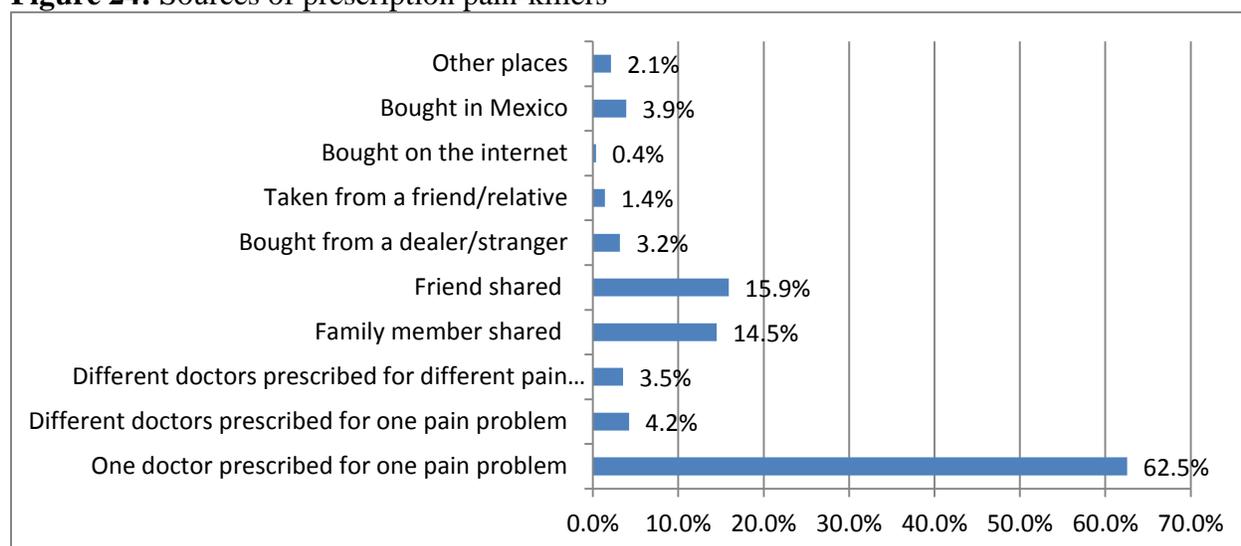


Reasons for prescription pain-killer use and sources of painkillers

Current users of painkillers were also asked about the reasons they used them. Respondents could select any of the relevant reasons. Not surprisingly, current users of prescription pain medications indicate that they principally use them for legitimate pain identified by a doctor (60.1%) (see Figure 23). About 25% of the sample reported using prescription pain medications for pain not identified by a doctor. This suggests that respondents are using medication left over from a previous prescription or are accessing pain medications from a family member, friend, or someone else rather than with a doctor’s prescription. Just over 10.6% indicate that they used prescription pain meds in the past 30 days to help them sleep, and another 8.8% to help them cope with anxiety or stress. It is disappointing to see that only 60% of 30-day pain-killer users reported using them with a physician’s approval, down from 75% in 2012. About 25% of current users of prescription pain-killers used them for pain not approved detected by a physician, up from 17.7% in 2012. Using prescription pain killers to get high or messed up more than doubled from 3% of respondents in 2012 to just over 8% in 2013. Using prescription pain killers to cope with stress or anxiety increased slightly as well from 6.8% in 2012 to 8.8% in 2013. Respondents were allowed to select all explanations that applied to their use.

Figure 23: Reasons for current prescription pain-killer use

Finally, current users of prescription pain meds were asked about where they obtained their medication; respondents were allowed to select all of the responses that applied to them. About 63% indicated that only one doctor prescribed the medication for a legitimate medical reason, which was down from over 75% in 2012. Increases in the prevalence of obtaining drugs from family members, friends, dealers, and in Mexico all increased in 2013. In particular, respondents reporting that friend and/or family member shared with them both more than doubled from 2012. Getting prescription pain killers from more than one doctor decreased slightly from 2012 (see Figure 24).

Figure 24: Sources of prescription pain-killers

Summary

Prescription drug abuse and associated overdose hospitalizations and deaths are on the rise in NM. Most of these overdoses are the result of prescription opioid or pain-killer use. About 23% of respondents report that they have received a prescription for a pain-killer from a physician in the past year suggesting that there is at least the potential for large, readily available quantities of pain-killers for potential misuse and abuse. While most respondents continue to report using pain medication in the last 30 days in order to address medically-legitimized pain, there is also an increasing subset of respondents who report using prescription pain-killers for other than their intended reasons. Veterans and active duty military personnel may be at greater risk for prescription pain-killer use because of receiving more prescriptions and binge drinkers report almost twice as much prescription pain killer use than non-binge drinkers. Females share their prescription meds more frequently than males but also are more likely to store their prescription pain medications securely. Use of prescription pain meds across age groups showed no clear pattern regarding the association between age and use of prescription pain meds, although 18 to 20 year olds reported more use than 21 to 39 year olds both in 2012 and 2013. It is concerning that a higher portion of 18-20 years old in 2013 reported use than in 2012 (18% vs. 15%). Whether this is due to legitimate reasons, such as sports injuries or dental work, common in adolescence or to recreational or other misuse/abuse is unknown.

This is the second time that we have collected data on prescription pain meds since 2012. It is difficult to construct trend data over two years to examine prescription pain-killer use among adults in NM at this point. Particularly there were only seven communities that conducted complete or partial prescription drug questions in 2013, whereas there were 36 communities in 2012. Given the capacity built among NM preventionists in addressing retail and social access to tobacco products and alcohol, also “legal” drugs, access to prescription pain medication may be an effective place to introduce and focus prevention efforts.

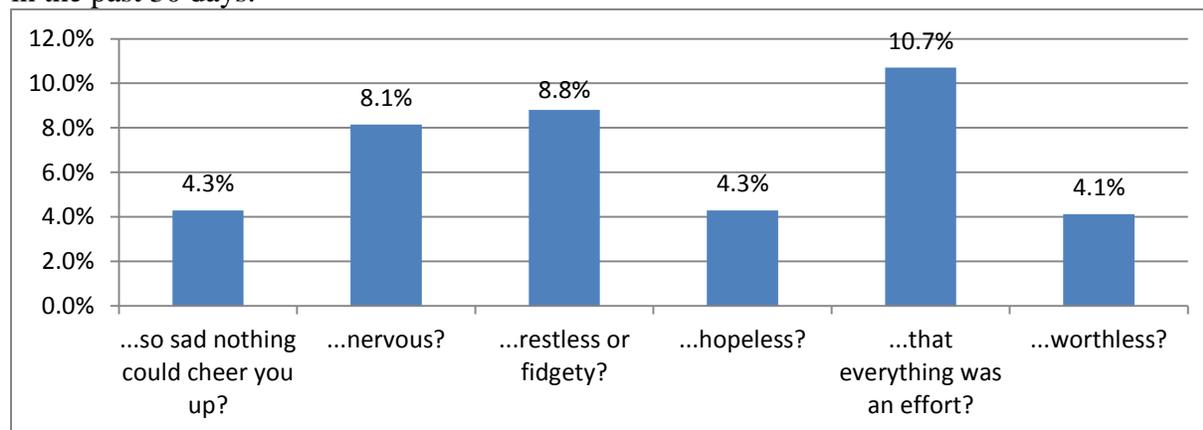
Mental Health

As in 2012, the 2013 NMCS also included measures of mental health. Twelve questions were asked of respondents to ascertain various degrees of mental health problems. A total of four communities in 2013 included the mental health questions in their community survey. Among them, only two communities included all 12 questions and the other two communities included 9 and 10 questions respectively.

Six of the questions were selected from the World Health Organization’s (WHO) World Mental Health Surveys (WMHS). They are also included on the U.S. National Health Interview Survey

(NHIS), self-administered version.⁴ Each question begins with the stem, “During the past 4 weeks (28 days) how much of the time did you feel...” followed by six different endings. Respondents replied on a 5-point scale (0-4) from none of the time to all of the time. Figure 25 shows the prevalence of respondents who responded either “all of the time” or “most of the time” for each item. There was a fairly low prevalence of respondents indicating they felt poorly all or most of the time for the six indicators. The item “...feeling that everything was an effort” stands out as relatively high compared with the other measures. A total score across the six items of 13 or more suggests the presence of a serious mental illness (SMI), such as major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder, panic disorder, post-traumatic stress disorder (PTSD) and borderline personality disorder. As a symptom screening tool, the scale does not actually diagnose or identify those respondents who may currently be successfully treated for a serious mental illness. Just 6.5% reported a total score of 13 or greater indicating the presence of a SMI, which coincides closely with the estimated 5-8% of the population the WMHS is designed to identify. The alpha coefficient for this scale was $\alpha = .87$, a respectable score of reliability.

Figure 25: The percent of respondents who reported they felt the following all or most of the time in the past 30 days.



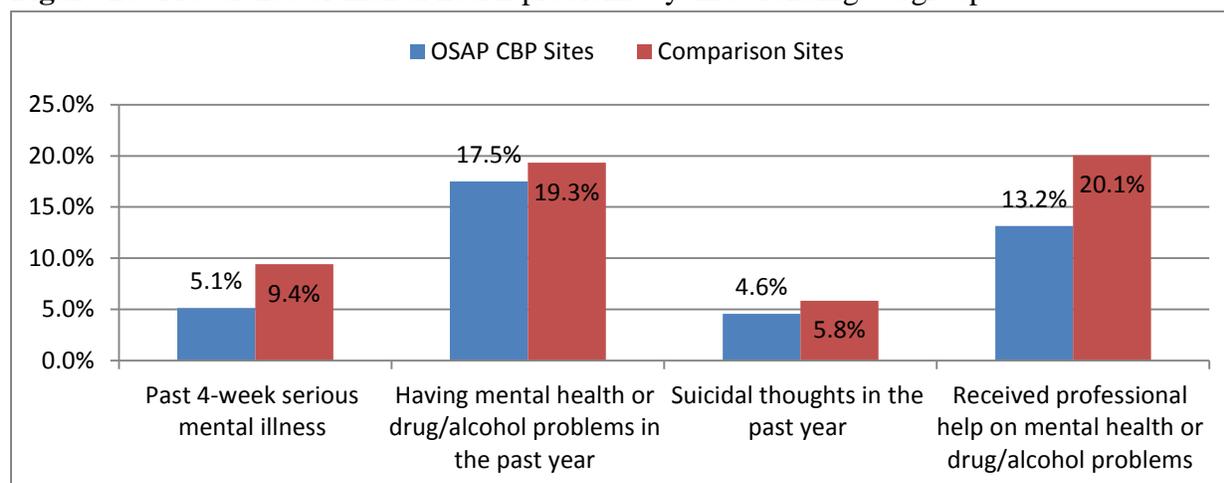
Mental health by prevention funding subgroup

Figure 26 below provides a breakdown of prevalence for four measures of mental health by funding subgroup. The first item is the indicator of the presence of a serious mental illness based on the WHO scale discussed above. Comparison communities in 2013 reported a higher prevalence of mental health problems than respondents in OSAP CBP communities on past 4-week SMI, past year experiencing a mental health, drug or alcohol problem and suicidal thoughts

⁴ Kessler, R.C., Barker, P.R., Colpe, L.J., Epstein, J.F., Gfroerer, J.C., Hiripi, E., Howes, M.J, Normand, S-L.T., Manderscheid, R.W., Walters, E.E., Zaslavsky, A.M. (2003). Screening for serious mental illness in the general population. *Archives of General Psychiatry*. 60(2), 184-189.

in the past year. It should be noted that this comparison was made between three OSAP CBP communities and one comparison community. Caution should be exercised when generating conclusions from these results. Interestingly, a larger percentage of respondents in comparison communities also received help from a health care professional.

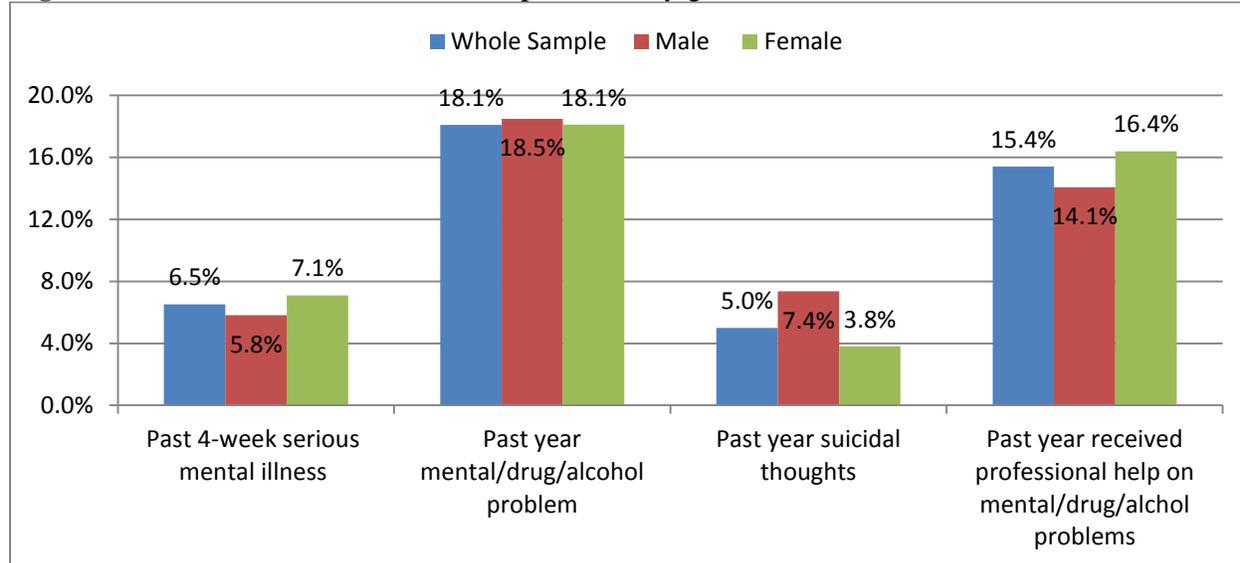
Figure 26: Prevalence of mental health problems by three funding subgroups



Mental health by gender

Gender differences in mental health measures are typically found in the research literature; females generally report more internal mental health problems such as depression and anxiety whereas males more often report externalized mental health problems such as engaging in risk behaviors such as substance use, DWI, or aggression. In 2013, the prevalence of SMI among females was slightly higher than males, but very similar to males in their prevalence of reported mental/drug/alcohol problems in the past year. They also were more likely to report receiving professional help on mental health issues than males. In the case of suicidal ideation, males reported a higher prevalence than females. This difference is of concern since males are more often successful at committing suicide than females because the methods typically used by males are more fatal.

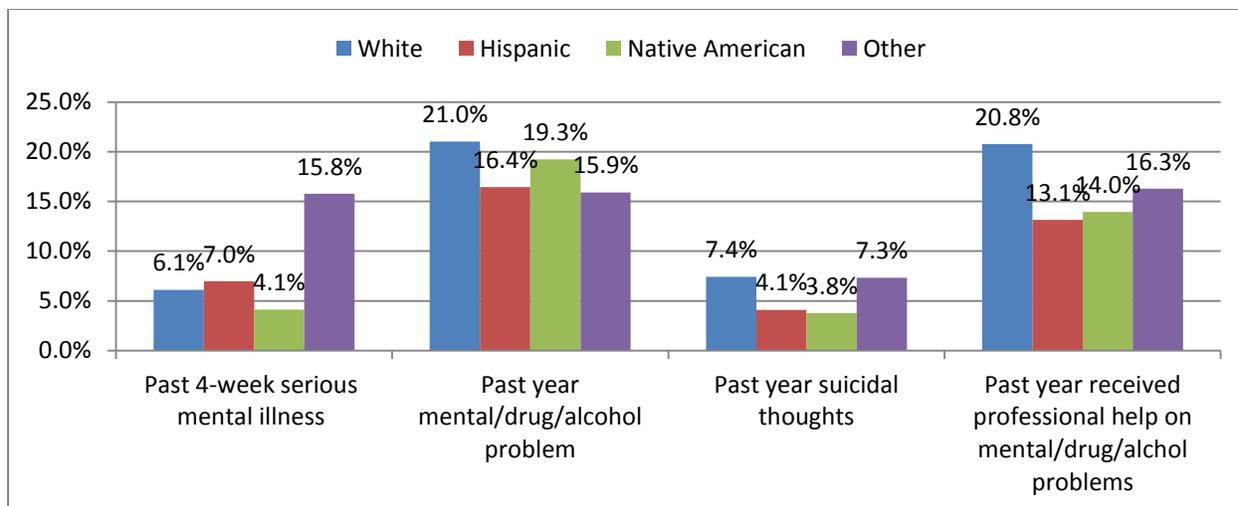
Figure 27 displays the differences in prevalence by gender compared to the whole sample. Of concern among the 2013 sample is that the prevalence of mental/drug/alcohol problems increased from approximately 15% in 2012 to 18% in 2013. In addition, suicidal ideation also increased slightly from 4% in 2012 to 5% in 2013. Fortunately, access to health care also increased from 10.6% in 2012 to 15.4% in 2013.

Figure 27: Prevalence of mental health problems by gender

Mental health by race/ethnicity

Mental health varied by race/ethnicity. Other race/ethnicities with African Americans/Blacks and Asian/Pacific Islanders, reported the highest prevalence of SMI. Non-Hispanic Whites report the highest prevalence of a mental health, drug, or alcohol problem in the past year but were also mostly likely to receive professional help for the problem compared the rest of the sample. Non-Hispanic Whites and other race/ethnicities are more likely to report suicidal ideation than Hispanics and Native Americans. Native Americans were least likely to report SMI in the past 30 days and Hispanics were least likely to have received professional health for their mental health problems (see Figure 28).

Figure 28: Prevalence of mental health problems by race/ethnicity1



Mental health by age groups

Mental health risk changes over the lifespan. Many adolescents experience depression and suicidal ideation during high school that resolves as they age. At the same time, unaddressed mental health or substance abuse issues in adolescence can deepen into more severe mental illness and/or addiction in adulthood. **Figure 29** and

Figure 30 compares the seven age groupings on the mental health measures. Compared to all other age groups, 18 to 20 year olds report the highest prevalence of SMI in the past 4 weeks and of suicidal ideation in the past year. Past-year mental health, drug, or alcohol problems were most prevalent among 31 to 40 year olds, but were prevalent across all age groups except those ages 61 and older. Mature adults are also less likely to have received professional help for mental health problems (6.8%).

Figure 29: Prevalence of serious mental illness and drug or alcohol problem by age groups

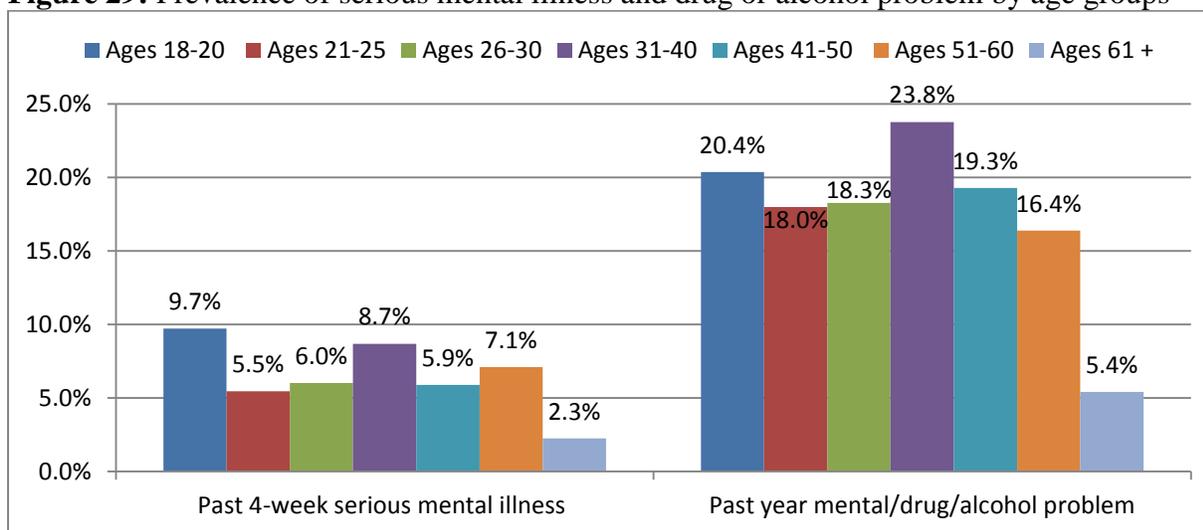
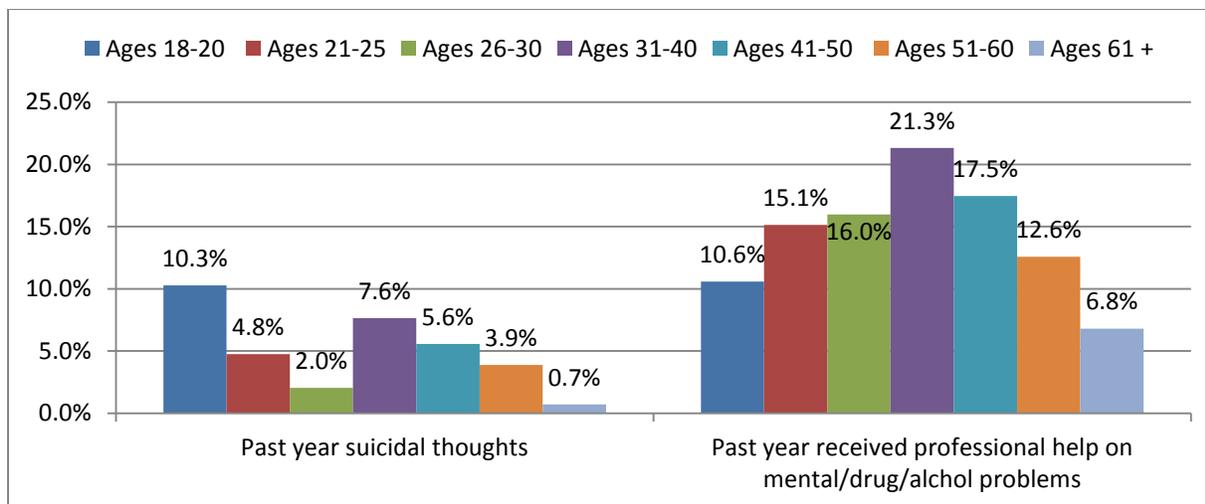


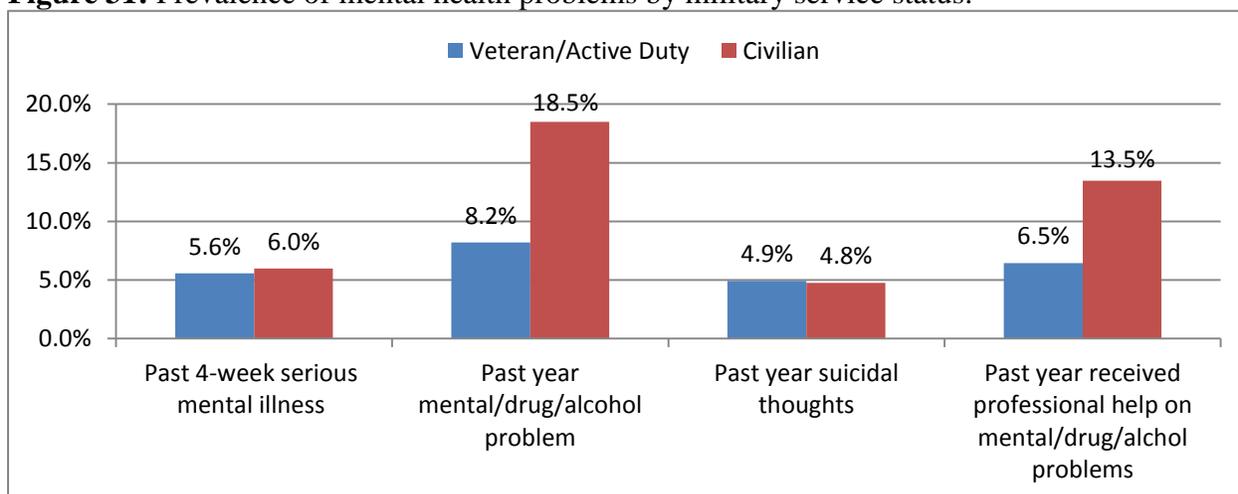
Figure 30: Prevalence of suicidal thoughts and receiving professional help by age groups



Military service and mental health

When examining mental health status among those who were veterans or are active duty military personnel, we found that civilians reported a much higher prevalence in mental health, drug, or alcohol problems in the past year than former and current military personnel. On the other hand, civilians were also more likely to report receiving professional help. Differences were much smaller in past 4-week SMI and last year suicidal thoughts. **Error! Reference source not found.** elow compares former and current military personnel with civilians.

Figure 31: Prevalence of mental health problems by military service status.

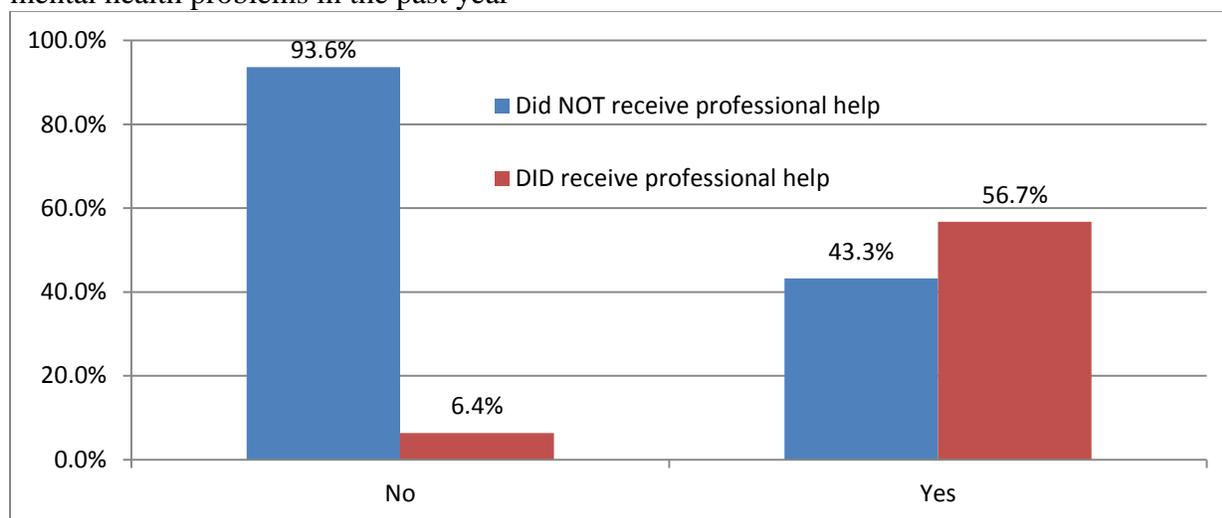


Mental health and access to care

Across the sample that completed in mental health questions, among those who reported a mental health, drug or alcohol problem in the past year, over half of them (57%) accessed professional help⁵ for their problem, up from 48.5% in 2012. A small percentage (6.4%) of respondents who did not indicate a mental health, drug or alcohol problem in the past year reported receiving professional help for a mental health problem although as expected most did not.

Figure 32 displays this association between mental health problems and receiving professional care.

Figure 32: Prevalence of receiving professional help dependent on whether one has experienced mental health problems in the past year

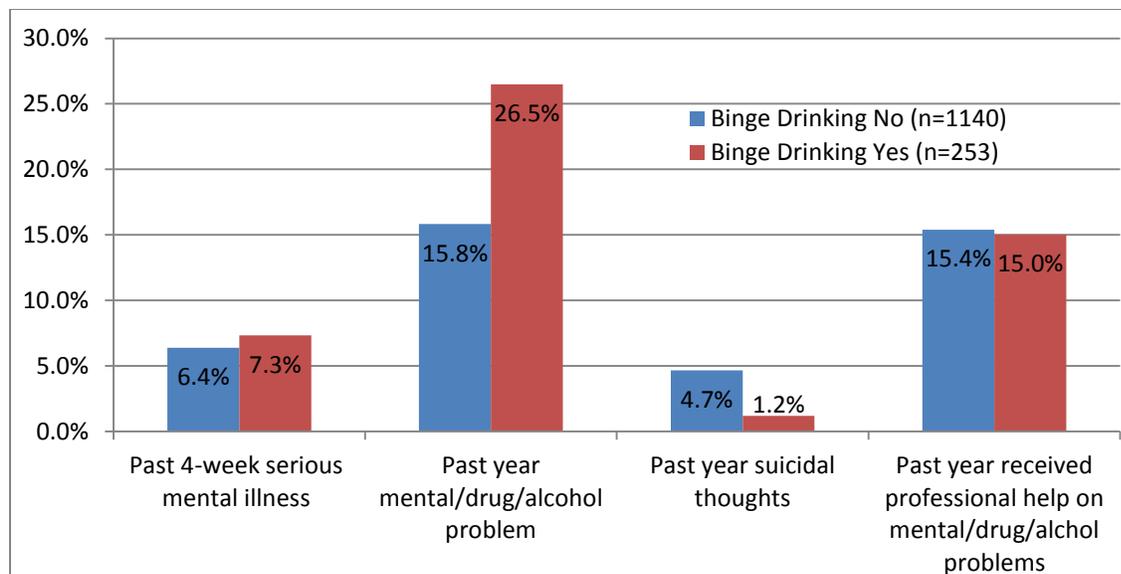


Binge drinking and mental health

Mental health is known to be correlated with substance use; therefore, we examined the mental health measures by whether respondents were current binge drinkers or not. Binge drinkers reported a much higher prevalence of mental health, drug, or alcohol problems in the past year yet a much lower prevalence of suicidal thoughts, although in 2012 they reported greater prevalence on both measures (see Figure 33).

Figure 33: Prevalence of mental health problems by past 30-day binge drinking

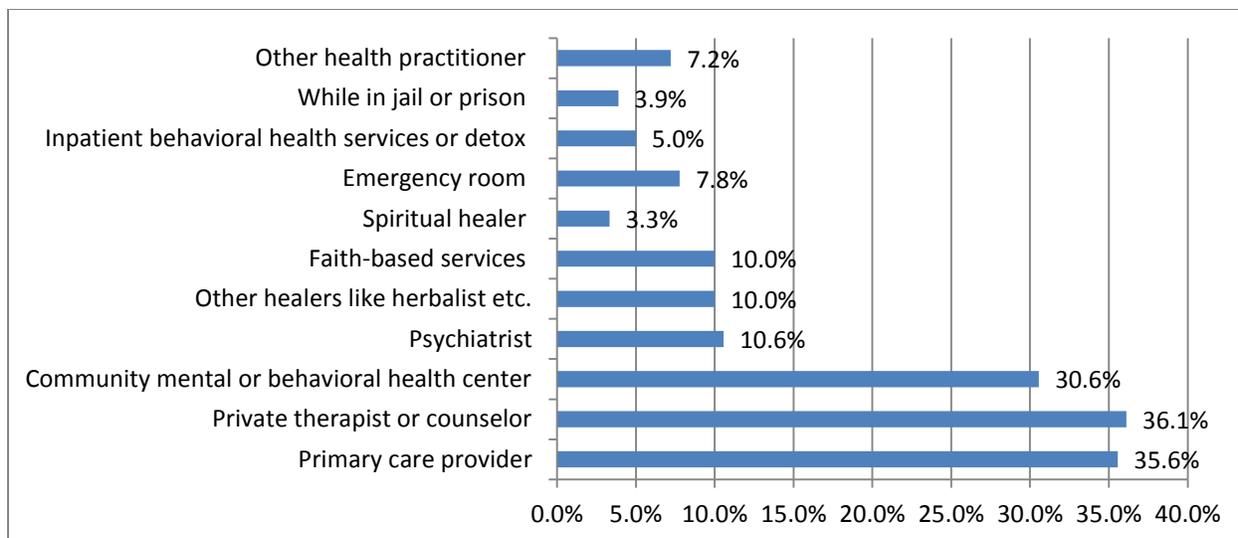
⁵ Note that “professional help” included private and public behavioral health agencies, as well as 12-step, faith based and alternative kinds of help that licensed service providers may not consider “professional.” The intent was to determine whether individuals were looking for outside help, rather than turning to friends, family or the internet for example. This definition also acknowledges that many of these non-licensed kinds of providers do consider their help to be professional.



Sources and types of mental health treatment

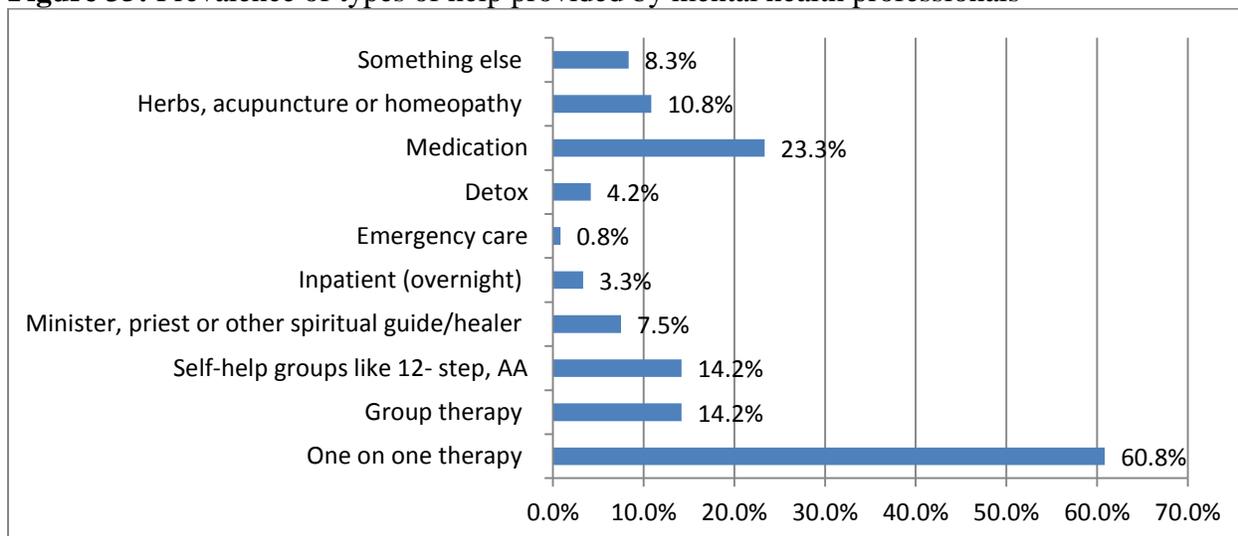
Those respondents who indicated having received professional help in the past year were asked two additional questions about where and what kind of help they received. Respondents selected all responses that applied to them. About 36% reported going to their primary care provider for help or saw a private therapist or counselor respectively down slightly from, 2012 when it was approximately 43%. Another 31% went to a community mental or behavioral health center: an increase from 2012 when only 21.4% reported seeking help at a community behavioral health center. Fewer respondents reported seeing a psychiatrist in 2013 (10.6%) than in 2012 (16.5%) and more reported seeking help at untraditional healers (6.8% in 2012 vs. 10.0% in 2013). Respondents could have accessed multiple sources for treatment. Respondents receiving professional mental health treatment in the emergency department, inpatient behavioral health/detox programs, in jail, or with a health care physician not their primary care provider all increased in 2013. Use of faith-based or spiritual healers decreased in 2013. Figure 34 breaks down the various responses provided by respondents.

Figure 34: Prevalence of where respondents went to receive professional help for mental health problems in the past year



Respondents were also asked to identify the “type” of help received such as individual or group counseling, medications, or other types. One-on-one therapy was by far the most prevalent form of treatment received followed by medication. This suggests many may be receiving what is considered best practice in the treatment of mental health problems, a combination of therapy with medication. Group therapy, self-help/12-step programs, and faith based services were also used with some frequency. Figure 35 provides a breakdown of various types of help received for mental health problems.

Figure 35: Prevalence of types of help provided by mental health professionals



Summary

In 2012, the NMCS included questions about mental health for the first time. These questions provide a baseline for mental health indicators in NM. In 2013, there were four communities that have administered the mental health questions. It is difficult to compare the 2013 results with the 2012 results and draw conclusions about mental health issues at state level given the size of the 2013 mental health sample. Considering the 2013 results, it appears that differences by gender as well as veteran status are minimal whereas there is greater discrimination by race/ethnicity and age. Young adults 18 to 20 and 31 to 40 year-olds seem to be most at risk for mental health problems. Non-Hispanic Whites experienced the highest prevalence of mental health problems compared to all other race/ethnicity categories. Native Americans and Hispanics are least likely to have accessed professional mental health services in the past year. More than half of the respondents who indicated having experienced a mental health, drug, or alcohol related problem in the past year also received professional help. As with prescription pain-killer use, binge drinking is associated with greater mental health and/or addiction problems.

County Level Estimates

The 2012 sample size was sufficient to acquire county-level estimates for most of the counties in NM and 3 major metropolitan areas in the state. In contrast there were only 9 communities that conducted the NMCS in 2013. Among them, 3 Native American communities were combined to form a separate Native American unit for analysis. Table 3 and Table 4 provide the prevalence estimates by counties and Native American unit where data were collected. Table 3 shows substance use estimates while Table 4 shows prescription pain-killer use and mental health estimates. When interpreting these estimates, it is important to note that the sample size within each community varies considerably. In looking at the tables, one can see significant variation of prevalence estimates among the geographic areas across the state. These differences likely reflect both population and geographic differences between subgroups.

Table 3: Percent of respondents reporting positively to questions on tobacco & alcohol use by “community” (defined by the geographic area where respondent lives)

County	Past 30 day cigarette use	Past 30 day tobacco use	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	Total N
Bernalillo	31.7	7.1	35.4	21.6	5.4	5.7	3.8	339
Catron	28.7	9.0	32.3	11.0	2.7	3.0	1.0	300
Hidalgo	33.3	15.2	44.6	30.6	16.2	15.3	5.2	315
Rio Arriba	22.3	7.0	39.3	17.0	4.8	5.2	2.3	230
San Juan	-	-	-	-	-	-	-	399
Taos	23.4	3.7	46.0	14.5	4.7	4.2	2.3	411
Native American	20.5	4.2	32.2	18.9	5.4	4.9	3.9	764

Source: 2013 NM Community Survey

Table 4: Percent of respondents reporting positively to Rx drug use and mental health questions by “community” (defined by the geographic area where respondent lives)

County	Past year prescribed painkillers by a medical professional for a medical problem	Past 30 days use prescription pain killers for any reason	Past 4 weeks depressive symptoms	Past year had mental health/drug/alcohol problem	Past 12 months suicidal thoughts	Past year receive professional help for mental health/alcohol/drug problems	Total N
Bernalillo	19.4	14.5	9.4	13.5	5.0	10.6	339
Catron	19.0	11.3	-	-	-	-	300
Hidalgo	19.9	17.4	-	-	-	-	315
Rio Arriba	-	-	-	-	-	-	230
San Juan	21.6	15.6	-	-	-	-	399
Taos	26.5	14.6	3.2	20.9	4.6	14.6	411
Native American	-	5.9	7.2	18.7	5.3	18.4	764

Source: 2013 NM Community Survey

Community Survey Conclusions

Perceptions of the risk of being caught and facing legal consequences for engaging in alcohol-related illegal behavior decreased between 2012 and 2013, mainly in OSAP-CBP communities. This is a trend that has continued since 2010 when the NM SPF SIG, which targeted perceived risk of legal consequences, ended. At the same time, OSAP experienced dramatic state funding decreases. With the relatively new Partnerships for Success II (PFS-II) grant funding now at work in community coalitions, and increased prevention funding overall, we hope to see this trend reverse over the next few years.

Comparing the 2013 data with the 2012 baseline data, we find that regular cigarette use among adults in NM remains high and unchanged. While the focus has been on reducing access to minors, prevention strategies and policies to address adult smoking need consideration. This may well be something that can be targeted through employer smoking cessation programs to reduce health insurance costs.

Prescriptions for pain-killers are commonplace in NM, which in all likelihood leads to greater access to and misuse of these drugs by those for whom they were not prescribed. Respondents indicated sharing their pain-killers with others. Proper use and disposal of prescription drugs needs to be addressed in addition to the wide-spread over-prescribing of pain-killers.

Approximately 6.5% of respondents were identified as having a serious mental illness. The prevalence of respondents reporting a mental, drug, or alcohol problem in the past year ranged from 5.4% among adults 61 and older to 23.8% among 31-40 year-olds. Just about 15.4% of those who reported a mental, drug, or alcohol problem actually received any professional help for the problem. The prevalence of suicidal ideation in the past year is highest among 18 to 20 years at 10.3%. Current binge drinkers reported more prescription drug use and mental health problems than non-binge drinkers.

Social access to alcohol for minors remains perhaps the biggest problem to address in order to prevent underage alcohol consumption. Making it difficult for youth to access alcohol and creating a strong perception that getting caught drinking will lead to unpleasant consequences both will contribute greatly to reducing underage drinking, which remains very common in NM. It is very positive that measures of alcohol consumption and drinking and driving on the whole tended to move in the desired direction between 2012 and 2013 for both males and females. This was not the case for the perception of risk, which tended to decrease, and the increased perception of ease of access.

Community survey findings should be used to inform the strategic direction and use of prevention funding and programming to target high need, high risk, and high population areas and to extend the reach of prevention services currently provided. However, results should be interpreted with some caution. These results are based on convenience data and not a probability sample. Therefore, communities need to take into consideration how their data collection methodology

differed in 2013 from previous years and whether it has influenced the findings. It is also important to recall that the 2013 community survey surveyed far fewer NM residents than in previous years. From a state-level perspective, 2013 data are less likely to provide a comprehensive picture of what is taking place across the state. This document reports out on aggregated data with the implication that it represents the state as a whole. It does not. It instead contributes to our knowledge of those particular communities that participated in the survey and where there is longitudinal data from those communities, we can start to examine local trends. While there are differences between 2012 and 2013, not all are meaningful changes or differences. Many findings are similar to what was found in previous iterations of the survey, which lends support to the possibility that these data are accurately describing a sample similar to that in previous survey iterations.

In 2014, we anticipate that our sample will increase again because of additional funding and wider coverage across the state. We will continue to examine trends over time and use statistical strategies to compensate for the limitations of non-random sampling.

A Note on Local Capacity as Reflected in Annual Reporting

In order to track progress on all IVs across all programs, PIRE reviewed FY2013 final reports to note local changes in the stated objectives. However, due to discrepancies in reporting, we were unable to document this change effectively. Most programs reported accurately on all intervening variables, while a few provided data on indicators not clearly linked to the objectives in their strategic plan. This inhibited the ability to review and aggregate across intervening variables with the resources at hand. In particular, several programs did not report on changes in perception of risk appropriately, reporting instead on changes in long term outcome indicators or on enforcement activities. Additionally, some programs' strategies were not transparent to the reviewer, either because they did not have an objective derived from the SMART Objectives document that states the strategy within the objective, or it did not match with the targeted IV.

Instead of aggregating progress by each IV, we produced a table that shows each IV and environmental strategies implemented by program. These do not directly correspond to the approved list of strategies, because providers approached each one and reported differently. Some of the long term outcome indicators/priorities have been changed from the information found in the reports (in relation to Goals), if they did not otherwise correspond. For example, a goal that only stated the reduction of only adult DWI and UAD when the objective or strategy was directed towards underage drinking would be changed to include underage drinking indicators. See Appendix A. We suggest further TA and support with programs *and* their evaluators to use the "SMART" document as a guide to reporting, not just developing their scopes of work as was the document's original intent. This document provides strategies alongside their corresponding goals, examples of SMART objectives for each approved strategy, and all known indicators for approved strategies.

APPENDIX A

Appendix A: Summary of Environmental Strategies by program, county and Long Term Outcome Indicator

Program	County or Tribe(s)	Enforcement									Perception of Risk of consequences			Social Access					Retail Access							Social Norms		Envt Factors						
		Secondary School Policy	College university policy	Increase SID , shoulder taps,	Increase MUI/MIP arrests	Increase DWI enf (satpat; chpt) and /or arrests	Increase providing alcohol to minors arrests.	Increase party patrols	Graduated license enforcement	Campaign changes and enforcement of laws, policies..statute changes	Drug Free Workplace	Publicize arrests & convictions	For UAD/contributing to UAD	Publicize Enforcement activities	Community Campaign	PWWLTM	Publicize 4 th Degree Felony/SHOs	Social Host Ordinance	Take Back Events	Alc Outlet density	Prevent License transfers	Restrict Alcohol Placement	Reduce Advertising	Reduce precursors	Increase PDMP use	Alc retail merchant training	Decrease hours, days times of sales	Retail policy change	Secondary School Social Norms Campaign	College/university social Norms campaign	Graffiti tagging	Property hazards		
BAMHS	Catron Hidalgo	Rx								Rx				Rx				Rx																
Carlsbad	Eddy	IID									IID							Rx				IID	Rx			Rx			IID	IID				
CCYES	Colfax	UBD UDWI		U/ABD U/ADWI		U/ABD U/ADWI									UBD UDWI																			
CAI	Chaves	UBD	UBD			UDWI																												
FSIP	Cochiti P	UBD										UBD UDWI																						
HACC	S. Rio Arriba	UBD	UBD UDWI			UBD UDWI						U/ABD U/ADWI				UBD UDWI				U/ABD U/ADWI														
Laguna Pueblo	Laguna P				UBD UDWI	U/ABD U/ADWI	UBD UDWI			UBD UDWI		ABD ADWI													UBD UDWI									
NCCBS	N. Rio Arriba	UBD				ADWI			UDWI			UDWI	UBD UDWI		UDWI					U/ABD U/ADWI														
PCA	Bernalillo	UBD											ABD ADWI					UBD UDWI			UBD UDWI				U/ABD U/ADWI									
RMYC	Taos	UBD		UBD UDWI		UBD UDWI						U/ABD U/ADWI																						
SCDWI	Sandoval	UBD UDWI		UBD UDWI	UBD UDWI	UBD UDWI		UBD UDWI																										
SJCP	San Juan	UBD												Rx		UBD									UBD		Rx							
SFPS	Santa Fe	UBD UDWI		UBD UDWI	UDWI							ADWI/ UDWI	UBD UDWI		UBD UDWI					UDWI ADWI						UBD UDWI								
SFMC	Rio Arriba	UBD										U/ABD U/ADWI	UBD UDWI													UBD UDWI								
SNMHD	S. Doña Ana	UBD UDWI																								UBD UDWI								
UNM COSAP	Bernalillo & others*		UBD UDWI									UBD UDWI																UBD UDWI						
YDI	Valencia	UBD UDWI				UDWI ADWI	UDWI ADWI	UBD UDWI				UBD UDWI	UBD UDWI			UBD UDWI																		

*UNM – Albuquerque/Bernalillo; NMSU Las Cruces/Doña Ana; ENMU Roswell/Eddy; SJC San Juan College; SFCC Santa Fe; UNM Valencia

KEY: Rx= Prescription pain killer misuse and abuse; IID= Illicit drug use; UDWI= Underage driving while intoxicated; UBD= Underage binge drinking; ADWI= adult driving while intoxicated; ABD= Adult binge drinking; U/ABD= Underage and adult binge drinking; U/ADWI= Underage and adult driving while intoxicated

