2018

Regional Needs Assessment

REGION 8 – UPDATED OCTOBER 9, 2018

PREVENTION RESOURCE CENTER

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Executive Summary

The Regional Needs Assessment (RNA) is a document created by the Prevention Resource Center (PRC) in Region 8 along with Evaluators from PRCs across the State of Texas and supported by San Antonio Council on Alcohol and Drug Awareness (SACADA) and the Texas Health and Human Services Commission (HHSC). The PRC 8 serves 28 counties in 8.

This assessment was designed to aid PRC's, HHSC, and community stakeholders in long-term strategic prevention planning based on most current information relative to the unique needs of the diverse communities in the State of Texas. This document will present a summary of statistics relevant to risk and protective factors associated with drug use, as well as consumption patterns and consequences data, at the same time it will offer insight related to gaps in services and data availability challenges.

A team of regional evaluators has procured national, state, regional, and local data through partnerships of collaboration with diverse agencies in sectors such as law enforcement, public health, and education, among others. Secondary qualitative data collection has also been conducted, in the form of surveys, focus groups, and interviews with key informants. The information obtained through these partnerships has been analyzed and synthesized in the form of this Regional Needs Assessment. PRC 8 recognizes those collaborators who contributed to the creation of this RNA.

Region 8 Key Findings from this assessment:

There are 908,543 persons (37.89%) age five and older that speak a language other than English at home; and 305,133 persons (11.68%) speak English less than "very well" according to self-ratings.

For persons of all ages 15.7 percent or 444,990 were living in poverty in 2016 slightly higher from 15.2 percent or 426,123 in 2015. For children under the age of 18, 22 percent or 161,691 were living in poverty in 2016 remaining unchanged from 22.1 percent or 160,273 in 2015. In addition, the poverty rate for children ages 5 to 17 in families remained unchanged at 20.8%.

The median household income for Region 8 was $49,732 in 2016, an increase of 1.9 percent from the 2015 median of $48,805. Bexar, our most populous county's median household income was $53,170 in 2016, an increase of 1.8 percent from the 2015 median of $52,230. From 2015 to 2016 forty-six percent of the counties in Region 8 experienced decreases in median household incomes.

One in three households have children living with a single-parent

Sixty-one percent of Region 8 counties have unemployment rates higher than both national (4.4%) and state (4.3%) rates.

In 2017, sixty-eight percent of the counties in Region 8 had higher percentages of recipients receiving Supplemental Nutrition Assistance (SNAP) benefits than the United States at 12.9 percent in 2017.

The percent of the student population eligible for free and/or reduced lunches increased from 60.69 percent or 316,462 students during the 2014-2015 school year to 60.71 percent or 321,382 students during 2015-2016.

In 2016, the Region 8 uninsured population under age 65 was 17.1 percent, down by 0.3 from 2015 at 17.4 percent. The estimated uninsured rate decreased between 2015 and 2016 for 19 counties or 67.9 percent of all Region 8 counties.

The educational attainment of persons 18 to 24 years of age reveals that 96 percent of the counties in Region 8 have higher percentages of persons with less than a high school education than the U.S average of 13.8 percent.

In 2016, thirty-two percent of Region 8 counties had dropout rates higher than Texas' rate of 6.2 percent. From 2013 to 2016, Texas saw a decrease in school dropouts by -6.1 percent. Fifty percent of Region 8 counties also saw a decrease in school dropout rates during the same period.

There was a reported total of 122,865 index offenses an increase of 5.3 percent when compared to 2015. The percent change for total violent crimes in Region 8 was nearly 3 times higher at 19.3 percent compared to Texas at 7 percent reported from 2015 to 2016.

During calendar year 2016, the Region 8 crime rate was 4,228.5 crimes per 100,000 persons. This is an increase of 5.2 percent from the previous year.

The total number of Region 8 family violence incidents in 2016 was 21,543, a 2.8 percent increase from 2015.

In 2017, Region 8 had the 2nd highest number of child abuse and or neglect victims investigated at 50.7 per 1,000 children. This was a 9.3 percent increase from 46.4 per 1,000 children investigated in 2016. Twenty-four or 86% of region 8 counties had higher rates of CPS victims investigated than Texas at 38.6 per 1,000 child population in 2017.

In FY 2017, Texas reported that 52 percent of fatalities caused by abuse or neglect included a parent or caregiver actively using a substance and/or under the influence of one or more substances that affected their ability to care for the child. No county data available.

Although marijuana continues to be the most illicit drug seized, Texas reported a 58 percent decrease in 2017 of 115,745 pounds compared to 276,483 pounds in 2016. Codeine solid pounds decreased by 41 percent and peyote decreased by 50 percent. Hashish solid pounds had the largest increase at 155.9 percent followed by cocaine at 52 percent from 13,069 solid pounds in 2016 to 19,814 solid pounds in 2017.

The most significant change in opiate seizures in 2017 is the 5,688 percent increase in codeine liquid ounces.

In 2015 Region 8, reported 331 suicides, down from 347 in 2014. On average, adjusted for age, the annual Region 8 suicide rate decreased 8 percent from 2014 to 2015, from 12.6 to 11.6 suicides per 100,000 people. The highest intentional deaths occurred among people 25 to 34 years of age of which 57 percent were white, 43 percent Hispanic. Four or 36 percent of our regions saw a decrease in intentional deaths between 2014 to 2015.

The total number of admissions for all substance use treatment decreased 2.2 percent from 75,613 reported in 2015 to 73,987 in 2016. Alcohol admissions for treatment continue to be the highest

followed by marijuana. Methamphetamine admissions increased by 11.8 percent or 1,326 clients while prescription opioid admissions decreased by 11.2 percent or 321 admissions

In 2017, Region 8 youth between the ages of 12 to 17, accounted for 7.5 percent of the total youth state funded treatment in Texas. Most of this age group received treatment for marijuana/hashish (84%) followed by synthetic cannabinoids (2.9%) and methamphetamines (2.6%). Outpatient services (61.7%) were most widely used followed by residential (35.4%) and co-occuring psychiatric and substance use disorder (2.9%). Fifteen (24.5%), 16 (32.8%) and 17 (21.4%) year olds accounted for 78.6 percent of all admissions.

In Texas, between 2015 and 2016, there was a 3.6 decrease in the reported adult depression from 16.1 percent reported in 2015 to 12.5 percent in 2016. More women report depression (15.8%) than males (7.7%) and individuals aged 55-64 report the highest rate of depression compared to the lowest rates for age 18-24 (11%) and 65 and older (11%). Those individuals with less than a college degree reported higher rates of depression as well as those that earned less than $50,000. Texas has continued to remain below the National rates over time.

2016 Texas School Survey of Substance

One in three (31.1%) perceive their friends use tobacco.

One in two (51.3%) perceive their friends use alcohol.

Almost one in two (43.2%) perceive their friends use marijuana, higher than tobacco.

Twelfth grade students' perception of obtaining marijuana increased 6.7 from 49 percent in 2014 to 55.7 percent in 2016;

One in eight seventh grade students (12.2%) report any tobacco product as somewhat easy to very easy to obtain while one in two 12th graders (55.7%) find tobacco products accessible.

One out of three students reported that alcohol was used at parties they attended. When asked, "where do you get your alcoholic beverages from", one out of four report they got it at parties (26.4%), followed by home (23.8%), friends (23.3%), store (6.5%) and other sources (14.7%).

Between 2014 and 2016, past month use of any alcohol increased across all grade levels with 12th grade showing the most significant increase of 10.7 from 33.6 percent in 2014 to 44.3 percent in 2016.

Students that reported binge drinking for one day in the past 30 days increased 1.1 percent while binge drinking for 2 or more days decreased for all grades.

Lifetime use for any tobacco product increased from 19.4 percent in 2014 to 28.8 percent in 2016. Past-month use of tobacco was 7.4 percent in 2014 and 13.8 percent in 2016. School year use increased from 10.3 percent in 2014 to 18.2 percent in 2016.

Between 2014 and 2016, past month use of marijuana increased across all grade levels with 12th grade students showing the most significant increase of 11.0 from 11.1 percent in 2014 to 22.1 percent in 2016.

Results from the 2017 Texas YRBS indicated, 39.2 percent of students had ever had sexual intercourse, a decrease of 6.7 from 45.9 reported in 2013. Students who had drank alcohol or used drugs before last sexual intercourse decreased 4.7 from 23.8 percent reported in 2013 to 19.1 percent in 2017.

Males (5.1%) were 3 times more likely to report having had sexual intercourse for the first time before age 13 than females (1.5%).

Males (15%) were two times more likely to report having had sexual intercourse with four or more people during their life than females (7.6%).

Seventy-nine percent of Region 8 counties have alcohol permit density rates higher then Texas' rate of one person per 500 population or 201.2 per 100,000 population. In 2017, Region 8 had 832 alcohol violations reported to the Texas Alcoholic Beverage Commission (TABC), a decrease of 3.5 percent from 2016 of 862 violations.

Between 2001 to 2011, alcohol use on Texas school campuses has steadily declined across all age groups, students 15 years of age or less decreased 3.1, 16 to 17 years of age decreased 1.0, and 18 and older decreased 3.0. Females are just as likely as males to consume alcohol on school campus. Male use decreased 2.8 while females decreased only 1.2 over the same period.

According to CDC Wonder there have been 8,007 deaths related to drug and alcohol in region 8 between 1999 and 2016. Twenty-nine percent of the counties in Region 8 have drug and alcohol death rates higher than Texas at 15.4 persons per 100,000 including Region 8 at 17.6 persons per 100,000.

In 2017, Region 8 reported 89 people were killed in motor vehicle traffic crashes where a driver was under the influence of alcohol. This is 26% of the total number of people killed in motor vehicle traffic crashes. Region 8 DUI fatalities decreased 19.1 percent from 110 DUI Fatalities in 2016 to 89 DUI fatalities in 2017. Persons between the ages of 21 to 25 for Texas and Region 8 accounted for the highest percent of DUI fatalities.

Region 8 and 4 counties have higher death crude rates for chronic liver disease and cirrhosis of the liver then Texas at 19.6 per 100,000 population.

Region 8 (152 per 100k) and 22 counties (78.6%) have higher malignant neoplasms crude death rates then Texas at 142.8 per 100,000 population. Twenty-five counties (89.3%) and Region 8 (177.6 per 100k) have higher crude death rates for heart disease then Texas at 155.1 deaths per 100,000.

Region 8 had 15,308 alcohol related arrests, including 63.8 percent for DUIs, 32 percent for Drunkenness, and 4.2 percent for Liquor Laws. Alcohol related arrersts increased 4.8 percent from 14,600 in 2016 to 15,308 in 2017.

Prevention Resource Centers

Our Purpose

Prevention Resource Centers (PRC) are a program funded by the Texas Health and Human Services Commission (HHSC) to provide data and information related to substance use and misuse, and to support prevention collaboration efforts in the community. There is one PRC located in each of the eleven Texas Health Service Regions (see Figure 1) to provide support to prevention providers located in their region with substance use data, trainings, media activities, and regional workgroups. Prevention Resource Centers have four fundamental objectives related to services provided to partner agencies and the community in general: (1) collect data relevant to alcohol, tobacco, and other drug use among adolescents and adults and share findings with community partners (2) ensure sustainability of a Regional Epidemiological Workgroup focused on identifying strategies related to data collection, gaps in data, and prevention needs, (3) coordinate regional prevention trainings and conduct media awareness activities related to risks and consequences of ATOD use, and (4) conduct voluntary compliance checks and education on state tobacco laws to retailers.

Efforts carried out by PRCs are focused on the state's three prevention priorities of underage drinking, use of marijuana and other cannabinoids, and prescription drug misuse.

Figure 1. Map of Health Service Regions serviced by the Prevention Resource Centers

Region 1	Panhandle and South Plains
Region 2	Northwest Texas
Region 3	Dallas/Fort Worth Metroplex
Region 4	Upper East Texas
Region 5	Southeast Texas
Region 6	Gulf Coast
Region 7	Central Texas
Region 8	Upper South Texas
Region 9	West Texas
Region 10	Upper Rio Grande
Region 11	Rio Grande Valley/Lower South Texas

Regional PRCs are tasked with compiling and synthesizing data and disseminating findings to the community. Data collection strategies are organized around risk and protective factors, consumption data, and related consequences associated with substance use and misuse. PRCs engage in building collaborative partnerships with key community members who aid in securing access to information.

How We Help the Community

PRCs provide technical assistance and consultation to providers, community groups, and other stakeholders in identifying data and data resources related to substance use or other behavioral health indicators. PRCs work to promote and educate the community on substance use and misuse and associated consequences through various data products, media awareness activities, and an annual regional needs assessment. These resources and information provide stakeholders with knowledge and understanding of the local populations they serve, help guide programmatic decision making, and

provide community awareness and education related to substance use and misuse. Additionally, the program provides a way to identify community strengths as well as gaps in services and areas of improvement.

Conceptual Framework

As one reads through this needs assessment, two guiding concepts will appear throughout the report: a focus on the youth population and the use of an empirical approach from a public health framework. For the purpose of strategic prevention planning related to drug and alcohol use among youth populations, this report is based on three main aspects: risk and protective factors, consumption patterns, and consequences of substance misuse and substance use disorders (SUDs).

Adolescence

The World Health Organization (WHO) identifies adolescence as a critical transition in the life span characterized by tremendous growth and change, second only to infancy. This period of mental and physical development poses a critical point of vulnerability where the use and misuse of substances, or other risky behaviors, can have long-lasting negative effects on future health and well-being. This focus of prevention efforts on adolescence is particularly important since about 90 percent of adults who are clinically diagnosed with SUDs, began misusing substances before the age of 18. [1]

The information presented in this document is compiled from multiple data sources and will therefore consist of varying demographic subsets of age which generally define adolescence as ages 10 through 17-19. Some domains of youth data conclude with ages 17, 18 or 19, while others combine "adolescent" and "young adult" to conclude with age 21.

Epidemiology: The WHO describes epidemiology as the "study of the distribution and determinants of health-related states or events (including disease), and the application of this study to the control of diseases and other health problems." This definition provides the theoretical framework through which this assessment discusses the overall impact of substance use and misuse. Through this lens, epidemiology frames substance use and misuse as a preventable and treatable public health concern. The Substance Abuse and Mental Health Services Administration (SAMHSA) establishes epidemiology to identify and analyze community patterns of substance misuse as well as the contributing factors influencing this behavior. SAMHSA adopted an epidemiology-based framework on a national level while this needs assessment establishes this framework on a regional level.

Socio-Ecological Model: The Socio-Ecological Model (SEM) is a conceptual framework developed to better understand the multidimensional factors that influence health behavior and to categorize health intervention strategies.[2] Intrapersonal factors are the internal characteristics of the individual of focus and include knowledge, skills, attitudes, and beliefs. Interpersonal factors include social norms and interactions with significant others, such as family, friends, and teachers. Organizational/institutional factors are social and physical factors that indirectly impact the individual of focus (e.g., zero tolerance

[1] The National Center on Addiction and Substance Abuse at Columbia University. 2011. *CASA analysis of the National Survey on Drug Use and Health, 2009* [Data file]. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[2] McLeroy, KR, Bibeau, D, Steckler, A, Glanz, K. (1988). An ecological perspective on health promotion programs. Health Education & Behavior, 15(4), 351-377.

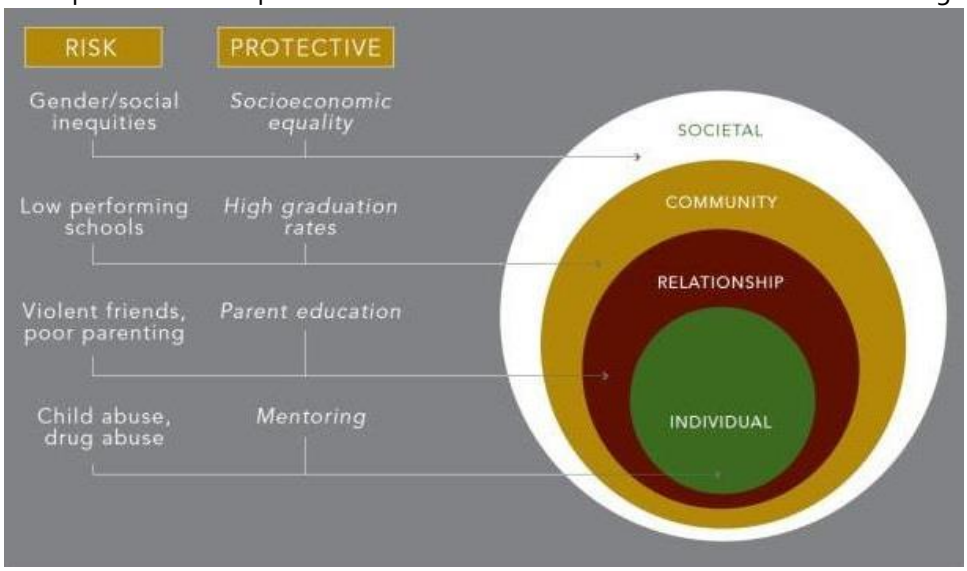
school policies, classroom size, mandatory workplace drug testing). Finally, community/societal factors include neighborhood connectedness, collaboration between organizations, and policy.

The SEM proposes that behavior is impacted by all levels of influence, from the intrapersonal to the societal, and that the effectiveness of health promotion programs is significantly enhanced through the coordination of interventions targeting multiple levels. For example, changes at the community level will create change in individuals and support of individuals in the population is essential for implementing environmental change.

Risk and Protective Factors

Researchers have examined the characteristics of effective prevention programs for more than 20 years. One component shared by effective programs is a focus on risk and protective factors that influence substance misuse among adolescents. Protective factors are characteristics that decrease an individual's risk for a substance use disorder. Examples may include factors such as strong and positive family bonds, parental monitoring of children's activities, and access to mentoring. Risk factors are characteristics that increase the likelihood of substance use behaviors. Examples may include unstable home environments, parental use of alcohol or drugs, parental mental illnesses, poverty levels, and failure in school performance. Risk and protective factors are classified under four main domains: societal, community, relationship, and individual (see Figure 2).[3]

Figure 2. Examples of risk and protective factors within the domains of the Socio-Ecological Model



Source: Urban Peace Institute. Comprehensive Violence Reduction Strategy (CVRS). http://www.urbanpeaceinstitute.org/cvrs/ Accessed May 29, 2018.

[3] Urban Peace Institute. Comprehensive Violence Reduction Strategy (CVRS). http://www.urbanpeaceinstitute.org/cvrs/. Accessed May 29, 2018.

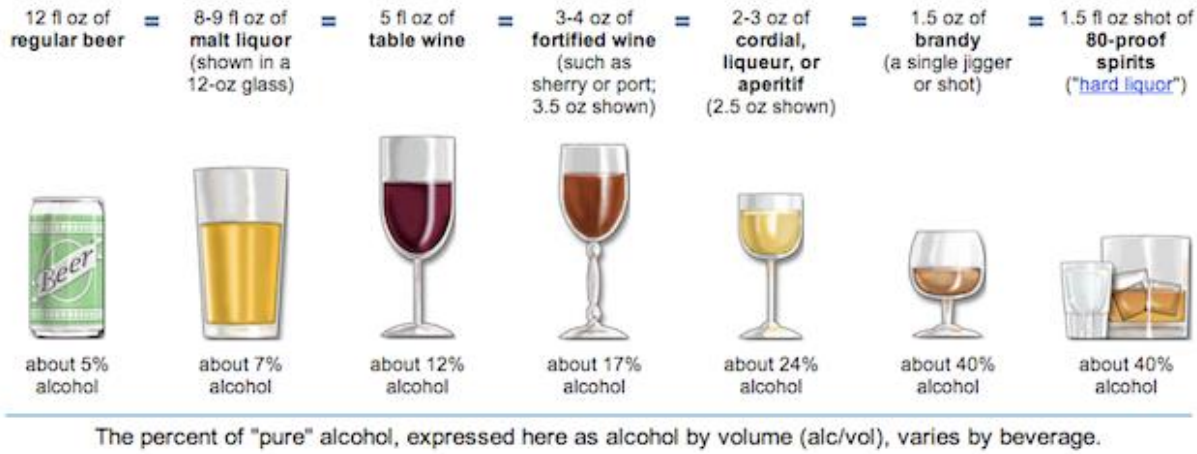
Consumption Patterns

For the purpose of this needs assessment, and in following with operational definitions typically included in widely used measures of substance consumption, such as the Texas School Survey of Drug and Alcohol Use (TSS)[4], the Texas Youth Risk Surveillance System (YRBSS)[5], and the National Survey on Drug Use and Health (NSDUH)[6], consumption patterns are generally operationalized into three categories: lifetime use (ever tried a substance, even once), school year use (past year use when surveying adults or youth outside of a school setting), and current use (use within the past 30 days). These three categories of consumption patterns are used in the TSS to elicit self-reports from adolescents on their use and misuse of tobacco, alcohol (underage drinking), marijuana, prescription drugs, and illicit drugs. The TSS, in turn, is used as the primary outcome measure in reporting on Texas youth substance use and misuse in this needs assessment.

Due to its overarching and historical hold on the United States, there exists a plethora of information on the evaluation of risk factors that contribute to Alcohol Use Disorder (AUD). According to SAMHSA, AUD is ranked as the most wide-reaching SUD in the United States, for people ages 12 and older, followed by Tobacco Use Disorder, Cannabis Use Disorder, Stimulant Use Disorder, Hallucinogen Use Disorder, and Opioid Use Disorder (presented in descending order by prevalence rates).[7] When evaluating alcohol consumption patterns in adolescents, more descriptive information beyond the aforementioned three general consumption categories is often desired and can be tapped by adding specific quantifiers (i.e., per capita sales, frequency and trends of consumption, and definitions of binge drinking and heavy drinking), and qualifiers (i.e., consequential behaviors, drinking and driving, alcohol consumption during pregnancy) to the operationalization process. For example, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) has created very specific guidelines that are widely used in the in quantitative measurement of alcohol consumption.[8] These standards define binge drinking as the drinking behaviors that raise an individual's Blood Alcohol Concentration (BAC) up to or above the level of .08gm%, which is typically five or more drinks for men and four or more drinks for women, within a two-hour time span. At-risk or heavy drinking, is defined as more than four drinks a day or 14 drinks per week for men and more than three drinks a day or seven drinks per week for women. "Benders" are considered two or more days of sustained heavy drinking. See Figure 3 for the NIAAA's operational definitions of the standard drink.

[4] Texas A&M University. *Texas School Survey of Drug and Alcohol Use: 2016 State Report*. 2016. http://www.texasschoolsurvey.org/Documents/Reports/State/16State712.pdf. Accessed May 30, 2018.
[5] Texas Department of State Health Services. *2001-2017 High School Youth Risk Behavior Surveillance System Data*. 2017. http://healthdata.dshs.texas.gov/HealthRisks/YRBS. Accessed April 27, 2018.
[6] Substance Abuse and Mental Health Services Administration. *National Survey on Drug Use and Health*. 2016. https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2016/NSDUH-DetTabs-2016.pdf. Accessed May 30, 2018.
[7] Substance Abuse and Mental Health Services Administration. Substance use disorders. https://www.samhsa.gov/disorders/substance-use. Updated October 27, 2015. Accessed May 29, 2018.
[8] National Institute for Alcohol Abuse and Alcoholism. What is a "standard" drink? https://www.rethinkingdrinking.niaaa.nih.gov/How-much-is-too-much/What-counts-as-a-drink/Whats-A-Standard-Drink.aspx. Accessed May 24, 2018.

Figure 3. NIAAA (2004) rubric for operationalizing the standard drink by ounces and percent alcohol across beverage type



Source: National Institute for Alcohol Abuse and Alcoholism. What is a "standard" drink? https://www.rethinkingdrinking.niaaa.nih.gov/How-much-is-too-much/What-counts-as-a-drink/Whats-A-Standard-Drink.aspx. Accessed May 24, 2018.

Consequences

One of the hallmarks of SUDs is the continued use of a substance despite harmful or negative consequences. The types of consequences most commonly associated with SUDs, the most severe of SUDs being addiction, typically fall under the categories of health consequences, physical consequences, social consequences, and consequences for adolescents. The prevention of such consequences has received priority attention as Goal 2 (out of four goals) on the 2016-2020 NIDA Strategic Plan titled *Develop new and improved strategies to prevent drug use and its consequences*.[9]

The consequences associated with SUDs tend to be developmentally, culturally, and contextually dependent and the measurement and conceptualization of such associations has proven to be quite difficult for various reasons, including the fact that consequences are not always caused or worsened by substance use or misuse.[10] Therefore, caution should be taken in the interpretation of the data presented in this needs assessment. Caution in inferring relationships or direction of causality should be taken, also, because only secondary data is reported out and no sophisticated analytic procedures are involved once that secondary data is obtained by the PRCs and reported out in this needs assessment, which is intended to be used as a resource.

Audience

Potential readers of this document include stakeholders from a variety of disciplines: substance use prevention and treatment providers; medical providers; school districts and higher education; substance use prevention community coalitions; city, county, and state leaders; and community members

[9] National Institute on Drug Abuse. *2016-2020 NIDA Strategic Plan*. 2016. https://d14rmgtrwzf5a.cloudfront.net/sites/default/files/nida_2016strategicplan_032316.pdf. Accessed May 29, 2018.
[10] Martin, CS., Langenbucher, JW, Chung, Sher, KJ. Truth or consequences in the diagnosis of substance use disorders. *Addiction*. 2014. 109(11): 1773-1778.

interested in increasing their knowledge of public health factors related to drug consumption. The information presented in this report aims to contribute to program planning, evidence-based decision making, and community education.

The executive summary found at the beginning of this report will provide highlights of the report for those seeking a brief overview. Since readers of this report will come from a variety of professional fields, each yielding specialized genres of professional terms and concepts related to substance misuse and substance use disorders prevention, a glossary of key concepts can be found in Appendix C of this needs assessment. The core of the report focuses on risk factors, consumption patterns, consequences, and protective factors. A list of tables and figures can be found in Appendix A.

Introduction

The Texas Health and Human Services Commission (HHSC) administers approximately 225 school and community-based prevention programs across 72 different providers with federal funding from the Substance Abuse Prevention and Treatment Block Grant to prevent the use and consequences of alcohol, tobacco and other drugs (ATOD) among Texas youth and families. These programs provide evidence-based curricula and effective prevention strategies identified by SAMHSA's Center for Substance Abuse Prevention (CSAP).

The Strategic Prevention Framework (SPF) provided by CSAP guides many prevention activities in Texas (see Figure 4). In 2004, Texas received a state incentive grant from CSAP to implement the Strategic Prevention Framework in close collaboration with local communities in order to tailor services to meet local needs for substance abuse prevention. This prevention framework provides a continuum of services that target the three classifications of prevention activities under the Institute of Medicine (IOM), which are universal, selective, and indicated.[11]

The Health and Human Services Commission Substance Abuse Services Funds Prevention Resource Centers (PRCs) across the state of Texas. These centers are part of a larger network of youth prevention programs providing direct prevention education to youth in schools and the community, as well as community coalitions that focus on implementing effective environmental strategies. This network of substance abuse prevention services work to improve the welfare of Texans by discouraging and reducing substance use and abuse. Their work provides valuable resources to enhance and improve our state's prevention services aimed to address our state's three prevention priorities to reduce: (1) underage drinking; (2) marijuana use; and (3) non-medical prescription drug abuse. These priorities are outlined in the Texas Behavioral Health Strategic Plan developed in 2012.

Our Audience

Readers of this document include stakeholders from a variety of disciplines such as substance use prevention and treatment providers; medical providers; school districts and higher education; substance use prevention community coalitions; city, county, and state leaders; and community members interested in increasing their knowledge of public health factors related to drug consumption. The information presented in this report aims to contribute to program planning, evidence-based decision making, and community education.

Purpose of This Report

This needs assessment reviews substance abuse data and related variables across the state that aid in substance abuse prevention decision making. The report is a product of the partnership between the regional Prevention Resource Centers and the Texas Department of State Health Services. The report seeks to address the substance abuse prevention data needs at the state, county and local levels. The assessment focuses on the state's prevention priorities of alcohol (underage drinking), marijuana, and prescription drugs and other drug use among adolescents in Texas. This report explores drug

[11] SAMHSA. Strategic Prevention Framework. https://www.samhsa.gov/capt/applying-strategic-prevention-framework. Last updated June 5, 2017.Accessed July 30, 2017.

consumption trends and consequences. Additionally, the report explores related risk and protective factors as identified by the Center for Substance Abuse Prevention (CSAP).

Figure 4. Strategic Prevention Framework (SPF)[12]

Source: SAMHSA.

[12] Strategic Prevention Framework. https://www.samhsa.gov/capt/applying-strategic-prevention-framework. Last updated June 5, 2017.Accessed July 30, 2018.

Methodology

Purpose

This needs assessment is a review of data on substance misuse, substance use disorders, and related variables that will aid in substance misuse prevention decision making at the county, regional, and state level. In this needs assessment, the reader will find the following: primary focus on the state-delineated prevention priorities of alcohol (underage drinking), marijuana, prescription drugs, and other drug use among adolescents; exploration of drug consumption trends and consequences, particularly where adolescents are concerned; and an exploration of related risk and protective factors as operationalized by CSAP.

Specifically, this regional needs assessment can serve in the following capacities:

- To determine patterns of substance use among adolescents and monitor changes in substance use trends over time;
- To identify gaps in data where critical substance misuse information is missing;
- To determine county-level differences and disparities;
- To identify substance use issues that are unique to specific communities;
- To provide a comprehensive resource tool for local providers to design relevant, data-driven prevention and intervention programs targeted to needs;
- To provide data to local providers to support their grant-writing activities and provide justification for funding requests;
- To assist policy-makers in program planning and policy decisions regarding substance misuse prevention, intervention, and treatment at the region and state level.

Process

The state evaluator and the regional evaluators collected primary and secondary data at the county, regional, and state levels between September 1, 2017 and May 30, 2018. The state evaluator met with the regional evaluators at a statewide conference in September 2017 to discuss the expectations of the regional needs assessment for the fourth year.

Between September and July the State Evaluator meet with Regional Evaluators via bi-weekly conference calls to discuss the criteria for processing and collecting data. The information is primarily gathered through established secondary sources including federal and state government agencies. In addition, region-specific data collected through local law enforcement, community coalitions, school districts and local-level governments are included to address the unique regional needs of the community. Additionally, qualitative data is collected through primary sources such as surveys and focus groups conducted with stakeholders and participants at the regional level.

Primary and secondary data sources are identified when developing the methodology behind this document. Readers can expect to find information from the American Community Survey, Texas Department of Public Safety, Texas School Survey of Drug and Alcohol Use, and the Community Commons, among others. Also, adults and youth in the region were selected as primary sources.

Qualitative Data Selection

During the year, focus groups, surveys and interviews are conducted by the Regional Evaluator to better understand what members of the communities believe their greatest need to be. The information collected by this research serves to identify avenues for further research and provide access to any quantitative data that each participant may have access to.

Focus Groups

Participants for the focus groups are invited from a wide selection of professionals including law enforcement, health, community leaders, clergy, high school educators, town councils, state representatives, university professors, and local business owners. In these sessions, participants discuss their perceptions of how their communities are affected by alcohol, marijuana, and prescription drugs.

Interviews

Interviews are conducted primarily with school officials and law enforcement officers. Participants are randomly selected by city and then approached to participate in an interview with the Regional Evaluator. Each participant is asked the following questions:

- What problems do you see in your community?
- What is the greatest problem you see in your community?
- What hard evidence do you have to support this as the greatest problem?
- What services do you lack in your community?

Other questions inevitably arise during the interviews, but these four are asked of each participant.

Surveys

Occasionally, organizations approach the PRC asking for guidance to construct and administer surveys in order to collect information about how their adolescents perceive and consume AOD. All survey questions are either copied from tools that have been tested and vetted or they are subjected to rigorous testing through focus groups or other research methods. Many of the questions used by the PRC originate from the following survey tools:

- 40 Developmental Assets Survey
- Youth Risk Behavior Surveillance System
- Monitoring the Future
- Texas School Survey

Longitudinally Presented Data

In an attempt to capture a richer depiction of possible trends in the data presented in this needs assessment, data collection and reporting efforts consist of multi-year data where it is available from respective sources. Most longitudinal presentations of data in this needs assessment consist of (but are not limited to) the most recently-available data collected over three years in one-year intervals of data-collection, or the most recently-available data collected over three data-collection intervals of

more than one year (e.g. data collection for the TSS is done in two-year intervals). Efforts are also made in presenting state-and national-level data with county-level data for comparison purposes. However, where it is the case that neither state-level nor national-level date are included in tables and figures, the assumption can be made by the reader that this data is not made available at the time of the data request. Such requests are made to numerous county, state, and national-level agencies in the development of this needs assessment.

Regional Demographics

By studying the statistical characteristics of a population's age, race, ethnicity, language, concentrations of population, and socioeconomic status on a smaller scale such as regional and county level we can assess a better understanding of the factors that influence risk and protection from substance misuse in our communities.

Region 8 is comprised of 28 counties located in the Upper Central South part of Texas and 2018 estimated population of 3,034,265. With over 31,057 square miles of land bordering the Rio Grande River and Mexico in the west and the Gulf Coast in the east. Our Region contains almost every type of geographical setting found in Texas: rolling hills and plains, hill country, coastal plains, brush country, and desert.

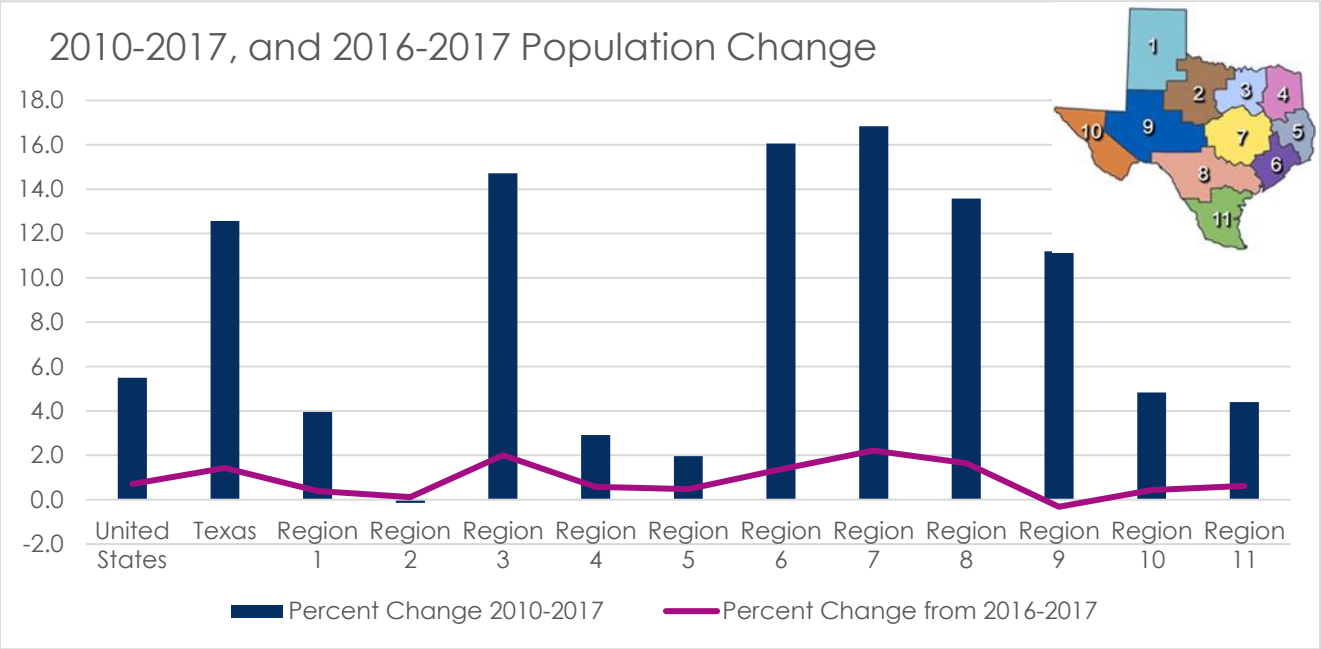
Counties served in Region 8 include Atascosa, Bandera, Bexar, Calhoun, Comal, Dewitt, Dimmit, Edwards, Frio, Gillespie, Goliad, Gonzales, Guadalupe, Jackson, Karnes, Kendall, Kerr, Kinney, LaSalle, Lavaca, Maverick, Medina, Real, Uvalde, Val Verde, Victoria, Wilson, and Zavala. (See appendix – for county data).

Population

When there is significant change in total population overtime it impacts access to healthcare and utilization of community resources.

The population in Texas between 2010 and 2017 increased by 3,159,035 persons or 12.6 percent with the most significant increase of 16.8 percent in Region 7 compared to Region 2 that experienced a decrease of -0.1 percent. Region 7 also had the highest increase in the past year of 2.2 percent compared to Region 9 that had a decrease of 0.3 percent. See Appendix A, Table 1 for Regional data.

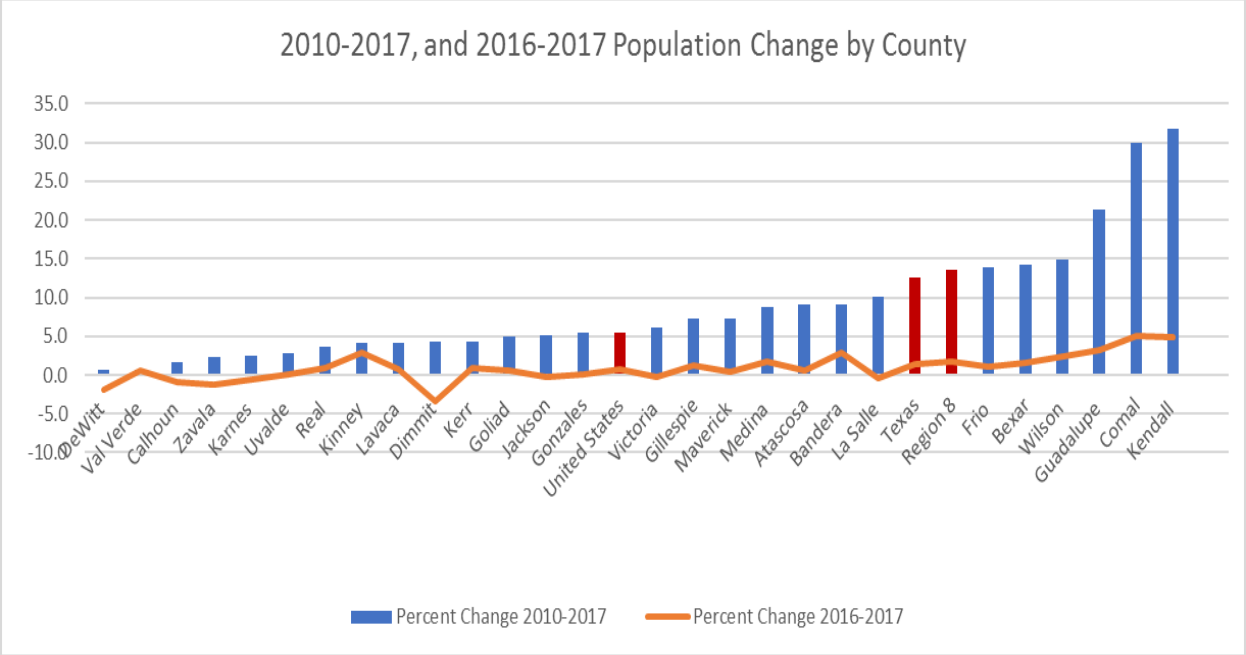
Figure 1. 2010 – 2017 and 2016-2017 Population Change by Region



Source: U.S. Census Bureau, 2000 and 2010 Census Count, 2010-2017 Population Estimates

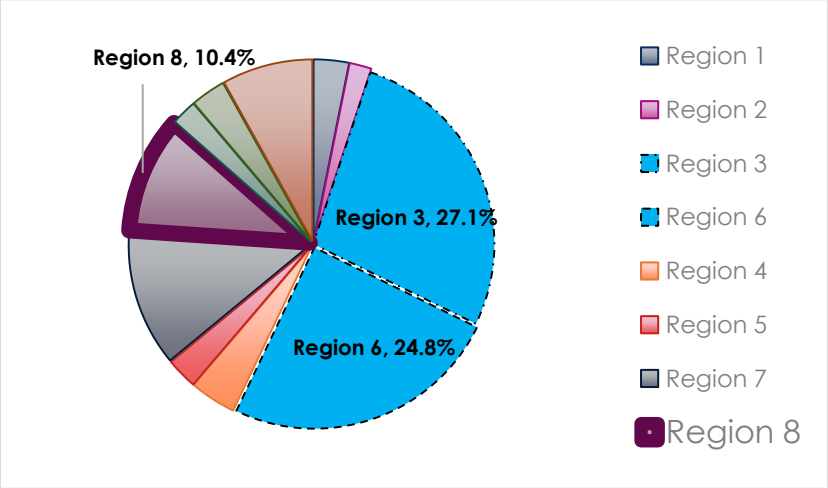
Region 8 population change from 2010 to 2017 increased 13.6 percent or 353,486 persons. Only Edwards county decreased (-2.4%) in population during the same period. Between 2016 and 2017 Region 8 reported a 1.7 percent increase or 48,091 persons even though eight counties experienced population declines. The three most popoulas counties in Region 8 comprise 76.4 percent of the total regional population including Bexar (66.2%), Guadalupe (5.4%) and Comal (4.8%). See Appendix A, Table 2 for county level data.

Diagram 2. 2010 – 2017 Region 8 Population Change by County



Source: U.S. Census Bureau, 2000 and 2010 Census Count, 2010-2017 Population Estimates

Diagram 3. 2016 Population Disbribution by Region, 2016



More than 1/2 (52%) of the Texas population resides within Regions 3 & 6.

Regions 7, 8 and 11 have among the highest populations and are located along the I35 corridor.

Source: Texas Demographic Center, Preliminary 2016 Texas Population Estimates

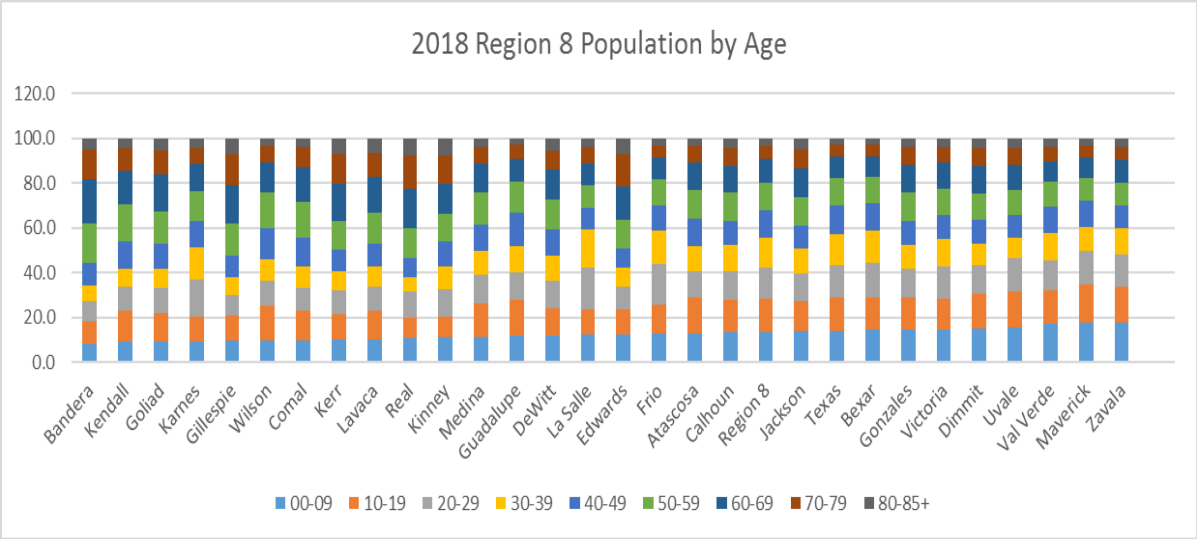
Most of the regional population resides in Bexar County

Age

Over one-quarter (28.2%) of the Region's residents were less than 19 years of age, similar to Texas at 28.8 percent; 62.5 percent were between the ages of 20 and 69 years of age, less than Texas at 63.0 percent; 9.3 percent were over the age of 70, more then Texas at 8.2 percent. Maverick county had the highest percentage of youth 0 to 19 years of age at 34.9 percent while Bandera county had 18.3 percent. The working class between the ages of 20 to 69 ranged between the lowest percentages in Atascosa

(56.6%) and Bandera (56.7%) counties and Maverick at the highest at 68.1 percent. Seniors 70 and older were the lowest in Bexar county (7.8%) with the highest percentage in Real county at 22.6 percent. Surprisingly Bexar, our most populus county that is the home to 66.2 percent of our residents had a disproportionatlely low percentage of seniors. Seniors were more likely to live in rural counties. See Appendix A, Table 3 for county data.

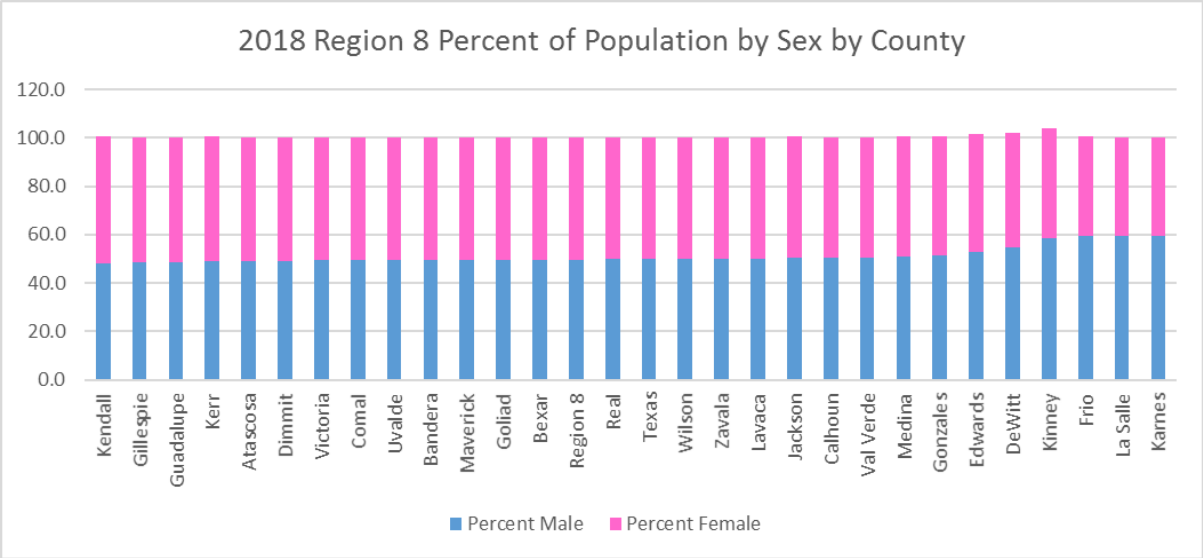
Diagram 4. 2018 Region 8 Population by Age



Source: Texas Demographic Center, Population Estimates, 2018

The Region 8 population was distributed among 50.4 percent females and 49.6 percent males, very similar to Texas at 50.2 percent females and 49.8 percent males. Kendall county reported the lowest male population at 47.7 percent compared to Karnes county at 59.4 percent male population. See Appendix A, Table 4 for county data.

Diagram 5. 2018 Region 8 Estimated Population by Sex by County

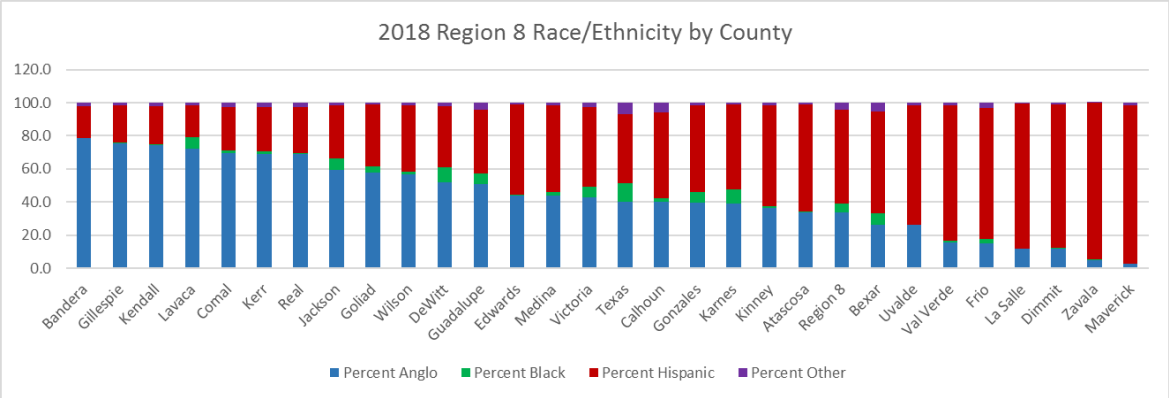


Source: Texas Demographic Center, Population Estimates, 2018

Race/Ethnicity

Latest estimates for Region 8 show that 56.5 percent of the population reported their race/ethnicity as Hispanic, followed by Anglo (33.6%); Black (5.6%) and Other (4.3%). Counties vary greatly across the region with Bandera county showing 78.4 percent White compared to Maverick county at 2.7 percent White. See Appendix A, Table 5 for county data.

Diagram 6, 2018 Region 8 Race/Ethnicity by County



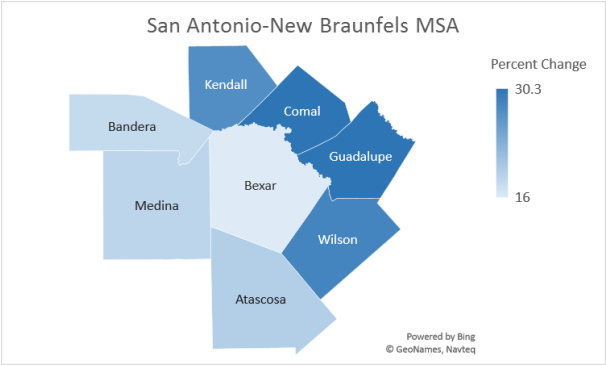
Concentrations of Populations

Region 8 includes two Metropolitan Statistical Areas (MSA) including San Antonio – New Braunfels MSA and Victoria Metropolitan MSA. Together they emcompas 87 percent of the Region 8 populatioin.

San Antonio–New Braunfels MSA also referred to as Greater San Antonio, include Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, and Wilson. The 2018 U.S. Census estimate showed the metropolitan area's population at 2,530,406 —up 18.1 percent from a reported 2,142,508 in 2010. San Antonio–New Braunfels is the third-largest metro area in Texas, after Dallas–Fort Worth–Arlington and Houston–The Woodlands–Sugar Land. [13]

Diagram 7, 2010-2018 Metro Statistical Areas (MSA)

2010-2018 San Antonio-New Braunfels MSA Population Change				
Area	Estimated Population as of July 1, 2018	2010 Census	Number Change from 2010 to 2018	Percent Change from 2010-2018
Atascosa	53,655	44,911	8,744	19.5
Bandera	24,187	20,485	3,702	18.1
Bexar	1,988,364	1,714,773	273,591	16.0
Comal	141,332	108,472	32,860	30.3
Guadalupe	171,409	131,533	39,876	30.3
Kendall	42,562	33,410	9,152	27.4
Medina	54,632	46,006	8,626	18.7
Wilson	54,265	42,918	11,347	28.4
San Antonio-New Braunfels MSA	2,530,406	2,142,508	387,898	18.1
Source: Texas Demographic Center, Population Estimates, 2018				

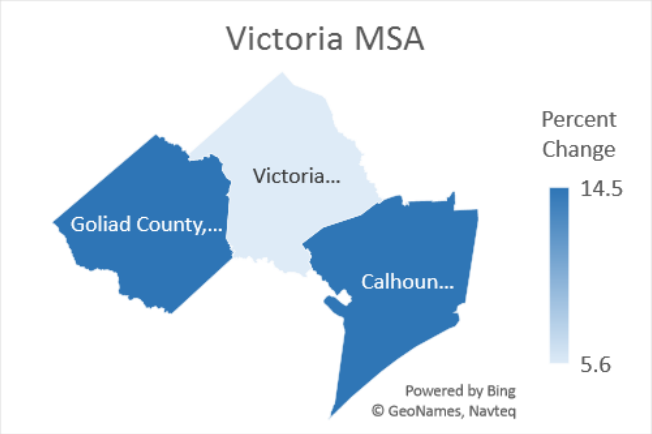


[13] Wikipedia contributors. Greater San Antonio. Wikipedia, The Free Encyclopedia. July 18, 2018, 23:25 UTC. Available at: https://en.wikipedia.org/w/index.php?title=Greater_San_Antonio&oldid=850935133. Accessed July 20, 2018.

Victoria MSA, also known as the Golden Crescent Region, include Calhoun, Goliad and Victoria counties.

Diagram 8, 2010-2018 Victoria Metro Statistical Area

2010-2018 Victoria MSA Population Change				
County	Estimated Population as of July 1, 2018	2010 Census	Number Change from 2010 to 2018	Percent Change from 2010-2018
Calhoun	24,472	21,381	3,091	14.5
Goliad	8,255	7,210	1,045	14.5
Victoria	91,624	86,793	4,831	5.6
Victoria MSA	124,351	115,384	8,967	7.8
Source: Texas Demographic Center, Population Estimates, 2018				



In addition, Region 8 encompasses the Kickapoo Traditional Tribe of Texas (KTTT), formerly known as the Texas Band of Traditional Kickapoo. It is one of three federally recognized Tribes of Kickapoo people. The KTTT Reservation is located on the Rio Grande on the US-Mexico border in western Maverick County. Also, it's just south of the city of Eagle Pass, as part of the community of Rosita Valley. The KTTT has a population of 960 enrolled members and was officially recognized by the Texas Indian Commission in 1977. [14]

Diagram 9. Kickapoo Traditional Tribe of Texas, Maverick County

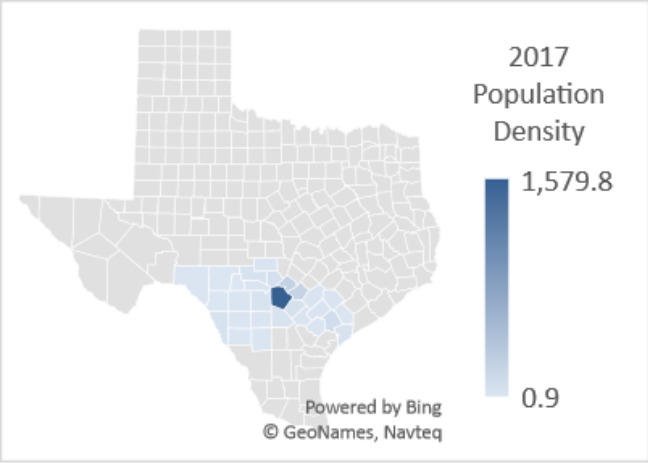
County	Estimated Population as of July 1, 2018	Land Area in Acres
Maverick	960	118.6
https://en.wikipedia.org/wiki/Kickapoo_Traditional_Tribe_of_Texas		

Texas' land area of 261,231.71 square miles places it as the 2nd largest state, behind Alaska's vast 570,640.95 square miles. The population density of Texas is 108.4 persons per square mile (density) compared to the United States at 92.2 persons per square mile.

In 2017, Region 8 showed 95.2 persons per square mile an increase of 11.4 persons from 2010 (83.9 persons per square mile). Edwards county reported the lowest density of 1 person per square mile (0.9) compared to 1,579.8 persons per square mile in Bexar county. County level data is available in Appendix A, table 6.

[14] Kickapoo Traditional Tribe of Texas. https://kickapootexas.org/. Accessed July 21, 2018

Diagram 10. 2017 Region 8 Population Density



Source: U.S. Census Bureau, QuickFacts, Population Estimates, (V2017), 2010

Eighty-two percent of Region 8 population resides in urban areas.

Research has shown there are environmental and social determinants of health in both urban and rural populations.

Urban	Rural
Social Enviornment	**Social Enviornment**
More likely to see large disparities in socioeconomic status, higher rates of crime and violence, the presence of marginalized populations (e.g., sex workers) with high risk behaviors, and a higher prevalence of psychological stressors that accompany the increased density and diversity of cities.	Rural elders have significantly poorer health status than urban elders, smoke more, exercise less, have less nutritional diets, and are more likely to be obese than suburban residents. Public health problems faced in rural areas (e.g., obesity, tobacco use, failure to use seat belts)
The Physical Environment	**The Physical Environment**
In densely populated urban areas, there is often a lack of facilities and outdoor areas for exercise and recreation. In addition, air quality is often lower in urban environments which can contribute to chronic diseases such as asthma.	While poor air quality and crime rates are likely to be less of an issue in rural areas, insufficiencies in the built environment make it difficult for rural residents to exercise and maintain healthy habits.
Access to Health and Social Service	**Access to Health and Social Service**

Persons of lower socioeconomic status and minority populations are more likely to live in urban areas and are more likely to lack health insurance. Thus, these populations face barriers to care, receive poorer quality care, and disproportionately use emergency systems. Other commonly represented populations in cities are undocumented immigrants and transient populations. The high prevalence of individuals without health insurance or citizenship creates a greater burden on available systems. This often leads to vast disparities in health care outcomes as well as a two-tiered health care system where insured individuals have access to preventive and routine health care while marginalized populations utilize "safety-net" emergency room care.	Evidence indicates that rural residents have limited access to health care and that rural areas are underserved by primary care physicians. Many rural individuals must travel substantial distances for primary medical care, requiring significantly longer travel times to reach care than their urban counterparts. Furthermore, some rural areas have a higher proportion of uninsured and individually insured residents than urban areas.
Source: Unite for Sight, *Urban Versus Rural Health*, http://www.uniteforsight.org/global-health-university/urban-rural-health#_ftn7	

With continuing urban growth, the state's major metropolitan areas can expect better employment prospects and greater access to a wider variety of goods and services. At the same time, though, urbanization will produce greater pressures on an MSA's education, housing, and transportation infrastructures. Finding a balance will require strategies that adapt to higher population densities while minimizing negative outcomes in the urban environment.

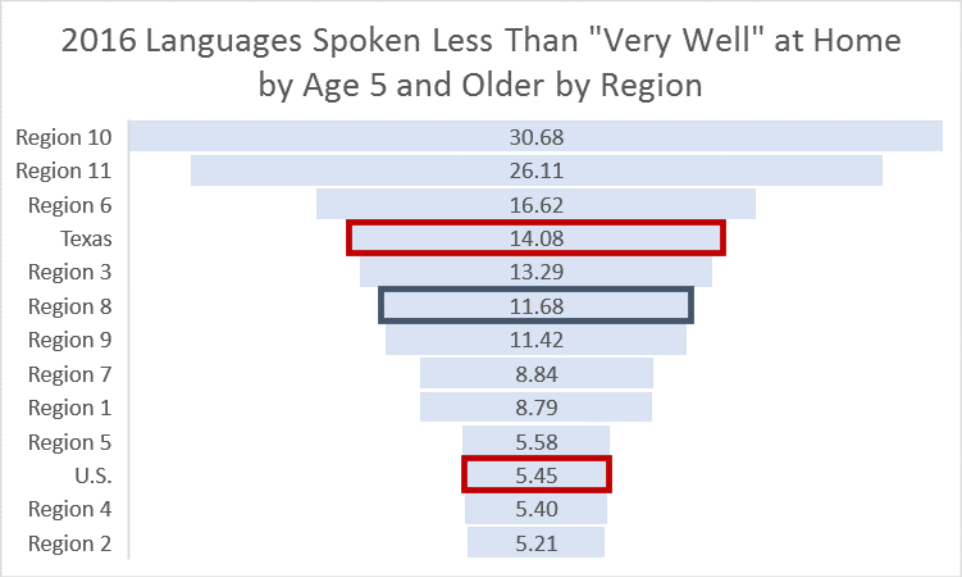
Languages

Language barriers can have deleterious effects. Patients who face such barriers are less likely than others to have a usual source of medical care; they receive preventive services at reduced rates; and they have an increased risk of nonadherence to medication. Among patients with psychiatric conditions, those who encounter language barriers are more likely than others to receive a diagnosis of severe psychopathology — but are also more likely to leave the hospital against medical advice.[15]

In 2016, the United States estimated that over 63 million people (21.15%) age five and older speak a language other than English at home; 16.3 million (5.45%) speak English less than "very well" according to self-ratings. In Texas, over 8.7 million people (35.19%) age five and older speak a language other than English at home; 3.5 million (14.08%) speak English less than "very well" according to self-ratings. The numbers are significantly higher in Regions that border Mexico; 31 percent of Region 10 and 26 percent of Region 11 residents report speaking English less than "very well". Appendix A, Table 7.

[15] Flores, Glenn MD., Language Barriers to Health Care in the United States, *N Engl J Med* 2006

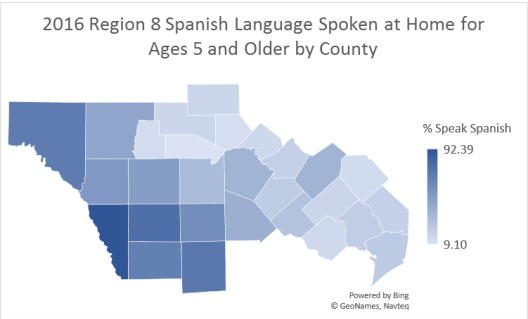
Diagram 11. 2016 Languages Spoken Less Than "Very Well" at Home

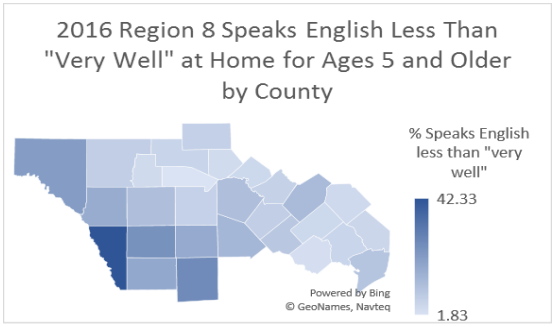


Source: U.S. Census Bureau. 2016 American Community Survey 5-year estimates

In Region 8, there are 908,543 persons (37.89%) age five and older that speak a language other than English at home; and 305,133 persons (11.68%) speak English less than "very well" according to self-ratings. The numbers are significantly higher in the counties that border Mexico; 92% of Maverick County residents speak Spanish, 6.68 percent speak English and 0.93 percent all other languages while 42.33 percent speak English less than "Very Well". Seventy-two percent of La Salle County residents speak Spanish; 28 percent speak English and 0.57 percent all other languages while 27 percent self report they speak English less than "Very Well". The maps below compare percent of Spanish speakers to percent of less than "Very Well" English speakers. See Appendix A, Table 8 for county data.

Figure 12. 2016 Region 8 Spanish Language Spoken at Home and Speaks Less Than "Very Well"

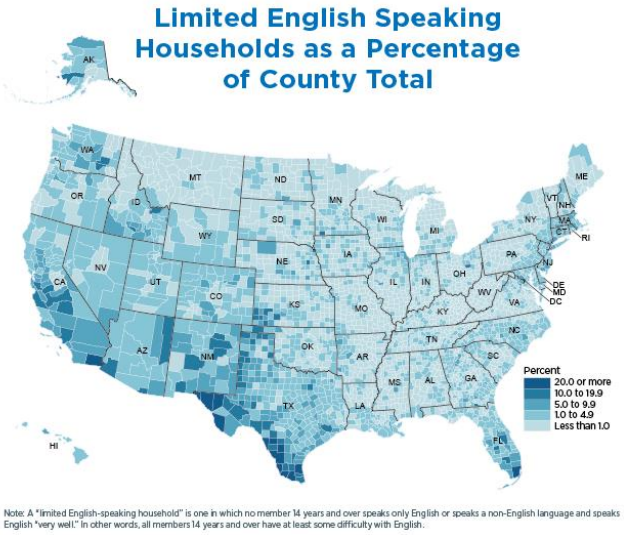




Source: U.S. Census Bureau. 2016 American Community Survey 5-year estimates

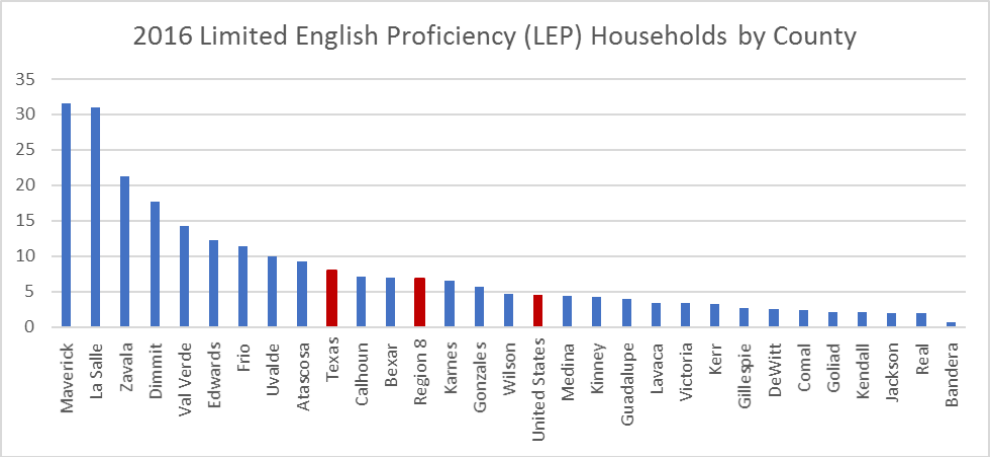
Another similar indicator is the number of households with limited English proficiency (LEP). In Texas, it is higher at 7.9 percent of all households versus 4.5 percent for the U.S.

Diagram 13.



Fifty percent of Region 8 counties report higher Limited English Proficiency (LEP) households than the United States at 4.5 percent. The households with Limited English proficiency (LEP) is lower in Region 8 (6.8%) than in Texas (7.9%). Those Counties with the highest percentages of LEP households are Maverick (31.6%) and La Salle (31%) while Real (2%) and Bandera (0.7%) report the lowest. See Appendix A, Table 9 for county level data.

Figure 14. Limited English Proficiency (LEP) Households by County



Source: 2012-2016 American Community Survey 5-Year Estimates

General Socioeconomics

Socioeconomic status (SES) encompasses not just income but also educational attainment, occupational prestige, and subjective perceptions of social status and social class. Socioeconomic status can encompass quality of life attributes as well as the opportunities and privileges afforded to people within society. Poverty, specifically, is not a single factor but rather is characterized by multiple

physical and psychosocial stressors. Further, SES is a consistent and reliable predictor of a vast array of outcomes across the life span, including physical and psychological health. Thus, SES is relevant to all realms of behavioral and social science, including research, practice, education, and advocacy. [16]

Lower levels of SES have been found to be associated with higher levels of emotional and behavioral difficulties; higher rates of depression, anxiety, attempted suicide, cigarette dependence, illicit drug use, and episodic heavy drinking among adolescents; higher levels of aggression, hostility, perceived threat, and discrimination for youth; and higher infant mortality.

The following topics will provide insight on vulnerable populations in the Region 8 community: Poverty, Median Household Income, Employment, Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), Free and Reduced School Lunch Program and the uninsured.

Poverty

The poverty rate is a key economic indicator often used by policy makers to evaluate current economic conditions within communities and to make comparisons between sectors of the population. It measures the percentage of people whose income fell below the poverty threshold. Federal and state governments use poverty estimates to allocate funds to local communities. Local communities often use these estimates to identify the number of individuals or families eligible for various programs.[17]

U.S. Department of Commerce, 2016 Poverty in the United States highlights:

- The official poverty rate in 2016 for all ages was 12.7 percent, down 0.8 percentage points from 13.5 percent in 2015. This is the second consecutive annual decline in poverty. Since 2014, the poverty rate has fallen 2.1 percentage points from 14.8 percent to 12.7 percent.

- In 2016 there were 40.6 million people in poverty, 2.5 million fewer than in 2015 and 6.0 million fewer than in 2014.

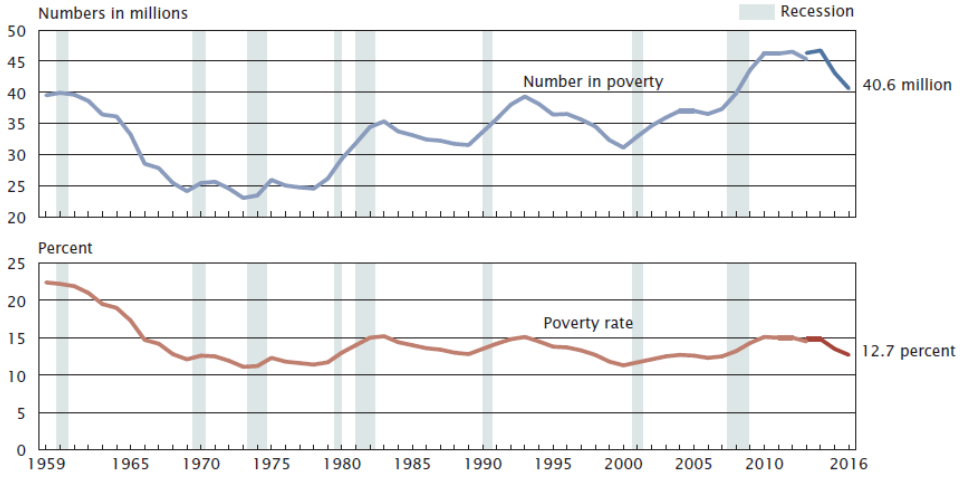
- The poverty rate in 2016 (12.7%) was not significantly higher than the poverty rate in 2007 (12.5%), the year before the most recent recession.

- For most demographic groups, the number of people in poverty decreased from 2015. Adults aged 65 and older were the only population group to experience an increase in the number of people in poverty.

- Between 2015 and 2016, the poverty rate for children under age 18 declined from 19.7 to 18.0 percent. The poverty rate for adults aged 18-64 declined from 12.4 to 11.6 percent. The poverty rate for adults aged 65 and older was 9.3 percent in 2016, not statistically different from the rate in 2015.[18]

[16] American Psychological Association. Children, Youth, Famillies and Socioeconomic Status. http://www.apa.org/pi/ses/resources/publications/children-families.aspx. Accessed June 6, 2018.
[17] Bishaw A, Fontenot K. Poverty: 2012 and 2013. American Community Survey Briefs. https://www.census.gov/content/dam/Census/library/publications/2014/acs/acsbr13-01.pdf . Issued September 2014. Accessed June 12, 2018.
[18] Semega, Jessica L., Kayla R. Fontenot, and Melissa A. Kollar, U.S. Census Bureau, Current Population Reports, P60-259, Income and Poverty in the United States: 2016, U.S. Government Printing Office, Washington, DC, 2017.

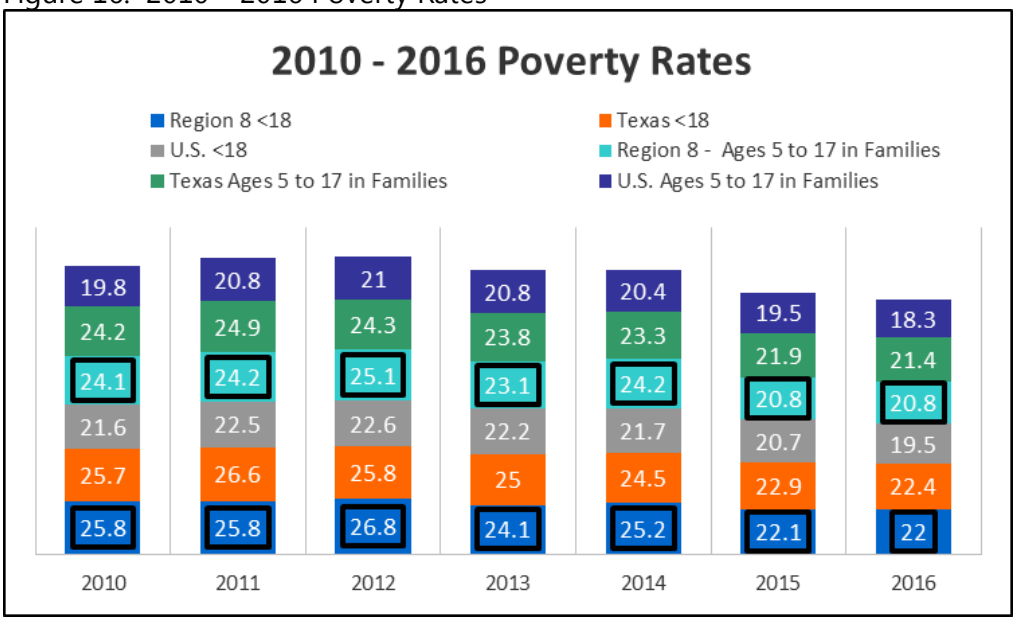
Diagram 15. Number in Poverty and Poverty Rate: 1959 to 2016



Note: The data for 2013 and beyond reflect the implementation of the redesigned income questions. The data points are placed at the midpoints of the respective years. For information on recessions, see Appendix A. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see <www2.census.gov/programs-surveys/cps/techdocs/cpsmar17.pdf>.
Source: U.S. Census Bureau, Current Population Survey, 1960 to 2017 Annual Social and Economic Supplements.

In Region 8, between 2010 and 2016, the poverty rate for children under age 18 declined 3.8 percentage points from 25.8 percent to 22 percent. In addition, the poverty rate for children ages 5 to 17 in families declined 3.3 percentage points from 24.1 percent to 20.8 percent.

Figure 16. 2010 – 2016 Poverty Rates



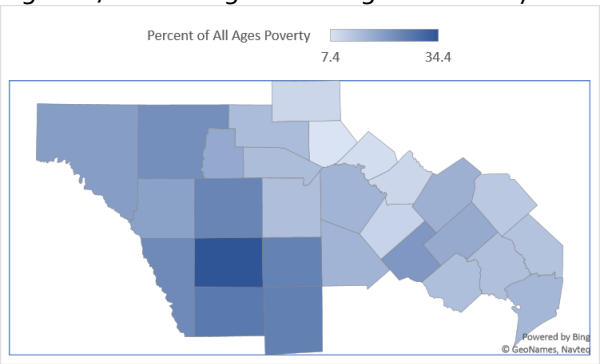
Source: SAIPE, 2010-2016

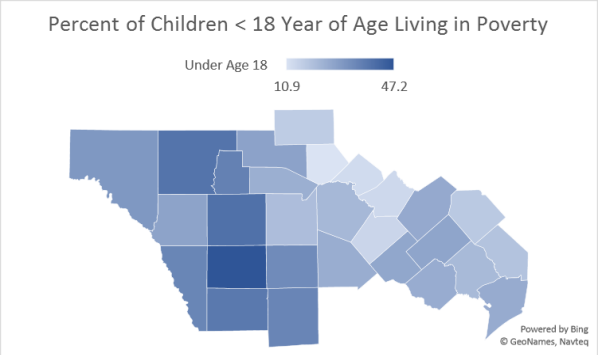
In Region 8 for persons of all ages 15.7 percent or 444,990 were living in poverty in 2016 slightly higher from 15.2 percent or 426,123 in 2015. For children under the age of 18, 22 percent or 161,691 were

living in poverty in 2016 remaining unchanged from 22.1 percent or 160,273 in 2015. In addition, the poverty rate for children ages 5 to 17 in families remained unchanged at 20.8%.

In 2016, Region 8 counties with people of all ages living in poverty ranged from a low of 7.4 percent in Kendall to 34.4 percent in Zavala. For children under the age of 18, ranged from the lowest at 10.9 percent in Kendall to 47.7 percent in Zavala. See Appendix A, Table 10 for county level data.

Figure 17. 2016 Region 8 All Ages in Poverty Versus Children Less Than 18 Years of Age





One in 5 Children Under the Age of 18 Live in Poverty in Region 8

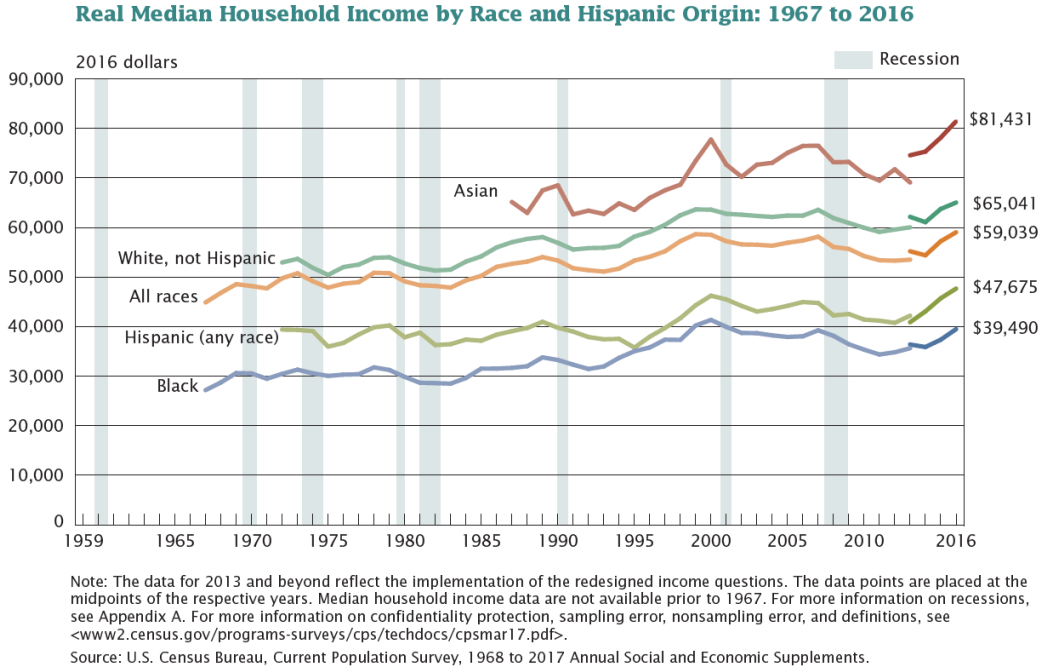
Median Household Income

U.S. Department of Commerce Income in the United States Highlights:

- Median household income was $59,039 in 2016, an increase in real terms of 3.2 percent from the 2015 median of $57,230. This is the second consecutive annual increase in median household income.
- For family households, real median income of married-couple households and households maintained by women with no husband present increased 1.6 percent and 7.2 percent between 2015 and 2016, respectively.
- The real median income of non-Hispanic White, Black, and Hispanic-origin households increased 2.0 percent, 5.7 percent, and 4.3 percent, respectively, between 2015 and 2016.6 This is the second annual increase in median household income for non-Hispanic White, Black, and Hispanic-origin households. For Asian households, the 2015 to 2016 percentage change in real median income was not statistically significant.
- The real median income of households maintained by a foreignborn person

increased by 4.9 percent, while the median income of households maintained by a native-born person increased 3.3 percent between 2015 and 2016.[19]

Figure 17. Real Median Household Income by Race and Hispanic Orgin: 1967 to 2016

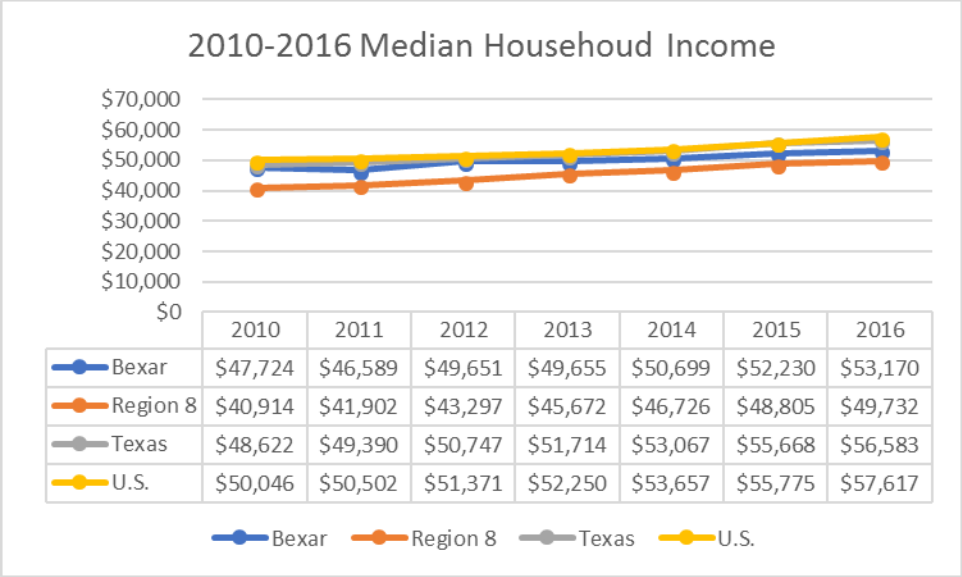


The 2016 median household income for Region 8 is 15.9 percent, lower than the United States and 13.8 percent lower than Texas. Eighty-two percent of Region 8 counties have lower median household incomes than the United States and Texas.

The median household income for Region 8 was $49,732 in 2016, an increase of 1.9 percent from the 2015 median of $48,805. Bexar, our most populous county's median household income was $53,170 in 2016, an increase of 1.8 percent from the 2015 median of $52,230. The United States median household income increased 3.3 percent and Texas at 1.6 percent from 2015 to 2016.

[19] Semega, Jessica L., Kayla R. Fontenot, and Melissa A. Kollar, U.S. Census Bureau, Current Population Reports, P60-259, Income and Poverty in the United States: 2016, U.S. Government Printing Office, Washington, DC, 2017. Accessed June 13, 2018

Figure 18. 2010 to 2016 Median Household Income

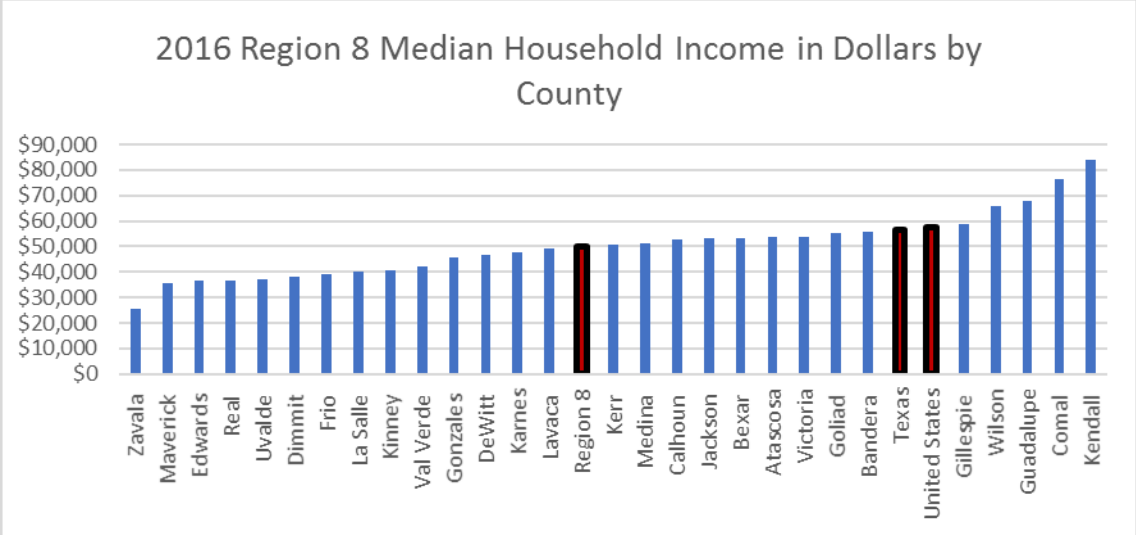


	2010	2011	2012	2013	2014	2015	2016
Bexar	$47,724	$46,589	$49,651	$49,655	$50,699	$52,230	$53,170
Region 8	$40,914	$41,902	$43,297	$45,672	$46,726	$48,805	$49,732
Texas	$48,622	$49,390	$50,747	$51,714	$53,067	$55,668	$56,583
U.S.	$50,046	$50,502	$51,371	$52,250	$53,657	$55,775	$57,617

Source: SAIPE, 2010-2016

The Region 8 median household income in 2016 ranges from $25,507 in Zavala county to $83,805 in Kendall county. The median household income for Bexar was $53,170.

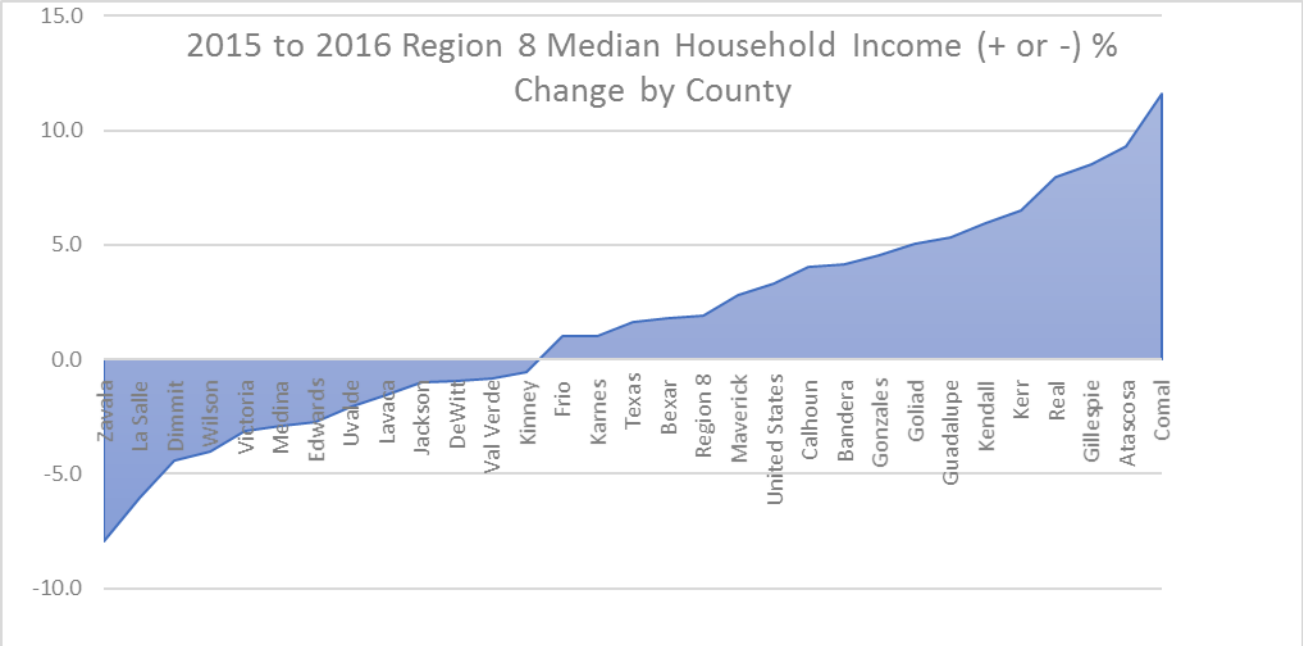
Figure 19. 2016 Region 8 Median Household Income by County.



Source: SAIPE, 2016

From 2015 to 2016 forty-six percent of the counties in Region 8 experienced decreases in median household incomes. Median Household Income by county is in Appendix A, Tables 10-12.

Figure 20. 2015 to 2016 Region 8 Median Household Income Percent Change by County



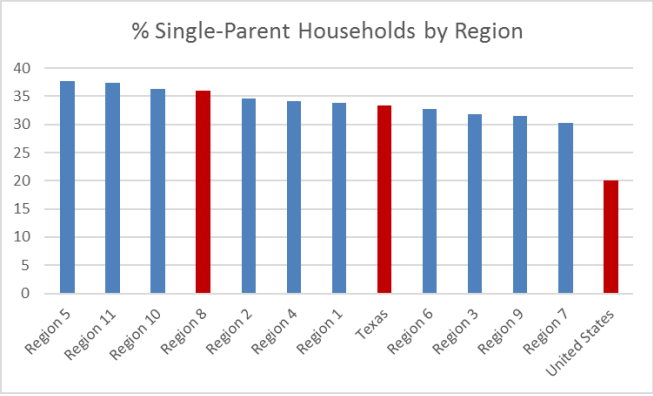
Source: SAIPE, 2010-2016

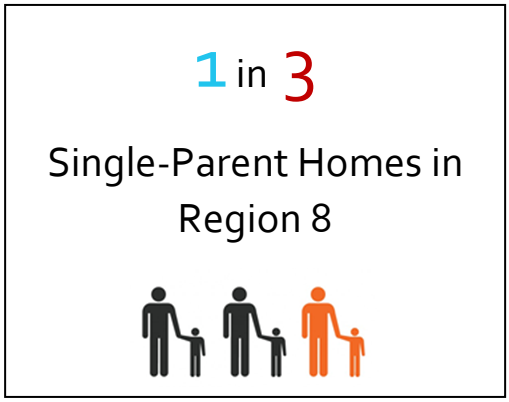
Houshold Composition

Children growing up in single-parent families typically do not have the same economic or human resources available as those growing up in two-parent families. Compared with children in married-couple families, children raised in single-parent households are more likely to drop out of school, to have or cause a teen pregnancy and to experience a divorce in adulthood.[20]

All Regions in Texas had significantly more children living in single-parent homes than the U.S. Among the Regions in Texas with single-parent households, Region 5 reported the highest at 38 percent and Region 7 with the lowest at 30 percent.

Figure 21. Percent of Single Parent- Households by Region



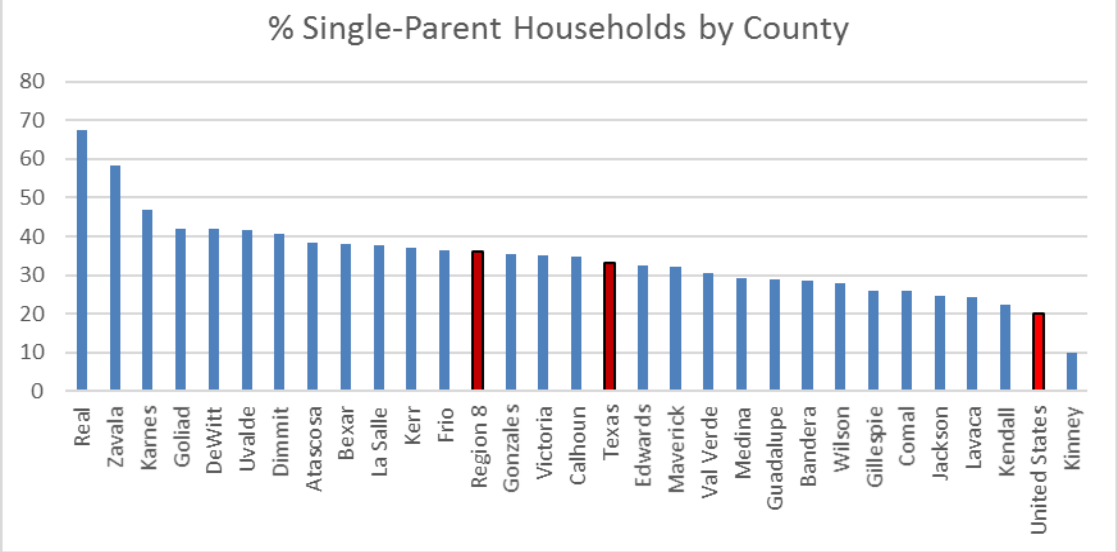


Source: County Health Rankings, 2018

[20] Kids Count Data Book. *Children in single-parent families.* http://datacenter.kidscount.org/publications. Accessed June 6, 2018

In Region 8, one in three households have children living with a single-parent. The breakdown for Region 8 can be seen in Figure 22 below. Real County had the highest percentage of children living in single-parent households at over 67 percent while Kinney County had the lowest at 10 percent. Over half (53.6%) of the counties in Region 8 had higher percentages of children living in single-parent households than Texas and 96 percent of Region 8 counties had higher percentages of children living in single-parent houshold than the United States. Appendix A, Table 13 for county data.

Figure 22. Percent of Single-Parent Households by County



Source: County Health Rankings, 2018

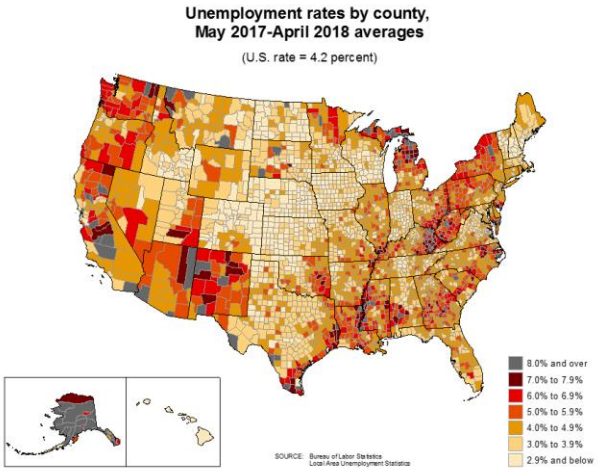
Employment

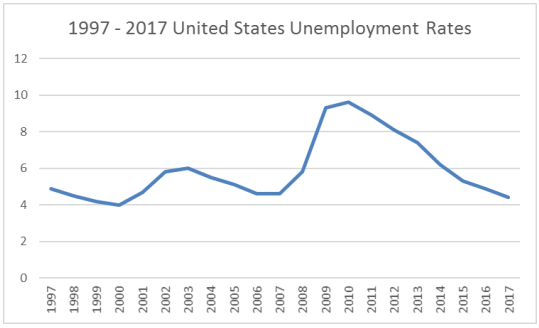
One of the most important factors related to risk for and protection from substance abuse is the ability to provide for the necessities of life. Research has shown that unemployed people are more likely to have poor health habits, characterized by excess drinking, smoking, lack of exercise, and a sedentary lifestyle.[21] In addition, the Center for Disease Control (CDC), reports the risk of depression is higher among the unemployed than among the employed, but little is known about the relationship between unemployment and mental health among emerging adults.[22]

The United States unemployment rate change has flucated over the past twenty years from its lowest in 2000 at 4 percent to its highest in 2010 at 9.6 percent. In 2017, the United States unemployment rate was 4.4, down by -0.5 from 2016 and is continuing to drop as seen in the figure below. Compared to other states, Texas ranked 26th in unemployment in 2017 with an unemployment rate of 4.3%, down by -0.3 from 2016.

[21] Leahy R, Ph.D, Unemployment is Bad for Your Health, The Blog, https://www.huffingtonpost.com/robert-leahy-phd/unemployment-health_b_2616430.html. Feb 5, 2013, , Updated Apr 7, 2013, Accessed Jun 11, 2018.
[22] McGee RE, Thompson NJ. Unemployment and Depression Among Emerging Adults in 12 States, Behavioral Risk Factor Surveillance System, 2010. Prev Chronic Dis 2015;12:140451. DOI: http://dx.doi.org/10.5888/pcd12.140451.

Diagram 23, U.S Unemployment

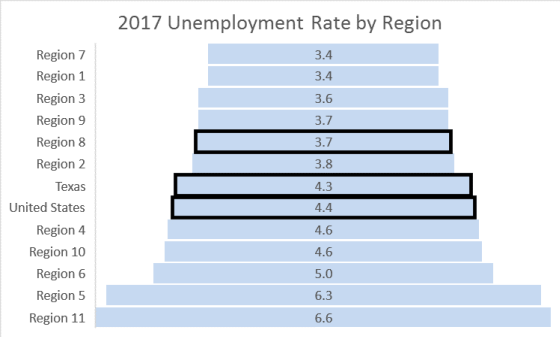


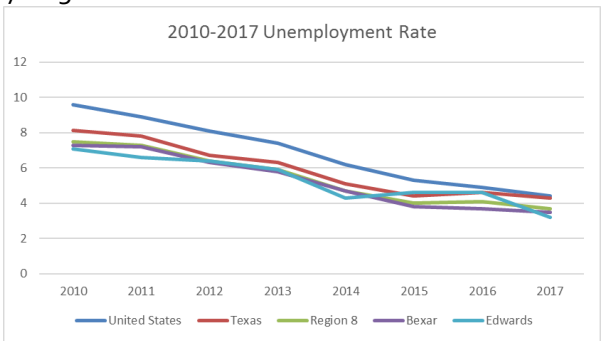


Source: Bureau of Labor Statistics

In 2017, Region 8 unemployment rate of 3.7 percent, was lower than the state and national averages. Since 2010, like the national rates, Texas, and all Region 8 counties have seen continual decreases.

Diagram 24. 2010 to 2017 Unemployment Rates by Region





Source: Bureau of Labor Statistics, 2017

2017 Unemployment rates for Region 8 counties ranged from a low of 2.6% in Gillespie county to a high of 11.1 percent in Zavala county. Sixty-one percent of Region 8 counties have unemployment rates higher than both national (4.4%) and state (4.3%) rates. See Appendix A, Tables 14-15 for county and regional tables.

Diagram 25. 2017 Unemployment Rates by County

Source: Bureau of Labor Statistics, 2017

TANF Recipients

The Temporary Assistance for Needy Families (TANF) program provides temporary financial assistance for pregnant women and families with one or more dependent children. TANF provides financial assistance to help pay for food, shelter, utilities, and expenses other than medical. The Temporary Assistance for Needy Families (TANF) program is designed to help needy families achieve self-sufficiency. States receive block grants to design and operate programs that accomplish one of the purposes of the TANF program.[23]

The four purposes of the TANF program are to:

- Provide assistance to needy families so that children can be cared for in their own homes
- Reduce the dependency of needy parents by promoting job preparation, work and marriage
- Prevent and reduce the incidence of out-of-wedlock pregnancies
- Encourage the formation and maintenance of two-parent families

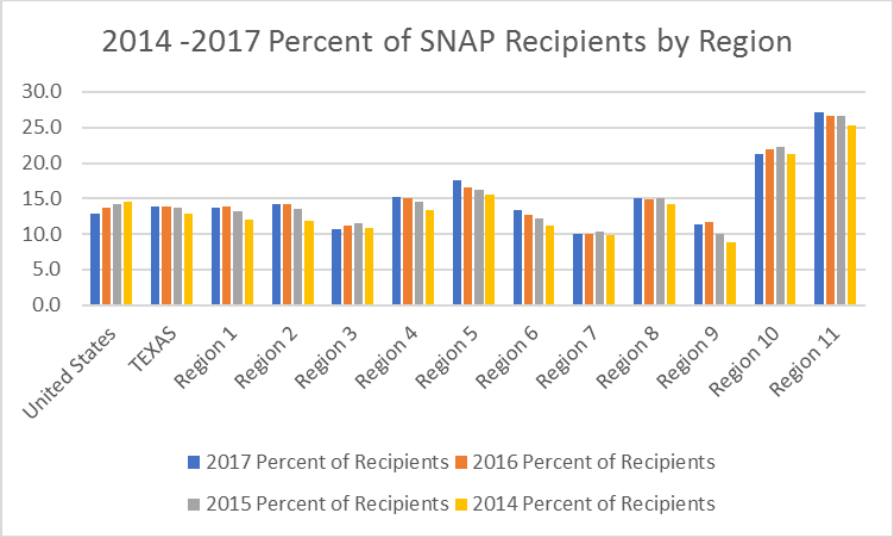
Food Assistance Recipients

The Supplemental Nutrition Assistance Program (SNAP) offers nutrition assistance to millions of eligible, low-income individuals and families and provides economic benefits to communities. SNAP is the largest program in the domestic hunger safety net. The Food and Nutrition Service (FNS) works with State agencies, nutrition educators, and neighborhood and faith-based organizations to ensure that those eligible for nutrition assistance can make informed decisions about applying for the program and can access benefits. FNS also works with State partners and the retail community to improve program administration and ensure program integrity.[24]

[23] U.S. Department of Health & Human Services, Administration for Children and Families, Temporary Assistance for Needy Families (TANF). https://www.acf.hhs.gov/ofa/programs/tanf . Last Reviewed June 28, 2017. Accessed June 15, 2018.
[24] United States Department of Agriculture, Food and Nutrition Service, Supplemental Nutrition Assistance Program (SNAP). https://www.fns.usda.gov/snap/supplemental-nutrition-assistance-program-snap. Last Published April 25, 2018. Accessed June 14, 2018.

Between 2014 and 2017, Region 11 has contined to have the highest percentage of SNAP recipients in Texas followed by Region 9 while Region 7 has remained with the lowest percentage. In 2017, the average monthly benefit in Texas was $257.98 down from $259.14 per person in 2016. For Region 8 the average monthly benefit was $263.69 an increase from $262.89 reported in 2016.

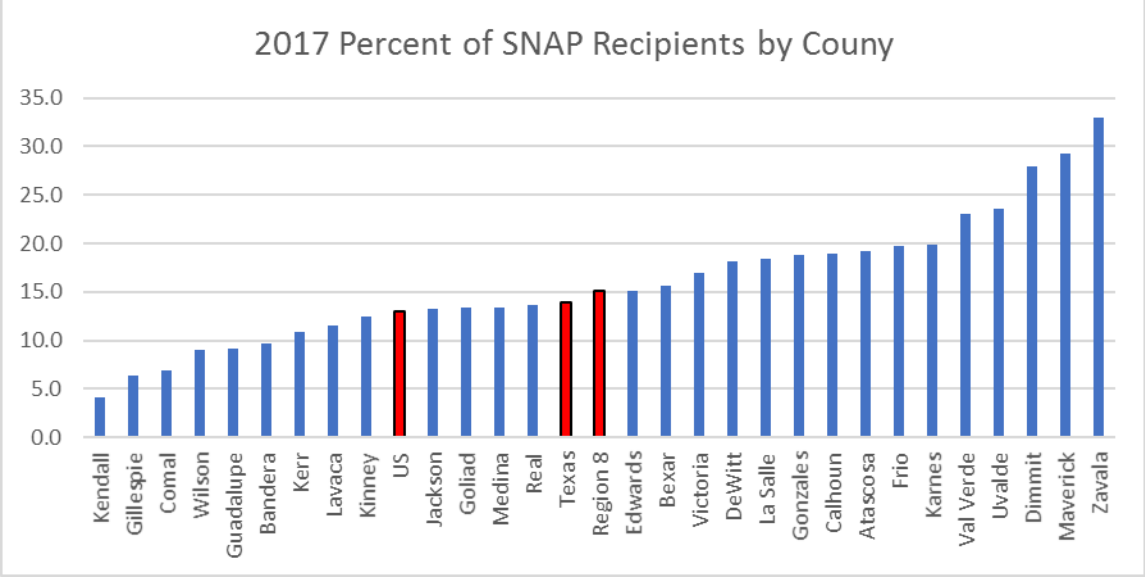
Diagram 26. 2014 – 2017 SNAP Recipients



Source: Supplemental Nutritional Assistance Program (SNAP) Statistics

In 2017, sixty-eight percent of the counties in Region 8 had higher percentages of recipients receiving Supplemental Nutrition Assistance (SNAP) benefits than the United States at 12.9 percent in 2017. Zavala and Maverick counties reported the highest percentages of recipients while Kendall and Gillespie reported the lowest. Appendix A, Table 16 for county data.

Diagram 27. 2017 Percent of SNAP Recipients by County



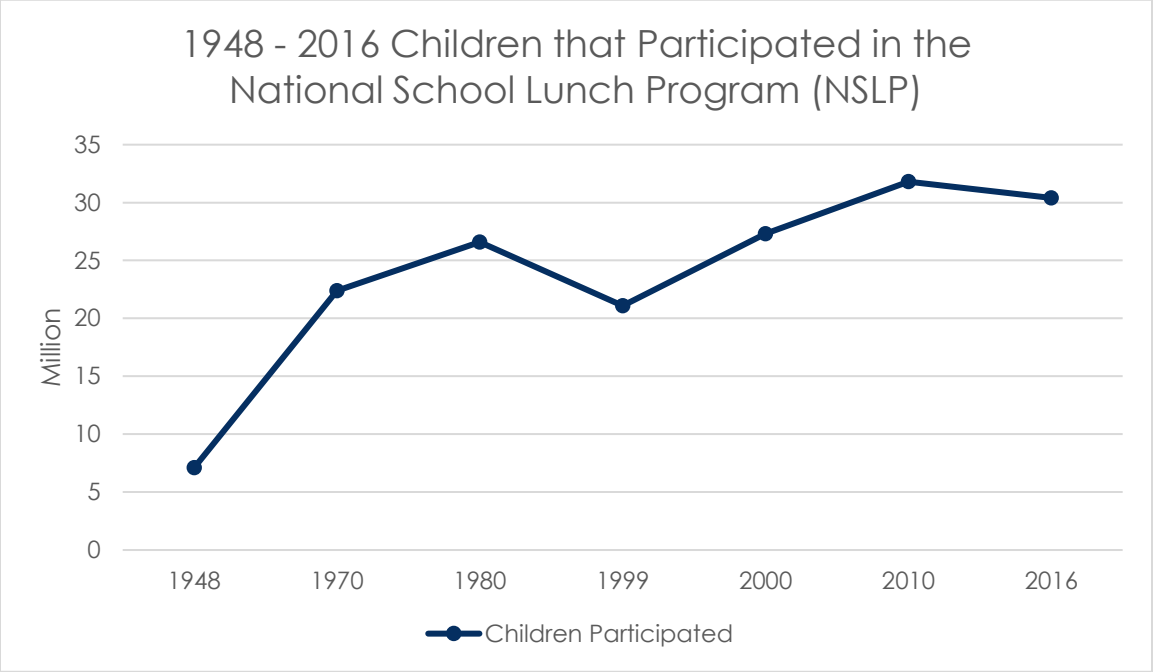
Source: Supplemental Nutritioinal Assistance Program (SNAP) Statistics

Free and Reduced-Price School Lunch Recipients

The National School Lunch Program (NSLP) is a federally assisted meal program operating in public and nonprofit private schools and residential child care institutions. It provides nutritionally balanced, low-cost or no-cost lunches to children each school day. The program was established under the Richard B. Russell National School Lunch Act, signed into law by President Harry Truman in 1946.

About 7.1 million children participated in the NSLP in its first year. Since then, the Program has reached millions of children nationwide: 1970: 22.4 million children; 1980: 26.6 million children; 1990: 21.1 million children; 2000: 27.3 million children; 2010: 31.8 million children; and 2016: 30.4 million children. [25]

Diagram 28, 1948 – 2016 Children that Participated in National School Lunch Program



Source: United States Department of Agriculture

Another measure of possible food insecurity is the percentage of children who are eligible for free or reduced-price lunches in public schools. Children from families with incomes at or below 130 percent of the poverty level are eligible for free meals. Those with incomes between 130 percent and 185 percent of the poverty level are eligible for reduced-price meals, for which students can be charged no more than 40 cents.

Region 11 has the highest percentage of students eligible for free lunches at 77.9 percent while Region 7 reports the least at 44 percent. Region 2 has the highest percent of students eligible for reduced price lunches at 8.5 percent while Region 11 has the lowest at 2 percent of students.

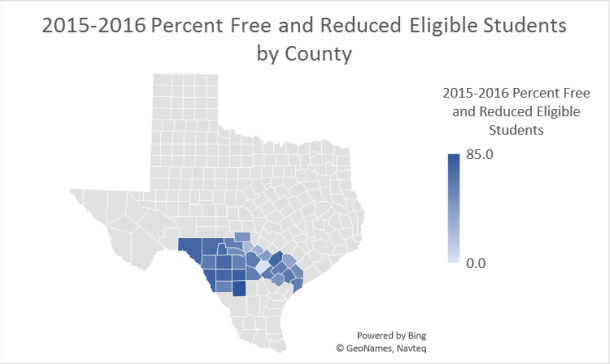
[25] U.S. Department of Agriculture, Food and Nutrition Service, Natioinal School Lunch Program (NSLP). https://www.fns.usda.gov/nslp/national-school-lunch-program-nslp . Accessed June 15, 2018.

Diagram 29. 2012 – 2016 Free/Reduced Eligible Lunches by Region

2012-2016 Free/Reduced Eligible Lunches by Region										
County Name	2015-2016 Percent Free Lunch Eligible	2015-2016 Percent Reduced Lunch Eligible	2014-2015 Percent Free Lunch Eligible	2014-2015 Reduced Price Eligible	2013-2014 Percent Free Lunch Eligible	2013-2014 Percent Reduced Lunch Eligible	2012-2013 Percent Free Lunch Eligible	2012-2013 Percent Reduced Price Eligible	2011-2012 Percent Free Lunch Eligible	2011-2012 Percent of Reduced Price Lunch Eligible
Region 1	52.4	7.3	50.8	7.8	51.5	8.6	51.4	8.7	50.2	8.7
Region 2	47.8	8.5	46.7	9.6	47.6	10.0	47.0	10.0	47.5	9.8
Region 3	47.6	6.2	46.9	6.5	47.7	6.4	48.1	6.2	46.7	6.6
Region 4	54.1	6.9	53.0	7.6	53.3	8.2	53.2	8.0	52.3	7.9
Region 5	54.9	6.1	54.3	6.9	55.8	7.3	54.8	7.3	53.6	7.4
Region 6	50.7	6.2	50.1	6.5	51.4	7.0	52.0	7.0	45.6	7.2
Region 7	44.0	7.0	44.1	7.7	45.1	7.6	45.4	7.6	45.4	7.6
Region 8	54.9	5.8	54.5	6.1	54.4	8.0	53.7	8.0	37.0	7.7
Region 9	42.7	8.0	39.2	8.4	41.4	9.2	42.7	9.1	41.9	9.0
Region 10	66.8	7.1	66.3	8.1	65.2	9.9	65.0	10.0	58.4	10.1
Region 11	77.9	2.0	77.0	2.4	77.7	3.3	77.3	3.4	25.2	3.4
Texas	52.6	5.9	51.9	6.4	52.9	6.9	53.3	6.9	44.1	7.0
Source: National Center for Education Statistics										

Diagram 30. 2015 – 2016 Percent Free and Reduced Eligible Students by County

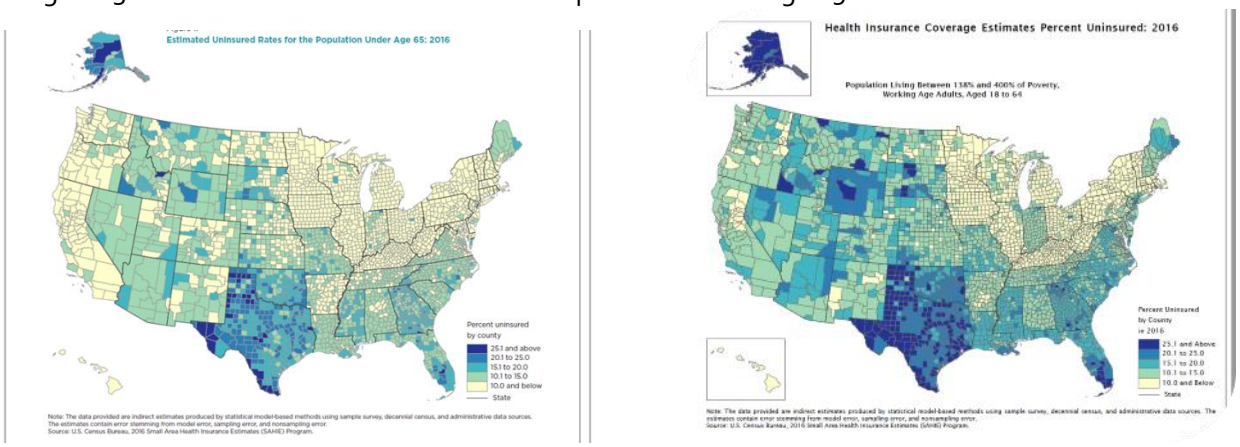
In Region 8 the percent of the student population eligible for free and/or reduced lunches increased from 60.69 percent or 316,462 students during the 2014-2015 school year to 60.71 percent or 321,382 students during 2015-2016. Counties in Region 8 ranged from a low in Kendall at 24.3 percent to a high in La Salle at 85 percent. See Appendix A, Table 17 for county data.



Insured and Uninsured

The lack of insurance can be a barrier to accessing healthcare and other health services that contribute to poor health outcomes. Texas has among the highest percentage of people without health insurance as seen below in 2016.

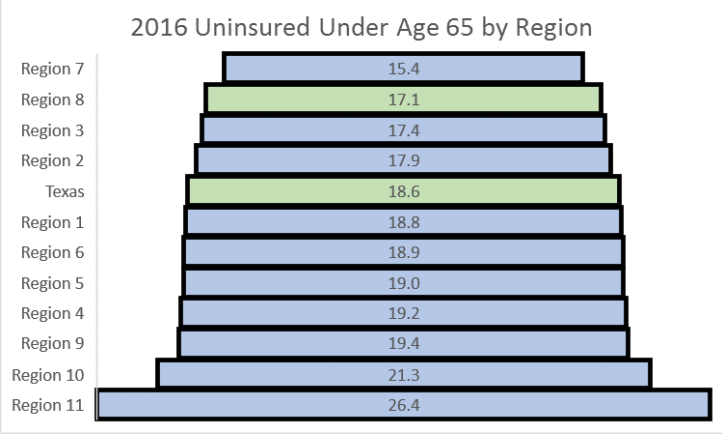
Diagram 32. 2016 U.S. Estimated Uninsured Population Under Age 65 Versus All Uninsured



Source: U.S. Census Bureau, 2016 Small Area Health Insurance Estimates (SAHIE) Program

In 2016, among the population under age 65, the Texas uninsured rate was 18.6 percent, down by 0.6 from 2015 at 19.2 percent. The estimated uninsured rate decreased between 2015 and 2016 for 174 counties or 68.5 percent of all Texas Counties. Region 8 has the second highest insured population at 83 percent, while Region 11 has the lowest insured rate at 74 percent.

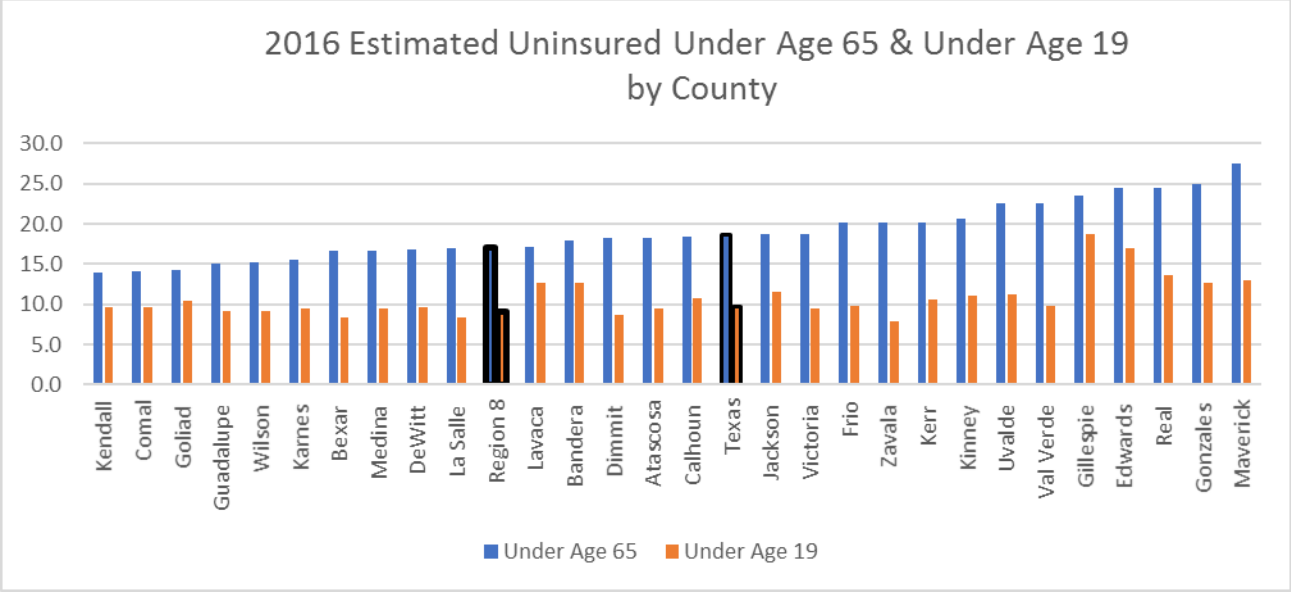
Diagram 33. 2016 Uninsured Under Age 65 by Region



Source: Small Area Health Insurance Estimates (SAHIE) Program, 2016

In 2016, the Region 8 uninsured population under age 65 was 17.1 percent, down by 0.3 from 2015 at 17.4 percent. The estimated uninsured rate decreased between 2015 and 2016 for 19 counties or 67.9 percent of all Region 8 counties. Fourty-six percent of the counties in Region 8 have higher rates of uninsured among the population under age 65 than Texas at 18.6 percent while fifty-four percent of the counties have higher rates among the population under age 19 than Texas at 9.7. See Appendix A, Table 18 for county data.

Diagram 34, 2016 Percent of Estimated Uninsured Under Age 65 by County



Source: Small Area Health Insurance Estimates (SAHIE) Program, 2016

Environmental Risk Factors

The influence of the home environment, especially during childhood, is a very important factor. Parents or older family members who abuse alcohol or drugs, or who engage in criminal behavior, can increase children's risks of developing their own drug problems. Friends and acquaintances can have an increasingly strong influence during adolescence. Drug-using peers can sway even those without risk factors to try drugs for the first time. Academic failure or poor social skills can put a child at further risk for using or becoming addicted to drugs. [26]

Region 8 environmental risk factors are discussed below.

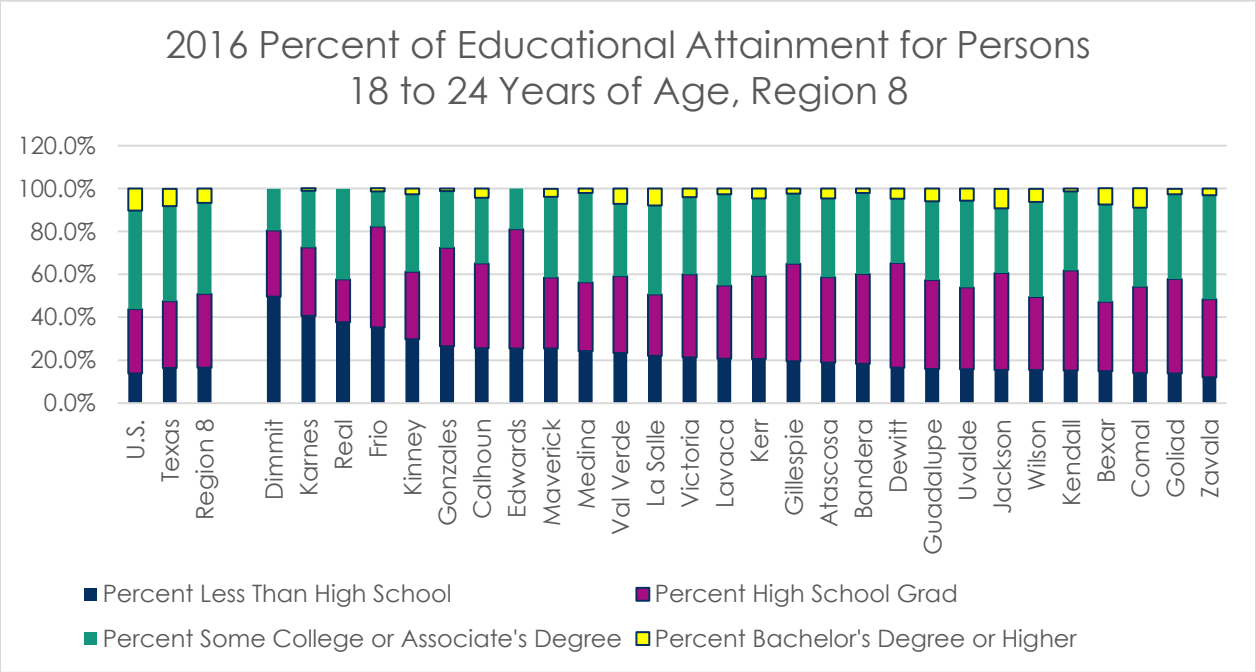
Education

Educational attainment is a predictor of well-being. Persons that have completed higher levels of education are more likely to achieve economic success than those who have not. The lack of educational attainment is associated with higher rates of substance use, lower earnings and lower economic status that continues into adulthood. A study was conducted using the 2010 National Survey on Drug Use and Health that compared high school dropouts with graduates with respect to substance use, mental health, and criminal behavior. The findings showed that dropouts were more likely to meet criteria for nicotine dependence and report daily cigarette use, and more likely to report having attempted suicide in the previous year, been arrested for larceny, assault, drug possession or drug sales relative to their high school graduate counterparts.[27]

[26] NIDA. (2014, July 1). Drugs, Brains, and Behavior: The Science of Addiction. Retrieved from https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction on 2018, June 20.
[27] Maynard, B.R., Salas-Wright, C.P. & Vaughn, M.G. Community Ment Health J (2015) 51: 289. https://doi.org/10.1007/s10597-014-9760-5).

The educational attainment of persons 18 to 24 years of age reveals that 96 percent of the counties in Region 8 have higher percentages of persons with less than a high school education than the U.S average of 13.8 percent. Texas estimates that 16.3 percent of persons 18 to 24 years of age have less than high school diploma, 31.2 percent are high school grads, 44.3 percent have some college or Associate degree and 8.1 percent have a bachelor's degree or higher. Region 8 estimates are like Texas with 16.5 percent of persons 18 to 24 years of age with less than high school diploma, 34.4 percent are high school grads, 42.4 percent have some college or associate degree and 6.7 percent have a bachelor's degree or higher. The Chart below shows the distribution of educational attainment of persons 18 to 24 Years of age in Region 8. See Appendix A, Table 19 for county data.

Diagram 35. 2016 Region 8 Percent of Educational Attainment for Person 18-24 Years of Age



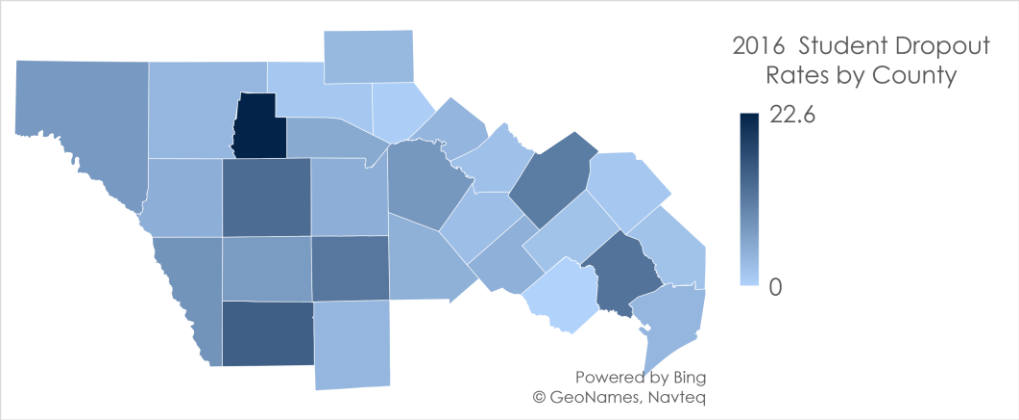
Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates

Dropout Rates

In 2016, thirty-two percent of Region 8 counties had dropout rates higher than Texas' rate of 6.2 percent. Out of 350,684 Texas students in the class of 2016, 89.1 percent graduated within four years. An additional 4.2 percent of students in the class of 2016 continued school the fall after expected graduation, and 0.5 percent received GED certificates. The four-year longitudinal dropout rate for the class of 2016 was 6.2 percent.

In the class of 2016, Real, Dimmit, Uvalde, Victoria, Frio, Gonzales, Bexar, Val Verde and Zavala Counties experienced the highest dropout rates and exceeded the State rate of 6.2 percent while Goliad, Kendall, Lavaca, Kerr, DeWitt and Jackson had the lowest dropout rates in Region 8. The figure below shows the dropout rates for Region 8 ranging from 0 percent to 22.6 percent.

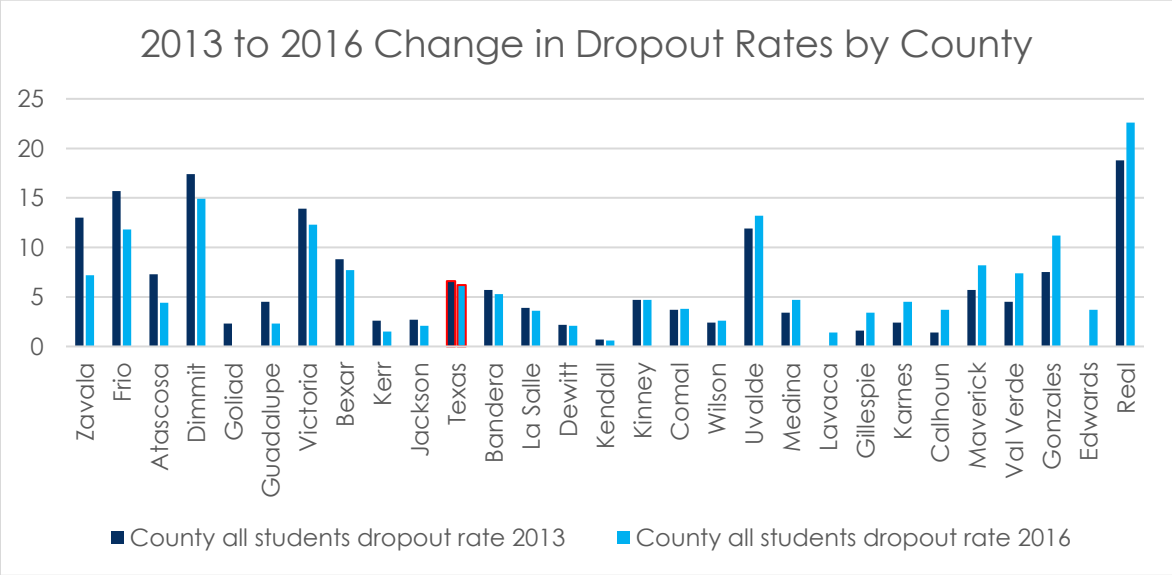
Diagram 36. 2016 Region 8 Student Dropout Rates by County



Source: TEA Division of Research and Analysis

From 2013 to 2016, Texas saw a decrease in school dropouts by -6.1 percent. Fifty percent of Region 8 counties also saw a decrease in school dropout rates during the same period. Zavala, Frio, and Atascosa counties had significant decreases while Edwards, Gonzales and Real experienced the highest increases. Appendix A, Table 20.

Diagram 37. 2013-2016 Region 8 Change in Dropout Rates by County



Source: TEA Division of Research and Analysis

School Discipline

The Council of State Governments Justice Center in partnership with the Public Policy Research Institute at Texas A&M University conducted a six-year study to help improve policymakers' understanding of who is suspended and expelled from public secondary schools, and the impact of those removals on students' academic performance and juvenile justice system involvement.

Like other states, school suspensions—and, to a lesser degree, expulsions—have become relatively common in Texas. For this reason and because Texas has the second largest public-school system in the nation (where nonwhite children make up nearly two-thirds of the student population), this study's findings have significance for—and relevance to—states across the country. The findings include:

1. Nearly six in ten public school students studied were suspended or expelled at least once between their seventh- and twelfth-grade school years.

2. African-American students and those with particular educational disabilities were disproportionately likely to be removed from the classroom for disciplinary reasons.

3. Students who were suspended and/or expelled, particularly those who were repeatedly disciplined, were more likely to be held back a grade or to drop out than were students not involved in the disciplinary system.

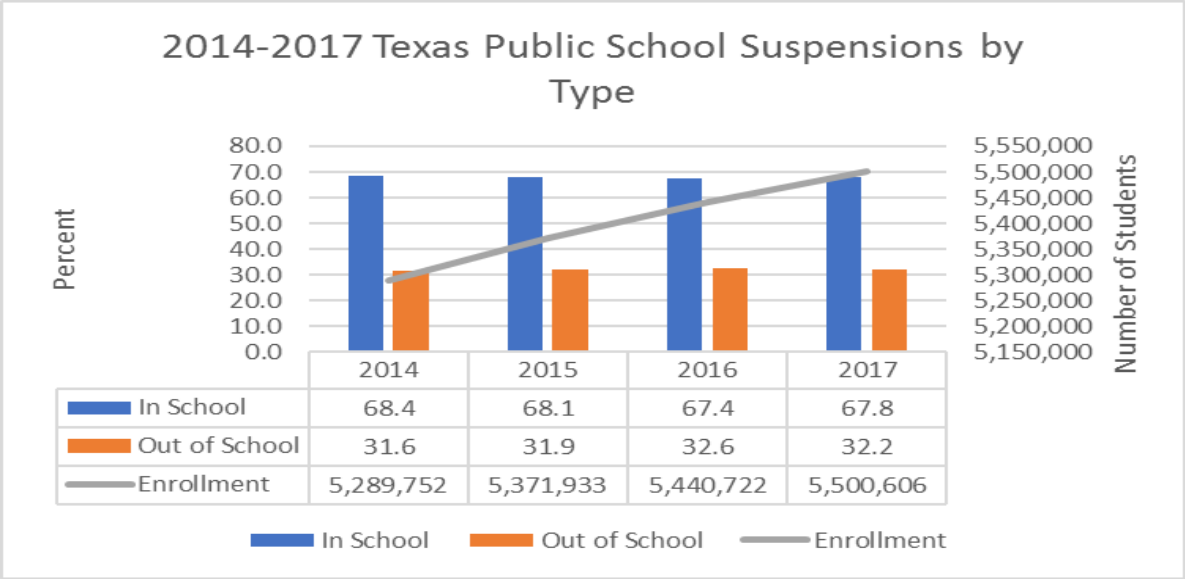
4. When a student was suspended or expelled, his or her likelihood of being involved in the juvenile justice system the subsequent year increased significantly.

5. Suspension and expulsion rates among schools—even those schools with similar student compositions and campus characteristics—varied significantly[28]

As the Texas school enrollment has increased the percentage of suspensions has remained constant for in-school and out-of-school. Appoximately 68 percent of students received an in-school suspension compared to 32 perent out-of-school suspensions.

[28] Council of State Governments Justice Center. Breaking Schools' Rules: A Statewide Study of How School Discipline Relates to Students' Success and Jevenile Justice Involvement. https://csgjusticecenter.org/wp-content/uploads/2012/08/Breaking_Schools_Rules_Report_Final.pdf . Published July 19, 2011.

Diagram 38. 2014-2017 Texas Public School Suspensions by Type



Source: Texas Education Agency, Peims Report

Criminal Activity

One of the most significant areas of risk with the use of alcohol and drugs is the connection between alcohol, drugs and crime. Alcohol and drugs are implicated in an estimated 80 percent of offenses leading to incarceration in the United States such as domestic violence, driving while intoxicated, property offenses, drug offenses, and public-order offenses. Our nation's prison population has exploded beyond capacity and most inmates are in prison, in large part, because of substance abuse:

- 80 percent of offenders abuse drugs or alcohol.
- Nearly 50 percent of jail and prison inmates are clinically addicted.
- Approximately 60 percent of individuals arrested for most types of crimes test positive for illegal drugs at arrest.

Alcohol, more than any illegal drug, was found to be closely associated with violent crimes, including murder, rape, assault, child and spousal abuse. About 3 million violent crimes occur each year in which victims perceive the offender to have been drinking and statistics related to alcohol use by violent offenders generally show that about half of all homicides and assaults are committed when the offender, victim, or both have been drinking. Among violent crimes, with the exception of robberies, the offender is far more likely to have been drinking than under the influence of other drugs.[29]

Index Violent Crime and Property Crime

To track the variations in crime, the Uniform Crime Reporting (UCR) data collection program uses a statistical summary tool referred to as the Crime Index. Rather than collecting reports of all crimes that

[29] National Council on Alcoholism and Drug Dependence, Inc. Alcohol, Drugs and Crime. https://www.ncadd.org/about-addiction/addiction-update/alcohol-drugs-and-crime . Last modified June 27, 2015. Accessed June 22, 2018.

were committed in a particular year, UCR collects the reports of seven index crimes. The crimes in this group are all serious, either by their very nature or because of the frequency with which they occur and present a common enforcement problem to police agencies. Crimes within this index can be further categorized as **violent crimes, which include murder, rape, robbery and aggravated assault**, or as **property crimes, which consist of burglary, larceny-theft, and motor vehicle theft**. By reducing the overall occurrence of crime to this Crime Index, the annual comparison of crime trends is simplified. Although arson and human trafficking are index crimes in that the number of reported offenses is collected, neither is a part of the Crime Index.[30]

Crime Volume: In Texas, during calendar year 2016, there was a reported total of 886,189 index offenses in Texas. The crime volume decreased 0.2 percent when compared to 2015. In Region 8, however, there was a reported total of 122,865 index offenses an increase of 5.3 percent when compared to 2015. The percent change for total violent crimes in Region 8 was nearly 3 times higher at 19.3 percent compared to Texas at 7 percent reported from 2015 to 2016 as seen in the diagrams below. Appendix A, Table 21 for county data.

Diagram 39. 2015 to 2016 Texas and Region 8 Crime by Volume Percent Change

Texas Crime by Volume Percent Change				
Offense	2015	2016	Number Change	% Change
Murder	1,314	1,473	159	12.1%
Rape	12,208	13,320	1,112	9.1%
Robbery	31,883	33,250	1,367	4.3%
Aggravated Assault	67,358	72,609	5,251	7.8%
Total Violent Crime	*112,763*	*120,652*	*7,889*	*7.0%*
Burglary	152,444	148,073	-4,271	-2.9%
Larceny-Theft	555,867	548,941	-6,926	-1.3%
Auto Theft	67,081	68,523	1,442	2.2%
Total Property Crime	*775,392*	*765,537*	*-9,755*	*-1.3%*
Index Crime Total	*888,155*	*886,189*	*-1,966*	*-0.2%*
Source: UCR, Crime Volume, 2015, 2016				

Region 8 Crime by Volume Percent Change				
Offense	2015	2016	Number Change	% Change
Murder	146	208	62	42.6%
Rape	1,584	1,786	202	12.9%
Robbery	2,342	2,684	342	14.6%
Aggravated Assault	7,725	9,391	1,666	21.6%
Total Violent Crime	*11,797*	*14,069*	*2,272*	*19.3%*
Burglary	18,259	18,525	266	1.5%
Larceny-Theft	78,744	81,075	2,331	3.0%
Auto Theft	7,871	9,196	1,325	16.8%
Total Property Crime	*104,874*	*108,796*	*3,922*	*3.7%*
Total Index Crime	116,671	122,865	6,194	5.3%
Source: UCR, Crime Volume, 2015, 2016				

Crime Rate: During calendar year 2016, Texas' crime rate was 3,185.2 crimes per 100,000 persons. This is a decrease of 1.5 percent from the previous year. The crime rate is based on the 2016 Texas population of 27,821,692. **During calendar year 2016, the Region 8 crime rate was 4,228.5 crimes per 100,000 persons. This is an increase of 5.2 percent from the previous year. The crime rate is based on the 2016 Region 8 population of 2,905,622**.

[30] Texas Department of Public Safety, 2016 Crime in Texas, Chapter 2, Texas Crime Analysis, http://www.dps.texas.gov/crimereports/16/citCh2.pdf. Updated February 2018. Accessed June 25, 2018.

Diagram 40, 2015-2016 Crime Rate Change

2016 Texas Crime Rate Change				
Offense	2015	2016	Number Change	% Change
Murder	4.8	5.3	0.5	10.4%
Rape	44.4	47.9	3.5	7.9%
Robbery	116.1	119.5	3.4	2.9%
Aggravated Assault	245.2	261.0	15.8	6.4%
Total Violent Crime	*410.5*	*433.7*	*23.2*	*5.7%*
Burglary	555.0	532.2	-22.8	-4.1
Larceny-Theft	2023.6	1973.1	-50.5	-2.5
Auto Theft	244.2	246.3	2.1	0.9
Total Property Crime	*2822.8*	*2751.6*	*-71.2*	*-2.5*
Index Crime Total	*3,233.3*	*3,185.3*	*-48.0*	*-1.5%*
Source: UCR, Crime Volume, 2015, 2016				

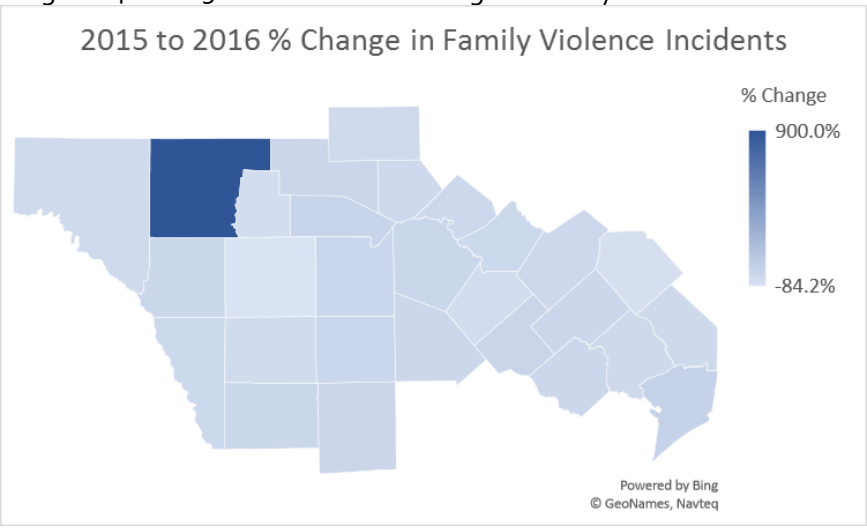
2016 Region 8 Crime Rate Change				
Offense	2015	2016	Number Change	% Change
Murder	5.1	7.2	2.1	41.2%
Rape	55.3	61.5	6.2	11.2%
Robbery	81.8	92.4	10.6	13.0%
Aggravated Assault	269.9	323.2	53.3	19.7%
Total Violent Crime	*412.1*	*484.3*	*72.2*	*17.5%*
Burglary	637.9	637.6	-0.3	-0.05%
Larceny-Theft	2751.0	2790.3	39.3	1.4%
Auto Theft	275.0	316.5	41.5	15.1%
Total Property Crime	*3663.9*	*3744.4*	*80.5*	*2.2%*
Index Crime Total	*4076.0*	*4288.7*	*212.7*	*5.2%*
Source: UCR, Crime Volume, 2015, 2016				

Family Violence

The Texas Family Code defines **Family Violence** as an act by a member of a family or household against another member that is intended to result in physical harm, bodily injury, assault, or a threat that reasonably places the member in fear of imminent physical harm. The law excludes the reasonable discipline of a child and defines abuse as physical injury that results in substantial harm or genuine threat; sexual contact, intercourse, or conduct; or compelling or encouraging the child to engage in sexual conduct.[31]

The total number of Texas family violence incidents in 2016 was 196,564. This represented a 0.9 percent increase when compared to 2015. These incidents involved 214,815 victims (up 1.7 percent from 2015) and 208,764 offenders (up 1.8 percent from 2015). **The total number of Region 8 family violence incidents in 2016 was 21,543, a 2.8 percent increase from 2015**. Changes in family violence incidents ranged from a 900 percent increase in Edwards county to an 84 percent decrease in Uvalde county. Our most populous county, Bexar increased by 7.9 percent. See Appendix A, Table 22 for county data.

Diagram 41. 2015 – 2016 Percent Change in Family Violence Incidents



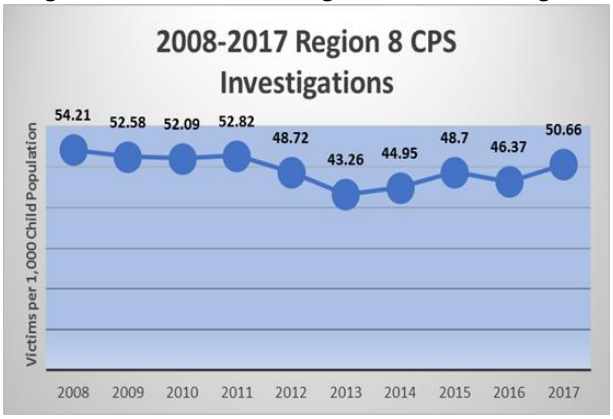
Source: Texas Department of Public Safety, Family Violence, 2015, 2016

[31] Texas Department of Public Safety, 2016 Crime in Texas, Chapter 5, Family Violence. http://www.dps.texas.gov/crimereports/16/citCh5.pdf. Accessed June 25, 2018.

Child Abuse

Between 2008 and 2017, Texas saw a 6.5 percent decrease in the number of victims investigated per 1,000 child population. In 2017 the total number of Child Protective Services (CPS) victims in Texas was 289,796 or 38.64 victims per 1,000 children. This was a 3.4 percent increase from 2016 with 276,763 or 37.36 victims per 1,000 children. Region 2 had the highest percent of child victims investigated at 73 per 1,000 children compared to the lowest reported in Region 10 at 33 per 1,000 children. Six of the eleven regions in Texas or 55% had higher numbers of victims per 1,000 children investigated by CPS during 2017 than the Texas rate of 38.6.

Diagram 42. 2008-2017 Region 8 CPS Investigations per 1,000 Child Population

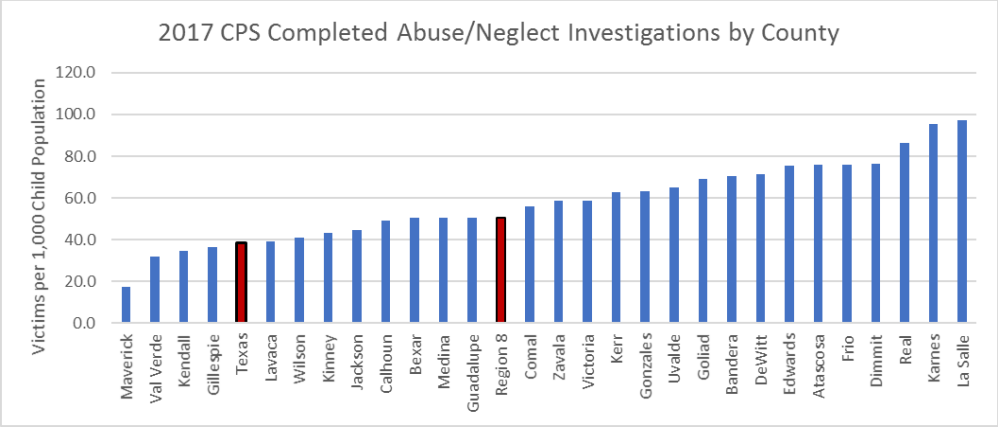


2016-2017 CPS Investigations by Region				
	2016 Victims Per 1,000 Child Population	2017 Victims Per 1,000 Child Populatioin	Number Change	% Change
Texas	37.4	38.6	1.3	3.4%
Region 1	46.0	47.1	1.1	2.4%
Region 2	72.3	73.0	0.7	1.0%
Region 3	31.6	34.6	3.0	9.5%
Region 4	54.1	50.0	-6.3	-11.6%
Region 5	56.3	50.3	-6.0	-10.7%
Region 6	30.6	32.5	1.9	6.2%
Region 7	38.7	38.6	-0.1	-0.3%
Region 8	46.4	50.7	4.3	9.3%
Region 9	49.4	42.1	-7.3	-14.8%
Region 10	31.9	32.8	0.9	2.8%
Region 11	38.3	38.0	-0.3	-0.8%
Source: DFPS, Data Book, 2016, 2017				

Source: DFPS, Data Book, 2008-2017

In 2017, Region 8 had the 2nd highest number of child abuse and or neglect victims investigated at 50.7 per 1,000 children. This was a 9.3 percent increase from 46.4 per 1,000 children investigated in 2016. Twenty-two percent of the victims investigated were confirmed as child abuse or neglect in 2017 compared to 20 percent in 2016. Twenty-four or 86% of region 8 counties had higher rates of CPS victims investigated than Texas at 38.6 per 1,000 child population in 2017. La Salle county had the highest at 97.3 per 1,000 child population compared to Maverick county with the lowest at 17.3. In addition, 19 or 68 percent of the counties in region 8 saw increases in their victim investigations from 2016 to 2017. See Appendix A, Table 23 for county data.

Diagram 43. 2017 Child Protective Services Investigations Completed by County



Source: DFPS, Data Book, 2017

Child Fatalities with Confirmed Abuse and Neglect

Based on administrative data and individual case reviews for confirmed child abuse and neglect related fatalities during FY2017, the following trends and areas for review have been identified:

General Findings

Diagram 44. 2010-2017 Child Population and Investigated Child Abuse and Neglect Fatalities

2010-2017 Child Population and Investigated Child Abuse and Neglect Fatalities								
Data Under Review	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Child Population of Texas	6,865,824	6,952,177	6,996,352	7,121,499	7,266,760	7,311,923	7,407,587	**
Number of Intakes Assigned for Investigationor Alternative Response by CPS	231,532	222,541	206,200	194,803	215,512	232,159	238,591	173,781
Number of Investigated Child Fatalities	1,024	973	882	804	797	739	796	807
Number of fatalities where abuse/neglect was confirmed	227	231	212	156	151	171	222	172
Child Fatality Rate per 100,000 Children	3.31	3.32	3.03	2.19	2.1	2.34	2.99	**
National Rate for Equivalent Federal Fiscal Year	2.1	2.11	2.18	2.09	2.14	2.25	**	**
**Federal Fiscal Year data for FY2015 not available at this time.								
Source: Data from US Census Bureau; Texas State Data Center; DFPS Data Books FY2010-FY 2015; DFPS Data Warehouse Report FT_06;								

1. **Texas had 172 confirmed child abuse and neglect-related fatalities in FY2017, a decrease of 22.5 percent compared to FY2016.**

    a. The decrease in drownings statewide, unsafe sleep (both statewide, but specifically in Region 8), and vehicle-related fatalities were significant.

    b. Physical abuse fatalities decreased by almost 32 percent. FY2017 had the lowest number of physical abuse fatalities since FY2010.

2. The number of child fatalities investigated by DFPS increased from 796 in FY2016 to 807 in FY2017, the highest number of investigations in the past five years.

3. Confirmed neglect-related fatalities historically account for almost 40 percent of child maltreatment fatalities, but in FY2017 were 34 percent.

    a. The most common causes of fatalities involving neglect were drowning, unsafe sleep, and vehicle-related. (Examples of vehicle-related deaths include: a child left in a hot car; a child unsupervised and struck by a vehicle; and a child riding in a car and the parent or caregiver driving was intoxicated or under the influence).

Victims

1. Based on the confirmed child abuse and neglect-related fatalities over the past five fiscal years, children 3 years of age and younger were almost 80 percent of all confirmed child abuse and neglect fatalities. Male children made up more than half of all confirmed child abuse and neglect-related fatalities.

2. During FY2017, Hispanic children accounted for the largest percentage of children who died from abuse or neglect. The per capita rate for African-American children who die from maltreatment continues to be higher than any other ethnicity in Texas. That is also true across the United States.

3. More than 57 percent of children who died from abuse or neglect in FY 2017 were too young for school and not enrolled in day care (as compared to 40 percent in FY2016.) Seven children were being cared for by illegal day care operations that were unknown to DFPS.

Perpetrators

1. Physical abuse-related fatalities most commonly involved blunt force trauma inflicted by a father or boyfriend.

2. Parents were the most common perpetrators of fatal child abuse and neglect.

3. In about half of the confirmed child abuse and neglect fatalities, neither the children nor the perpetrator had prior history with CPS.

4. **Risk factors such as substance abuse, mental health concerns, and domestic violence were common factors in confirmed child abuse and neglect fatalities**:

    a. **In FY2017, 52 percent of fatalities caused by abuse or neglect included a parent or caregiver actively using a substance and/or under the influence of one or more substances that affected their ability to care for the child. No county data available.**

    b. Almost 23 percent of child abuse and neglect fatalities involved a parent or caregiver with reported or confirmed mental health concerns.

    c. Active domestic violence concerns were identified in 17 percent of the child fatalities confirmed to be from abuse or neglect. In 40 percent of all child fatalities confirmed to be from abuse or neglect, families had a history of domestic violence.[32]

Drug Seizures/Trafficking Arrests

The Texas Department of Public Safety provides the Uniform Crime Report for drug seizures identified by type and quantity. Although marijuana continues to be the most illicit drug seized, Texas reported a 58 percent decrease in 2017 of 115,745 pounds compared to 276,483 pounds in 2016. Codeine solid pounds decreased by 41 percent and peyote decreased by 50 percent. Hashish solid pounds had the

[32] Texas Department of Family and Protective Services, Fiscal Year 2017 Child Maltreatment Fatalities and Near Fatalities Annual Report, https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/PEI/documents/2018/2018-03-01-Child_Fatality_Annual_Report-FY2017.pdf. March 1, 2018. Accessed June 25, 2018.

largest increase at 155.9 percent followed by cocaine at 52 percent from 13,069 solid pounds in 2016 to 19,814 solid pounds in 2017. Appendix A, Tables 24-25 for Texas Seizures.

Diagram 45. 2013-2017 Texas Drug Seizures in Pounds

2013-2017 Seizures in Pounds							
	2013	2014	2015	2016	2017	Number Change 2016 to 2017	% Change 2016 to 2017
Marijuana(Packaged)	814,952	1,502,123	138,001	276,483	115,745	-160,738	-58.1%
Cocaine(Solid)	410	5,478	16,218	13,069	19,814	6745	51.6%
Other Drugs(Methamphetamines)	2,464	8,012	5,827	4,651	4,895	244	5.2%
Hallucinogens(Designer Drugs)	768	1,470	6,726	579	627	48	8.3%
Opiates(Heroin)	422	358	508	655	878	223	34.0%
Hashish(Solid)	81	146	68	311	796	485	155.9%
Opiates(Codeine)	120	236	187	586	346	-240	-41.0%
Other Drugs(Amphetamines)	87	79	58	466	612	146	31.3%
Hallucinogens(Peyote)	197	1	0	4	2	-2	-50.0%
Source: Texas Department of Public Safety, https://txucr.nibrs.com/							

The most significant change in opiate seizures in 2017 is the 5,688 percent increase in codeine liquid ounces.

Diagram46. 2016-2017 Texas Opiate Siezures Percent Change

2016-2017 Texas Opiate Drugs Percent Change											
Year	Description	Solid Pounds	% Change	Solid Ounces	% Change	Solid Grams	% Change	Liquid Ounces	% Change	Dose Units	% Change
2016	Opiates(Codeine)	586		683		2,123		**20,124**		25,139	
2017	Opiates(Codeine)	346	-41.0%	519	-241.0%	1,717	-19.1%	**1,164,779**	**5688.0%**	19,522	-22.3%
2016	Opiates(Heroin)	655		786		5,488		2,590		1,400	
2017	Opiates(Heroin)	878	34.0%	930	18.3%	5,998	9.3%	71	-97.3%	1,044	-25.4%
2016	Opiates(Morphine)	12		16		412		28		2,187	
2017	Opiates(Morphine)	2	-83.3%	48	200.0%	467	13.3%	9	-67.9%	3,071	40.4%
2016	Opiates(Gum Opium)	10		58		376		0		0	
2017	Opiates(Gum Opium)	8	-20.0%	57	-1.7%	595	58.2%	0	0.0%	0	0.0%
Source: Texas Department of Public Safety, https://txucr.nibrs.com/											

Mental Health

According to the 2016 National Survey on Drug Use and Health, an estimated 44.7 million adults aged 18 or older in the United States reported Any Mental Illness (AMI). This number represented 18.3% of all U.S. adults. The prevalence of AMI was higher among women (21.7%) than men (14.5%). Young adults aged 18-25 years had the highest prevalence of AMI (22.1%) compared to adults aged 26-49 years (21.1%) and aged 50 and older (14.5%). The prevalence of AMI was highest among the adults reporting two or more races (26.5%), followed by the American Indian/Alaska Native group (22.8%). The prevalence of AMI was lowest among the Asian group (12.1%).

Diagram 47. 2008 – 2016 U.S. Any Mental Illness (AMI) in the Past Year Among Adudlts 18 or Older by Percentages

2008-2016 U.S. Any Mental Illness (AMI) in the Past Year Among Adults 18 or Older by Percentages									
Age	2008	2009	2010	2011	2012	2013	2014	2015	2016
18 or Older	17.7	18.1	18.1	17.8	18.6	18.5	18.1	17.9	18.3
18 to 25	18.5*	18.0*	18.1*	18.5*	19.6*	19.4*	20.1*	21.7	22.1
26 to 49	20.7	21.6	20.9	20.3	21.2	21.5	20.4	20.9	21.1
50 or Older	14.1	14.5	15.1	15.0	15.8	15.3	15.4	14.0	15.5
* Difference between this estimate and the 2016 estimate is statistically significant at the .05 level.									
Source: NSDUH, 2016									

An estimated 10.4 million adults in the nation had Seriouss Mental Illness (SMI) in the past year, and 34.3 million adults had AMI excluding SMI in the past year. The number of adults with SMI represents 4.2 percent of adults in 2016, and the number of adults with AMI excluding SMI represents 14.0 percent of adults. Among adults with AMI in the past year, 23.2 percent had SMI, and 76.8 percent did not have SMI.

The adults aged 18 to 25 years had the highest prevalence of SMI (5.9%) compared to adults 26 to 49 years (5.3%) and ages 50 and over (2.7%). [33]

Diagram 48. 2008-2016 U.S. Serious Mental Illness (SMI) in the Past Year Among Adults 18 or Older by Percentages

2008-2016 U.S. Serious Mental Illness (SMI) in the Past Year Among Adults 18 or Older by Percentages									
Age	2008	2009	2010	2011	2012	2013	2014	2015	2016
18 or Older	3.7*	3.7*	4.1	3.9	4.1	4.2	4.1	4.0	4.2
18 to 25	3.8*	3.3*	3.9*	3.8*	4.1*	4.2*	4.8*	5.0*	5.9
26 to 49	4.8*	4.9	5.2	5.0	5.2	5.3	4.9	5.0	5.3
50 or Older	2.5	2.5	3.0	2.8	3.0	3.2	3.1	2.8	2.7
* Difference between this estimate and the 2016 estimate is statistically significant at the .05 level.									
Source: NSDUH, 2016									

Drug use disorders commonly occur with mental illnesses and research suggest the following possibilities for the common co-occurrence:

- Drug abuse may bring about symptoms of another mental illness. Increased risk of psychosis in vulnerable marijuana users suggests this possibility.

- Mental disorders can lead to drug abuse, possibly as a means of "self-medication." Patients suffering from anxiety or depression may rely on alcohol, tobacco, and other drugs to temporarily alleviate their symptoms.

These disorders could also be caused by shared risk factors, such as—

[33] National Institute of Mental Health, Mental Illness. https://www.nimh.nih.gov/health/statistics/index.shtml. Last Updated November 2017. Accessed June 29, 2018.

- Overlapping genetic vulnerabilities. Predisposing genetic factors may make a person susceptible to both addiction and other mental disorders or to having a greater risk of a second disorder once the first appears.

- Overlapping environmental triggers. Stress, trauma (such as physical or sexual abuse), and early exposure to drugs are common environmental factors that can lead to addiction and other mental illnesses.

- Involvement of similar brain regions. Brain systems that respond to reward and stress, for example, are affected by drugs of abuse and may show abnormalities in patients with certain mental disorders.[34]

Between 2011 and 2015, in **Texas**, an annual average of about 1,197,000 adults aged 18 or older with Any Mental Illness (AMI), reported only 38 percent received mental health services while 62 percent did not receive mental health services.

Among adults served in Texas's public mental health system in 2015, 54.1 percent of those aged 18–20, 63.4 percent of those aged 21–64, and 89.7 percent of those aged 65 or older were not in the labor force.

In 2015, 75,259 children and adolescents (aged 17 or younger) were served in Texas's public mental health system.

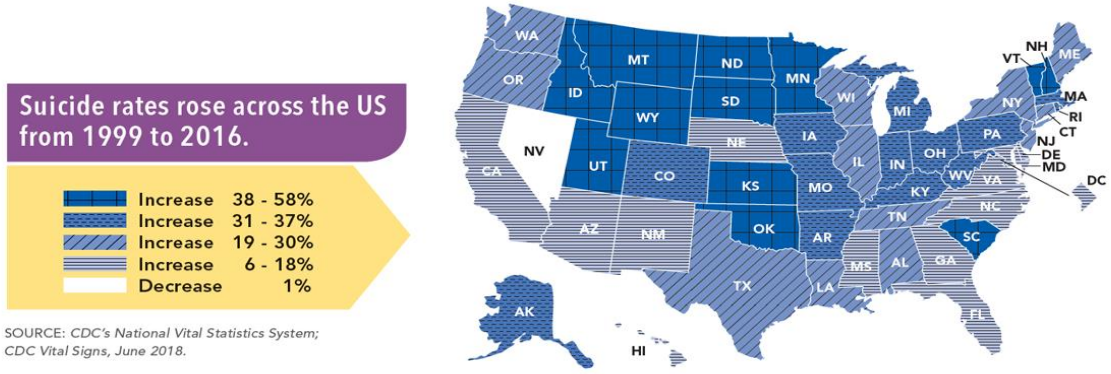
The annual average percentage of children and adolescents (aged 17 or younger) reporting improved functioning from treatment received in the public mental health system was lower in Texas than in the nation as a whole. The annual average percentage for adults (aged 18 or older) was lower in Texas than in the nation as a whole. [35]

Suicide

In 2016, nearly 45,000 Americans age 10 or older died by suicide. Suicide is the 10th leading cause of death and is one of just three leading causes that are on the rise. Researchers found that more than half of people who died by suicide did not have a known diagnosed mental health condition at the time of death. Relationship problems or loss, substance misuse; physical health problems; and job, money, legal or housing stress often contributed to risk for suicide. Firearms were the most common method of suicide used by those with and without a known diagnosed mental health condition. The map below suggest that Texas had an increase of suicides between 19 to 30 percent. The U.S. overall percentage change increased by 25.4 percent compared to an 18.9 percent change in Texas.[36]

[34] NIDA. (2011, March 1). Comorbidity: Addiction and Other Mental Disorders. Retrieved from https://www.drugabuse.gov/publications/drugfacts/comorbidity-addiction-other-mental-disorders on 2018, June 27.
[35] Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Texas, Volume 4: Indicators as measured through the 2015 National Survey on Drug Use and Health, the National Survey of Substance Abuse Treatment Services, and the Uniform Reporting System. HHS Publication No. SMA–17–Baro–16–States–TX. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017.
[36] CDC, Suicide Rates Rising Across the U.S. Retrieved from https://www.cdc.gov/media/releases/2018/p0607-suicide-prevention.html on June 28, 2018. Last updated June 7, 2018.

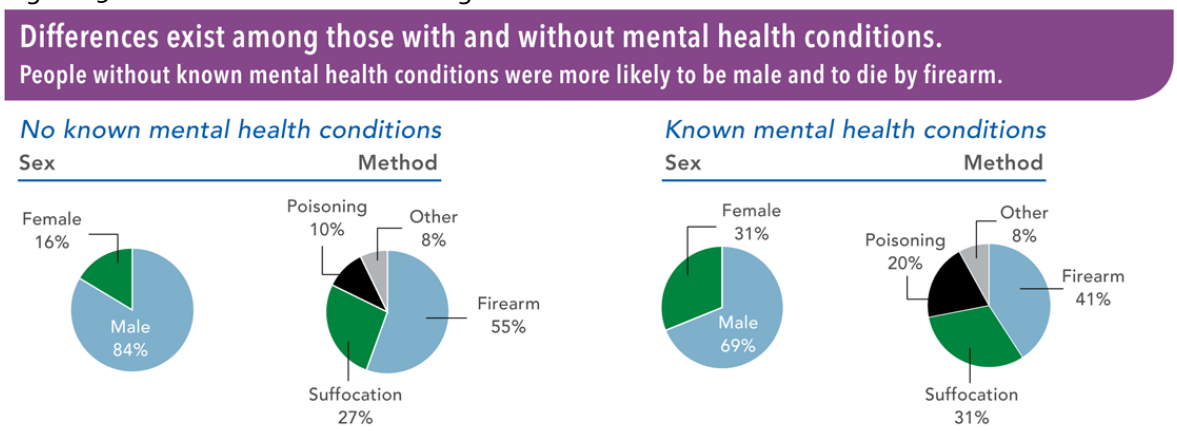
Diagram 49. Suicide Rates Across the U.S. from 1999-2016



SOURCE: CDC's National Vital Statistics System

People without known mental health conditions were more likely to be male and die by firearm.

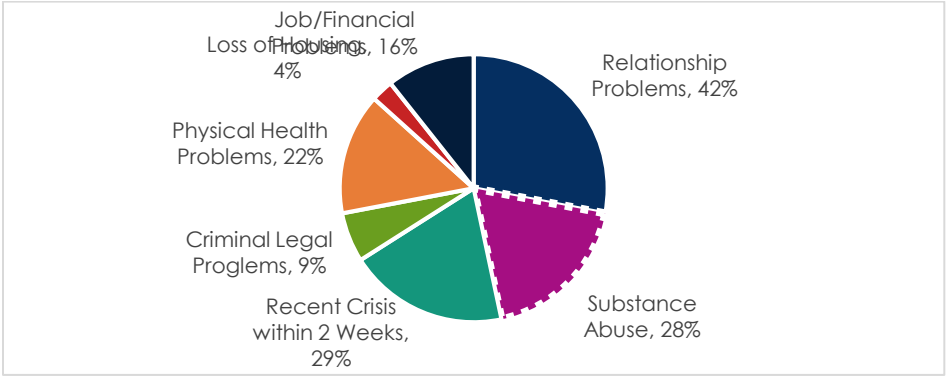
Diagram 50. Suicide Differences Among Those With and Without Mental Health Conditions



SOURCE: CDC's National Vital Statistics System

Across the U.S., persons who died by suicide may have had multiple circumstances. Data on mental health conditions and other factors are from coroner/medical examiner and law enforcement reports. It is possible that mental health conditions or other circumstances could have been present and not diagnosed, known, or reported.

Diagram 51: Factors that Contribute to Suicide



Source: CDC's National Violent Death Reporting System, data from 27 states participating in 2015.

In 2015, there were 3,368 suicides, up from 3,225 in 2014, according to the Texas Department of State Health Services (DSHS). On average, adjusted for age, the annual Texas suicide rate increased 2.5 percent from 2014 to 2015, from 12.1 to 12.4 suicides per 100,000 people.

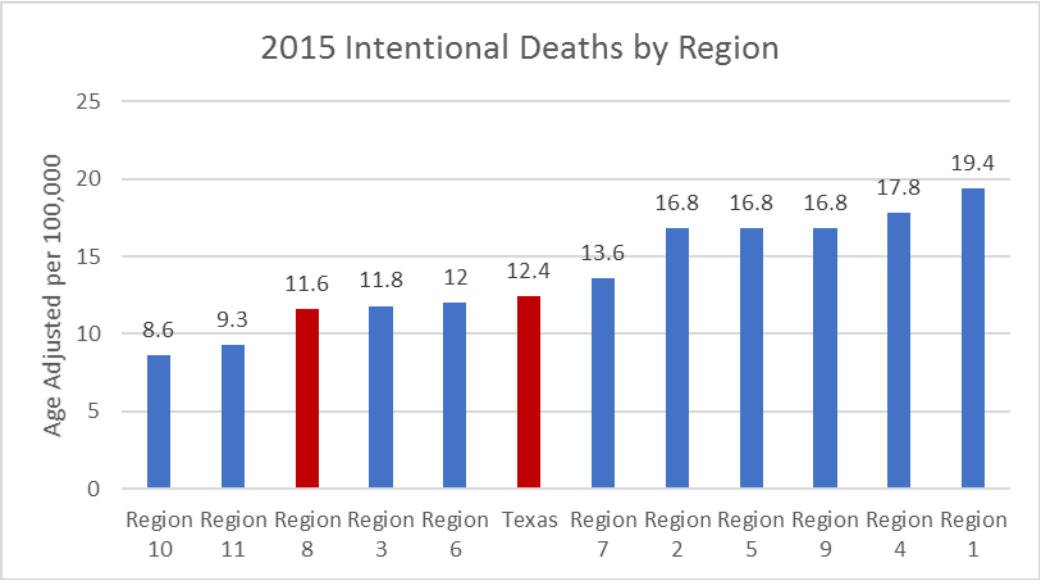
In Region 8, during the same period, there were 331 suicides, down from 347 in 2014. **On average, adjusted for age, the annual Region 8 suicide rate decreased 8 percent from 2014 to 2015, from 12.6 to 11.6 suicides per 100,000 people.**

Diagram 52. 2014 – 2015 Intentional Self-Harm (Suicide) Deaths by Region

2014-2015 Intentional Self-Harm (Suicide) (ICD 10 Codes X60-X84, Y87.0) by Region											
Area	Year	# Suicides	Crude Death Rate	Age Adjusted Rate		Year	# Suicides	Crude Death Rate	Age Adjusted Rate	Age Adjusted Number Change 2014-2015	Percent Change 2014-2015
Region 1	2014	139	17.4	18.2		2015	148	18.5	19.4	1.2	6.6%
Region 2	2014	116	22.7	22.7		2015	83	16.5	16.8	-5.9	-26.0%
Region 3	2014	802	11.1	11.2		2015	862	11.7	11.8	0.6	5.4%
Region 4	2014	189	16.6	16.7		2015	210	18.4	17.8	1.1	6.6%
Region 5	2014	132	17.0	16.7		2015	128	16.7	16.8	0.1	0.6%
Region 6	2014	702	10.5	10.7		2015	802	11.8	12	1.3	12.1%
Region 7	2014	443	13.9	14.1		2015	442	13.5	13.6	-0.5	-3.5%
Region 8	2014	347	12.5	12.6		2015	331	11.6	11.6	-1	-7.9%
Region 9	2014	86	14.8	14.6		2015	97	16.9	16.8	2.2	15.1%
Region 10	2014	95	11.2	11.8		2015	71	8.4	8.6	-3.2	-27.1%
Region 11	2014	174	7.9	8.4		2015	194	8.8	9.3	0.9	10.7%
Texas	2014	3,225	12.0	12.1		2015	3,368	12.3	12.4	0.3	2.5%
Source: Texas Department of State Health Services, DSHS Center for Health Statistics											

Six of the eleven or 55 percent of the regions had higher rates of intentional deaths reported in 2015 than Texas' age adjusted rate of 12.4 deaths per 100,000 people. Four or 36 percent our regions saw a decrease in intentional deaths between 2014 to 2015.

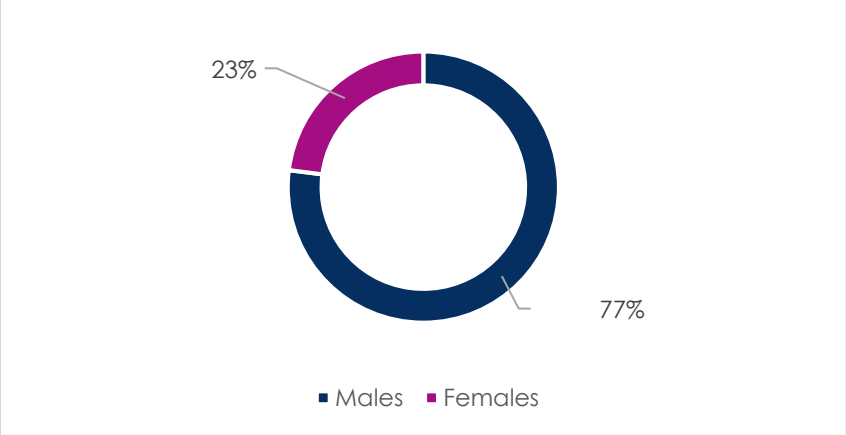
Diagram 53. 2015 Intentional Deaths by Region



Source: Texas Department of State Health Services (DSHS) Center for Health Statistics

The 2015 intentional crude death rate for Texas males was 19.0 deaths per 100,000 male population compared to females at 5.6 deaths per 100,000 females. **In Region 8, the highest intentional deaths occurred among people 25 to 34 years of age of which 57 percent were white, 43 percent Hispanic.** For all intentional deaths, 57 percent were White, 3 percent Black, 35 percent Hispanic and 14 percent Other. Appendix A, Table 26.

Diagram 54. 2015 Texas and Region 8, Male and Female Intentional Deaths

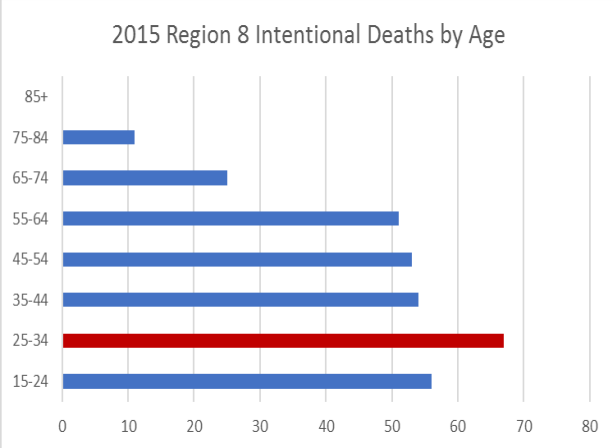


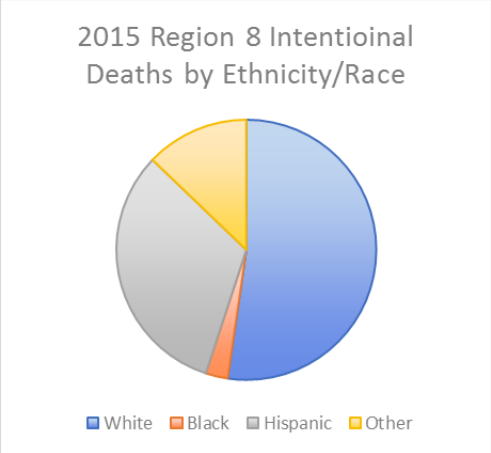
In 2015, intentional deaths for **males** were over **3 times higher** than females in Region 8 and Texas.

Area	Males	Females
Texas	2,594	774
Region 8	256	75

Source: Source: Texas Department of State Health Services, DSHS Center for Health Statistics

Diagram 55. 2015 Region 8 Intentional Deaths by Age





Source: Source: Texas Department of State Health Services, DSHS Center for Health Statistics

Psychiatric Hospital Admissions

In 2016, an estimated 35.0 million adults aged 18 or older (14.4 percent of adults) received mental health care during the past 12 months. Among the 44.7 million adults with AMI, 19.2 million (43.1 percent) received mental health services in the past year. About 6.7 million of the 10.4 million adults with past year SMI (64.8 percent) received mental health services in the past year. The percentages of adults with AMI or SMI who received mental health care in 2016 were similar to the corresponding percentages in most years from 2008 to 2015.

Between 2016 and 2017, adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED) in Texas, reported an 8.2 percent increase in the number of clients served by Psychiatric hospitals. Children between the ages of 0 to 17 saw a 17.7 percent increase, ages 18-20 reported a 16.7 percent increase and 21-64 years of age reported a 7 percent increase. Seniors 65 and older saw a decrease of 0.9 percent. For the 2017 reporting period, Texas reported 15,536 individuals received mental health treatment in a psychiatric hospital. 8.3 percent were between the ages of 0-17, 6.7 percent were 18-20, 83 percent 21-64, and 2 percent were 65 years of age or older.[37]

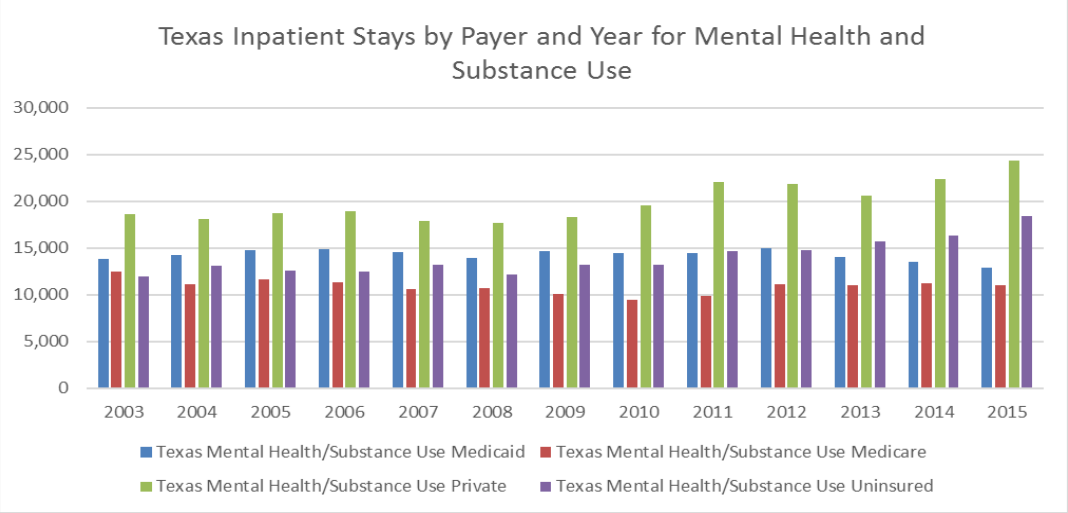
Diagram 56. 2016-2017 Number of Clients Served in Psychiatric Hospitals in Texas

2016-2017 Number of Clients Served in Psychiatric Hospitals in Texas				
	2016 Number Clients in Psychiatric Hospitals	2017 Number Clients in Psychiatric Hospitals	Number Change	% Change
0-17	1,091	1,284	193	17.7
18-20	893	1,042	149	16.7
21-64	12,050	12,895	845	7.0
65+	318	315	-3	-0.9
	14,352	15,536	1,184	8.2
Source: SAMHSA Uniform Reporting System (URS) Output Tables 2016, 2017				

Adults Mental Health and Substance Abuse Inpatient Stays by Payer

Below is a diagram of the number of inpatient stays by payer. Private payers (37%) and the uninsured payers (28%) reported their highest percentages since 2003 in 2015

Diagram 57. Texas Inpatient Stays by Payer for Mental Health and Substance Use



[37] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016.

Between 2014 and 2015 Medicaid payers decreased 4.8 percent, and Medicare decreased 2.2 percent while Private payers increased 8.9 percent and the Uninsured increased 13.2 percent, the highest percent change during this period.

Diagram 58. 2014-2015 Percent change in Inpatient Stays by Payer

2014 to 2015 Texas Percent Change in Inpatient Stays by Payer				
Type	2014	2015	Number Change	Percent Change
Medicaid Age 65+	13,550	12,900	-650	-4.8
Medicare Age 19 to 64	11,250	11,000	-250	-2.2
Private Age 19 to 64	22,350	24,350	2,000	8.9
Uninsured Age 19 to 64	16,300	18,450	2,150	13.2
Total Inpatient Stays by Payer	63,450	66,700	3,250	5.1
Source: HCUP Reports. Healthcare Cost and Utilization Project (HCUP). June 2018. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports.jsp.				

Source: HCUP Reports. Healthcare Cost and Utilization Project (HCUP). June 2018. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports.jsp.

Adolescents and Adults Receiving Substance Abuse Treatment

In 2016, in the United States an estimated 21.0 million people aged 12 or older needed substance use treatment. This translates to about **1 in 13 people needing treatment**. Among young adults aged 18 to 25, however, about **1 in 7 people** needed treatment. For NSDUH, people are defined as needing substance use treatment if they had a SUD in the past year or if they received substance use treatment at a specialty facility in the past year.

In 2016, 1.4 percent of people aged 12 or older (3.8 million people) received any substance use treatment in the past year, and 0.8 percent (2.2 million) received substance use treatment at a specialty facility. Only about 1 in 10 people aged 12 or older who needed substance use treatment received treatment at a specialty facility in the past year (10.6 percent). Among adolescents aged 12 to 17, 180,000 received any substance use treatment in the past year, or 0.7 percent of adolescents. An estimated 624,000 young adults aged 18 to 25 received any substance use treatment in the past year; this number represents 1.8 percent of young adults receiving any substance use treatment. About 3.0 million adults aged 26 or older received any substance use treatment in the past year, or 1.4 percent of adults in this age group.[38]

State Level Clients Receiving Substance Use Treatment: 2016

For 2016, Texas reported 68,135 admissions to programs treating substance use disorders that were reported to the Clinical Management for Behavioral Health Services (CMBHS). The CMBHS is a web-based clinical record keeping system for state-contracted community mental health and substance abuse service providers. Each admission does not necessarily represent one individual as clients may be admittied more than once. Sixty percent (59.6%) of the total admissions served were males. Whites represented 52.2 percent, Blacks represented 16.1 percent; Hispanic represented 30.3; Asian represented 0.3 precent and Other represented 1.0 percent. People seeking alcohol (26.1%) treatment was the highest followed by marijuana 24.8 percent and then methamphetamine 18.4 percent, heroin 15.2 percent, cocaine/crack 8.9 percent, prescription opioids 3.7 percent, benzodiazepines, 2.0 percent and synthetic cannabinoids 1.0 percent.

Young Adults Aged 18 to 25 Receiving Substance Use Treatment: 2016

In 2016, Young adults between the ages of 18 to 25 accounted for eighteen percent (17.9%) of the total admissions in Texas in 2016. Young adults sought treatment for marijuana 26.5 percent the most followed by Benzodiazepines and Synthetic Cannabinoids both at 26.1 percent, heroin 19.5 percent, methamphetamines 18.5 percent, prescription opioids 12.9 percent, alcohol 11.2% and cocaine/crack 9.7%.

Adults Aged 26 to 44 Receiving Substance Use Treatment: 2016

Adults is this age group accounted for over half (51.9%) of the total admissions. These adults received alcohol (26.1%) treatment the most followed by methamphetamine (23.8%) and then heroin (18.6%)

[38] SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2016.

and marijuana (14.5%). The average age of treatment for marijuana was the youngest at 25 years of age compared to the oldest average age of treatment for cocaine/crack at 40 years of age.

Adults Aged 45 and Older: 2016

The older adults accounted for 18.7 percent of all treatment admissions. Almost half of older adult admissions were for alcohol (48.2%) treatment followed by cocaine/crack (16.9%) and then heroin (13.0%) and methamphetamines (12.0%).

Diagram 59. 2016 Texas Demographic and Drug Characteristics of Primary Treatment Admissions for Substances of Abuse for Ages 18 and Older

	2016 Texas Demographic and Drug Use Characteristics of Primary Treatment Admissions for Select Substances of Abuse															
	Alcohol		Cocaine/Crack		Heroin		Prescription Opioids		Meth-amphetamine **		Marijuana		Benzo-diazepines		Synthetic Cannabinoids ***	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
Number of Admissions (#)	**17,778**	**100.0%**	**6,043**	**100.0%**	**10,328**	**100.0%**	**2,546**	**100.0%**	**12,519**	**100.0%**	**16,886**	**100.0%**	**1,337**	**100.0%**	**698**	**100.0%**
Sex (%)																
Male	11,977	67.4%	3,207	53.1%	6,128	59.3%	1,005	39.5%	5,492	43.9%	11,744	69.5%	564	42.2%	479	68.6%
Female	5,801	32.6%	2,836	46.9%	4,200	40.7%	1,541	60.5%	7,027	56.1%	5,142	30.5%	773	57.8%	219	31.4%
Race/Ethnicity(%)																
White, Non-Hisp	9,612	54.1%	1,700	28.1%	6,500	62.9%	1,845	72.5%	9,602	76.7%	5,235	31.0%	785	58.7%	282	40.4%
African-Am/Black, Non-Hisp	2,266	12.7%	2,583	42.7%	599	5.8%	240	9.4%	500	4.0%	4,551	27.0%	144	10.8%	97	13.9%
Hispanic/Latino	5,609	31.6%	1,692	28.0%	3,125	30.3%	433	17.0%	2,237	17.9%	6,876	40.7%	389	29.1%	313	44.8%
Asian	77	0.4%	20	0.3%	20	0.2%	0	0.0%	23	0.2%	73	0.4%	0	0.0%	0	0.0%
Other	214	1.2%	48	0.8%	84	0.8%	28	1.1%	157	1.3%	151	0.9%	19	1.4%	6	0.9%
Age Group (%)																
18-25	1,998	11.2%	586	9.7%	2,019	19.5%	328	12.9%	2,312	18.5%	4,473	26.5%	349	26.1%	182	26.1%
26-44	9,391	52.8%	3,162	52.3%	6,568	63.6%	1,714	67.3%	8,429	67.3%	5,141	30.4%	684	51.2%	284	40.7%
45+	6,130	34.5%	2,150	35.6%	1,665	16.1%	470	18.5%	1,527	12.2%	660	3.9%	78	5.8%	37	5.3%
Average Age	39		40		34		35		33		25		28		26	
Route of Administration (%)																
Smoked	62	0.3%	3,197	52.9%	228	2.2%	10	0.4%	6,668	53.3%	16,584	98.2%	6	0.4%	685	98.1%
Inhaled	18	0.1%	2,590	42.9%	1,410	13.7%	58	2.3%	1,240	9.9%	14	<0.1%	30	2.2%	0	0.0%
Injected	8	<0.1%	148	2.4%	8,602	83.3%	187	7.3%	4,118	32.9%	7	<0.1%	4	0.3%	0	0.0%
Oral/Other/Unknown	17,690	99.5%	108	1.8%	88	0.9%	2,291	90.0%	493	3.9%	281	1.7%	1,297	97.0%	13	1.9%
None	9,448	53.1%	2,054	34.0%	4,045	39.2%	844	33.2%	4,640	37.1%	7,545	44.7%	213	15.9%	242	34.7%
Alcohol	8	<0.1%	1,761	29.1%	907	8.8%	292	11.5%	1,822	14.6%	3,773	22.3%	184	13.8%	54	7.7%
Cocaine/Crack	2,391	13.4%	119	2.0%	1,244	12.0%	122	4.8%	739	5.9%	1,381	8.2%	98	7.3%	60	8.6%
Heroin	308	1.7%	109	1.8%	3	<0.1%	115	4.5%	396	3.2%	132	0.8%	45	3.4%	6	0.9%
Prescription Opioids	296	1.7%	55	0.9%	641	6.2%	196	7.7%	325	2.6%	311	1.8%	135	10.1%	5	0.7%
Methamphetamine**	1,314	7.4%	295	4.9%	1,407	13.6%	272	10.7%	76	0.6%	1,365	8.1%	159	11.9%	64	9.2%
Marijuana	3,205	18.0%	1,327	22.0%	939	9.1%	276	10.8%	3,627	29.0%	8	<0.1%	401	30.0%	223	31.9%
Benzodiazepines	431	2.4%	124	2.1%	924	8.9%	345	13.6%	417	3.3%	1,504	8.9%	18	1.3%	26	3.7%
Synthetic Cannabinoids***	85	0.5%	34	0.6%	31	0.3%	5	0.2%	95	0.8%	314	1.9%	18	1.3%	2	0.3%

Notes

***Admissions:** Includes all admissions to programs treating substance use disorders reported to the clinical Management for Behavioral Health Services (CMBHS) of the Texas HHSC, Behavioral Health Services (HHSC BHS). Each admission does not necessarily represent a unique individual because some individuals are admitted to treatment more than once in a given period.

****Methamphetamine:** Includes amphetamines and methamphetamine.

***** **HHSC** collects data on "Other Cannabinoids", which may not include all the synthetic cannabinoids.

Percentages may not sum to 100 due to either rounding, missing data, and/or because not all possible categories are presented in the table (and category frequencies may not add to drug total because not all possible categories are presented in the table).

Data Not Availabale for Synthetic Stimulants

Source: Data provided to the Texas NDEWS SCE by the Texas Health and Human Services Commission, Behavioral Health Services (HHSC BHS).

According to the 2017 Texas NDEWS report, the total number of admissions for all substance use treatment decreased 2.2 percent from 75,613 reported in 2015 to 73,987 in 2016. Alcohol admissions for treatment continue to be the highest followed by marijuana. Methamphetamine admissions increased by 11.8 percent or 1,326 clients while prescription opioid admissions decreased by 11.2 percent or 321 admissions.

Diagram 60. 2015-2016 Texas Change in Admissions for Treatment for Selected Substances

2015-2016 Texas Change in Admissions for Treatment for Selcted Substances							
	2012	2013	2014	2015	2016	2015 to 2016 # Change	2015 to 2016 % Change
Total Admissions (#)	73,774	77,338	77,494	75,613	73,987	-1,626	-2.2%
Alcohol	20,691	20,556	19,495	19,283	17,778	-1,505	-7.8%
Cocaine/Crack	8,801	7,927	7,269	6,410	6,043	-367	-5.7%
Heroin	9,082	10,186	10,895	10,747	10,328	-419	-3.9%
Prescription Opioids	4,010	3,617	3,458	2,867	2,546	-321	-11.2%
Methamphetamine	7,031	9,418	10,873	11,193	12,519	1,326	11.8%
Marijuana	16,552	17,571	17,233	16,968	16,886	-82	-0.5%
Benzodiazepines	1,279	1,182	1,202	1,282	1,337	55	4.3%
MDMA	92	90	90	92	124	32	34.8%
Synthetic Cannabinoids	145	379	457	646	698	52	8.0%
Other Drugs/Unknown	6,091	6,412	6,522	6,125	5,728	-397	-6.5%

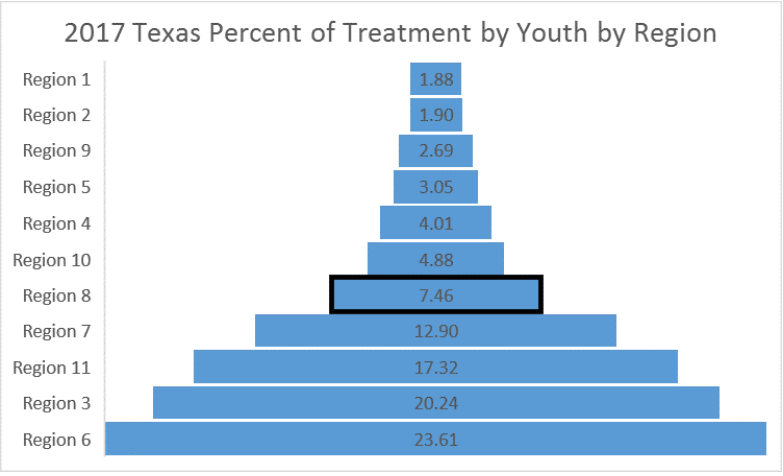
Source: Data provided to the Texas NDEWS SCE by the Texas Health and Human Services Commission, Behavioral Health Services (HHSC BHS).

In 2017, 4,691 youth received treatment in state funded facilities, an increase of 1.2 percent from 2015 (4,636). Region 1 reported the smallest percentage of youth receiving state funded treatment compared to Region 6, that accounted for 23.6 percent.

Region 8 Youth Admissions: 2017

During the same time, Region 8 youth between the ages of 12 to 17, accounted for 7.5 percent of the total youth state funded treatment in Texas. County level data not available.

Diagram 61a. 2017 Texas Percent of Treatment by Youth by Region



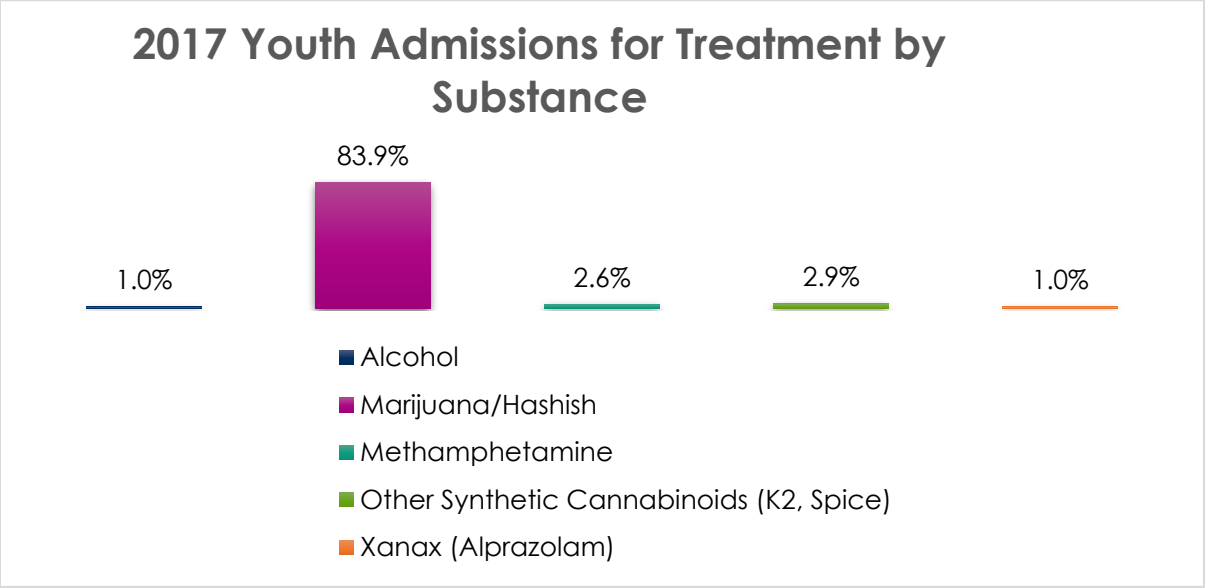
2017 Region 8 Admissions by Age		
Age	Number	Percent
12	4	1.04
13	21	5.47
14	49	12.76
15	94	24.48
16	126	32.81
17	82	21.35

Source: HHSC Behavioral Health Services, Office of Decision Support

Source: HHSC Behavioral Health Services, Office of Decision Support

Most of this age group received treatment for marijuana/hashish (84%) followed by synthetic cannabinoids (2.9%) and methamphetamines (2.6%).

Diagram 61b. 2017 Youth Admission for Treatment by Substance



Outpatient services (61.7%) were most widely used followed by residential (35.4%) and co-occuring psychiatric and substance use disorder (2.9%). Fifteen (24.5%), 16 (32.8%) and 17 (21.4%) year olds accounted for 78.6 percent of all admissions.

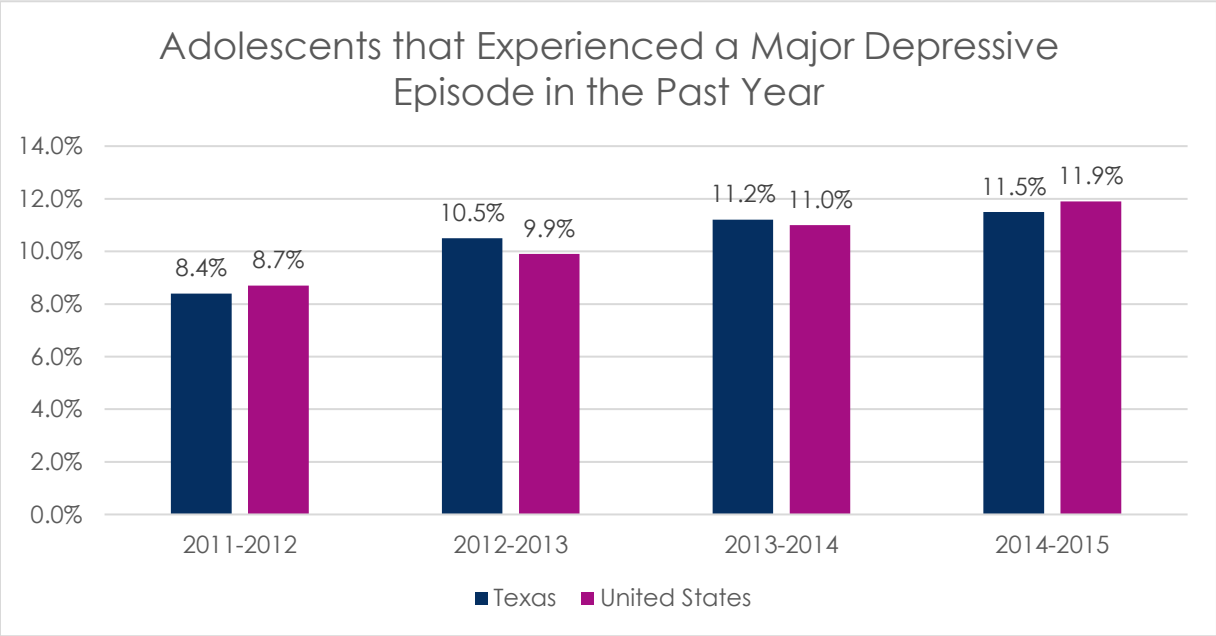
Depression

Depression is a mental illness frequently co-occurring with substance use. The relationship between the two disorders is bi-directional, meaning that people who abuse substances are more likely to suffer from depression, and vice versa. People who are depressed may drink or abuse drugs to lift their mood or escape from feelings of guilt or despair. But substances like alcohol, which is a depressant, can increase feelings of sadness or fatigue. Conversely, people can experience depression after the effects of drugs wear off or as they struggle to cope with how the addiction has impacted their life.[39]

In Texas, an annual average of about 272,000 adolescents aged 12–17 (**11.5% of all adolescents**) in 2014–2015 had experienced an MDE in the past year. The annual average percentage in 2014–2015 was higher than the annual average percentage in 2011–2012.

[39] Smith K, Ph.D. Substance Abuse and Depression, https://www.psycom.net/depression-substance-abuse. Accessed July 9, 2018. Last Updated February 13, 2018

Diagram 62. Texas and United States Adolescents that Experienced a Major Depressive Episode (MDE) in the Past Year

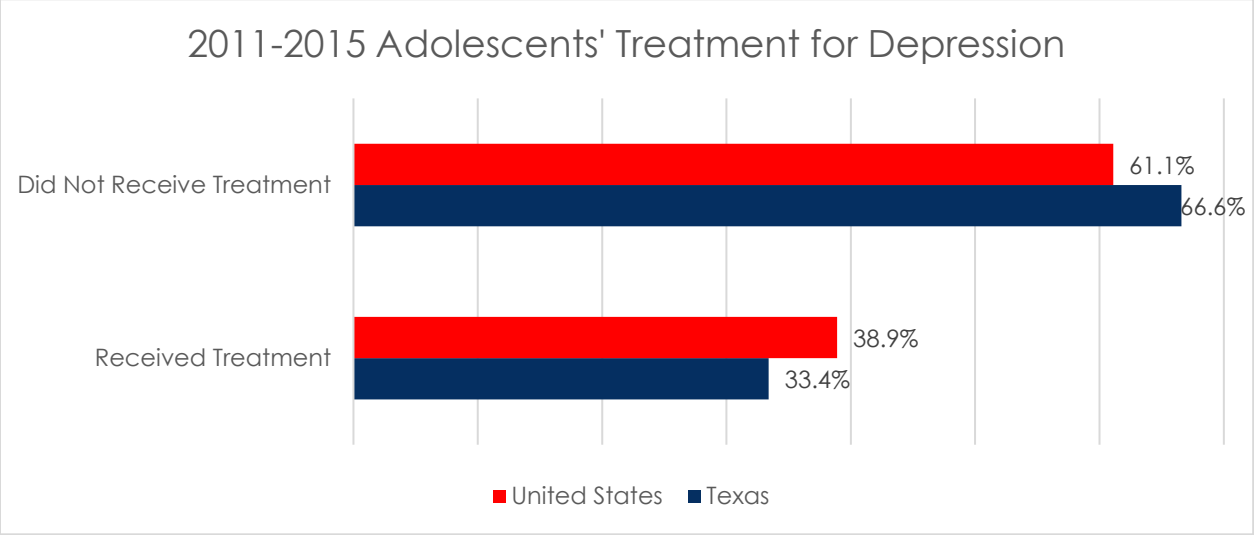


Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2011–2012 to 2014–2015.

In Texas, an annual average of about 77,000 adolescents aged 12–17 with past year MDE (33.4% of all adolescents with past year MDE) from 2011 to 2015 received treatment for their depression in the past year. Texas' annual average percentage of past year treatment for depression among adolescents aged 12-17 with past year MDE was lower than the corresponding national annual average percentage of 38.9 percent.[40]

[40] Substance Abuse and Mental Health Services Administration. *Behavioral Health Barometer: Texas, Volume 4: Indicators as measured through the 2015 National Survey on Drug Use and Health, the National Survey of Substance Abuse Treatment Services, and the Uniform Reporting System*. HHS Publication No. SMA–17–Baro– 16–States–TX. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2017.

Diagram 63. 2011-2015 Texas and United States Annual Average of Adolscents that Received Treatment for Depression

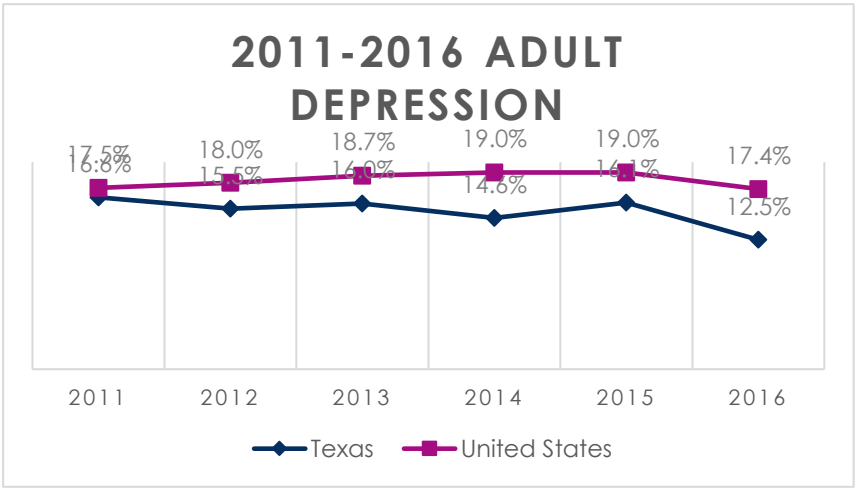


Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2011–2012 to 2014–2015.

The Behavioral Risk Factor Surveillance System (BRFSS) is an annual state-based telephone survey of the U.S. civilian, non-institutionalized adult population. One of the core questions asked is about whether a person has been diagnosed with depression. In Texas, between 2015 and 2016, there was a 3.6 decrease in the reported adult depression from 16.1 percent reported in 2015 to 12.5 percent in 2016. More women report depression (15.8%) than males (7.7%) and individuals aged 55-64 report the highest rate of depression compared to the lowest rates for age 18-24 (11%) and 65 and older (11%). Those individuals with less than a college degree reported higher rates of depression as well as those that earned less than $50,000. Texas has continued to remain below the National rates over time.

Diagram 64. 2011-2016 Adult Depression BFRSS

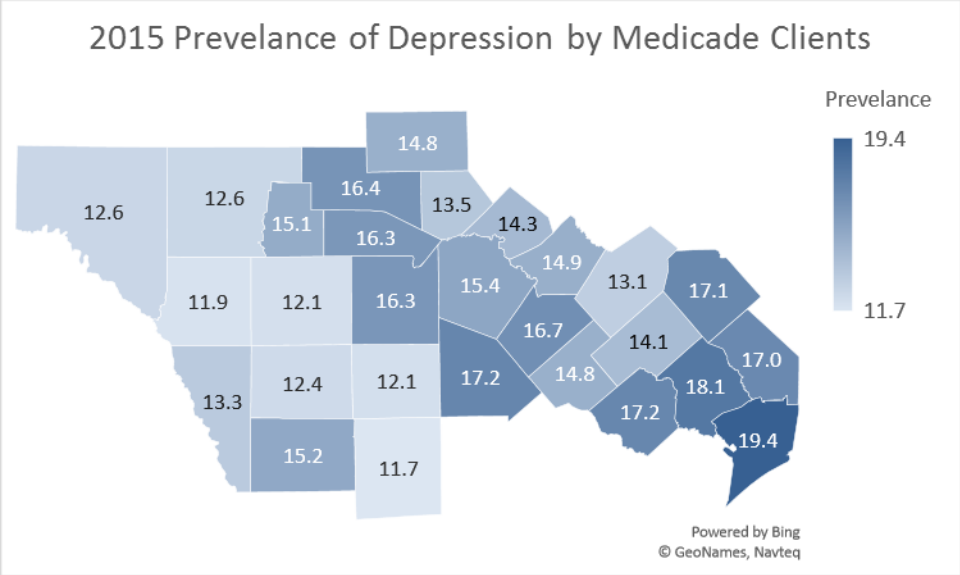
2016 Characteristics of Depression	
Percent	Race/Ethnicity
15.2	White, non-Hispanic
14.9	Black, non-Hispanic
8.7	Hispanic
Percent	Income
17.4	Less than $15,000
15	$15,000-$24,999
12.4	$25,000-$34,999
13.2	$35,000-$49,999
9.7	$50,000+
Percent	Education Level
14.1	Some post-H.S.
12.3	Less than H.S.
11.9	H.S. or G.E.D.
11.4	College graduate
Source: Behavioral Risk Factor Surveillance System	



Source: Behavioral Risk Factor Surveillance System

The Centers for Medicare and Medicaid Services provides statistics and data by county for chronic conditions like depression. In 2015, reports of depression ranged from the lowest in La Salle county at 11.7 percent to the highest in Calhoun at 19.4 percent. County level data is available in Appendix A, Table 27.

Diagram 65. 2015 Prevelance of Depression by Medicade Clients by County



Source: CMS.gov - Chronic Condition Data Warehouse (CCW)

Social Factors

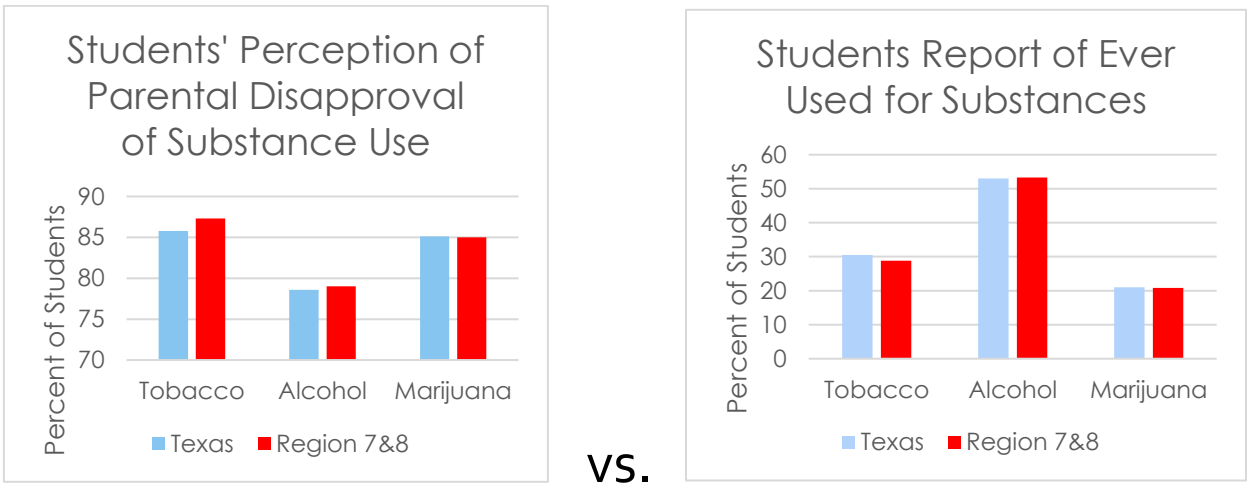
While parents may provide the first form of protection against risk for substance abuse, it's not long before they compete for a young person's attention from a variety of societal influences. Thrust into unfamiliar conditions, the desire for companionship can lead to poor decision-making. The process of self-discovery changes dramatically during formative years. Media messages also continue to portray drugs and alcohol as acceptable, enjoyable ways to relate to others and have a good time. Peer pressure can make even the most steadfast young adult submit to experimentation and a "just this once" mindset. Even with no other risk factors present, peer pressure can be one of the most influential forces in an individual's life. Add to all the above the desire for stress relief, and social factors present a strong influence on teen substance abuse. Below are some results from the 2016 Texas School Survey of Drug and Alcohol Use relating to what the data shows regarding the social factors of substance abuse as reported by the surveyed students.

Youth Perception of Parental Approval of Consumption

While many parents think that allowing their teens and their teens' friends to drink at home under adult supervision keeps kids safe and leads to healthier attitudes about drinking, there are serious negative consequences for both parents and teens. Supplying alcohol to minors increases, rather than decreases, the risk for continued drinking in the teenage years and leads to problem drinking later in life. Research from the Partnership Attitude Tracking Study (PATS) reveals that teens who perceive their parents to be more permissive about alcohol use are more likely to abuse alcohol and to use other drugs.

In 2016, Texas Health and Human Services Commission (HHSC), in conjunction with the Public Policy Research Institute (PPRI) at Texas A&M University, conducted its fifthteenth biennial Texas School Survey of Substance Use (TSS). The survey collects self-reported tobacco, alcohol, and substance use data among students in grades 7 through 12 in Texas public schools. The chart below displays the students' perception of how their parents feel (strongly or mildly disapprove) about kids their age using tobacco, alcohol and marijuana versus what they report as ever used. Alcohol was reported as the substance with the least parental disapproval and as the substance most ever used.

Diagram 66, Students' Perception of Parental Disapproval vs. Use



Source: Texas School Survey 2016

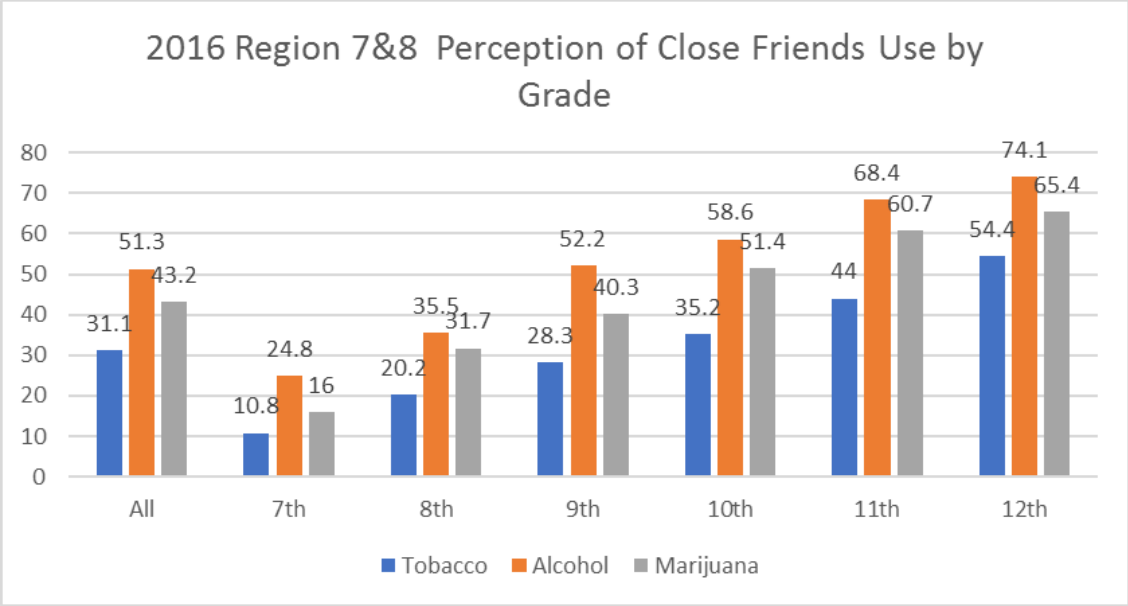
Youth Perception of Peer Approval of Consumption

People that are of the same age, with the same experiences and interests often influence each other's choices and behaviors. As youth become more independent, their peers begin to play a bigger role because they spend more time with them than they do with their parents or siblings. As students advance through middle school and high school, they are more likely to report peer approval of tobacco, alcohol, marijuana, and other drugs. Research has shown that a predictor for substance misuse and other problem behaviors is the association with friends.

The 2016 TSS asked students "About how many of your close friends use tobacco, alcohol or marijuana". The findings of students' perceptions for ther friends use:

- One in three (31.1%) perceive their friends use tobacco.
- One in two (51.3%) perceive their friends use alcohol.
- Almost one in two (43.2%) of their friends use marijuana, higher than tobacco.
- The gap between the perception of friends that use alcohol (35.5%) and marijuana (31.7%) are closest for 8th grade students.
- Alcohol (74.1%) is perceived to be used the most followed by marijuana (65.4%) and then tobacco (54.4%) across all grades.

Diagram 67. Region 7&8 Perception of Close Friends Use of Selected Substances by Grade



Source: Texas A&M, PPRI, TSS 2016

Cultural Normas and Substance Abuse

Human behavior is motivated, in part, by perceptions of what is common (descriptive norms) and what is socially acceptable (injunctive norms; Cialdini, 2003). Social norms have well documented associations with adolescent substance use in US samples. Youth who perceive more substance use among their friends and/or schoolmates are more likely to use alcohol, cigarettes, or marijuana themselves. Youth who believe that their friends and peers are accepting of substance use are also more likely to use substances (e.g., Elek, Miller-Day, & Hecht, 2006).[41]

Adolescent Sexual Behavior

Many young people engage in sexual risk behaviors and experiences that can result in unintended health outcomes. For example, among U.S. high school students surveyed in 2017:

- 40 percent had ever had sexual intercourse; Texas reported 39.2 percent.
- 10 percent had four or more sexual partners; Texas reported 11.2 percent.
- 7 percent had been physically forced to have sexual intercourse when they did not want to.
- 30 percent had had sexual intercourse during the previous 3 months (Texas 27.5%), and, of these
    - 46 percent did not use a condom the last time they had sex; Texas reported 47.6 percent.
    - 14 percent did not use any method to prevent pregnancy.

[41] Lori-Ann Palen, *Adolescent Substance Use Norms in Cape Town, South Africa*. National Institute on Drug Abuse. https://www.drugabuse.gov/international/abstracts/adolescent-substance-use-norms-in-cape-town-south-africa. Published 2008. Accessed June 5, 2018.

- 19 percent had drunk alcohol or used drugs before last sexual intercourse; Texas reported 19.1 percent.

Nearly 10% of all students have ever been tested for human immunodeficiency virus (HIV). (The CDC recommends all adolescents and adults 13-64 get tested for HIV at least once as part of routine medical care.)

CDC data show that lesbian, gay, and bisexual high school students are at substantial risk for serious health outcomes as compared to their peers.

Sexual risk behaviors place youth at risk for HIV infection, other sexually transmitted diseases (STDs), and unintended pregnancy:

- Young people (aged 13-24) accounted for an estimated 21% of all new HIV diagnoses in the United States in 2016.
- Among young people (aged 13-24) diagnosed with HIV in 2016, 81% were gay and bisexual males.
- Half of the 20 million new STDs reported each year were among young people, between the ages of 15 to 24.
- Nearly 210,000 babies were born to teen girls aged 15–19 years in 2016.[42]

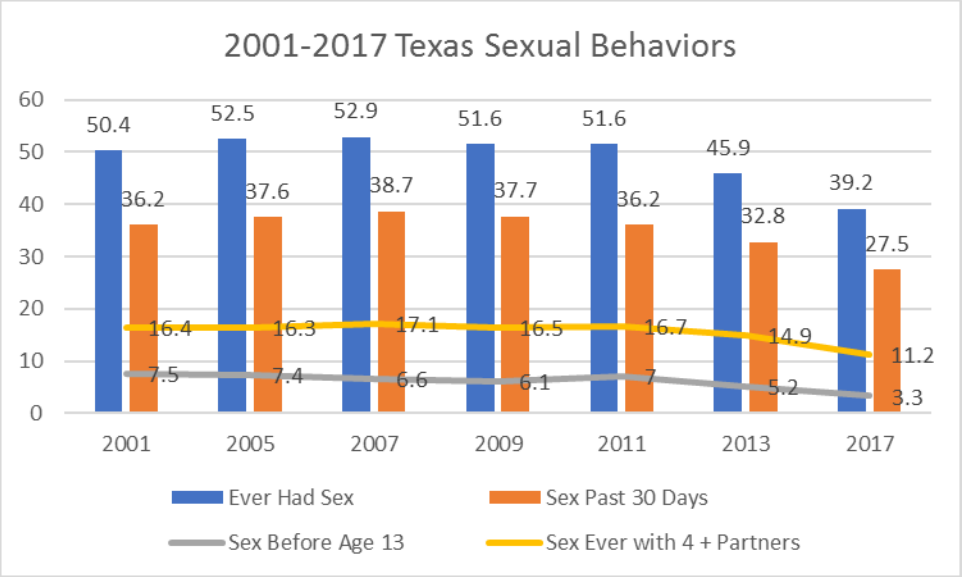
Results from the 2017 Texas YRBS indicated, 39.2 percent of students had ever had sexual intercourse, a decrease of 6.7 from 45.9 reported in 2013. Students who had had sexual intercourse with four or more persons during their life decreased 3.7 from 14.9 percent reported in 2013 to 11.2 percent. Among currently sexually active students, 47.6 percent reported that either they or their partner had used a condom during their last sexual intercourse, a decrease of 5.3 from 52.9 reported in 2013. Students who had drank alcohol or used drugs before last sexual intercourse decreased 4.7 from 23.8 percent reported in 2013 to 19.1 percent in 2017.

Males (5.1%) were 3 times more likely to report having had sexual intercourse for the first time before age 13 than females (1.5%).

Males (15%) were two times more likely to report having had sexual intercourse with four or more people during their life than females (7.6%).

[42] CDC. Sexual Risk Behaviors: HIV, STD, & Teen Pregnancy Prevention. Division of Adolescent and School Health, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention. https://www.cdc.gov/healthyyouth/sexualbehaviors/index.htm#1. Updated June 14, 2018. Accessed July 11, 2018.

Diagram 68. 2001-2017 Texas Sexual Behaviors



Source: Texas Youth Risk Behavior Surveillance System

Misunderstandings about Marijuana

On June 1, 2015, Gov. Greg Abbot signed SB 339 into law. Known as the Texas Compassionate Use Act, it is intended to allow some qualifying patients to access "low-THC cannabis," marijuana that contains 10% or more cannabidiol ("CBD") and not more than 0.5% tetrahydrocannabinol ("THC"). The legislation allows regulated businesses known as "dispensing organizations" to cultivate, process, and distribute low-THC cannabis to certain patients.

Unlike other states with similar laws establishing limited access to CBD-based medical marijuana products, the Texas law requires that qualified doctors join a physician registry and include information in the registry itself such as the dosage recommendations, means of administration, and the total amount of low-THC cannabis required to fill the patient's prescription. If issued, the prescription would also order a licensed marijuana establishment to distribute cannabis to the patient. In several respects, the Texas law attempts to mimic the prescription system put in place by federal authorities.

There are several facts about marijuana use that are commonly misunderstood due to the growing popularity of legalizing this substance. Some common arguments used is that marijuana is a natural substance therefore it is good to smoke, marijuana will not affect us long-term, marijuana has medicinal properties, marijuana is not a gateway drug, people do not become addicted, our jails are full of people with only marijuana charges, legalizing the substance would put drug cartels out of business, marijuana will not affect my behavior in any way. All of these are not based on evidence or scientific data; they are simply built on a small truth and then distorted into popular demands driven by society. The National Institute on Drug Abuse and the Substance Abuse and Mental Health Services Administration as well as prevention professionals throughout the state of Texas continuously combat arguments and false information. New reports from Colorado such as the Rocky Mountain High Intensity Drug Trafficking Area report on "The Legalization of Marijuana in Colorado: The Impact" reports some of the effects of

how legalization is now affecting society since marijuana was legalized. At times it may be popular to believe such misunderstandings; however, it is crucial to make policy decisions, data-driven decisions.

Accessibility

Effective social policy can put into place measures that control the supply of alcohol, tobacco and other durgs and affect population-wide demand for these substances. Comprehensive policies address legal measures to: control supply and demand, control access (by age, location and time), provide public education and treatment for those who need assistance, levy taxation to affect prices and to pay for problems generated by consumption, and harm-reduction strategies to limit ATOD-related problems such as impaired driving and domestic violence. A very interesting mechanism is to examine how available youth believe certain substances to be. Where the perceived access is high, there is a greater risk of consumption.

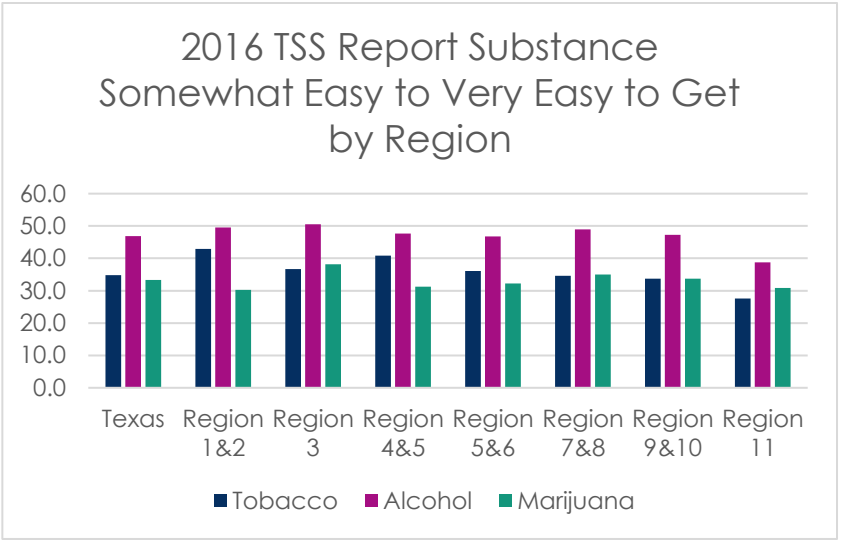
The Prevention Resource Centers across Texas collected data related to adolescents' perceptions about alcohol, tobacco, and other drugs from the Texas School Survey (TSS) administered in 2016. The Texas School Survey of Drug and Alcohol Use is an annual collection of self-reported tobacco, alcohol, inhalant, and substance (both licit and illicit) use data from students throughout the state of Texas. The survey, conducted by the Public Policy Research Institute (PPRI) in conjunction with the Texas Health and Human Services Commission (HHSC), is available for students in grades 7 through 12.

Across Texas, 600 campuses were randomly selected to participate in the survey. Initially 187 schools signed up, 47 dropped out and 147 participated. Most campuses declined due to the lack of time and resources involved in the survey administration. Each campus was given $500 when the survey materials were returned to the Public Policy Research Institute at Texas A&M University. Over 50,000 students participated, 1,071 were rejected for exaggerated responses and questions about a fake drug.

Regions 7&8, had 8,132 students to participate in the school survey. No school in Bexar County has participated in the school survey since 2012, however there are schools that have elected to participate in the 2018 survey due out in the fall of 2018.

Participants responded on the ease of obtaining substances and as seen in the table below, alcohol remains the most commonly used substance as well as the easiet to obtain among students in Texas. The ease of obtaining marijuana and tobacco are equal.

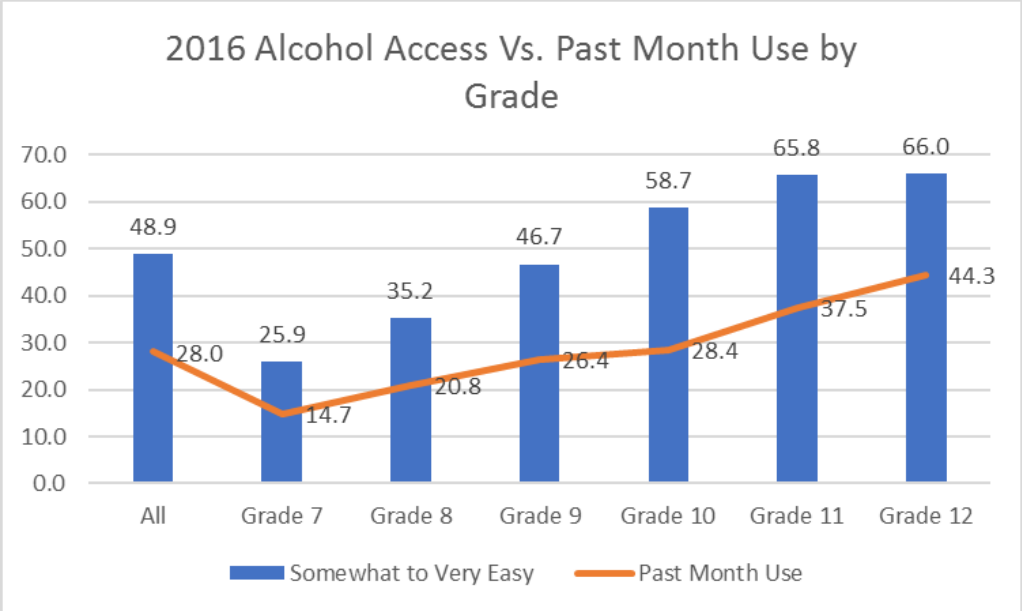
Diagram 69, Students' Perception of Access by Region



Perceived Access of Alcohol

In Region 7&8, almost one-half (48.9%) of all students surveyed reported alcohol somewhat easy to very easy to obtain. This is an increase of 5.3 from 43.6 percent reported in 2014. Nearly one in four seventh grade students (25.9%) report alcohol somewhat easy to very easy to obtain while one in 7 (14.7%) reported alcohol use in the past month. More than one-half (66%) of seniors reported alcohol somewhat easy to very easy to obtain, while 44.3 percent used alcohol in the past month. As students progress through grade levels their access to alcohol increases and so does their use as seen in the diagram below.

Diagram 70. 2016 Alcohol Access Versus Past Month Use by Grade

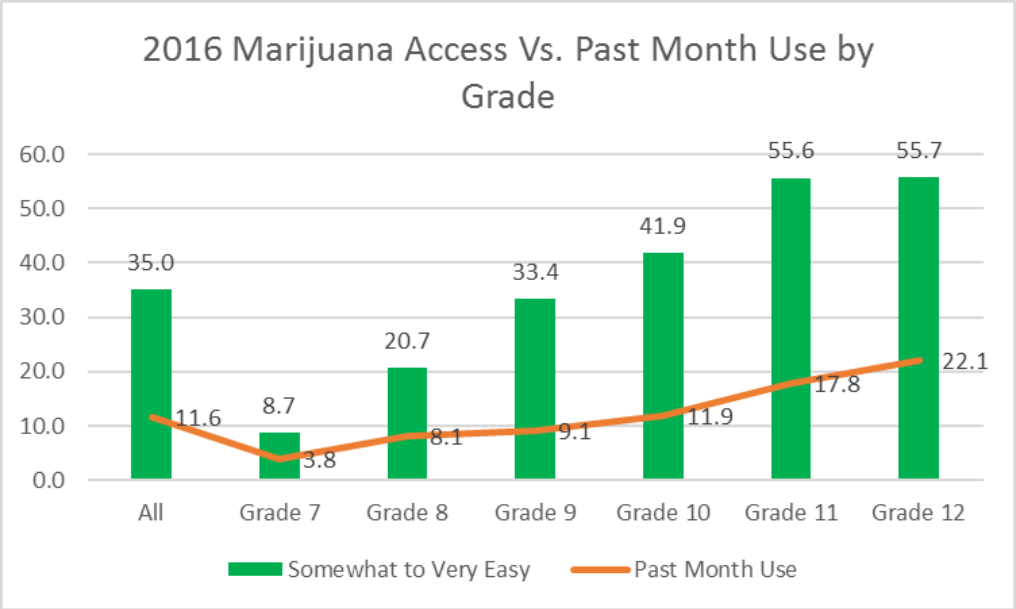


Source: Texas A&M, PPRI, TSS 2016

Perceived Access of Marijuana

In Region 7&8, over one-third (35.0%) of all students surveyed reported marijuana somewhat easy to very easy to obtain.

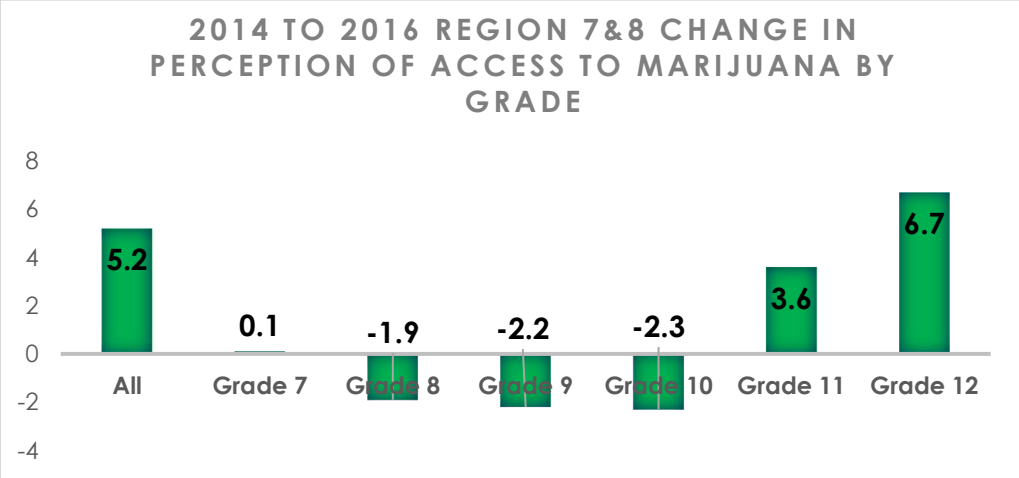
Diagram 71. 2016 Perception of Marijuana Access Vs. Past Month Use by Grade



Source: Texas A&M PPRI, TSS 2016

Twelfth grade students' perception of obtaining marijuana increased 6.7 from 49 percent in 2014 to 55.7 percent in 2016; while tenth grade students reported the most significant decrease of 2.3 from 44.2 in 2014 to 41.9 in 2016.

Diagram 72, Change in Perception of Access to Marijuana



Source: Texas A&M, PPRI, TSS 2014, 2016

Perceived Access of Prescription Drugs

Young people who do not think that using prescription drugs is harmful are more likely to use them for non-medical reasons than those who view them as harmful. Many young people think that prescription drugs are safer than other drugs because they are legal and prescribed by a doctor.

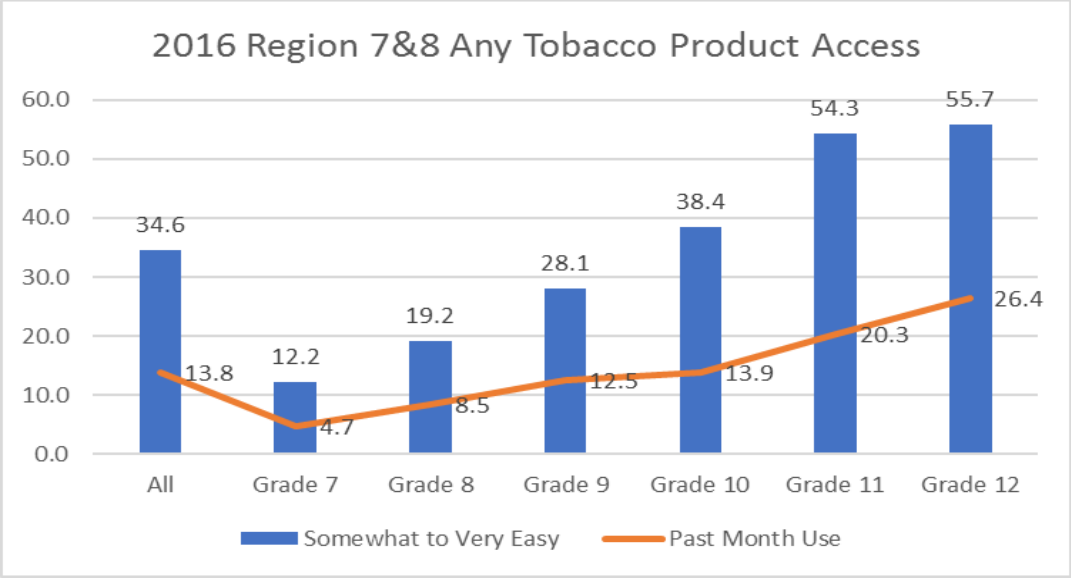
Greater access to prescription drugs also increases the chances of use. Doctors are prescribing an increasing number of prescription drugs in the US. Over the past two decades, there has been a three-fold increase in opioid prescriptions and a major increase in stimulant prescriptions given out by pharmacies nationally. This means teens are more likely to know someone with a prescription for these drugs or are more likely to have them in their home.

The 2013 Monitoring the Future report, a yearly survey of adolescent behavior and attitudes, revealed that over half of 12th grade students surveyed reported that it would be "fairly easy" or "very easy" to get prescription narcotic drugs (eg, Vicodin, OxyContin, Percocet), saying that friends and relatives would be the primary source. Narcotic pain relievers and stimulants used to treat Attention Deficit Hyperactivity Disorder (ADHD) are the most commonly misused prescription drugs among young people. The use of Adderall and Ritalin has almost doubled in use since 2008. These drugs can provide a high or are perceived to increase attention and focus.[43]

Perceived Access of Tobacco and Other Nicotine Products

In Region 7&8, over one-third (34.6%) of all students surveyed reported any tobacco product somewhat easy to very easy to obtain. This is an increase of 2.7 from 31.9 percent reported in 2014, however during 2016 sixth grade students were **not included** in the survey. As students progress through grade levels their perception of access to tobacco products increases as well as their use as seen in the diagram below.

Diagram 73. 2016 Region 7&8 Any Tobacco Product Access

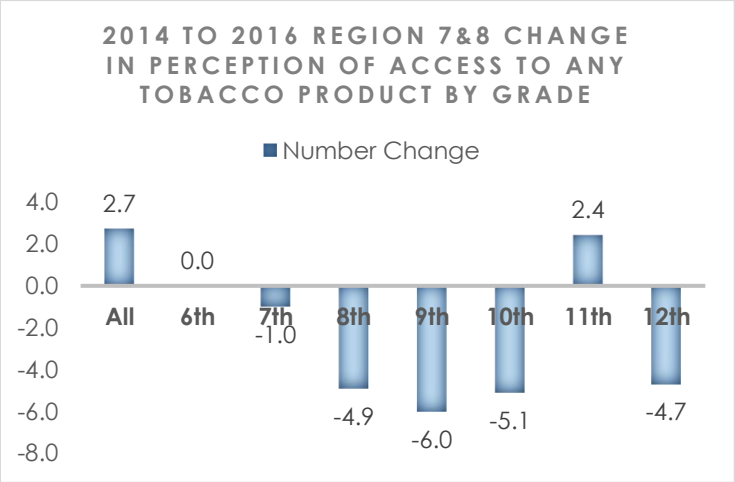


[43] The Conversation. Easier Access to Prescription Drugs Puts Teens at Risk. February 18, 2015. https://theconversation.com/easier-access-to-prescription-drugs-puts-teens-at-risk-34910. Accessed July 12, 2018.

Source: Texas A&M PPRI, TSS 2016

Only 11th Grade students' perception of access increased 2.4 from 51.9 percent in 2014 to 54.3 percent in 2016. **One in eight seventh grade students (12.2%) report any tobacco product as somewhat easy to very easy to obtain while one in two 12th graders (55.7%) find tobacco products accessible.**

Diagram 74 and 75, 2014-2016 Perception of Access to Tobacco



2014 - 2016 TSS Change in Perception of Access to Tobacco Products			
	2014 SW to Very Easy to Obtain	2016 SW to Very Easy to Obtain	Number Change
All	31.9	34.6	2.7
Grade 6	5.0	NA	NA
Grade 7	13.2	12.2	-1.0
Grade 8	24.1	19.2	-4.9
Grade 9	34.1	28.1	-6.0
Grade 10	43.5	38.4	-5.1
Grade 11	51.9	54.3	2.4
Grade 12	60.4	55.7	-4.7

Source: Texas A&M, PPRI, TSS 2014,2016 Region 7&8

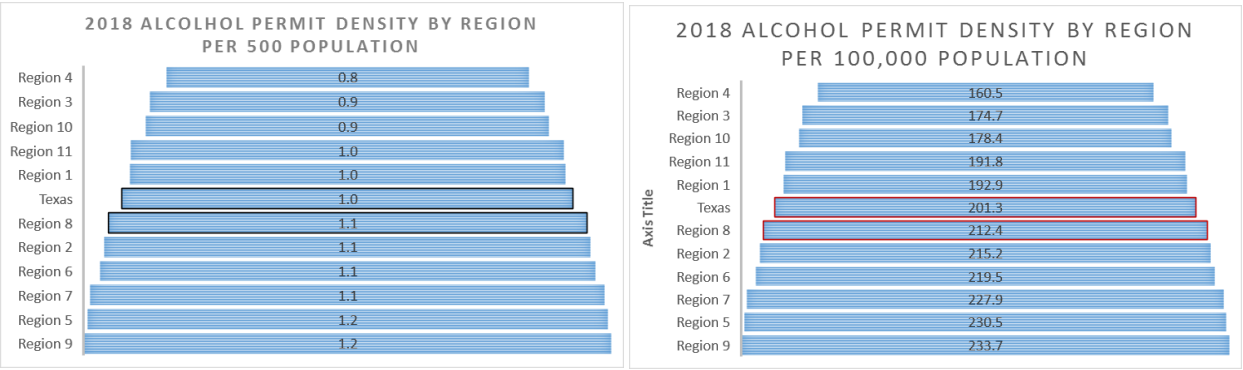
Source: Texas A&M, PPRI, TSS 2014, 2016 Region 7&8

Alcohol Retail Permit Density and Violations

The number and density of bars, taverns and liquor stores in communities has been shown to correlate with alcohol-related problems such as assault, traffic crashes, injury, suicide and child abuse.[44] Areas with higher concentrations of alcohol outlets (per capita) have higher concentrations of alcohol-related problems.

Six of the 11 (54.5%) Regions in Texas have alcohol permit density rates higher then Texas' rate of 201.3 persons per 100,000 population. Region 9 rate is the highest at 233.7 persons per 100,000 population compared to Region 4 at 160.5 persons per 100,000 population. The rate for alcohol permits in Region 8 at 212.4 is higher then Texas.

Diagram 76. 2018 Alcohol Permit Density by Region

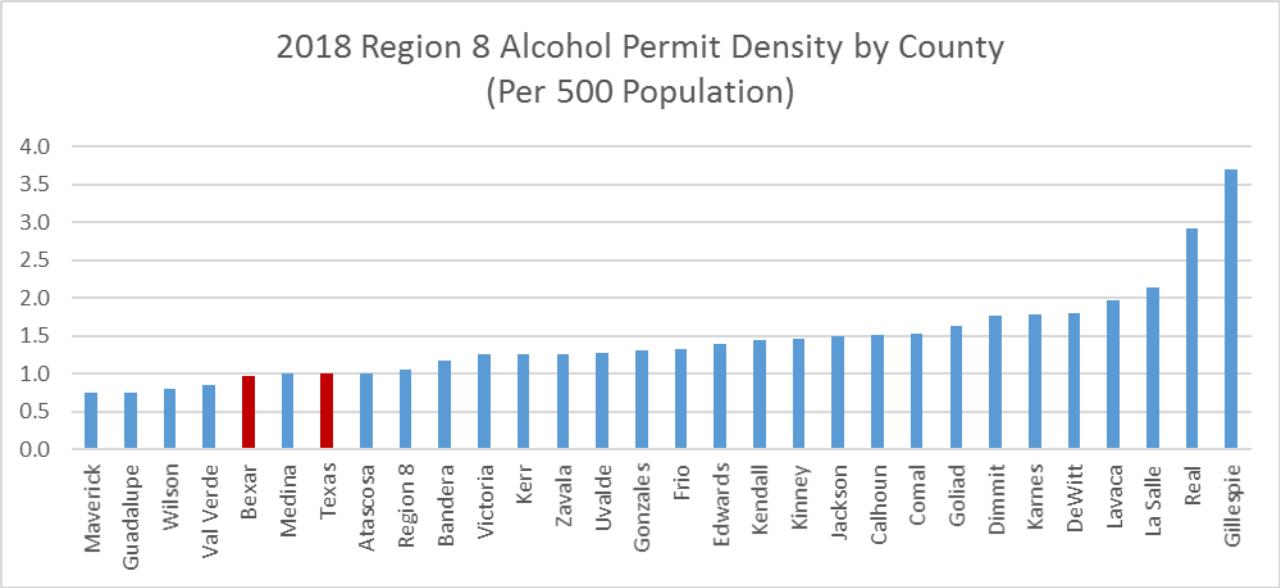


Source: Texas Alcoholic Beverage Commission, Texas Demographic Center, Pop Est. 2018

[44] Gormon, D.m; Speer, P.W.; Gruenewald, P.J.; and Labouvie, E.W. (2001) Spatial dynamics of alcohol availability, neighborhood structure and violent crime. Published online: January 4, 2015. https://doi.org/10.15288/jsa.2001.62.628. Accessed July 17, 2018

Seventy-nine percent of Region 8 counties have alcohol permit density rates higher then Texas' rate of one person per 500 population or 201.2 per 100,000 population. Gillespie county rate is the highest at 3.7 persons per 500 population compared to Maverick county at 0.7 persons per 500 population. Bexar county rate is 1 person per 500 population or 192.7 per 100,000 population. County level information about the number of alcohol sales licenses in relation to the number of people in the county are in Appendix A, Table 28.

Diagram 77, 2018 Region 8 Alcohol Permit Density by County



Source: Texas Alcoholic Beverage Commission, Texas Demographic Center, Pop Est. 2018

In 2017, Region 8 had 832 alcohol violations reported to the Texas Alcoholic Beverage Commission (TABC), a decrease of 3.5 percent from 2016 of 862 violations. In 2017, 19 percent of the violations involved the selling or serving to a minor or permitting a minor to possess or consume alcohol and or other miscellaneous violations. This was a .7 percent decrease from 2016.

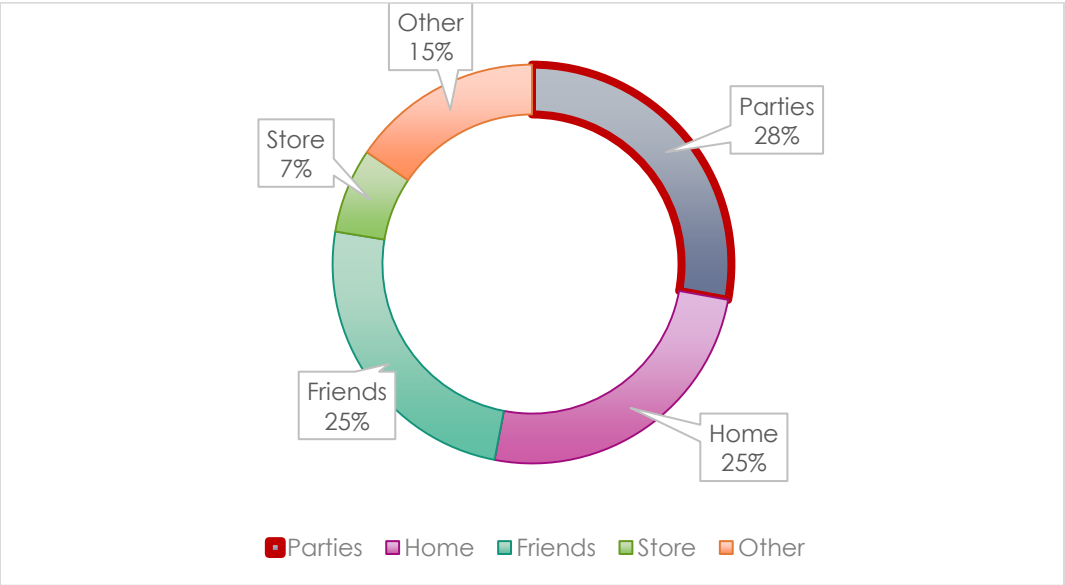
As of July 2018, 10 alcohol pemits in Region 8 were suspended. 7 in Bexar, 1 Guadalupe, 1 La Salle and 1 in Lavaca county.[45]

Social Hosting of Parties

A social host is an adult who host parties or allow alcohol to be served to minors on property they control. **In Region 7&8, one out of three or 30 percent of students reported that alcohol was used at parties they attended**. When asked, "*where do you get your alcoholic beverages from"*, one out of four report they got it at parties (26.4%), followed by home (23.8%), friends (23.3%), store (6.5%) and other sources (14.7%).

[45] Texas Alcoholic Beverage Commission. TABC: Online. https://www.tabc.state.tx.us/PublicInquiry/Default.aspx. Accesssed July 23, 2018

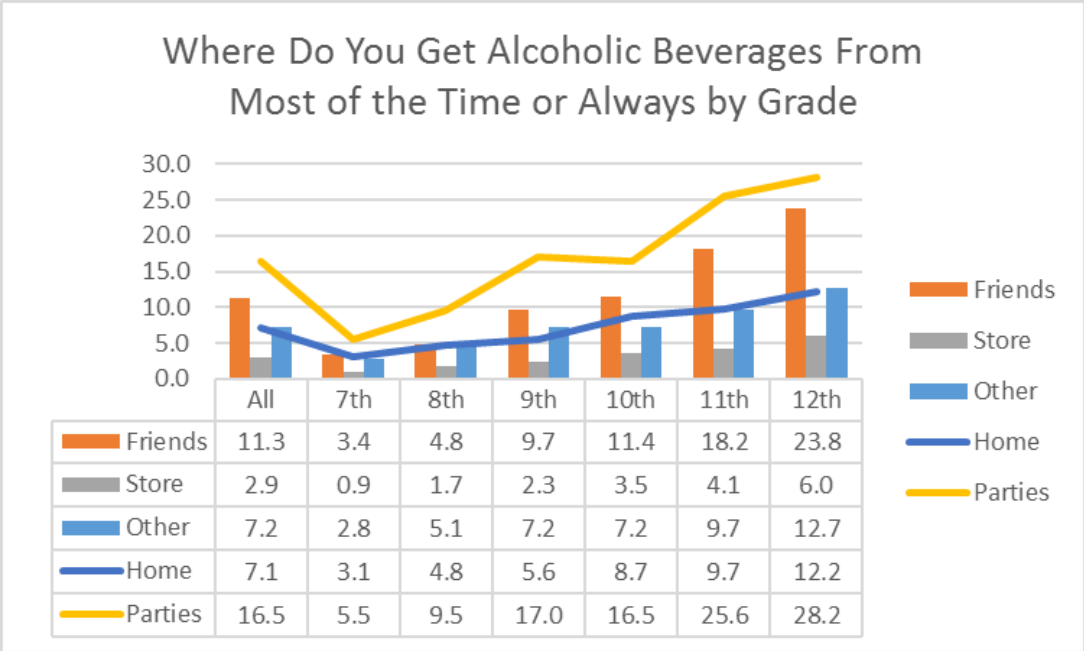
Diagram 78. Where Do Youth Get Alcoholic Beverages From?



Source: Texas A&M, PPRI, Texas School Survey, Region 7&8, 2016

Before youth have the means to socialize outside of the family, they experiment with what they have access too, which for many, begins with the family liquor cabinet. As they become older and have more freedom and spend more time with friends they increase their access through social gatherings like parties.

Diagram 79. 2016 TSS, Region 7&8, Get Alcoholic Beverages Most of the Time or Always



	All	7th	8th	9th	10th	11th	12th
Friends	11.3	3.4	4.8	9.7	11.4	18.2	23.8
Store	2.9	0.9	1.7	2.3	3.5	4.1	6.0
Other	7.2	2.8	5.1	7.2	7.2	9.7	12.7
Home	7.1	3.1	4.8	5.6	8.7	9.7	12.2
Parties	16.5	5.5	9.5	17.0	16.5	25.6	28.2

Source: Texas A&M, PPRI, TSS Region 7&8, 2016

The Texas social host law holds party hosts liable in two circumstances; if the hosts knowingly serve alcohol to minors on their property, or if the hosts supply car keys to an intoxicated adult on the host's

property. The law requires knowledge by the host of the minor's age. Without actual knowledge of the minor's age, a party host will not be liable so long as the host's assumption is reasonable.

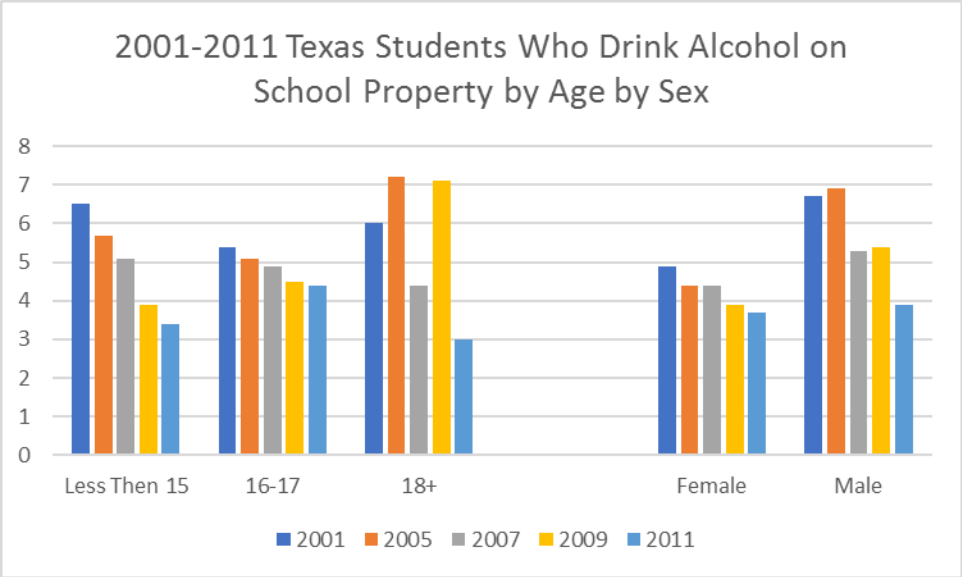
However, El Paso, Palmview and San Antonio, Texas have passed social host ordinances that hold homeowners or private property owners responsible when they supply minors with the environment to drink alcohol. By imposing fines on homeowners and/or property owners with each successive offense, the goal is to discourage underage drinking at house parties[46]

Substance Use on School Property

The Youth Risk Behavior Surveillance Survey (YRBSS) asks questions about substance related behaviors on school campus. The first indicator addresses students' behavior of consuming alcohol on school campus followed by students who were offered, sold or given illegal drugs on school campus.

Between 2001 to 2011, alcohol use on Texas school campuses has steadily declined across all age groups, students 15 years of age or less decreased 3.1, 16 to 17 years of age decreased 1.0, and 18 and older decreased 3.0. Females are just as likely as males to consume alcohol on school campus. Male use decreased 2.8 while females decreased only 1.2 over the same period.

Diagram 80. 2001-2011 Texas Students Who Drink on School Campus

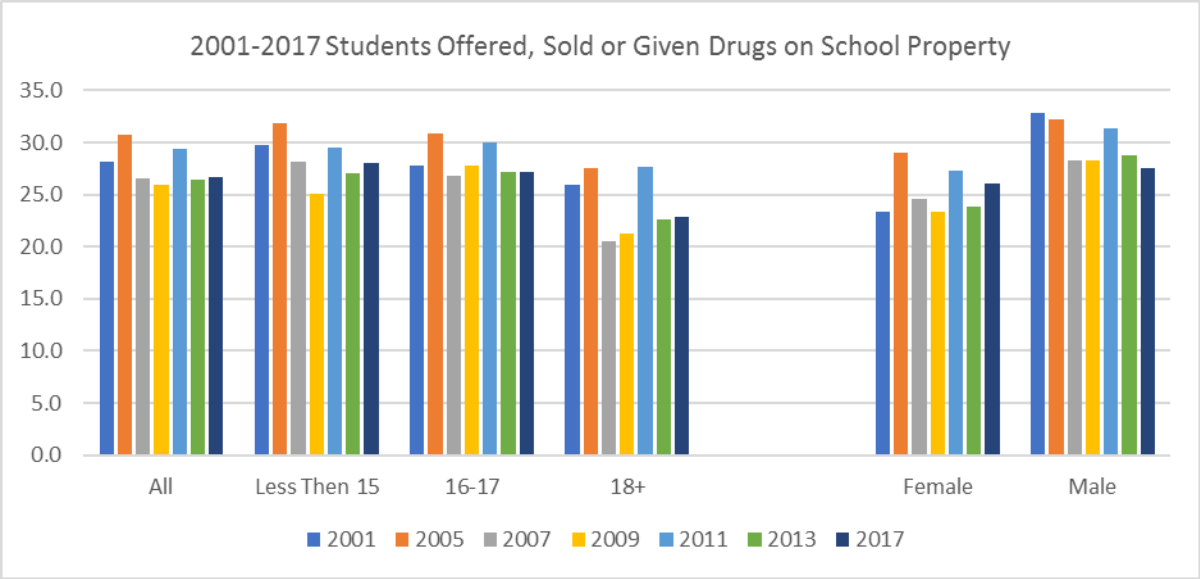


Texas Department of State Health Services. 2001 - 2011 High School Youth Risk Behavior Survey Data.

Between 2001 to 2017 there were significant increases in 2005 and 2011 of students who were offered, sold or given drugs on school campus while there has been no significant change between 2013 and 2017. Female students who were offered, sold or given drugs on school property increased 2.7 from 23.3 percent in 2001 to 26 percent in 2017 while males decreased 4.2 from 32.8 percent in 2001 to 27.5 percent in 2017. The most significant increase occurred with the students less than 15 years of age, increasing 1.0 from 27 percent in 2013 to 28 percent in 2017.

[46] Circles of San Antonio. No Party Parents. http://nopartyparents.com/. Accessed July 17, 2018.

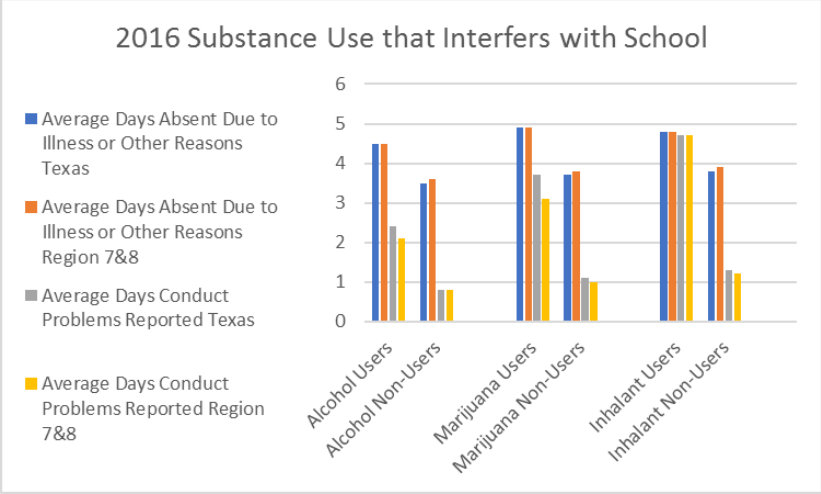
Diagram 81. 2001-2017 Students Offered, Sold or Given Drugs on School Property



Texas Department of State Health Services. 2001 - 2017 High School Youth Risk Behavior Survey Data.

The Texas School Survey provides some insight into the associated behaviors of substance use and student campus life. With the first indicator, students self-report their conduct problems and absenteeism for those who identify as user and non-users of alcohol, marijuana and inhalants. Non-users are less likely to miss school or have bad conduct days compared to those who use substances. Marijuana users are more likely to miss school, while inhalant users are more likely to have bad conduct days as seen in the diagram below.

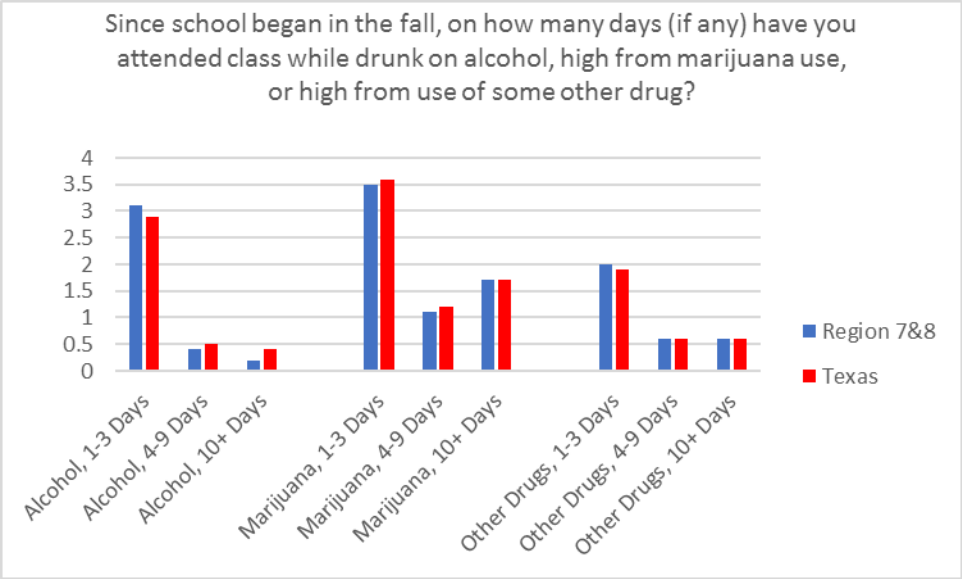
Diagram 82. 2016 Substance Use that Interfers with School



Source: Texas A&M, PPRI, TSS Region 7&8, Texas, 2016

Finally, the second indicator, students self-report the number of days they attened classes while drunk on alcohol, high from marijuana use, or high from some other drug. Students are more likely to attend school while high from marijuana use than from any other substance as shown in the diagram below.

Diagram 83. Students Self-Report Attending School Drunk or High

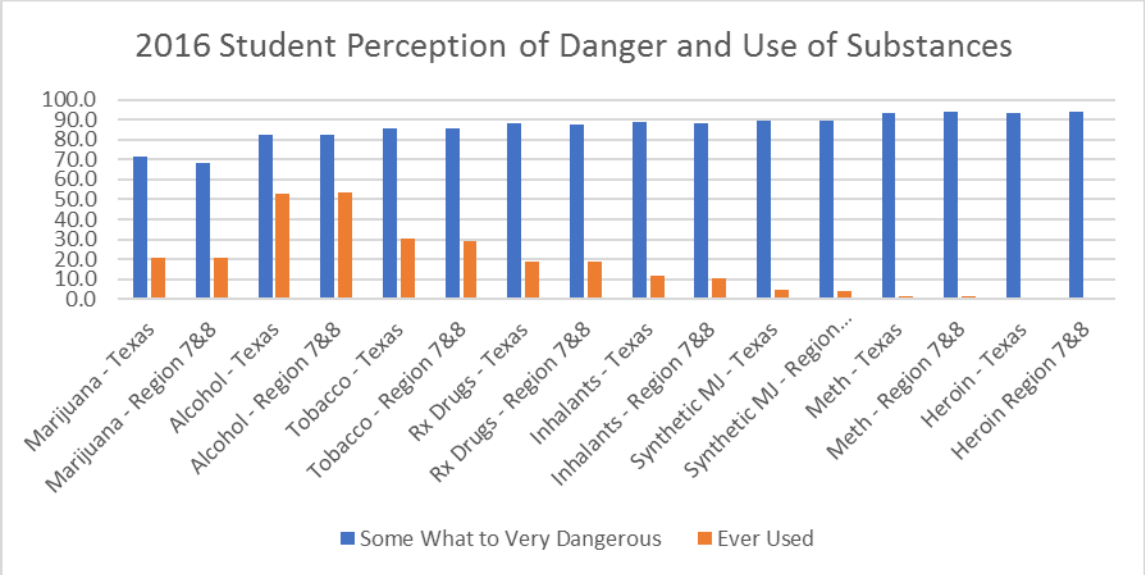


Source: Texas A&M, PPRI, TSS, Region 7&8, Texas, 2016

Perceived Risk of Harm

The perception of risk (danger) associated with drug use has been established as a key factor in the decision of whether to use a drug or not. When the perception of harm is high, students are less likely to use. Heroin is perceived as having the highest risk of danger therefore, has the least use by students. Tobacco, alcohol and marijuana have the least perception of harm and have the highest percentage of usage.

Diagram 84. 2016 Student Perception of Danger and Use of Substances



Source: Texas A&M, PPRI, TSS Region 7&8, Texas, 2016

Regional Consumption

The Texas School Survey is the most comprehensive survey for substance use in Texas and will be used for our regional consumption data. The survey, administered every two years, provides timely and relevant information about current drug and alcohol use patterns among young people enrolled in Texas' public schools. Various regional breakdowns including border, non-border and regional analyses provide the ability to compare various diverse areas of Texas with the state as a whole. These results can yield important information on the unique needs of different regions in Texas, thus informing policy makers for purposes of program design and resource allocation for substance abuse prevention among youth in Texas. Furthermore, longitudinal analysis can provide insight into changes in drug and alcohol prevalence over time.[47]

Early Initiation of Alcohol, Tobacco and Marijuana

Alcohol, tobacco, and marijuana are the substances American adolescents use the most. A recent study led by researchers at the National Institute on Alcohol Abuse and Alcoholism examined how adolescents' substance use patterns are associated with substance use disorders in young adulthood. Their findings, published in Drug and Alcohol Dependence in March 2014, show that adolescents who drink alcohol and also smoke cigarettes and marijuana are more likely to suffer from alcohol and other substance use disorders as young adults than adolescents who delay trying these substances.

The researchers used data from Waves I (1994–1995) and IV (2008) of the National Longitudinal Study of Adolescent Health (Add Health), the largest, most comprehensive survey of adolescents in the United States, to estimate the prevalence of various patterns of early adolescent use of alcohol, cigarettes, and marijuana, individually and in combination. They also examined the differences in these patterns based on age, gender, and race/ethnicity among users of all three substances. Then, they examined the effects of these patterns on subsequent young adult substance use behaviors and DSM-IV substance use disorders.

Researchers found that multiple substance use is highly prevalent among U.S. adolescents, with 34.1% reporting early use of alcohol and marijuana, or alcohol, marijuana and cigarettes. They also found that early use of multiple substances is associated with higher rates of substance use dependence in young adults. According to their analyses, about one-fourth of young adults ages 24 to 32 who had used alcohol, marijuana, and cigarettes before age 16 met the DSM-IV criteria for a substance use disorder. By contrast, only about 16% of young adults who had used these same substances after age 16 met the criteria for a substance use disorder.

The researchers also examined the associations between the use of multiple substances in early adolescence with a range of subsequent young adult substance use behaviors. **They found that adolescents who used alcohol, cigarettes, and marijuana prior to age 16 were twice as likely to meet the criteria for marijuana dependence and three times as likely to be dependent on other illicit drugs**.

[47] Texas A&M University. Texas School Survey of Drug and Alcohol Use: 2016 Methodology Report. http://texasschoolsurvey.org/Documents/Reports/Methods/2016Methods.pdf. Accessed July 25, 2018

The authors conclude that prevention programs should aim to encourage kids to delay use of all three problematic substances – alcohol, cigarettes, and marijuana – rather than targeting each substance separately.[48]

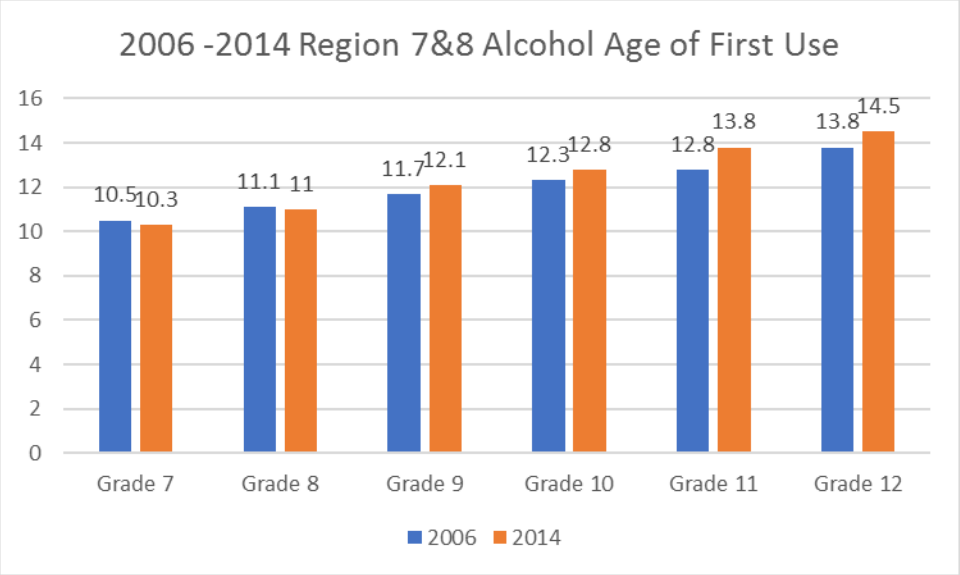
Alcohol

Alcohol continues to be the substance most commonly used by adults and youth.

Alcohol Age of Initiation

The 2016 Texas School Survey of Substance did not include age of initiation for alcohol, however 2006 and 2014 (most current age of first use) years are used for comparison. For 7th and 8th grade students, age of first use has not changed significantly, however, grades 9 thru 12 have shown the age of first use as being older. Eleventh grade students show the most significant increase of 1.

Diagram 85. 2006-2014 Region 7&8 Alcohol Age of First Use



Source: Texas A&M, PPRI, TSS Region 7&8 2014, Region 8 2006

Alcohol Current, School Year and Lifetime Use

Between 2014 and 2016, past month use of any alcohol increased across all grade levels with 12th grade showing the most significant increase of 10.7 from 33.6 percent in 2014 to 44.3 percent in 2016. Students that self-reported alcohol consumption during the school year also increased across all grade levels showing 12th grade with the highest increase of 9.1 from 45.8 percent in 2014 to 54.9 percent in 2016. Seventh grade lifetime alcohol use showed the highest increase of 9.4 from 27.8 percent in 2014 to 37.2 percent in 2016. The only decreases for alcohol occurred in lifetime use for 9th, 10th and 11th grade students.

[48] Babitz S, Combined use of alcohol, cigarettes, and marijuana in early adolescence can lead to substance dependence in early adulthood. NIH, https://www.niaaa.nih.gov/research/niaaa-research-highlights/combined-use-alcohol-cigarettes-and-marijuana-early-adolescence. Published March 14, 2014, Accessed July 25, 2018.

Diagram 86. 2014-2016 Alcohol Consumption by Grade

2014-2016 Alcohol Consumption by Grade														
	All	6th	7th	7th Grade Change +/-	8th	8th Grade Change +/-	9th	9th Grade Change +/-	10th	10th Grade Change +/-	11th	11th Grade Change +/-	12th	12th Grade Change +/-
Past Month 2014	18.6	5.9	10.4		13.0		20.1		24.7		28.1		33.6	
Past Month 2016	28.0	NA	14.7	4.3	20.8	7.8	26.4	6.3	28.4	3.7	37.5	9.4	44.3	10.7
School Year 2014	26.1	9.2	12.2		20.1		28.4		34.6		39.9		45.8	
School Year 2016	34.1	NA	17.4	5.2	24.5	4.4	31.9	3.5	35.8	1.2	45.7	5.8	54.9	9.1
Ever 2014	45.7	20.4	27.8		38.5		53.7		60.0		64.7		61.5	
Ever 2016	53.3	NA	37.2	9.4	45.3	6.8	50.5	-3.2	57.5	-2.5	63.5	-1.2	70.2	8.7
Notes: Red shaded cells indicate an increase in use and green shaded cells indicate a decrease in use. 6th grade students were not surveyed in 2016														
Source: Texas A&M, PPRI, TSS Region 7&8, 2014, 2016														

According to the 2015 National Survey on Drug Use and Health (NSDUH), 86.4 percent of people ages 18 or older reported that they drank alcohol at some point in their lifetime; 70.1 percent reported that they drank in the past year; 56.0 percent reported that they drank in the past month.

Alcohol Current High-Risk Use – Binge

Centers for Disease Control and Prevention (CDC), conducted a survey that analyzed data on self-reported binge drinking during the past 30 days (2015 Behavioral Risk Factor Surveillance System (BRFSS). U.S. adults consumed more than 17 billion binge drinks in 2015, or about 470 binge drinks per binge drinker. 1 in 6, or 37 million, adults binge drink about once a week, consuming an average of seven drinks per binge. Binge drinking is defined as consuming five or more drinks for men, or four or more drinks for women, in about two hours. Additional findings include:

- While the prevalence of binge drinking was more common among young adults ages 18-34 years, more than half of the binge drinks consumed each year were by adults ages 35 years and older.
- About 4 in 5 total binge drinks were consumed by men.
- Binge drinkers with lower household incomes (less than $25,000 a year) and lower educational levels (less than high school) consumed substantially more binge drinks per year than those with higher incomes and educational levels.[49]

Students that reported binge drinking for one day in the past 30 days increased 1.1 percent while binge drinking for 2 or more days decreased for all grades. Students report beer as their alcohol of choice, but when it comes to binge drinking, students report drinking liquor 8.1 percent of the time and beer 6 percent of the time.

[49] Centers for Disease Control and Prevention. During Binges, U.S. Adults have 17 Billion Drinks a Year. https://www.cdc.gov/media/releases/2018/p0316-binge-drinking.html. Page last reviewed March 16, 2018, Accessed July 24, 2018.

Diagram 87. 2014-2016 Binge Drinking in the Past 30 Days, Region 7&8

During the Past 30 Days, on How Many Days Have You Had Five or More Drinks of Alcohol in a Two Hour Period?													
	1 Day		2 Days		3 to 5 Days		6 to 9 Days		10 + Days		Total Binge		**Change +/-**
	2014	2016	2014	2016	2014	2016	2014	2016	2014	2016	2014	2016	
Grade 7	2.0	2.3	1.8	1.2	0.5	0.7	0.3	0.0	0.6	0.4	5.2	4.7	**-0.5**
Grade 8	3.2	3.3	2.7	1.3	1.3	1.1	0.6	0.4	1.6	0.6	9.3	6.6	**-2.7**
Grade 9	3.4	3.4	2.5	1.9	2.5	1.7	0.7	0.4	2.4	1.3	11.5	8.6	**-2.9**
Grade 10	6.1	4.4	5.2	2.7	1.8	2.6	1.1	0.6	2.0	1.3	16.2	11.6	**-4.6**
Grade 11	4.7	6.1	4.2	4.2	3.9	2.9	1.7	0.9	2.6	1.7	17.1	15.9	**-1.2**
Grade 12	7.7	8.7	3.5	4.1	3.7	3.8	2.7	1.8	3.3	2.4	21.0	20.8	**-0.2**
Cells with the higher percentage are highlighted													
Source: Texas A&M, PPRI, TSS, Region 7&8 2014, 2016													

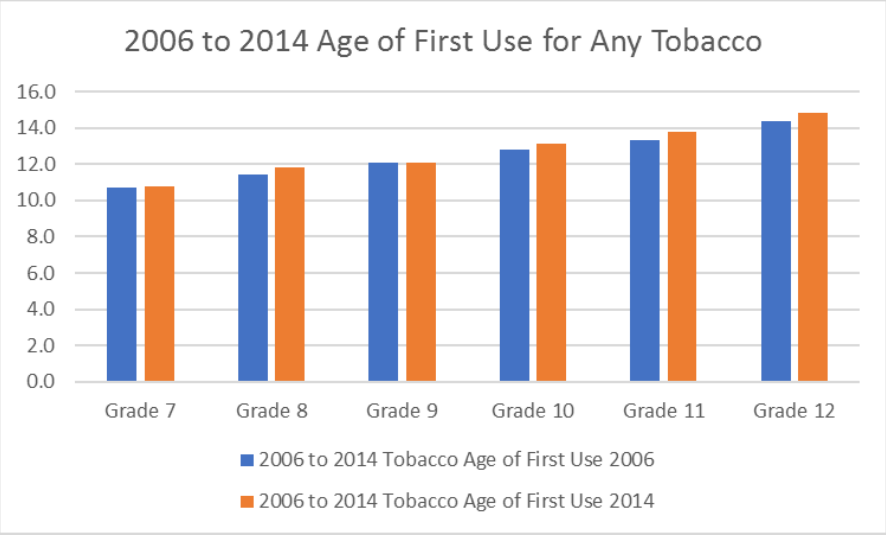
Tobacco

Cigarette smoking is the leading cause of preventable disease and death in the United States, accounting for more than 480,000 deaths every year, or about 1 in 5 deaths. In 2016, more than 15 of every 100 U.S. adults aged 18 years or older (15.5%) currently* smoked cigarettes. This means an estimated 37.8 million adults in the United States currently smoke cigarettes. More than 16 million Americans live with a smoking-related disease. Current smoking has declined from 20.9% (nearly 21 of every 100 adults) in 2005 to 15.5% (more than 15 of every 100 adults) in 2016. The proportion of ever smokers who had quit increased; however, current smoking prevalence did not change significantly during 2015-2016.[50]

Tobacco Age of Initiation

Age of first use increased across all grade levels ever so slightly between 2006 and 2014. Eleventh grade showed the highest increase of 0.5 from 13.3 in 2006 to 13.8 in 2014.

Diagram 88. 2006-2014 Age of First Use for Tobacco



Source: Texas A&M, PPRI, TSS Region 7&8, 2014. 2006

[50] Centers for Disease Contgrol and Prevention, Current Cigarette Smoking Among Adults in the United States. https://www.cdc.gov/tobacco/data_statistics/fact_sheets/adult_data/cig_smoking/index.htm. Updated February 15, 2018. Accessed July 25, 2018

Tobacco Current, School Year and Lifetime Use

In 2016, the Texas School Survey of Substance included electronic vapor products in the tobacco survey, resulting in a significant increase in tobacco use. Lifetime use for any tobacco product increased from 19.4 percent in 2014 to 28.8 percent in 2016. Past-month use of tobacco was 7.4 percent in 2014 and 13.8 percent in 2016. School year use increased from 10.3 percent in 2014 to 18.2 percent in 2016. Although all grades increased, 12th grade students had the highest increases for past month, school year and lifetime use.

Diagram 89. 2014-2016 Tobacco Consumption by Grade

2014-2016 Tobacco Consumption by Grade														
	All	6th	7th	7th Grade Change +/-	8th	8th Grade Change +/-	9th	9th Grade Change +/-	10th	10th Grade Change +/-	11th	11th Grade Change +/-	12th	12th Grade Change +/-
Past Month 2014	7.4	1.3	1.9		5.5		7.2		10.4		13.4		15.3	
Past Month 2016	13.8	NA	4.7	2.8	8.5	3.0	12.5	5.3	13.9	3.5	20.3	6.9	26.4	11.1
School Year 2014	10.3	1.8	3.4		7.2		10.2		14.7		17.8		21.0	
School Year 2016	18.2	NA	6.0	2.6	11.4	4.2	16.2	6.0	19.6	4.9	25.8	8.0	34.2	13.2
Ever 2014	19.4	5.3	8.8		13.3		21.8		27.7		31.9		32.5	
Ever 2016	28.8	NA	12.7	3.9	21.3	8.0	27.6	5.8	31.1	3.4	38.7	6.8	45.8	13.3
Notes: Red shaded cells indicate an increase in use and green shaded cells indicate a decrease in use. 6th grade students were not surveyed in 2016														
Source: Texas A&M, PPRI, TSS Region 7&8, 2014, 2016														

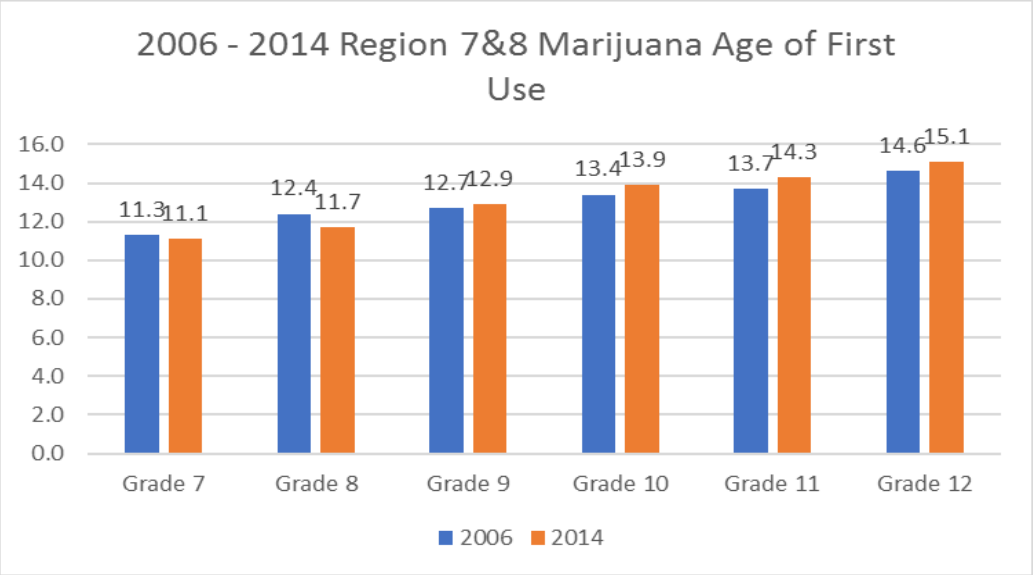
Marijuana

Marijuana remains the most widely used illicit drug among youth and adults.

Marijuana Age of Initiation

The average age of first use for marijuana was younger in 2016 than 2014 for 7th and 8th grade students, while the age of first use for 9th, 10th, 11th and 12th grade students was older. Eleventh grade students had the highest increase of 0.6 from the average age of first use at 13.7 in 2006 to 14.3 in 2014.

Diagram 90. 2006-2014 Region 7&8 Marijuana Age of First Use by Grade



Source: Texas A&M, PPRI, TSS, Region 7&8 2014, 2006

Marijuana Current, School Year and Lifetime Use

Between 2014 and 2016, past month use of marijuana increased across all grade levels with 12th grade students showing the most significant increase of 11.0 from 11.1 percent in 2014 to 22.1 percent in 2016. Students that self-reported marijuana consumption during the school year decreased 0.6 for 9th grade and 0.1 for 10th grade students, while 12th grade increased 9.1 from 16.9 percent in 2014 to 26 percent in 2016. Significant decreases in lifetime use for marijuana occurred in 9th, 10th and 11th grades while 8th grade students reported the highest increase of 2.8 from 10.5 percent in 2014 to 13.3 percent in 2016.

Diagram 91. 2014 – 2016 Marijuana Consumption by Grade

2014-2016 Marijuana Consumption by Grade														
	All	6th	7th	7th Grade Change +/-	8th	8th Grade Change +/-	9th	9th Grade Change +/-	10th	10th Grade Change +/-	11th	11th Grade Change +/-	12th	12th Grade Change +/-
Past Month 2014	6.9	0.8	1.7		4.3		7.9		10.9		13.7		11.1	
Past Month 2016	11.6	NA	3.8	2.1	8.1	3.8	9.1	1.2	11.9	1.0	17.8	4.1	22.1	11.0
School Year 2014	9.8	0.8	2.5		4.9		12.0		16.6		17.5		16.9	
School Year 2016	14.5	NA	4.5	2.0	9.4	4.5	11.4	-0.6	16.5	-0.1	22.8	5.3	26.0	9.1
Ever 2014	19.2	2.7	5.1		10.5		22.9		30.4		33.1		35.0	
Ever 2016	20.8	NA	7.0	1.9	13.3	2.8	15.6	-7.3	23.8	-6.6	32.8	-0.3	37.6	2.6
Notes: Red shaded cells indicate an increase in use and green shaded cells indicate a decrease in use. 6th grade students were not surveyed in 2016														
Source: Texas A&M, PPRI, TSS Region 7&8, 2014, 2016														

Prescription Drugs

Prescription drug misuse ranks the 4th most widely substance consumed by our youth, followed behind alcohol, tobacco and marijuana.

Prescription Drug Age of Initiation

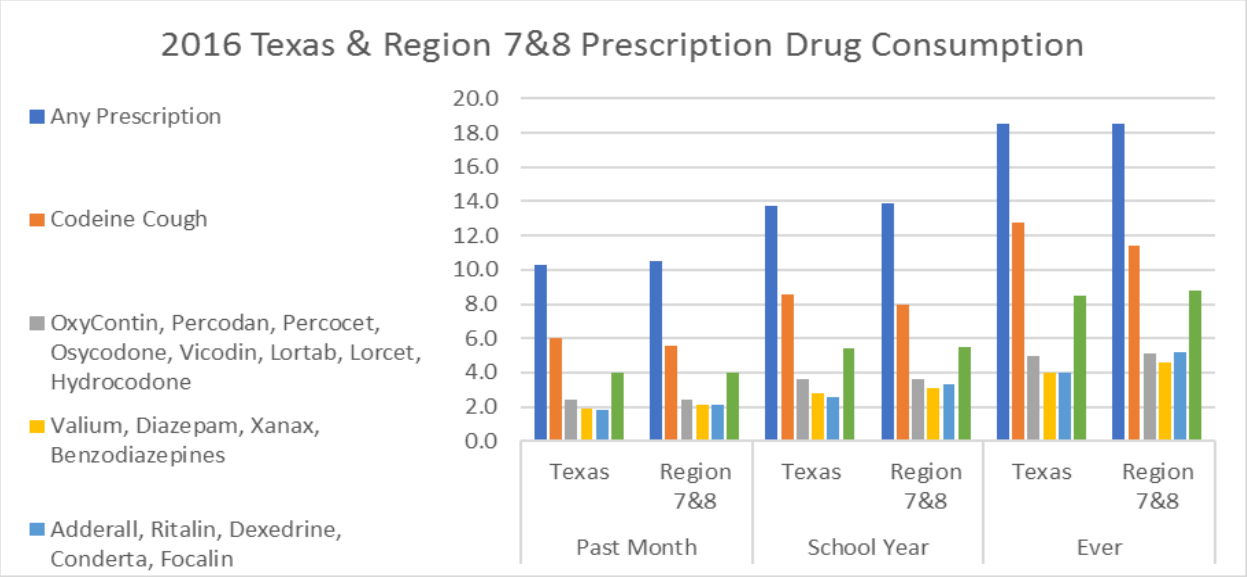
The Texas School Survey of Substance did not have a survey question about the age of first use for prescriptioin drugs but will be in the upcoming 2018 survey.

Results from the latest completed National Survey on Drug Use and Health show that the average age at first drug use in 2012 varied considerably with the substance in question. The oldest average age (26.2 years old) occurred among those individuals who initiated drug use by abusing prescription sedative-hypnotics. In descending order, the drugs with the next highest average ages at first use were prescription tranquilizers (23.6 years old), heroin (23.0 years old), opioid painkillers (22.3 years old), stimulants other than cocaine (22.1 years old), MDMA (20.3 years old), cocaine (20.0 years old), LSD (19.0 years old) and marijuana (17.9 years old). The youngest average age (16.9 years old) occurred among those individuals who initiated drug use with PCP.[51]

Prescription Drug Current, School Year and Lifetime Use

Not all prescription drug use data was comparable between 2014 and 2016 due to changes in the survey questions, however comparison between the 2016 State and 2016 Region 7&8 data are below. Region 7&8 consumption of any prescription drugs was 0.2 higher for past month use and 0.4 higher for school year use compared to Texas. Region 7&8, students reported current use of benzodiazepines and amphetamines higher compared to Texas.

Diagram 92. 2016 Prescriptioin Drug Consumption



Source: Texas A&M, PPRI, TSS State, Region 7&8, 2016

[51] Substance Abuse and Mental Health Services Administration, Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013. https://www.samhsa.gov/data/sites/default/files/NSDUHresults2012/NSDUHresults2012.pdf.

Additional findings in Region 7&8 for nonmedical use of Prescription drugs:

Codeine Cough Syrup

- In 2014, about 12.1 percent of students reported using codeine cough syrup non-medically at some point in their lives, and 5.8 percent reported that they used in the past month. These prevalence rates decreased in 2016 with 11.4 percent of students reporting having ever used codeine cough syrup and 5.6 percent of students reported using in the past month.

Opioids – Used for Pain

- Two commonly abused narcotic prescription drugs: Oxycodone products (OxyContin, Percodan, and Percocet) and hydrocodone products (Vicodin, Lortab, and Lorcet) were first asked in the 2008 school survey. In 2016, these narcotics were combined into one question. In 2016, 5.1 percent of students reported using these products non-medically in their lifetime and 2.4 percent of students reported using these products in the past month. These reports do not represent a significant increase from past years.

Benzodiazepines - Anti-Anxiety

- Two popularly prescribed anti-anxiety drugs, **Valium (or Diazepam)** and **Xanax (or Alprazolam),** were first asked in the 2008 school survey. In 2016, these narcotics were combined into one question. About 4.6 percent of students reported non-medical use of these narcotics in their lifetime and 2.1 percent reported use in the past month. These combined reports represent an increase from reported use of Valium (1.2 percent reported lifetime use) and Xanax (3.5 percent reported lifetime use) in 2014.

Amphetamines - Stimulants

- In 2016, a new question was added to capture the use of **Adderall, Ritalin, Dexedrine, Concerta,** or **Focalin**. These drugs are stimulants commonly prescribed for attention deficit hyperactivity disorder (ADHD) but also abused by students seeking to improve their academic performance. In 2016, 5.2 percent of students reported using these substances in their lifetime and 2.1 percent reported using them in the past month. These percentiles are **higher** than the State (Ever used 4.0 percent and Past-month 1.8 percent).

Special Topic: Opiates

Both opiates and opioids are used medically and may be prescribed for pain relief, anesthesia, cough suppression, diarrhea suppression, and for treatment of opiate/opioid use disorder. Both opiates and opioids may also be used illicitly by people with a substance use disorder. The main difference is in how opiates and opioids are made. Both groups are referred to as narcotics, meaning sleep-inducing or numbness indusing. Today when people refer to all these drugs, they often call them opioids. [52]

Opioids are chemical compounds that generally are not derived from natural plant matter. Most opioids are "made in the lab" or "synthesized." Example of Opioids:

Dextromethorphan, Dextropropoxyphene, Loperamide, Hydrocodone, Oxycodone, Oxymorphone, Meperidine, Methadone, Fentanyl, Carfentanyl

[52] Oregon Alcohol and Drug Policy Commission. "Opiates" or Opioids" – What's the Difference? https://www.oregon.gov/adpc/Pages/Opiate-vs.-Opioid.aspx. Accessed July 26, 2018

Opiates are chemical compounds that are extracted or refined from natural plant matter (poppy sap and fibers. Example of opiates:

Opium, morphine, codeine, heroin

Opioid National Crisis

Every day, more than 115 people in the United States die after overdosing on opioids. The misuse of and addiction to opioids—including prescription pain relievers, heroin, and synthetic opioids such as fentanyl—is a serious national crisis that affects public health as well as social and economic welfare. The Centers for Disease Control and Prevention estimates that the total "economic burden" of prescription opioid misuse alone in the United States is $78.5 billion a year, including the costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement.

- Roughly 21 to 29 percent of patients prescribed opioids for chronic pain misuse them.
- Between 8 and 12 percent develop an opioid use disorder.
- An estimated 4 to 6 percent who misuse prescription opioids transition to heroin.
- About 80 percent of people who use heroin first misused prescription opioids.
- Opioid overdoses increased 30 percent from July 2016 through September 2017 in 52 areas in 45tates.
- The Midwestern region saw opioid overdoses increase 70 percent from July 2016 through September 2017.
- Opioid overdoses in large cities increased by 54 percent in 16 states.

This issue has become a public health crisis with devastating consequences including increases in opioid misuse and related overdoses, as well as the rising incidence of neonatal abstinence syndrome due to opioid use and misuse during pregnancy. The increase in injection drug use has also contributed to the spread of infectious diseases including HIV and hepatitis C. As seen throughout the history of medicine, science can be an important part of the solution in resolving such a public health crisis.[53]

National Opioid Current Use

The United States had an estimated 3.3 million people aged 12 or older in 2016 were **current misusers of pain relievers**, which represents 1.2 percent of the population aged 12 or older. In 2016, an estimated 239,000 adolescents aged 12 to 17 were current misusers of pain relievers, which corresponds to 1.0 percent of adolescents. An estimated 631,000 young adults aged 18 to 25 misused pain relievers in the past month, which represents 1.8 percent of young adults. An estimated 2.5 million adults aged 26 or older were current misusers of pain relievers, which corresponds to 1.2 percent of adults aged 26 or older.[54]

[53] National Institute on Drug Abuse. Opioid Overdose Crisis. Revised March 2018, https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis. Accessed July 25, 2018

[54] Substance Abuse and Mental Health Services Administration. (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

The total number of **drug seizures** that were tested by forensic laboratories and reported to **contain fentanyl** to the Drug Enforcement Agency's (DEA) National Forensic Laboratory Information System (NFLIS) in 2016 increased 121.1 percent from 13,002 seizures in 2015 to 15,749 in 2016. In 2016, Texas had 94 fentanyl seizures reported to NFLIS.

Opioid Overdose Death

During 2015, a total of 33,091 persons in the United States died from drug overdoses involving opioids (e.g., oxycodone, hydrocodone, heroin); the age-adjusted rate was 10.4 (per 100,000). Among males, the rate was 13.7; among females, it was 7.1. The rate was 19.4 in persons aged 25-34 years and 18.4 in persons aged 35-44 years. By race and ethnicity, the death rate was 13.9 in non-Hispanic whites, 6.6 in non-Hispanic blacks, and 4.6 in Hispanics.

By region, age-adjusted death rates from drug overdoses involving opioids were 13.6 per 100,000 in the Northeast, 12.2 in the Midwest, 9.8 in the South, and 7.4 in the West.

By urbanization, age-adjusted death rates from drug overdoses involving opioids were 11.8 in medium metropolitan areas and 9.4 per 100,000 in large central metropolitan areas.

In 2015, a total of 29,382 persons in the U.S. died from unintentional drug overdoses involving opioids; the age-adjusted rate was 9.3 per 100,000. A total of 1,857 persons died of drug overdoses of undetermined intent involving opioids; the age-adjusted rate was 0.6.

Prescription Opioid Overdose Deaths

During 2015, a total of 15,281 persons in the United States died from drug overdoses involving prescription opioids (e.g., oxycodone, hydrocodone); the age-adjusted rate was 4.7 (per 100,000). Among males, the rate was 5.4; among females, it was 4.0. The rate was 9.5 in persons aged 45-54 years and 8.4 in persons aged 35-44 years. By race and ethnicity, the death rate was 6.4 in non-Hispanic whites, 2.6 in non-Hispanic blacks, and 1.8 in Hispanics.

By region, age-adjusted death rates from drug overdoses involving prescription opioids were 5.2 in the South, 4.5 per 100,000 in the Northeast and West, and 4.2 in the Midwest.

By urbanization, age-adjusted death rates from drug overdoses involving prescription opioids were 5.9 in noncore areas and 4.1 per 100,000 in large central metropolitan areas.

In 2015, a total of 12,923 persons in the U.S. died from unintentional drug overdoses involving prescription opioids; the age-adjusted rate was 4.0 per 100,000. A total of 985 persons died of drug overdoses of undetermined intent involving prescription opioids; the age-adjusted rate was 0.3.

Natural and Semi-synthetic Opioid Overdose Deaths

During 2015, a total of 12,727 persons in the United States died from drug overdoses involving natural and semi-synthetic opioids (e.g., oxycodone, hydrocodone, morphine); the age-adjusted rate was 3.9 (per 100,000). Among males, the rate was 4.4; among females, it was 3.4. The rate was 8.1 in persons aged 45-54 years and 6.9 in persons aged 35-44 years. By race and ethnicity, the death rate was 5.3 in non-Hispanic whites, 2.1 in non-Hispanic blacks, and 1.5 in Hispanics.

By region, age-adjusted death rates from drug overdoses involving natural and semi-synthetic opioids were 4.4 per 100,000 in the South, 3.8 in the West, 3.6 in the Northeast, and 3.4 in the Midwest.

By urbanization, age-adjusted death rates from drug overdoses involving natural and semi-synthetic opioids were 5.1 per 100,000 in noncore areas and 3.3 in large central metropolitan areas.

In 2015, a total of 10,621 persons in the U.S. died from unintentional drug overdoses involving natural and semi-synthetic opioids; the age-adjusted rate was 3.3 per 100,000. A total of 807 persons died of drug overdoses of undetermined intent involving natural and semi-synthetic opioids; the age-adjustedrate was 0.3.

Methadone Overdose Deaths

During 2015, a total of 3,301 persons in the United States died from drug overdoses involving methadone; the age-adjusted rate was 1.0 (per 100,000). Among males, the rate was 1.2; among females, it was 0.8. The rate was 2.0 in persons aged 45-54 years and 1.8 in persons aged 35-44 years. By race and ethnicity, the death rate was 1.4 in non-Hispanic whites, 0.6 in non-Hispanic blacks, and 0.5 in Hispanics.

By region, age-adjusted death rates from drug overdoses involving methadone were 1.1 per 100,000 in the Northeast, and 1.0 in the Midwest, the South, and the West.

By urbanization, age-adjusted death rates from drug overdoses involving methadone were 1.2 per 100,000 in medium metropolitan and noncore areas and 0.9 in large fringe metropolitan areas.

In 2015, a total of 2,955 persons in the U.S. died from unintentional drug overdoses involving methadone; the age-adjusted rate was 0.9 per 100,000. A total of 237 persons died of drug overdoses of undetermined intent involving methadone; the age-adjusted rate was 0.1.

Synthetic Opioids (other than Methadone) Overdose Deaths

During 2015, a total of 9,580 persons in the United States died from drug overdoses involving synthetic opioids other than methadone (e.g., fentanyl, tramadol); the age-adjusted rate was 3.1 (per 100,000). Among males, the rate was 4.2; among females, it was 1.9. The rate was 6.6 in persons aged 25-34 years and 5.6 in persons aged 35-44 years. By race and ethnicity, the death rate was 4.2 in non-Hispanic whites, in non-Hispanic blacks, 2.1 and Hispanics, 0.9.

By region, age-adjusted death rates from drug overdoses involving synthetic opioids other than methadone were 5.6 per 100,000 in the Northeast, 3.9 in the Midwest, 2.8 in the South, and 0.9 in the West.

By urbanization, age-adjusted death rates from drug overdoses involving synthetic opioids other than methadone were 3.9 per 100,000 in large fringe metropolitan areas and 2.4 in large central metropolitan areas.

In 2015, a total of 8,609 persons in the U.S. died from unintentional drug overdoses involving synthetic opioids other than methadone; the age-adjusted rate was 2.8 per 100,000. A total of 544 persons died of drug overdoses of undetermined intent involving synthetic opioids other than methadone; the age-adjusted rate was 0.2.

Heroin Overdose Deaths

During 2015, a total of 12,989 persons in the United States died from drug overdoses involving heroin; the age-adjusted rate was 4.1 (per 100,000). Among males, the rate was 6.3; among females, it was 2.0. The rate was 9.7 in persons aged 25-34 years and 7.4 in persons aged 35-44 years. By race and ethnicity, the death rate was 5.4 in non-Hispanic whites, 3.1 in non-Hispanic blacks, and 2.3 in Hispanics.

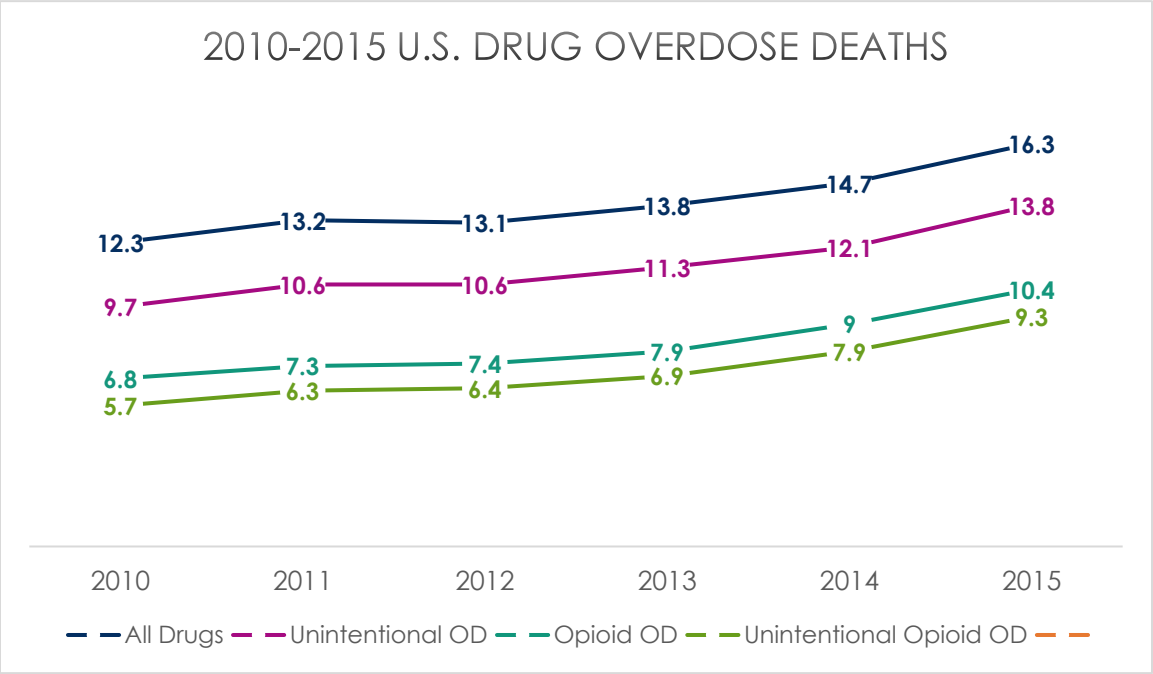
By region, age-adjusted death rates from drug overdoses involving heroin were 6.3 per 100,000 in the Northeast, 6.1 in the Midwest, 3.2 in the South, and 2.4 in the West.

By urbanization, age-adjusted death rates from drug overdoses involving heroin were 5.0 per 100,000 in large fringe metropolitan areas and 2.1 in noncore areas.

In 2015, a total of 12,284 persons in the U.S. died from unintentional drug overdoses involving heroin; the age-adjusted rate was 3.9 per 100,000. A total of 586 persons died of drug overdoses of undetermined intent involving heroin; the age-adjusted rate was 0.2. [55]

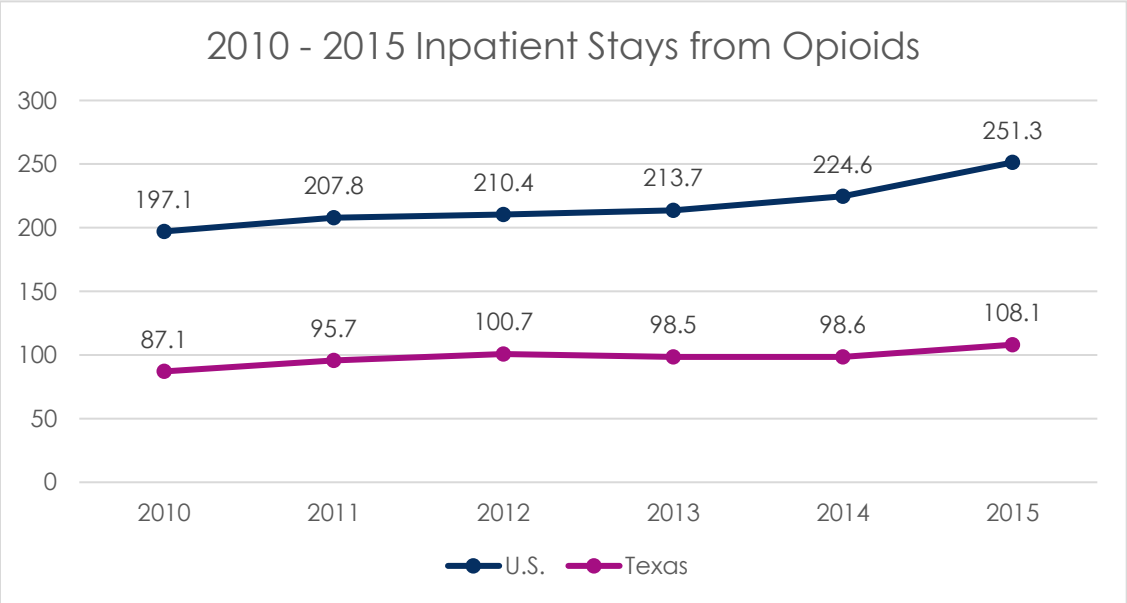
[55] Centers for Disease Control and Prevention. Annual Surveillance Report of Drug-Related Risks and Outcomes — United States, 2017. Surveillance Special Report 1. Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. Published August 31, 2017. Accessed July 26, 2018 from **https://www.cdc.gov/ drugoverdose/pdf/pubs/2017cdc-drug-surveillance-report.pdf**

Diagram 93. 2010-2015 U.S. Drug Related Deaths by All By Opioid per 100,000 Age-Adjusted



Source: Centers for Disease Control and Prevention

Diagram 94. 2010-2015 Inpatient Stays from Opioids



Source: Agency for Healthcare Research and Quality

Emerging Trends

Dr. Jane Maxwell, University of Texas Austin, Substance Abuse Trends in Texas 2017 reports the following highlights to the National Drug Early Warning System for methamphetamine, heroin, other opiates, benzodiazepines, cocaine, marijuana, synthetic cannabinoid and synthetic cathinone, PCP, and MDMA.

Methamphetamine remains the major drug threat, according to half of the 18 DEA offices in Texas. There were 715 deaths due to methamphetamine in Texas in 2016, as compared with 539 due to heroin. Key indicators are far higher than when the drug was made from pseudoephedrine, and with the phenyl-2-proponone method, the drug is now 95% potent. Seizures at the Texas–Mexico border have increased by 103% since 2014. Methamphetamine in solution ("Liquid Meth"), which is easier to transport into the United States, is increasing and the price of methamphetamine has dropped by half. The relationship between methamphetamine and HIV is increasing, with the proportion of HIV cases resulting from men having sex with men now as high in Texas as it was in 1987 when HIV data were first reported.

Heroin indicators are varied. Seizures along the Texas–Mexico border decreased 2%, although DEA reported Mexican opium production is increasing to sustain the increasingly high levels of demand in the United States. Texas has not yet suffered the epidemic of overdoses seen in the northeast because the heroin in Texas is Mexican Black Tar which cannot easily be mixed with fentanyl. The purity of Black Tar is 45%-50% as compared to 80%-85% purity for Mexican-South American heroin in the northeast.

Other Opiates such as fentanyl in Texas had previously involved transdermal patches, but rogue fentanyl powder began appearing in spring 2016 and more events are being reported. The drug is being mixed with other opiates and benzodiazepines, not heroin. In addition, the pattern of drinking codeine cough syrup, which was popular years ago, has returned recently with mentions of drinking not only codeine cough syrup ("Drank") but also of drinking promethazine syrup.

Benzodiazepines comprise less than 5% of all items seized and identified, but the number of persons admitted to treatment with a primary problem with benzodiazepines is increasing. Alprazolam (Xanax®) is the most abused benzodiazepine, and in combination with hydrocodone and carisoprodol it is known as the Houston Cocktail or Holy Trinity.

Cocaine indicators are mixed, with the number of toxicology items identified increasing, but the amount seized on the border and in treatment admissions decreasing. Crack cocaine and synthetic cannabinoids remain drugs of choice among the homeless and those living in tent cities, but outreach workers report increased popularity of powder cocaine. Cocaine availability is expected to increase in the future as a result of increased acreage planted, decreased use of herbicides, and the FARC peace treaty in South America.

Marijuana is ranked as the #1 threat by the other half of DEA offices in Texas because of the trafficking in and across Texas, not only north-south but also east-west. Seizures at the Texas–Mexico border are down 125% since 2014, but there is more domestic indoor and outdoor growing as well as more supply from states where the drug is legal or decriminalized. The demand for the drug has been influenced by changes in patterns of use with blunts and now electronic cigarettes and the "vaping" of hash oil and "shatter."

The synthetic cannabinoid and synthetic cathinone situation has changed: Poison center cases involving both cannabinoids and cathinones have decreased while toxicology and treatment cases involving these synthetics have increased. The chemical formulations and characteristics of persons using cannabinoids continue to change, with more cases occurring among the homeless population.

PCP remains a problem. The number of PCP items identified by forensic labs has increased, but

poison center calls and treatment admissions are down. The pattern of dipping small cigarillos filled with synthetic cannabinoids into bottles of PCP continues, and overdoses from synthetic cannabinoids, which may be exacerbated by PCP, are occurring.

Use of **novel psychoactive substances** including MDMA and the 2 C-xx phenethylamines change depending on availability of the drug and perceived effects. Use of these drugs was lower in 2016 than in previous years.

Drug patterns on the Texas Border continue to show high levels of use of marijuana, steady levels of heroin, slight increases in methamphetamine, and decreasing admissions for cocaine. In comparison, treatment admissions in the nonborder area show increases in methamphetamine and heroin, level use of marijuana, and the same decrease in cocaine use.[56]

E-Cigarettes/Vaping The National Poison Data System data between January 2012 and April 2017 indicates there were more than 8,000 e-cigarette and liquid nicotine exposures amongst children under six. Exposure to nicotine in children is especially dangerous and can result in serious harm or even death. The FDA has collaborated with the Federal Trade Commission (FTC) to warn companies about selling e-liquids used in e-cigarettes with advertising that resemble kid-friendly products.

Children are mistaking these products for juice boxes, cookies, or candy and consuming the products. The FDA is considering issuing product standards and other regulations on e-cigarettes and similar products, including limiting flavors that appeal to youth, implementing child-resistant packaging, and instituting strict product labeling.

The JUUL brand is especially popular in youth and teens because it resembles a flash drive and is therefore difficult for parents and teachers to recognize. These products have high levels of nicotine and emissions that are hard to see. Reports show that teens are using and liking these products without knowing that they contain nicotine. This is problematic because we know that an adolescent brain is still developing, and early nicotine use can cause changes in the brain that result in continued use as an adult.[57]

Consequences of Alcohol and Drug Misuse

Alcohol and drug misuse can have a wide range of effects; a single instance of alcohol or drug misuse can have profound negative consequences. The specific effects associated with substance misuse depend on the substances used, how much and how often they are used, how they are taken (e.g., orally vs. injected), and other factors. Some of these effects include:

- Immediate, direct consequences: effects on heart rate and regulatioin of body temperature to psychotic episodes, overdose, and death.

[56] Maxwell J. Substance Abuse Trends in Texas 2017. Steve Hicks School of Social Work, University of Texas at Austin. Revised November 6, 2017

[57] National Institute on Drug Abuse. Emerging Trends and Alerts. https://www.drugabuse.gov/drugs-abuse/emerging-trends-alerts. May 8, 2018.

- Indirect consequences related to risky behaviors that often accompany alcohol and drug misuse: Alcohol and drug misuse can impair judgment, leading to risky behaviors including driving under the influence (DUI), unprotected sex, and needle/syringe sharing.

- Longer-term health effects on a person's physical and mental health: For example, heavy drinkingii can lead to hypertension, liver disease, and cancer; regular marijuana use is associated with chronic bronchitis; and use of stimulants such as cocaine can lead to heart disease.11-13 In addition, substance misuse during pregnancy can result in long lasting health effects for the baby including fetal alcohol spectrum disorders (FASDs).

- Longer-term societal consequences: These can include reduced productivity, higher health care costs, unintended pregnancies, spread of infectious disease, drug-related crime, interpersonal violence, stress within families, and many other direct and indirect effects on communities, the economy, and society as a whole.[58]

Overview of Consequences

Mortality

According to the National Institute on Drug Abuse (NIDA), drug-related deaths have more than doubled since 2000. There are more deaths, illness, and disabilities from substance abuse than from any other preventable health condition. Today, one in four deaths is attributable to alcohol, tobacco, and illicit drug use.[59] Some of the mortality factors considered for this Regional Needs Assessment include: suicide, overdose deaths, and drug/alcohol related fatalities.

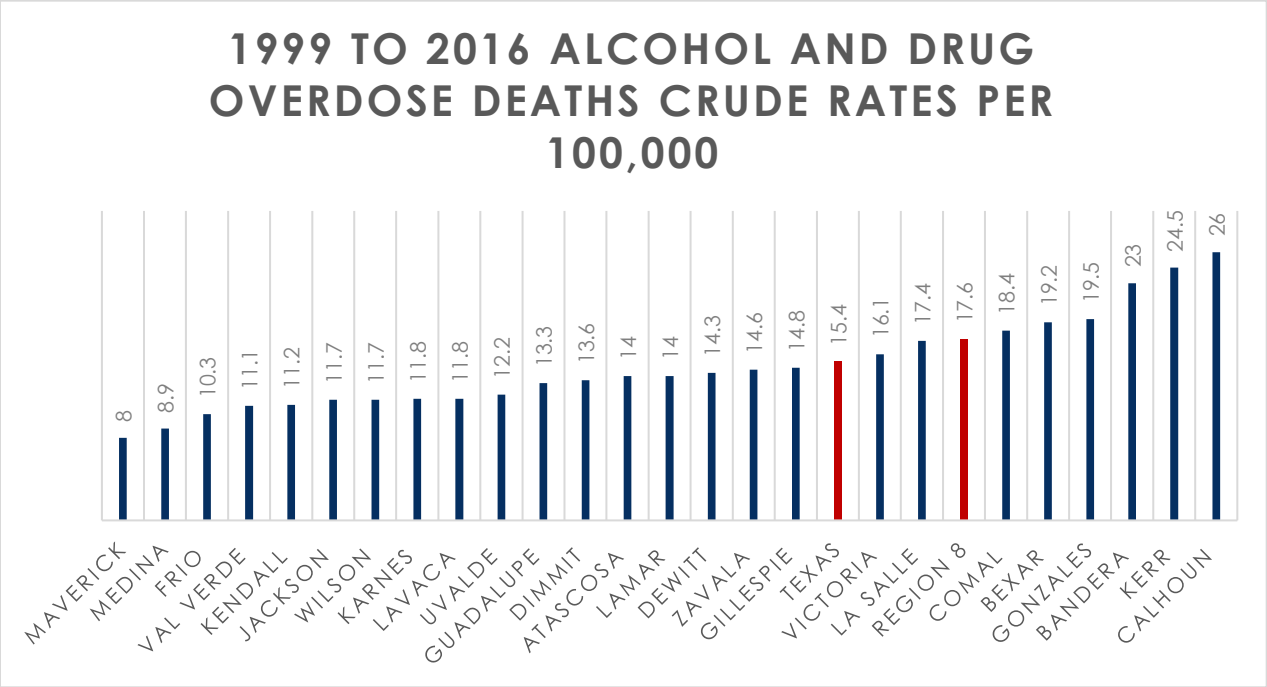
Overdose Deaths

The CDC reports in the United States, 63,632 drug overdose deaths occurred in 2016; 42,249 (66.4%) involved any opioid. From 2015 to 2016, deaths increased across all drug categories examined including 15,469 deaths involved heroin; 14,487 deaths involved natural and semi-synthetic opioids; 3,373 deaths involved methadone; and 19,413 deaths involved synthetic opioids other than methadone, a category which includes fentanyl. The sum of those numbers is greater than the total opioid involved deaths because, as noted by the CDC, "Deaths involving more than one opioid category (e.g., a death involving both methadone and a natural or semisynthetic opioid such as oxycodone) are counted in both categories."The largest overall rate increases occurred among deaths involving cocaine (52.4%) and synthetic opioids (100%), likely driven by illicitly manufactured fentanyl. Increases were observed across demographics, urbanization levels, and states and DC.

According to CDC Wonder there have been 8,007 deaths related to drug and alcohol in region 8 between 1999 and 2016. Twenty-nine percent of the counties in Region 8 have drug and alcohol death rates higher than Texas at 15.4 persons per 100,000 including Region 8 at 17.6 persons per 100,000. Four counties (Goliad, Real, Edwards and Kinney) were excluded due to having counts less than 10. Of the overdose deaths, 56% were drug related and 43% alcohol related. Appendix A, Table 29.

[58] Surgeon General.gov. https://addiction.surgeongeneral.gov/sidebar-many-consequences-alcohol-and-drug-misuse. Accessed July 27, 2018.
[59] NIH. Health Consequences of Drug Misuse. https://www.drugabuse.gov/publications/health-consequences-drug-misuse/death. Updated March 2017.

Diagram 95. 1999-2016 Alcohol and Drug Overdose Deaths



Source: CDC, National Center for Health Statistics

Drug and Alcohol Related Fatalities

In 2017, Texas reported that 1,024 people were killed in motor vehicle traffic crashes where a driver was under the influence of alcohol. This is 28% of the total number of people killed in motor vehicle traffic crashes across Texas. During 2017, more DUI - Alcohol crashes were reported in the hour between 2:00 am and 2:59 am than any other hour of the day. Also, more of these crashes occurred on Sunday than any other day of the week.[60] **Texas DUI fatalities increased 0.6% from 1,018 DUI fatalities in 2016 to 1,024 DUI fatalities in 2017.**

In 2017, Region 8 reported 89 people were killed in motor vehicle traffic crashes where a driver was under the influence of alcohol. This is 26% of the total number of people killed in motor vehicle traffic crashes**. Region 8 DUI fatalities decreased 19.1 percent from 110 DUI Fatalities in 2016 to 89 DUI fatalities in 2017.** County data available in Appendix A, tables 30-32.

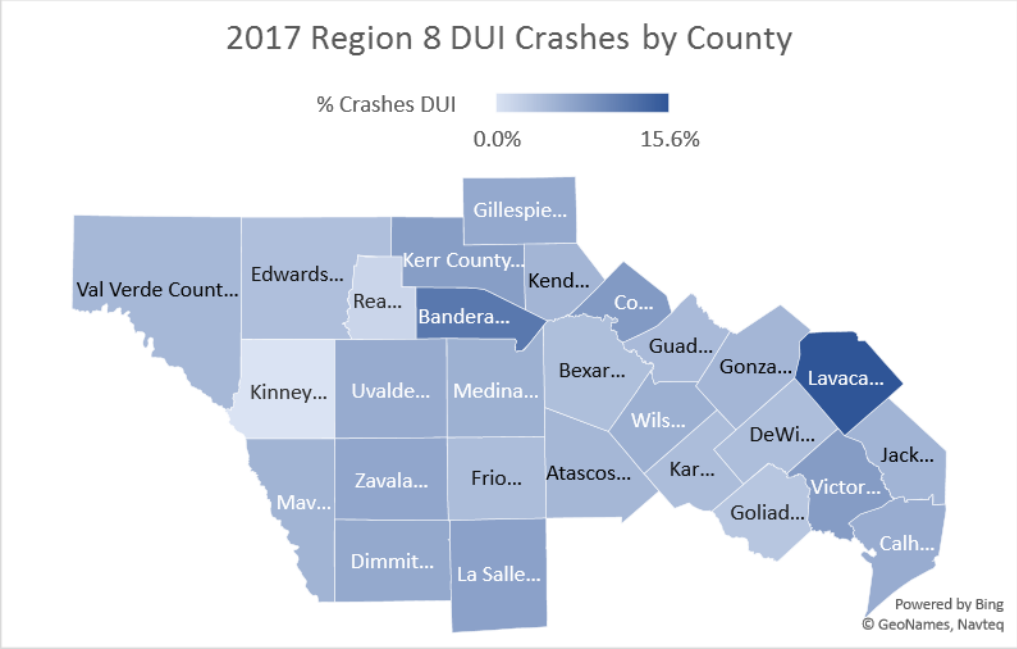
[60] Texas Department of Transportation. Texas Motor Vehicle Traffiic Crash Facts 2017. http://ftp.dot.state.tx.us/pub/txdot-info/trf/crash_statistics/2017/01.pdf. Accessed July 26, 2018

Diagram 96. 2016 to 2017 Change in DUI Fatalities

Area	2016 DUI Fatalities	2017 DUI Fatalities	Number Change from 2016 to 2017	Percent Change from 2016 to 2017
Texas	1,018	1,024	6	0.6%
Region 8	110	89	-21	-19.1%
Source: Texas Department of Transportation, Texas Peach Officer's Crash Reports (CR-3)				

Lavaca county reported the highest percentage of DUI crashes at 15.6 percent, compared to Region 8 at 4.5 percent and Texas at 4.4 percent.

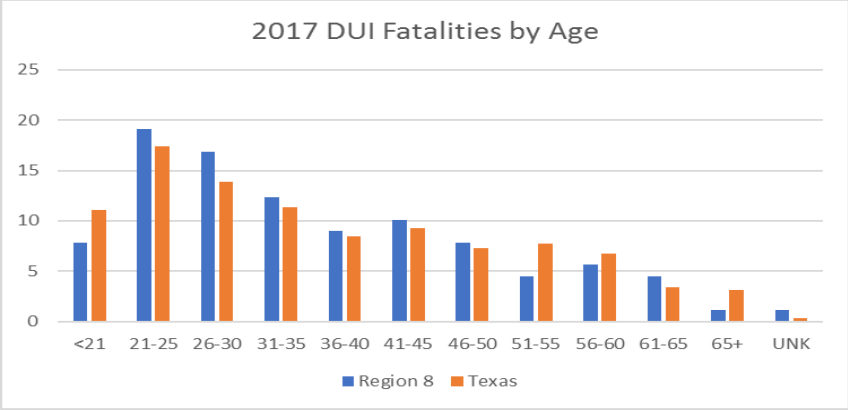
Diagram 97. 2017 Region 8 Percent of DUI Crashes



Source: Texas Department of Transportation, Texas Peace Officer's Crash Reports (CR-3)

Persons between the ages of 21 to 25 for Texas and Region 8 accounted for the highest percent of DUI fatalities.

Diagram 98. 2017 DUI Fatalities by Age



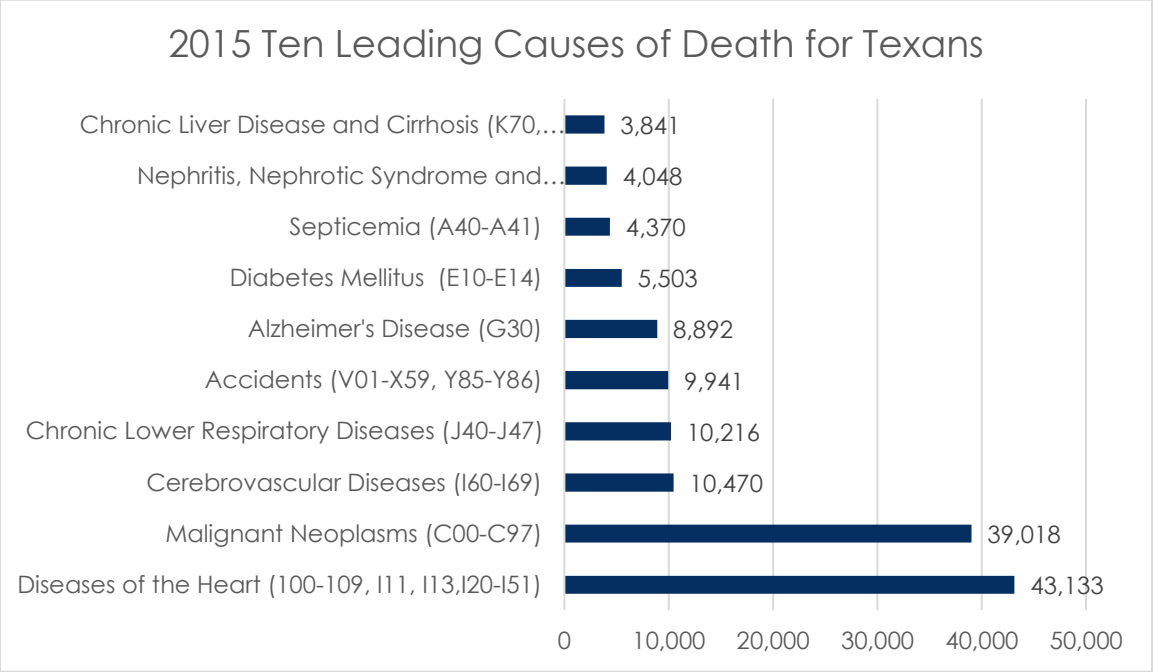
Source: Texas Department of Transportation, Texas Peace Officer's Crash Reports (CR-3).

Disease (Morbidity) Related to Substance Abuse

As previously discussed, the longer-term health effects on a person's physical and mental health from, heavy drinking can lead to hypertension, liver disease, and cancer; regular marijuana use is associated with chronic bronchitis; and use of stimulants such as cocaine can lead to heart disease. In addition, substance misuse during pregnancy can result in long lasting health effects for the baby including fetal alcohol spectrum disorders (FASDs).

Liver disease, heart disease and cancer are among the ten leading causes of death for Texas residents seen below.

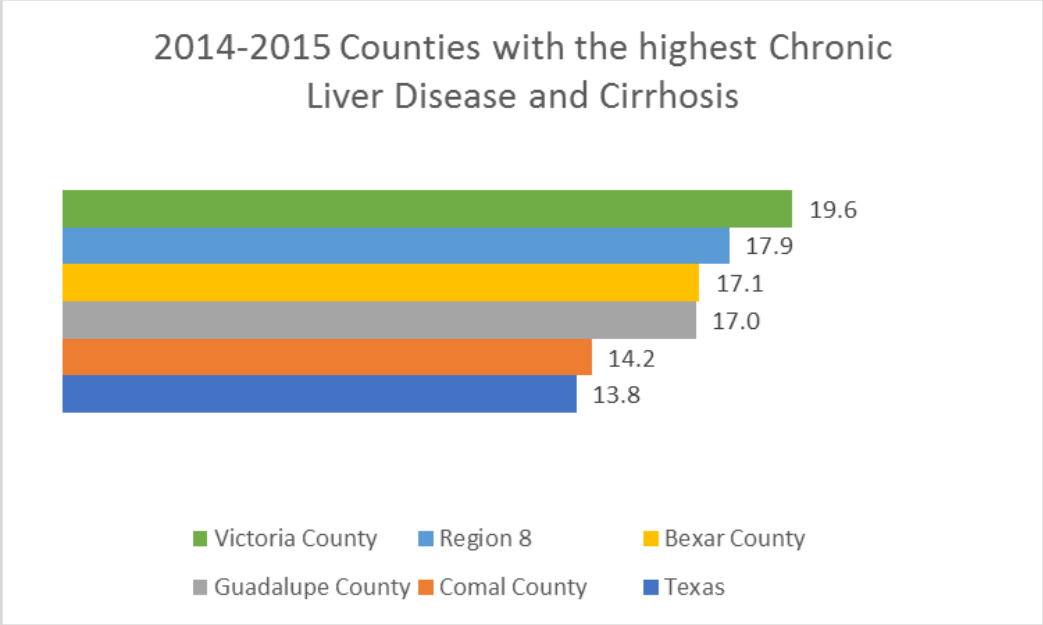
Diagram 99. Ten Leading Causes of Death for Texas Residents



Source: Texas Health Data, Center for Health Statistics

Region 8 and 4 counties have higher death crude rates for chronic liver disease and cirrhosis of the liver then Texas at 19.6 per 100,000 population. Victoria county has the highest death crude rate followed by Comal, Guadalupe, and Bexar as seen in the table below. County data is available in Appendix A, table 33.

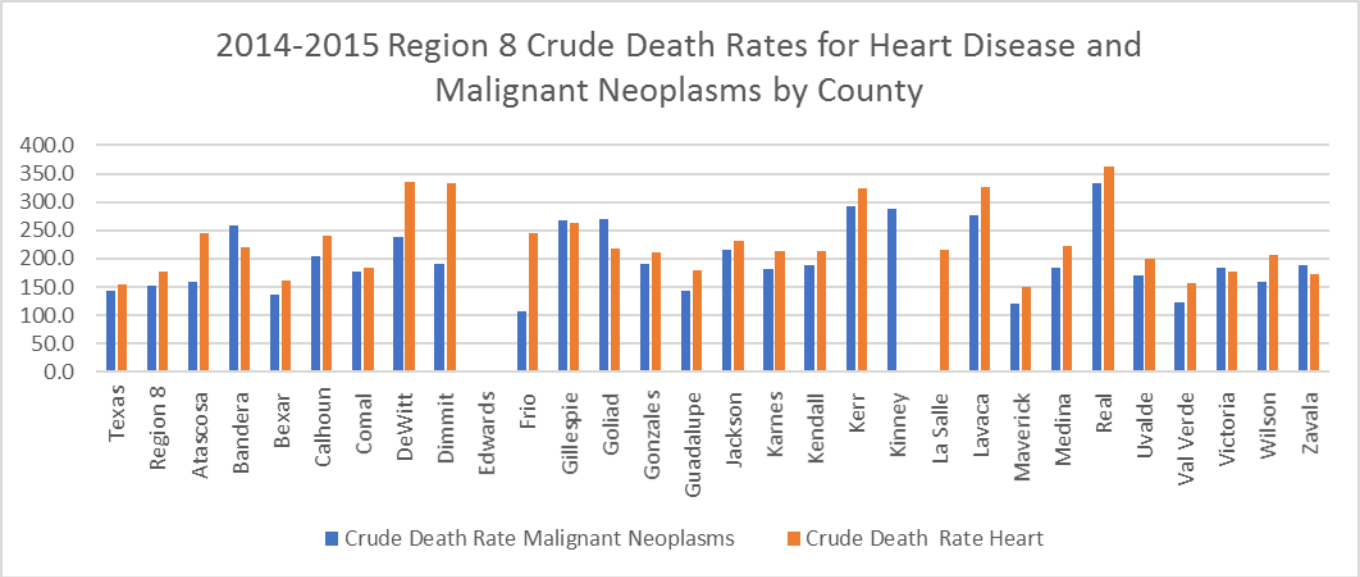
Diagram 100. 2014-2015 Region 8 Counties with the Highest Chronic Liver Disease and Cirrhosis



Source: Texas Health Data, Center for Health Statistics

Region 8 (152 per 100k) and 22 counties (78.6%) have higher malignant neoplasms crude death rates then Texas at 142.8 per 100,000 population. Twenty-five counties (89.3%) and Region 8 (177.6 per 100k) have higher crude death rates for heart disease then Texas at 155.1 deaths per 100,000.

Diagram 101. 2014-2015 Region 8 Crude Death Rates for Heart Disease and Malignant Neoplasms by County



Source: Texas Health Data, Center for Health Statistics

Legal Consequences

Substance abuse involving drugs, alcohol, or both has been associated with a range of destructive social conditions, including family disruptions, financial problems, lost productivity, failure in school, domestic violence, child abuse, and crime. In addition, both social attitudes and legal responses to the consumption of alcohol and illicit drugs make substance abuse one of the most complex public health issues.

The use of alcohol and drugs can negatively affect all aspects of a person's life, impact their family, friends and community, and place an enormous burden on American society. One of the most significant areas of risk with the use of alcohol and drugs is the connection between alcohol, drugs and crime.

Alcohol and drugs are implicated in an estimated 80% of offenses leading to incarceration in the United States such as domestic violence, driving while intoxicated, property offenses, drug offenses, and public-order offenses.

Our nation's prison population has exploded beyond capacity and most inmates are in prison, in large part, because of substance abuse:

- 80% of offenders abuse drugs or alcohol.
- Nearly 50% of jail and prison inmates are clinically addicted.
- **Approximately 60% of individuals arrested for most types of crimes test positive for illegal drugs at arrest.**

The relationship between drugs and crime is complex, and one question is whether drug use leads people into criminal activity or whether those who use drugs are already predisposed to such activity. Many illegal drug users commit no other kinds of crimes, and many persons who commit crimes never use illegal drugs. However, at the most intense levels of drug use, drugs and crime are directly and highly correlated and serious drug use can amplify and perpetuate preexisting criminal activity.

There are essentially three types of crimes related to drugs:

- Use-Related crime: These are crimes that result from or involve individuals who ingest drugs, and who commit crimes as a result of the effect the drug has on their thought processes and behavior.
- Economic-Related crime: These are crimes where an individual commits a crime in order to fund a drug habit. These include theft and prostitution.
- System-Related crime: These are crimes that result from the structure of the drug system. They include production, manufacture, transportation, and sale of drugs, as well as violence related to the production or sale of drugs, such as a turf war.

Those with a drug use dependency are more likely to be arrested for acquisitive crimes such as burglary or shop theft, or for robbery and handling stolen goods -- crimes often related to "feeding the habit." For example, in 2004, 17% of state prisoners and 18% of federal inmates said they committed their current offense to obtain money for drugs. There are also close links between drug use and women, men and children who are involved in, or exploited by, the sex trade, many of whom are caught up in the criminal justice system. However, there is evidence that drug use is both a pre-determining factor in such sexual exploitation and a means of coping with it.

Driving Under the Influence

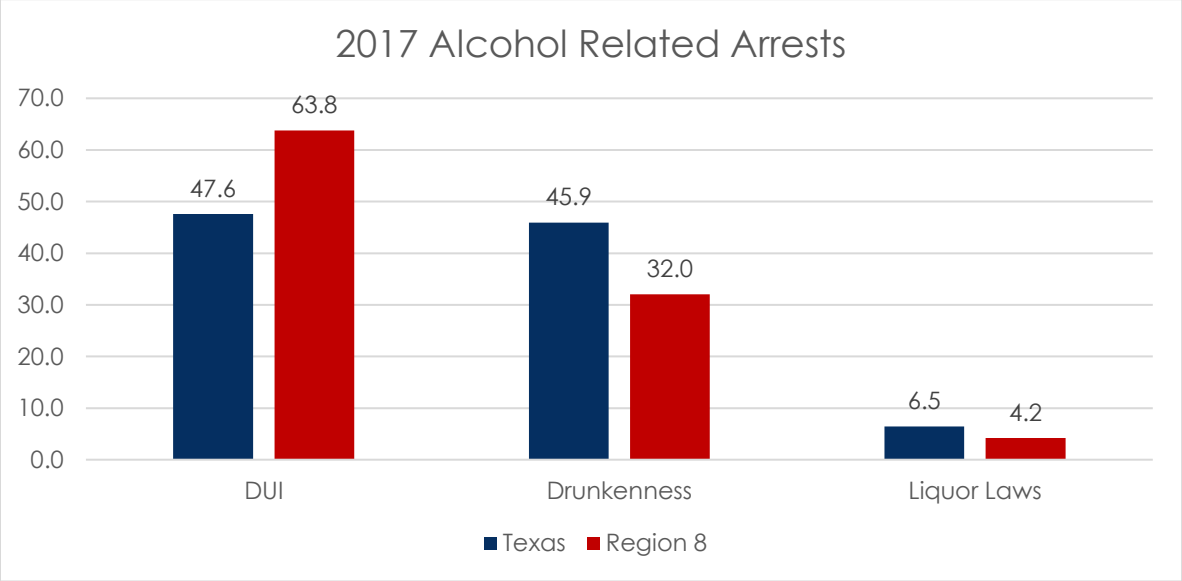
According to the 2017 Texas Department of Public Safety, 147,460 persons were arrested for alcohol related crimes including DUIs, Drunkenness and Liquor Laws. Region 8 had 15,308 alcohol related arrests, including 63.8 percent for DUIs, 32 percent for Drunkenness, and 4.2 percent for Liquor Laws. See Appendix A for county data, table 34.

Diagram 102a. 2017 Alcohol Related Arrests

2017 Alcohol Related Arrests					
2017	Juvenile	Adult	Total	% Juvenile	% Adult
Texas Alcohol Related Arrests	912	146,548	147,460	0.6	99.4
Texas DUI	136	70,066	70,202	0.2	99.8
Texas Drunkenness	201	67,521	67,722	0.3	99.7
Texas Liquor Laws	575	8,961	9,536	6.0	94.0
	Juvenile	Adult	Total	% Juvenile	% Adult
Region 8 Alcohol Related Arrests	36	15,272	15,308	0.2	99.8
Region 8 DUI	3	9,762	9,765	0.03	99.96
Region Drunkenness	7	4,893	4,900	0.1	99.9
Region 8 Liquor Laws	26	617	643	4.0	96.0
Source: Texas Department of Public Safety, 2017, updated 10/8/2018					

Region 8 arrests for Driving Under the Influence (DUI)at 63.8 percent were significantly higher then Texas at 47.6 percent, and Texas arrests for Drunkenness at 45.9 percent was significantly higher then Region 8 at 32 percent.

Diagram 102b. 2017 Alcohol Related Arrests



Source: Texas Department of Public Safety, 2017, updated 10/8/2018

Region 8 alcohol related arrests increased 4.8 percent from 14,600 in 2016 to 15,308 in 2017.

Diagram 103. 2016 to 2017 Region 8 Alcohol Related Arrests Percent

2016 to 2017 Region 8 Alcohol Related Arrests Percent Change					
Arrests Region 8	Juvenile	Adult	Total	2016 to 2017 Number Change	2016 to 2017 Percent Change
2016 Alcohol Related Arrests	36	14,564	14,600		
2017 Alcohol Related Arrests	36	15,272	15,308	708	4.8%
Source: Texas Department of Public Safety, 2016, 2017, updated 10/8/2018					

Economic Impacts

Substance misuse and substance use disorders cost the U.S. more than $442 billion annually in crime, health care, and lost productivity.

- These costs are almost twice as high as the costs associated with diabetes, which is estimated to cost the United States $245 billion each year.
- Alcohol misuse and alcohol use disorders cost the United States Approximately $249 billion in lost productivity, health care expenses, law enforcement, and other criminal justice costs.
- The costs associated with misuse of illegal drugs and non-prescribed medications and drug use disorders were estimated to be more than $193 billion in 2007.[61]

Underage Drinking/Drug Use

In 2013, underage drinking cost the citizens of Texas $5.5 billion. These costs include medical care, work loss, and pain and suffering associated with the multiple problems resulting from the use of alcohol by youth. This translates to $2,075 per year for each youth in the state or $3.50 per drink consumed underage. Excluding pain and suffering from these costs, tangible costs of underage drinking including medical care, criminal justice, property damage, and loss of work in Texas totaled $1.78 billion each year or $1.14 per drink. In contrast, a drink in Texas retails for $0.78.[62]

Environmental Protective Factors

The Substance Abuse and Mental Health Services Administration defines protective factors as those characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's impact. Protective factors may be seen as positive countering events.[63]

[61] U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC: HHS, November 2016.
[62] Pacific Institute for Research and Evaluation (PIRE). Underage Drinking in Texas, Office of Juvenile Justice and Delinquency Prevention (OJJDP), March 2015.
[63] SAMHSA. Risk and Protective Factors. https://www.samhsa.gov/capt/practicing-effective-prevention/prevention-behavioral-health/risk-protective-factors. July 6, 2018. Accessed July 28, 2018.

Overview of Protective Factors

A NIDA-funded study has identified a number of protective factors that can help prevent high-risk youths from engaging in delinquency and drug use. An accumulation of these protective factors in different areas of an adolescent's life strongly predicts resistance to drug use and delinquency stated NIDA, on their publication, Protective Factors Can Buffer High-Risk Youths from Drug Use.

Protective Factors

Family Factors	**Parental Supervision** **Child's Attachment to Parent** **Parent's Attachment to Child** Parent's Involvement in Child's Activities
Educational Factors	**Reading Percentile** **Mathematics Percentile** **Commitment to School** **Attachment to Teachers** Aspirations to Go to College Expectations to Go to College **Parent's Expectation for Child to Go to College** **Parent's Values About College**
Peer Factors	**Peers Have Conventional Values** **Parent's Positive Evaluation of Peers**
Other Resources	Child's Self Esteem Child's Involvement in Religious Activities Child's Involvement in Prosocial Activities Child Is Close to an Adult Outside the Family

Source: National Institute on Drug Abuse (NIDA), Protective Factors Can Buffer High-Risk Youths from Drug Use, 1996

The protective factors in bold consistently distinguished high-risk youths who remained drug free from high-risk youths who used drugs. The factors that are not bold did not have an impact on drug use among the high-risk youths in the study.

The most important finding in this article is that it is the accumulation of protective factors in school, family, and peer environments that has a positive effect on drug use over the longer term.

SAMHSA asserts that substance use is a complex problem that develops in response to multiple influences. These spheres of influences of activity, usually are called domains and include the individual, family, peers, school, community, and society/environment. Characteristics and conditions that exist within each domain of influence also work as risk or protective factors that help propel individuals to or safeguard them from substance abuse.

Community Domain

Specific community-based programs, such as prevention programs and community coalitions, offer drug overdose and underage drinking and driving prevention services to persons who use drugs, their families, and service providers (e.g., healthcare providers, homeless shelters, and substance abuse treatment programs). These services include education regarding overdose risk factors, recognition of signs of opioid and other drugs overdose, appropriate responses to an overdose, among other drug use consequences.

Principles of Effective Substance Abuse Prevention:

SAMHSA provided a listing of the scientifically defensible principles that can help service providers design and implement programs that work.

- Develop integrated, comprehensive prevention strategies rather than one-time community-based events.
- Control the environment around schools and other areas where youth gather.
- Provide structured time with adults through mentoring.
- Increase positive attitudes through community service.
- Achieve greater results with highly involved mentors.
- Emphasize the costs to employers of workers' substance use and abuse.
- Communicate a clear company policy on substance abuse.
- Include representatives from every organization that plays a role in fulfilling coalition objectives.
- Retain active coalition members by providing meaningful rewards.
- Define specific goals and assign specific responsibility for their achievement to subcommittees and task forces.
- Ensure planning and clear understanding for coalition effectiveness.
- Set outcome-based objectives.
- Support a large number of prevention activities.
- Organize at the neighborhood level.
- Assess progress from an outcome-based perspective and make adjustments to the plan of action to meet goals.
- Involve paid coalition staff as resource providers and facilitators rather than as direct community organizers.

In Region 8, there are the following prevention coalitions funded by HHSC: Circles of San Antonio Community Coalition (COSA), Bethel Prevention, Maverick County Coalition against Drugs, Texans Standing Tall, Karnes County Community Coalition, Caring Community Coalition (Comal County), and Texans Standing Tall Coalition that provide educational and prevention resources to the communities across the counties in the region.

Community Coalitions

Community coalitions promote a drug free environment by bringing communities together through collaborative efforts, such as substance use trends presentations, community health fairs, town hall meetings, creation of local ordinances that address specific drug use issues, and outreach activities that

promote healthy lifestyles. The coalitions address community concerns regarding the prevention and reduction of the illegal and harmful use of alcohol, tobacco, and other drugs in the target counties across Texas. The primary emphasis is the reduction in youth and young adult use by promoting and conducting community-based and environmental strategies. The Texas Health and Human Services Commission (HHSC)) requires all contractors to implement the Strategic Prevention Framework (SPF) model for evidence-based practices within community coalitions.

Furthermore, the coalitions in Region 8 have an enormous impact in the community as it is through their assiduous effort that state and local representatives are able to create and approve ordinances and policies that contribute to preventing minors from falling into drug addiction.

Environmental Changes

Although the PRC Region 8 does not work strategically on environmental changes, the information and data from the Regional Needs Assessment will be instrumental for coalitions and organizations that do. As defined by the Substance Abuse Mental Health Services Administration (SAMSHA), environmental changes target a broad audience and have the potential to produce widespread changes in behavior at the population level. When implemented effectively, they can create shifts in both individual attitudes and community norms that can have long-term, substantial effect. Through data request, the PRC Region 8 will be able to see which coalitions and organizations are requesting data, the type of data they are collecting and which communities within the region they are working with. In following up with these coalitions and organizations reports and needs assessments, the PRC Region 8 will anticipate seeing environmental changes.

Regional Coalitions

Aside from having the support of organizations and agencies throughout the region, PRC Region 8 also collaborates actively with community coalitions that focus on providing prevention services related to underage drinking, tobacco use, illicit drug use, as well as recreational use of prescription medications among youth. These coalitions mobilize their communities to address the needs of the population in the region and provide evidence-based program services that aim to reduce the incidence of substance abuse among youth and adults.

The Prevention Resource Center in Region 8 has a strong partnership with the following community coalitions:

- Circles of San Antonio (COSA) Community Coalition – creates change through collaboration with community stakeholders to educate and motivate individuals, families, organizations and institutions with the goal of preventing and reducing alcohol and substance abuse. COSA is the only community coalition program (CCP) funded through the Texas Department of State Health Services for Region 8.

Treatment/Intervention Providers

Prevention programs address all forms of drug abuse, alone or in combination, including the underage use of legal drugs (e.g., tobacco or alcohol); the use of illegal drugs (e.g., marijuana or heroin); and the inappropriate use of legally obtained substances (e.g., inhalants), prescription medications, or over-the-

counter drugs. These programs are tailored to address risks specific to population or audience characteristics, such as age, gender, and ethnicity, to improve program effectiveness.

Outreach, Screening, Assessment and Referral Centers (OSARs) are the first point of contact for those seeking substance abuse treatment services. Regardless of ability to pay, Texas residents who are seeking substance abuse services and information may qualify for services based on need.

Region 8 HHSC Substance Abuse Services Funded Prevention and Intervention Programs:

- CONNECTIONS INDIVIDUAL AND FAMILY SERVICES INC - a non-profit organization that provides a safe and secure alternative to the "streets" for homeless, abused, or at-risk youth. The organization provides program services, counseling and prevention education services for youth, adults, and families, as well as short-term residential services for runaway, abused or neglected, homeless, and at-risk youth. Serves Atascosa, Comal, Frio, Goliad, Gonzales, Guadalupe, Karnes, and Wilson Counties. P.O. Box 311268, New Braunfels, TX 78131, (830) 629-6571.

- Serving Children and Adults in Need (SCAN) – aims to foster the healthy development of individuals and families through empowerment opportunities that are effective, culturally responsive, trauma-informed and community-centered. This organization provides prevention services to youth and adult populations. Serves Dimmitt, Edwards, Frio, Kinney, LaSalle, Maverick, Real, Uvalde, Val Verde and Zavala Counties.

- San Antonio Council on Alcohol and Drug Awarness (SACADA) is a nonprofit organization that provides education, youth prevention programs, information resources and services to prevent alcohol and drug abuse. We serve nearly 60,000 people in Bexar County and 28 surrounding counties in South Central Texas. Serves Atascosa, Bandera, Bexar, Calhoun, Comal, Dewitt, Dimmit, Edwards, Frio, Gillespie, Goliad, Gonzales, Guadalupe, Jackson, Karnes, Kendall, Kerr, Kinney, LaSalle, Lavaca, Maverick, Medina, Real, Uvalde, Val Verde, Victoria, Wilson and Zavala Counties. 9700 US Hwy 90 West, Dave Coy Bldg, Suite 201, San Antonio, TX 78227, 210-225-4741.

- Alpha Home, Inc., - is a non-profit treatment center providing gender-specific services to chemically dependent women and men. Addiction is three-fold—body, mind, and spirit. At Alpha Home, we treat all three, not just the physical addiction but the complete person. Alpha Home is accredited by CARF and the Better Business Bureau and is proud to be a United Way of San Antonio and Bexar County agency. Serves Bexar, Comal, Guadalupe, and Medina Counties.

- Center for Health Care Services, The Bexar Co. MHMR Center - Provides assessment and intervention services 24 hours for individuals experiencing psychiatric emergency. Services include face-to-face screening /assessment; linkage/referral/ outreach; 23 hour outpatient observation; mental health warrant applications. Serves Bexar County. 601 N. Frio, San Antonio, TX 78207, 210) 225-5481.

- Family Violence Association of San Antonio, (FVPS) has been helping victims of domestic violence in San Antonio since 1977. FVPS began as an emergency shelter for women and children and we now offer a complete array of shelter, transitional housing, counseling, children's, and legal services to help individuals and families recover from the pain and long-term effects of domestic violence. Contact our Crisis Hotline: (210) 733-8810, 24 Hours a Day, 365 Days a Year. Serves Bexar County.

- Family Service Association of San Antonio, Inc., - has been building strong families since 1903. It is the oldest human service agency in San Antonio dedicated to helping children, seniors, and families in need. From five neighborhood locations and from more than 56 school campuses, Family Service provides high quality service in English and Spanish to the residents of 28 counties of all ethnic and racial backgrounds and all socio-economic levels. Family Service is a private, non-profit, non-sectarian agency funded by the United Way, United States Department of Health and Human Services, fee-for-service contracts with both public and private organizations, foundation and corporate grants, private contributions, client fees, and outpatient mental health insurance. Fees are charged on a sliding scale, and no one is denied help because of their inability to pay the full cost of service. Serves Atascosa, Bandera, Bexar, Calhoun, Comal, Dewitt, Dimmit, Edwards, Frio, Gillespie, Goliad, Gonzales, Guadalupe, Jackson, Karnes, Kendall, Kerr, Kinney, LaSalle, Lavaca, Maverick, Medina, Real, Uvalde, Val Verde, Victoria, Wilson and Zavala Counties.

  • Joven – Juvenile Outreach and Vocational Educational - is a 501(c)3 nonprofit based in San Antonio, which provides life skills education to youth who may be at risk due to poverty, an incarcerated parent, sibling gang involvement, single parent homes, or poor community environment. Joven provides After-school, Summer Camp, Prevention curriculum, and Dance. Located at 102 W. White San Antonio, TX. Serves Bexar County.

  • South Texas Rural Health Services Inc., - This clinic was founded in 1975 and began providing health services in 1976 to the people of LaSalle, Dimmitt, and Frio counties. This service area has been designated as a Medically Underserved Area and as a Health Professional Shortage Area. The clinic maintains five program/service delivery sites and provides services such as laboratory, pharmacy, radiology, dental, family planning, HIV/AIDS testing and counseling, health education, nutrition counseling, substance abuse counseling, and transportation assistance. 1-800-788-6950. Serves Dimmitt, Frio, LaSalle, Maverick, Medina, Real, Uvalde, and Zavala Counties.

- Karnes/Wilson Juvenile Board – Provides prevention and intervention programs, 115 N. Market, Karnes City, TX 78118, (830) 780-2228. Serves Atascosa, Frio, Karnes, LaSalle and Wilson Counties.

Local Social Services

Throughout Region 8, there are many programs that service and reach out to the diverse communities in the area including:

- The San Antonio Council on Alcohol and Drug Awarness (SACADA) is a nonprofit organization that provides education, youth prevention programs, information resources and services to prevent alcohol and drug abuse to youth and adults in Bexar County and the 28 surrounding counties of Region 8. The SACADA youth prevention programs are targeted to youth in Bexar County, providing evidence-based, age-appropriate curriculum, to elementary, middle and high school youth. The youth prevention programs also provide prevention service to youth and adults though presentations on alcohol, tobacco and other drugs and information on living healthy lifestyles.

- Center for Health Care Services– focuses on improving the lives of people with mental health disorders, substance abuse challenges and developmental disabilities. Primary service area includes the 28 counties of Region 8.

- Connections Individual and Family Services - focuses on providing a safe and secure alternative to the "streets" for homeless, abused, or at-risk youth. Connections Individual and Family Services provides program services in 18 rural counties and operates thirteen 13 counseling offices and three 3 residential locations. Connections services are available to the following counties: Aransas, Atascosa, Bastrop, Bee, Caldwell, Comal, Frio, Goliad, Gonzales, Guadalupe, Karnes, Lee, Live Oak, McMullen, Refugio, San Patricio, Wilson, and Zavala.

- Family Service Association – is a private, non-profit, non-sectarian agency funded by the United Way, United States Department of Health and Human Services, fee-for-service contracts with both public and private organizations, foundation and corporate grants, private contributions, client fees, and outpatient mental health insurance. Prevention services include providing prevention education and Families and Schools Together (FAST). FAST services 7 elementary schools, 2 middle schools and 4 Head Start centers in Bexar County, as well as families and 9 schools in Uvalde and Zavala Counties. In a collaborative effort among schools, Family Service Association and families, FAST focuses on children at risk for school failure, juvenile delinquency and substance abuse in adolescence.

- Family Violence Prevention Services – focuses on breaking the cycle of violence to strengthen families, by providing the necessary tools for self-sufficiency through the delivery of emergency shelter, transitional housing, education, effective parenting education, and early intervention with children and youth. Primary service area for prevention includes Bexar County.

- Karnes/Wilson Juvenile Board- focuses on providing evidence-based, age-appropriate curriculum, to elementary, middle and high school youth. Primary service area includes Karnes, Wilson, Atascosa, Frio, LaSalle counties.

- JOVEN-Juvenile Outreach and Vocational Educational – focuses on developing character and resiliency in children by providing them with innovative and exciting programs, as well as structured alternative activities that are designed to help them to succeed. JOVEN provides in-

school programming in 8 school districts in the surrounding areas of Bexar, Guadalupe and Comal County.

- South Texas Rural Health – focuses on providing health services to the people of LaSalle, Dimmitt, and Frio counties. This service area has been designated as a Medically Underserved Area and as a Health Professional Shortage Area. The clinic maintains five program/service delivery sites and provides services such as laboratory, pharmacy, radiology, dental, family planning, HIV/AIDS testing and counseling, health education, nutrition counseling, substance abuse counseling, and transportation assistance

- Servicing Children and Families in Need (SCAN), Inc. – focuses on fostering the healthy development of individuals and families through empowerment opportunities that are effective, culturally-responsive, trauma-informed and community-centered. Provides services to the following Region 8 counties including: Dimmit, Frio, LaSalle, Maverick, Real, Uvalde, and Zavala.

Law Enforcement Capacity and Support

The San Antonio Police Department has embraced Community Policing for many decades, through its Community Services and School Services Programs, Crime Prevention Programs (Neighborhood Watch, National Night Out), Store Fronts, Decentralized Patrol Substations, and the Downtown Foot and Bicycle Patrol Unit. In 1995 the Department created a special Community Policing Unit, the San Antonio Fear Free Environment Unit (SAFFE) which links closely with community involvement programs, such as Cellular on Patrol (initiated in 1993) and the Citizen Police Academy (initiated 1994).

Southwest Texas Fusion Center (SWTFC)

The Southwest Texas Fusion Center (SWTFC) was recognized by the State of Texas and the Department of Homeland Security (DHS) as a Level 2 Major Urban Area Fusion Center in November 2011. A Fusion Center is a collaborative effort of two or more agencies that provide resources, expertise, and information to the center with the goal of maximizing their ability to detect, prevent, investigate and respond to criminal and terrorist activity. The mission of the SWTFC is to serve as an all threat/all hazard center for information/intelligence sharing and public safety through a process of collaboration with other regional and national partners, which is balanced and guided by the need and responsibility to preserve the rights and privacy of the citizens we protect. The SWTFC is managed by the San Antonio Police Department (SAPD) and operates under the guidance of an advisory board that includes representatives from public and private partners throughout the southwest Texas region.

The San Antonio Regional Intelligence Center (SARIC) provides intelligence for officers of the SAPD and its regional partners. This has been accomplished by means of strengthening intelligence sharing methods and receiving support from local, state and federal law enforcement as SARIC continues to support the efforts of the Southwest Texas Fusion Center.

Bexar County Sheriff's Office

After years of planning and implementation, the Bexar County Sheriff's Office, Bexar County Fire Marshal, Bexar County Constables, and several municipal police departments supported by Bexar County, went live on a new public safety command and control system in August 2010. The new system

was developed through a regional partnership including Bexar County, Bexar Metro 911, City of San Antonio and City of Schertz to improve the flow of information between the participating communication centers and field personnel.

A critical component of the new system included TriTech's Inform Mobile data solution which provides an automated and accelerated flow of data, including locations, incident information, and historical information directly to resources in the field. With immediate access to comprehensive data and extensive messaging capabilities, Inform Mobile serves as a seamless extension of Inform computer aided dispatch (CAD). With real-time information, field personnel are empowered to make quick, informed decisions.

Agencies Served:

- 16 Law Enforcement Agencies:
    - o Bexar County Sheriff's Office
    - o Constable Pct. 1
    - o Constable Pct. 2
    - o Constable Pct. 3
    - o Constable Pct. 4
    - o Fire Marshal's Office
    - o China Grove PD
    - o Elmendorf PD
    - o Hill Country Village PD
    - o Hollywood Park PD
    - o Somerset PD
    - o Von Ormy City Marshal
    - o East Central ISD PD
    - o Judson ISD PD
    - o Southside ISD PD
    - o Texas A&M University PD

Healthy Youth Activites

Many alternative activities have been identified as health activities for youth to participate in to curb illicit drug use and alcohol consumption. Below are some of the identified youth activities and services that can be found in Region 8.

Youth participation in sport and other organized physical activity can very easily be considered a double-edged sword in reference to substance abuse and prevention. Evidence suggests that youth participation in prosocial activities such as sport and exercise can build positive social relationships, self-confidence, and life skills (CCSA); all of which are considered protective factors against substance abuse. However, it has also been noted that sport participation has been found to be associated with increases in alcohol consumption and/or steroid use. Keeping in mind that these activities help to build self-confidence and self-esteem, their inherent value should not be negated. To support this, it has been shown that experiential challenge programs are highly effective in building these characteristics and have been implemented for prevention purposes through the following forms (NIDA; HSR):

- Experiential Wilderness Programs
- Ropes Courses

- Recreation & Sport Programs

Entities in Region 8 that provide services that actively engage youth populations in physical activity and sports are the YMCA/YWCA and the Boys & Girls Club of America. These organizations provide afterschool programming for youth (children & teens) to participate in physical activity and social bonding.

Work Force Training

Allowing youth to engage in workforce aptitude testing and training early can help to provide them with a sense of self-efficacy and confidence in their development trajectory. In Region 8, Gary Job Corps offers hands-on career training and education for youth ages 16-24. These programs offer zero-tolerance for substance abuse and violence, creating an environment that is indicative of substantial learning and growth.

Religion and Prevention

Engagement in prosocial activities and involvement religious activities has been determined by the National Institute on Drug Abuse (1996) as a protective factor against substance abuse and other behavioral issues in youth. Churches and religious entities are paramount to the success of communities and often provide services in the form of support groups and facility space for prevention and recovery programs. In Region 8, the Methodist Health Care Ministries offer a range of in-patient and day treatment programs for persons with mental health and chemical dependency concerns. In addition to this, some churches host 12-step programs, alcohol-anonymous, and chemical dependence support.

School Domain

The risk factors associated with the school domain include lack of commitment to education, poor grades or school failure, lack of attachment to school, negative school climate, and lenient school policies with regard to the use of some substances, as stated by SAMHSA.

Principles of Effective Substance Abuse Prevention:

SAMHSA provided a listing of the scientifically defensible principles that can help service providers design and implement programs that work.

- Avoid relying solely on knowledge-oriented interventions designed to supply information about negative consequences.
- Correct misconceptions about the prevalence of use in conjunction with other educational approaches.
- Involve youth in peer-led interventions or interventions with peer-led components.
- Give students opportunities to practice newly acquired skills through interactive approaches. Help youth retain skills through booster sessions.
- Involve parents in school-based approaches.
- Communicate a commitment to substance abuse prevention in school policies.

SAMHSA also argues that school climate is another factor contributing to the lack of attachment to school. Together, teachers' instructional methods, classroom management techniques, class size, student-teacher ratios, classroom organization, and educators' attitudes toward students affect the climate in a particular school.

YP Programs

The Youth Prevention (YP) programs consist of using age-appropriate, evidence-based curriculum to educate youth on the negative health consequences of alcohol tobacco and other drugs. These curriculums are incorporate life skills which, coupled with drug education, can build resiliency in youth. The prevention programs are broken down in to three sub-categories: Universal, Selected and Indicated.

- Universal prevention (YPU) reaches the general population, without regard to individual risk factors, and are generally designed to reach a very large audience or population, such as a community, school, or neighborhood. Participants are not recruited to participate in the activities and the degree of individual substance abuse.

- Selective prevention (YPS) activities promote a proactive process to address health and wellness for individuals, families, and communities by enhancing protective factors and by averting and precluding negative factors that place individuals at risk for substance abuse. Selective prevention activities target subgroups of the general population that are determined to be at risk for substance abuse.

- Indicated prevention (YPI) approaches are used for individuals who are experiencing early signs of substance use and other related problem behaviors associated with substance use. The individuals may or may not be abusing substances, but exhibit risk factors such as school failure, interpersonal social problems, delinquency, or other antisocial behaviors, or psychological problems, such as depression or suicidal behaviors that increase their chances of developing a drug abuse problem.

Region 8 has 7-substance abuse prevention providers as funded by Texas Health and Human Services Commission (HHSC). The service area each organization covers, age-group targeted, and prevention sub-category taught is all directed by the grants.

Students Receiving AOD Education in School

In 2016, the Region 7&8, TSS reported 66 precent of the students surveyed had received information on drugs or alcohol since school began. This was an increase from 62 percent reported in 2014. Most information was received during a school assembly (41.9%) or during Health class (39.8%).

The Center for Substance Abuse Prevention (CSAP) identifies prevention education as one of the six CSAP Prevention Strategies and defines prevention education as a two-way communication and is distinguished from merely disseminating information by the fact that it is based on an interaction between the educator and the participants. The activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills and critical analysis (e.g. of media messages). Students receiving alcohol and other drug (AOD) education in school vary from district to district. There are a number of districts who provide AOD education through the health education classes, and others who collaborate with community organizations to bring in presentations and curriculum.

The following organizations are prevention providers who are funded by HHSC to provide prevention education in Region 8:

- The San Antonio Council on Alcohol and Drug Awareness (SACADA)
- Connections Individual and Family Services
- Family Service Association
- Family Violence Prevention Services
- Karnes/Wilson Juvenile Board
- Mid-Coast Family Services
- JOVEN-Juvenile Outreach and Vocational

Sober Schools

High schools specifically designed for students recovering from a substance use disorder (substance abuse or dependence) have been emerging as a continuing care resource since 1987. According to the Association of Recovery Schools (ARS), this continuing care model has slowly grown since that time to include 31 high schools in 10 states. Texas has 8 Recovery high Schools

The recovery high schools conduct an Annual Recovery School Survey which was last administered in the spring of 2015. Nineteen recovery schools participated in the survey.

- 26 percent were classified as Charter schools, 37 percent Alternative, 16 percent Private and 21 percent Other.
- Average student enrollment at a Recovery high school, 24 males and 19 females.
- Range of students enrolled 2 – 115.
- Average student enrollment is 32.
- Average GPA 2.75 compared to National GPA 3.0.
- Students average 2 treatment episodes prior to Recovery school admittance.[64]

Alternative Peer Group

The Alternative Peer Group (APG) model encompasses the necessary ingredients for successful treatment of adolescents struggling with substance abuse or drug addictions. This model was created in Houston, Texas about forty years ago. Alternative Peer Groups were created to address the emotional, psychological, spiritual and social needs of teens struggling with substance abuse.

The APG model integrates important peer connections with clinical practice through intervention, support, education, and parent involvement. The foundation of this model is the basic assumption that peer relationships, much like the ones that initiate and support drug and alcohol use, are necessary to facilitate recovery. The ultimate goal is to remove the teen from a negatively pressured environment and offer them a new group of friends that exert positive peer pressure and provide support for the necessary changes they need to make in order to recover.

[64] Association of Recovery Schools. (2016). The State of Recovery High Schools, 2016 Biennial Report. Denton, TX. Retrieved from www.recoveryschools.org. Accessed July 29, 2018

Dr. Scott Basinger of Baylor College of Medicine has been studying the outcomes of alternative peer groups and recently presented his data at the Teens and High-Risk Symposium. He compared the national rates of teen relapse to the rates of teens enrolled in local APGs. The national relapse rate for teens in recovery is between 50-90%. In Houston, for those adolescents participating in APGs between January 2007 and 2010, the relapse rates were between 8%-11%. Overall, since APGs have been in existence, they have a recovery rate greater than 85% versus a nationwide recovery rate of around 30% according to the research gathered in Journal of Groups in Addiction & Recovery, Alternative Peer Group: A Model for Youth Recovery, 2014.

Just like Sober Schools, the Alternative Peer Groups, are currently not available here in Region 8; this can be seen as a gap within our region.

High School to College and Academic Achievement

In Academic Year 2013 to 2014, 303,109 Texas Public High School Graduates enrolled in Texas Higher Education during academic year 2014-2015. Region 8 accounted for 10.4 percent or 31,379 of those students. Forty-two percent of Region 8 students chose to attend a college or university out of state. See Appendix A, Table 35 for county data.

Diagram 105. 2013-2014 Graduates Enrolled in Higher Education during 2014-2015 Academic Year

Area	4 Year	2 Year	Not Trackable	Not in Texas	Total
Texas	26.1	31.4	5.2	37.3	303,109
Region 8	25.5	29.5	2.4	42.4	31,379

Family Domain

Parental/Social Support

Family domain risk factors include parental and sibling drug use or approval of use, inconsistent or poor family management practices—including lack of supervision, lack of parental involvement in children's lives, family conflict, sexual or physical abuse, economic instability, and lack of attachment to parents, often called low family bonding. For immigrant families, problems adapting to the mainstream culture can also be a serious risk factor.

Principles of Effective Substance Abuse Prevention:

SAMHSA provided a listing of the scientifically defensible principles that can help service providers design and implement programs that work.

- Target the entire family.
- Help develop bonds among parents in programs; provide meals, transportation, and small gifts; sponsor family outings; and ensure cultural sensitivity.
- Help minority families respond to cultural and racial issues.
- Develop parenting skills.
- Emphasize family bonding.

- Offer sessions where parents and youth learn and practice skills.
- Train parents to both listen and interact.
- Train parents to use positive and consistent discipline techniques.
- Promote new skills in family communication through interactive techniques.
- Employ strategies to overcome parental resistance to family-based programs.
- Improve parenting skills and child behavior with intensive support.
- Improve family functioning through family therapy when indicated.
- Explore alternative community sponsors and sites for schools.
- Videotape training and education.

Research has shown that parental monitoring is related to adolescent drug abuse, and recent data continue to support this. The Partnership Attitude Tracking Study, Teens & Parents, 2013 states the following research:

- teens who report that their parents show concern for them and are monitoring their behaviors are less likely to engage in substance abuse
- teens are less likely to use substances if they have learned a lot about the risks of drug use from their parents or from schools

The recent research developments are reinforced by the fact that, according to the U.S. Census Bureau, 35 % of children are raised in households where the mother and father no longer live together. Further to this point, additional data show that children raised by single parents suffer negative impacts to their emotional, mental and physical health.

The Centers for Disease Control, the Department of Justice, the Census Bureau and numerous researchers have reported alarming outcomes for the 35% of children who are raised by single parents versus shared parenting. Yet, until now, this factor has been largely ignored in the conversation about child wellbeing.

Children raised by single parents account for:

- 63% of teen suicides;
- 70% of juveniles in state-operated institutions;
- 71% of high school drop-outs;
- 75% of children in chemical abuse centers;
- 85% of those in prison;
- 85% of children who exhibit behavioral disorders; and
- 90% of homeless and runaway children.

Whether the problem is emotional disturbances of children, drug use, alcohol use, teen pregnancy, poor performance in school, trouble with the law or running with gangs, being raised by a single parent is a powerful risk factor. Conversely, children on average do much better on all these measures if they have shared parenting.

For parents, shared parenting significantly increases child support compliance, diminishes parental conflict and domestic violence, and allows both parents to pursue their careers, social lives and other interests without the burden of single handedly raising a child.

Unfortunately, according to the U.S. Census Bureau, only 17% of children of separated or divorced parents have shared parenting, which prevents their ability to benefit equally from both parents and has a tremendous impact on their emotional, mental and physical health.

Parental Attitudes toward Alcohol and Drug Consumption

The risk factors that impact adolescents' substance use or abuse include individual-level characteristics, peer attitudes and behaviors, community norms, and family characteristics. Research has shown, when parents hold attitudes favorable to the use of alcohol and other drugs, or engage in heavy drinking or drug use themselves, their children are more likely to drink alcohol or use drugs, according to the publication, the role of risk and protective factors in substance use across adolescence, National Institute of Health.

According to the Partnership Attitude Tracking Study (PATS), Teens & Parents, 2013:

- one-third of parents (34%) believe there is little they can do to prevent their kids from trying drugs other than alcohol
- one in four parents (23%) feel uncomfortable telling their child not to use drugs because of their own history of drug use
- Among parents who suspect their child has used drugs or alcohol, one in five (21%) have not intervene.
- PATS data show that if parents communicate their disapproval of marijuana use, and if they effectively communicate the risks associated with heavy marijuana use, then they increase the chances that their child will avoid becoming a heavy marijuana user, even if he or she decides to experiment with marijuana.
- More than one in ten teens (12%) continue to indicate their parents would be okay with their marijuana use.
- perceived parental permissiveness and perceived risk in using marijuana regularly also has a strong influence on the more frequent marijuana user.
- More than one in five teens (22%) say parents would not care as much if their teen were caught abusing or misusing prescription drugs, when compared to illicit drugs.
- More than half of parents (55%) say anyone can access their medicine cabinet

• one-third of teens (32 percent) believe their parents would say it's okay for them to drink beer every once in a while, while only 4 percent of parents corroborate this statement.

Students Talking to Parents about ATOD

According to the National Crime Prevention Council, their research shows the main reason that kids don't use alcohol, tobacco, or drugs is because of their parents. Their parents positive influence and because they know it would disappoint them are the main reasons why kids' abstain from drug use. It is so important that parents build a strong relationship with their kids and talk to them about substance abuse.

The role of parents is critical, if a teen learns about the risks from his or her friends or "on the street" rather than from parents, then that teen is more likely to engage in substance use according to the research from this publication.

Individual Domain

Risk factors for drug abuse in the individual domain consist of the following, lack of knowledge about the negative consequences associated with using illegal substances, attitudes favorable toward use, early onset of use, biological or psychological dispositions, antisocial behavior, sensation seeking, and lack of adult supervision, according to SAMHSA in their Guide to Science- Based Practices, Principles of Substance Abuse Prevention.

SAMHSA states that most interventions aimed at the individual are designed to change knowledge about and attitudes toward substance abuse with the ultimate goal of influencing behavior.

Principles of Effective Substance Abuse Prevention:

SAMHSA provided a listing of the scientifically defensible principles that can help service providers design and implement programs that work.

• Social and personal skills-building can enhance individual capacities, influence attitudes, and promote behavior inconsistent with use. These interventions usually include information about the negative effects of substance use.

• To be effective, interventions must be culturally sensitive and consider race, ethnicity, age, and gender in their designs.

• Youth tend to be more concerned about social acceptance and the immediate rather than long-term effects of particular behaviors. Citing consequences such as stained teeth and bad breath has more impact than threats of lung cancer, which usually develops later in life.

• Used alone, information dissemination and media campaigns do not play a major part in influencing individual knowledge, attitudes, and beliefs, but they can be effective when combined with other interventions.

• Alternatives such as organized sports, involvement in the arts, and community service provide a natural and effective way of reaching youth in high-risk environments who are not in school and who lack both adequate adult supervision and access to positive activities. Positive alternatives can help youth develop personal and social skills inconsistent with substance use.

• Effective programs recognize that relationships exist between substance use and a variety of other adolescent health problems, such as mental disorders, family problems, pregnancy, sexually transmitted diseases, school failure, and delinquency—and include services designed to address them.

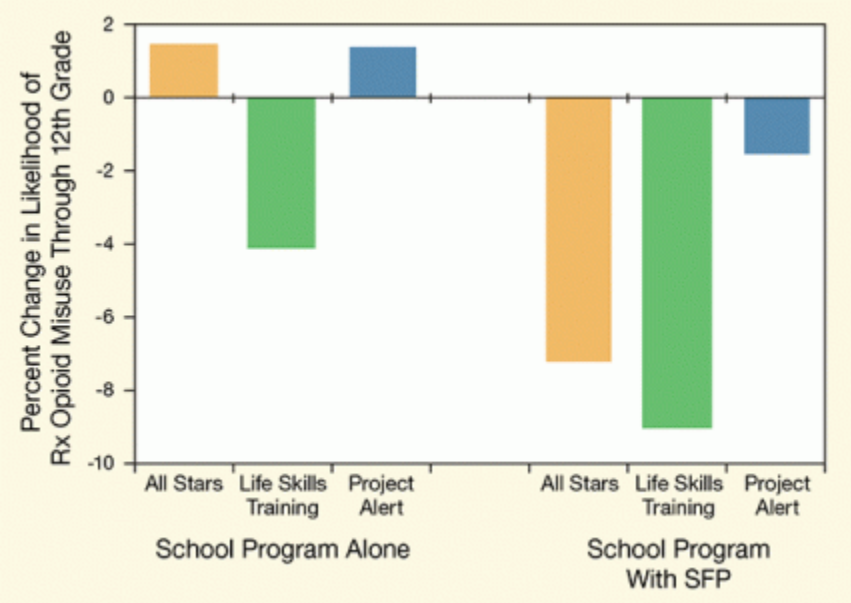
• Incorporating problem identification and referral into prevention programs helps to ensure that participants who are already using drugs will receive treatment.

• Providing transportation to treatment programs can encourage youth participation.

SAMHSA states, Life Skills Training (LST) Program demonstrates that linking key skills development with information targeting social influences to use, and reinforcing these strategies with booster sessions, can produce durable reductions in use.

Eric Sarlin, M.Ed., M.A., NIDA Notes Contributing Writer reported, Evidence-Based Prevention Programs for 7th Graders Lower Risk for Prescription Opioid Misuse Before 12th Grade Researchers calculated that participating in Life Skills Training (LST) in 7th grade reduced a child's likelihood of initiating prescription opioid misuse before 12th grade by 4.4 percent. Of the 6 prevention approaches used in the PROSPER study, LST plus Strengthening Families: for Parents and Youth 10–14 (SFP) reduced children's risk of prescription opioid misuse the most.[65]

Diagram 104, Life Skills Training (LST)



Life Skills Learned in YP Programs

Botvin Life Skills Training (LST) is a research-validated substance abuse prevention program proven to reduce the risks of alcohol, tobacco, drug abuse, and violence by targeting the major social and psychological factors that promote the initiation of substance use and other risky behaviors. This

65

NIDA. (2015, December 3). Life Skills Training Shields Teens From Prescription Opioid Misuse. Retrieved from https://www.drugabuse.gov/news-events/nida-notes/2015/12/life-skills-training-shields-teens-prescription-opioid-misuse on 2018, July 29

comprehensive program provides adolescents and young teens with the confidence and skills necessary to successfully handle challenging situations.

LST promotes healthy alternatives to risky behavior through activities designed to:

- Teach students the necessary skills to resist social (peer) pressures to smoke, drink, and use drugs
- Help students to develop greater self-esteem and self-confidence
- Enable students to effectively cope with anxiety
- Increase their knowledge of the immediate consequences of substance abuse
- Enhance cognitive and behavioral competency to reduce and prevent a variety of health risk behaviors

Summary of Life Skills Training Evaluation Research:

- Cuts tobacco, alcohol and marijuana use by up to 75%
- Booster sessions maintain prevention effects
- Effects last up to 6 years
- Cuts polydrug use by up to 66%
- Decreases use of inhalants, narcotics and hallucinogens
- Effective with white, African-American and Hispanic youth
- Effective when taught by teachers, peer leaders or health professionals

Mental Health and Family Recovery Services

Mental and substance use disorders can have a powerful effect on the health of individuals, their families, and their communities, according to SAMHSA.

SAMHSA also reports, in 2012:

- 9.6 million adults aged 18 and older in the United States had a serious mental illness
- 2.2 million youth aged 12 to 17 had a major depressive episode during the past year
- 23.1 million Americans aged 12 and older needed treatment for substance use

Many of which these mental and substance use disorders may allure to a disability in the US, causing a significant cost to families, employers, publicly funded health systems and much more. Statistics has demonstrated that prevention and early intervention can have positive outcome on the health of people, their families and communities, and is analytical imperative to handling mental issues to prevent more serious problems like unemployment, homelessness, poverty, and suicide.

Youth Employment

A significant portion of teens work while in school and the consequences of that work are of potential concern to society according to research done at the National Institute of Health, The Benefits and Risks of Adolescent Employment, 2010. Debates surrounds the consequences of adolescent employment, with researchers coming to different conclusions regarding teens working being good, bad, work doesn't matter. Employment is important to some adolescents but not others, their prior backgrounds, attributes and the contexts of their employment depend on this view states this publication. Some parents support for combining work and school, and there is some research that employment has positive effects on youth development, but there is also research that has revealed some potentially harmful consequences of employment among teens.

Employment can have both negative and positive effects, and research on substance use, problem behavior, and other negative consequences of employment shows that these are largely attributable to self-selection rather than to work experience itself. Research states parents, play an important role in guiding their teens toward the kinds of work experiences that will be most beneficial, and should help them to avoid the risks of employment.

Youth Perception of Access

Perceived availability of alcohol, tobacco, marijuana and other drugs: The more available alcohol, tobacco, and other drugs are in a community, the higher the risk that the youth will use them. Increased use is also associated with the perception that substances are readily available, regardless if the perception is accurate.

Youth Perception of Risk and Harm

For many drugs, the level of risk attributed to use varies considerably with the intensity of use being considered. Knowing the health risks that come with using or abusing drugs convinces most adolescents (and adults) to stay away from them. Research has demonstrated that when an adolescent thinks a drug can be harmful, they are less likely to abuse it.

The perception of risk and harm in using alcohol and other drugs is a significant factor in decreasing use and abuse. Throughout the research, it has demonstrated that as perception of harmfulness decreases, the inclination for substance use to increase according to SAMHSA. Therefore, it is very important for adolescents to be informed of the medical and psychological risks and hazards of using alcohol, and other drugs.

Trends of Declining Substance Use

Monitoring the Future (MTF) is a long-term study of substance use and related factors among U.S. adolescents, college students, and adult high school graduates through age 55. It is conducted annually and supported by the National Institute on Drug Abuse.The 2017 Monitoring the Future survey (MTF) shows decreasing use of several substances, including Synthetic Marijuana, Salvia, Bath Salts, Vicodin, OxyContin and Ritalin.

- ***Synthetic marijuana*** use declined for the three grades combined—down 0.4 percentage points to 2.8% (s). Its use declined only in grades 8 and 10 this year, significantly so in 8th. Annual

prevalence has declined by more than half at each grade level since it was first measured around 2013.

- Annual prevalence for ***salvia*** had declined appreciably in all three grades prior to 2017, and it declined further in 2017, but only among 8th graders (down 0.6 percentage points to 0.4%, s). This drug is now below 1.6% annual prevalence in all three grades.

- ***Bath salts*** (synthetic stimulants) continued their long-term decline in 2017 in all three grades, though only the decline for all three grades combined reached statistical significance (down 0.3 percentage points to 0.5%, s). Annual prevalence is now below 0.7% in all three grades.

- Use of ***Vicodin***, a narcotic analgesic, fell in all three grades, though significantly so only in 12th grade, where annual prevalence dropped by 1.0 percentage points to 2.0% (s). There has been a sharp drop in its use in all grades since around 2010.

- ***OxyContin*** has also shown an appreciable drop in use over the same interval, though it started from a lower level than Vicodin. Annual prevalence continued down in 12th grade, but that decline did not quite reach statistical significance (down 0.7 percentage points to 2.7%, ns).

- ***Ritalin***, a prescription-controlled stimulant, also has been gradually decreasing in use since it was first measured in 2001. It continued to decline in the lower two grades in 2017, significantly so in 8th grade (annual prevalence down 0.4 percentage points to 0.4%, s).[66]

Region in Focus

The Prevention Resource Center (PRC) is dedicated to capturing the needs of the Region 8 communities by identifying the gaps in resources, current drug trends, drug prevention resources and prevention training needs.

Through data collection efforts and partnerships with key stakeholders, schools, and organizations, the PRC serves as an invaluable resource to all who seek relevant information as it pertains to the 28 counties of Region 8.

We serve our communities by providing data on the state's Three Prevention Priorities of alcohol, marijuana, and prescription drug use, as well as tobacco and other drugs. We provide data to schools, colleges, universities, coalitions, councils, events, and other stakeholders within our communities. This is done through Information Dissemination which provides awareness and knowledge of substance abuse issues and trends through the data collected by the central data repository.

Gaps in Services

The PRC Region 8 has identified data availability, as well as geographical size of the target population, creates a gap. Certain parts of the region must travel outside their community because services are not available in their particular county. There are also limited organizations that provide substance abuse

[66] Johnston, L. D., Miech, R. A., O'Malley, P. M.,Bachman, J. G., Schulenberg, J. E., & Patrick, M. E.(2018). *Monitoring the Future national survey results on drug use: 1975-2017: Overview, key findings on adolescent drug use*. Ann Arbor: Institute for Social Research, The University of Michigan. Accessed July 29, 2018

prevention education and must rely on the Prevention Resource Center for these types of services. Other gaps include lack of community awareness and participation in prevention activities from both the schools and the community.

Other gaps include the budget shortfalls with school districts and the lack of participation in the Texas School Survey. Since the schools are working with less, there is more of a demand for PRC Region 8 services including literature, community outreach and presentations.

Gaps existing in training within the targeted communities include training space, lack of information on the types of training PRC provides, and encouraging communities to continue education on substance abuse all year round instead of just during Red Ribbon Week. The PRC is currently working on a tool to survey the entire Region 8 counties, soliciting for training request that is beyond what DSHS training are necessary to prevention providers.

As this Regional Needs Assessment has shown, complex factors are influencing rates of general health, mental health, and legal problems related to problematic substance use and abuse in Region 8. Ethnicity, education level, income, and other important factors seem to play a significant role in the problems Region 8 is experiencing with substance use and abuse, especially with our youth. Texas Department of State Health Services provide a summary of adults and youth on a waiting list by substance abuse programs.

Gaps in Data

There are still data gaps in county-level data collection efforts across the region. Yet, as efforts are made to unify the counties for data collection, the need to gather data in Spanish is also relevant. A growing issue in Region 8 is the language barrier. Not all service providers can help the Spanish-speaking population, this becomes more apparent in rural areas where services are already limited.

A significant source of surveying across the region is conducted through the Public Policy Research Institute with the use of the Texas School Survey. For the most part, drug and alcohol data collected from adolescents throughout the region is short of rich and detailed regional assessment, especially at the county-level. There are a number of coalitions assessing their community needs, but data outcomes are not representative of the region. Community-level data reporting can be collected for our evaluation and study of variables and factors at work, but more region-wide data collection is necessary. As a result, existing data is currently the only feasible way to begin assessing and estimating the effects of alcohol, marijuana, and prescription drugs in the region. Therefore, continued encouragement and support for community-level efforts in the region is needed. Further community-level activity is necessary in order to translate community-level data to a regional-level assessment. What community-level data can do by expanding their efforts is to begin developing county-level assessment and relational connections to neighboring counties.

The evaluation of certain seasonal occurrences is also necessary to assess. For instance, among marijuana users time related to the numerical value of 420 is commonly use as when to conduct marijuana activity. The numerical value 420 can mean April 20th as the day for marijuana use or the time 4:20pm or 4:20am. Also, the term "420 friendly" is sometimes used in online social media setting as an indication of being open to marijuana use. Additionally, alcohol use is generally seen to increase during

holidays (e.g., New Year's Eve). However, measures are needed to observe spikes in alcohol and substance abuse in order to deter instances in the following year.

The national, state and local statistics are breathtaking in their wealth of information; however they are not consistent and some research is contradicting or outdated. Regardless of the data gaps, Region 8 will provide data at a national, state, and local level per request that fulfill its requirements, from all the various systems; data can be analyzed with or without interpretation from the available resource with clear evidence drawn from reputable sources if requested as well.

Regional Partners

There are many local social services agencies that facilitate access to information and resources across the diverse communities in Region 8. These agencies focus on prevention as well as remediation of problems and maintaining a commitment to improving the overall quality of life of service populations. Some of the local social services agencies that provide aid to the population in the region and that contribute to strengthen communities include: The San Antonio Food Bank, and the Communities in School (CIS) program.

The San Antonio Food Bank informs, refers and assists clients in the Food Stamp application process along with any other assistance available through Health and Human Services Commission. The San Antonio Food Bank provides food and grocery products to more than 500 partner agencies in 16 counties throughout Southwest Texas including Atascosa, Bandera, Bexar, Comal, Edwards, Frio, Guadalupe, Karnes, Kendall, Kerr, La Salle, Medina, Real Uvalde, Wilson and Zavala.

Communities in Schools (CIS) program was created to promote and facilitate delivery of community social services, health, educational services, enrichment and other support services to youth and their families. This initiative was established to address the high rate of dropouts that exists within school districts. CIS is a year-round program with services based on an individual assessment of the participant, family and school. Services include the support and promotion of health awareness, healthy life styles and provision of basic needs; provide support and help to increase the participation of parents in the students' educational experience; provide support in all educational areas as needed to promote student achievement and success in their school experience, as well as activities that promote career awareness, job readiness, skills training, preparation for the workforce and assistance in the attainment of employment. This program is being implemented across the region, and students and families are able to benefit from the variety of services that it offers.

Furthermore, there are community programs in the region that provide training to local residents as "promotoras" to provide and lead culturally appropriate group education and exercise sessions in community centers located across South Texas and the Central Rio Grande Valley. Texas A&M University Colonias Program, located in Webb County with community resources centers in Maverick and Val Verde Counties, provide community health advisor, emergency response, cancer survivorship, and "taking control of your health" program education to local residents to form a core leadership group in order to help fellow colonia residents to gaining access to education, health, job training, human services, youth, and elderly programs in the colonia areas. Promotoras disseminate knowledge through door to door visits to their colonia neighbors, and they provide a break through the communication barriers that exist between colonia residents and service and program providers.

These agencies contribute to better access of resources to populations in region 8. They promote improved service delivery systems by addressing not only the quality of direct services, but by also seeking to improve accessibility, accountability, and coordination among professionals and agencies in service delivery for all communities in the region.

Regional Successes

Since its development, the Prevention Resource Center 8 has been able to secure networks and strong collaboration alliances with diverse local and regional organizations and their key representatives. This combined effort has made it possible for PRC 8 to gain access to a great deal of data and information that only strengthen the information that is already available through national and federal resources. Additionally, these partnerships have successfully enabled PRC 8 to share resources and information relevant to each organization's unique needs.

The Circles of San Antonio Community Coalition is working on a social host accountability ordinance locally and increasing the alcohol excise tax at the state level to reduce youth access to alcohol. The Social Host accountability Ordinance was passed in December 2016 and is in the implementation phase. The coalition's collaboration with the City of San Antonio and the San Antonio Police Department (SAPD) produced a public service announcement to educate the community on the new ordinance, Additionally, the coalition has created a web page www.nopartyparents.com that contains information on underage drinking and the new ordinance. The coalition has also produced violation notice rack cards to be distributed to all of the substation precincts in San Antonio. Mothers Against Drunk Driving (MADD), a coalition collaborative partner, recently awarded their Outstanding Service Award to the SAPD Detective/Circles of San Antonio member who serves as the lead investigator for the Social Host initiative. This year the coalition is gathering data to support both strategies. It is imperative to have a strong collaborative relationship with law enforcement when working to with create and implement possible ordinances to ensure that they are enforced.

The coalition collaborated with Bexar County DWI Task Force to train local police officers on reducing underage drinking. In addition to this, the coalition has joined forces with Texans Standing Tall (TST) to train San Antonio Police Department Vice Unit on how to break up underage drinking parties. The coalition will be implementing additional controlled party dispersal trainings to local law enforcement through the collaboration with Bexar County DWI Task Force and Texans Standing Tall and local university police departments.

The Circles of San Antonio Community Coalition collaborated with the Prevention Resource Center Region-8 and the San Antonio Health District and the to increase the purchase age of tobacco from 18 to 21. This initiative, Tobacco 21, was successfully passed in the San Antonio City Council in January 2018 and becomes effective October 21, 2018. The Tobacco 21 ordinance includes all tobacco products; cigarettes, cigars, pipe tobacco, chewing tobacco (dip), snuff, snus, electronic smoking devices (e-cigs) disposable or refillable, electronic smoking device liquids (vapes), and hookahs. The initiative is aimed at preventing the access of tobacco products by minors by cutting of the primary supply of tobacco to those under 18. Tobacco sales data indicates that only 2% of tobacco sold is purchased by 18-20 year olds. However, that 2% supplies 90% of the tobacco to younger people through peer to peer influences. The premise is that if an 18 year old, who is still in high school can purchase tobacco then it is easily transferred through their relationships with 14-17 year olds. A 21 year old person is less likely to interact

daily with 14-17 year olds due age differences and social involvement. When tobacco purchase is restricted to the purchase age of 21 this interrupts the majority of the peer to peer transfer of tobacco. Since the passage of the Tobacco 21 ordinance, the team has collaborated to educate all tobacco retailers in San Antonio. Compliance education visits has occurred in more than 1,460 tobacco retail stores in San Antonio.

Our youth coalition members have been very instrumental members of the coalition and has assisted these strategies through advocacy and education from a youth perspective. They have produced opinion editorials that have been published and continue to educate on the dangers of substance use and misuse. Five coalition members attended the TST Statewide Summit and educated state elected officials on evidenced based prevention strategies to reduce underage drinking. The Coalition boasts great involvement with two local universities that have substance abuse and HIV prevention grants.

The coalition has received a Drug Free Communities grant this fiscal year and is in the assessment phase to determine strategies for the zip codes in the San Antonio Independent School District boundaries. The coalition has secured a collaborative agreement with the San Antonio Independent School District to conduct the Drug Free Communities Core Measures survey in the 2018-2019 school year at participating middle and high school campuses. The coalition continues to collaborate with the three other Drug Free Communities grantees and providing technical assistance on environmental prevention strategies.

Furthermore, coalition's efforts to mobilize communities throughout the region have been improving the way substance abuse and related behavioral issues among youth are addressed locally. Awareness and prevention efforts made by coalitions, along with the support from county officials and key organization members have made an impact in Region 8.

Conclusion

This needs assessment provides a review of data on substance abuse and related variables across the state that will aid in substance abuse prevention decision making and will contribute to the creation of new treatment and prevention services for mental health and substance abuse, which are lacking throughout Region 8. This document has incorporated data from many quantitative secondary sources such as governmental, law enforcement, educational and mental health organizations. Aside from facilitating evidence-based decision-making, this Regional Needs Assessment was also created with the intent of assessing the nature and extent of available data relating to State and Regional alcohol, drug abuse, tobacco and health information as well as to determine difficulties in obtaining meaningful data and recognizing the availability of the same.

By completing this RNA, the Prevention Resource Center 8 has also been able to identify some of the gaps that exist in the region's and state's data collection infrastructure. While the Prevention Resource Center 8 in collaboration with the Statewide Evaluator and the other Regional Evaluators from the rest of the Sate were able to access a good amount of local data for use in its analyses, there were instances where certain data were not available at the desired geographic scale or not available at all. The organization of the available data in the structured Regional Needs Assessment format allowed the identification of significant gaps that exist in the data. These identified gaps will facilitate guidance for future research work and help ensure that it focuses on generating and collecting the most useful and

relevant data that will aid in substance abuse prevention and treatment as well as addressing health-related issues of the community as a whole.

Throughout Region 8, many of the social problems in our neighborhoods, such as economic deprivation and crime, can be associated with the use of drugs and alcohol. Research shows how substance abuse has some role in creating these social barriers, sustaining them, or making them worse. Substance abuse affects all directly or indirectly in one way or another. Substance abuse generates a stress on, and limits the effectiveness of institutions or programs that are intended to help people. Region 8 like other regions, demonstrates that drugs and alcohol are a significant problem. The Regional 8 PRC needs assessment should serve as a comprehensive snapshot of the 28 counties within the region and as an instrument for substance use prevention.

Moving Forward

This Regional Needs Assessment provides an opportunity for key stakeholders, business professionals, and community members in general to identify regional strengths and weaknesses as well as become able to produce comparisons among the diverse counties of the region. This document highlights the main strengths of the region while also addressing the gaps found in services and data available. As stated in the earlier pages of this document, this regional assessment serves the following purposes:

- To discover patterns of substance use among adolescents and monitor changes in substance use trends over time.
- To identify gaps in data where critical substance abuse information is missing.
- To determine regional differences and disparities throughout the state.
- To identify substance use issues that are unique to specific communities and regions in the state.
- To provide a comprehensive resource tool for local providers to design relevant, data driven prevention and intervention programs targeted to needs.
- To provide data to local providers to support their grant-writing activities and provide justification for funding requests.
- To assist policy-makers in program planning and policy decisions regarding substance abuse prevention, intervention, and treatment in the state of Texas.

This report also provides a means to facilitate data-driven decisions and mobilization of communities, as it informs key community, local, state, and federal representatives about the needs that communities in Region 8 and the rest of the State have. This RNA helps gain a deeper understanding of the community, as each community within the region has its own needs and assets, as well as its own culture and social structure. Furthermore, this document will help make decisions related to priorities for program or system improvement. In order to address community issues, one has to fully understand what the problems are and how they arose. This in turn will increase the community's capacity for solving its own problems and creating its own change, with support of state and federal authorities.

How Should You Use This Information?

Potential readers of this document include stakeholders who are vested in the prevention, intervention, and treatment of adolescent substance use in the state of Texas, as well as concerned community members who desire to mobilize their own communities and stay informed about the major issues that directly impact their homeland. Stakeholders include but are not limited to substance abuse prevention and treatment providers; medical providers; school districts and higher education; substance abuse community coalitions; city, county, and state leaders; prevention program staff; and community members vested in preventing substance use.

Appendix A, Table 1, 2010-2017 Population Change by Region

2010 - 2017 Population Change by Region, 2016 - 2017 Population Change							
Geography	**April 1, 2010 - Census**	**Population Estimate (as of July 1) - 2016**	**Population Estimate (as of July 1) - 2017**	**Number Change 2010-2017**	**Percent Change 2010-2017**	**Number Change 2016-2017**	**Percent Change 2016-2017**
United States	308,745,538	323,405,935	325,719,178	16,973,640	5.5	2,313,243	0.7
Texas	25,145,561	27,904,862	28,304,596	3,159,035	12.6	399,734	1.4
Region 1	839,586	869,363	872,729	33,143	3.9	3,366	0.4
Region 2	550,250	548,780	549,447	-803	-0.1	667	0.1
Region 3	6,733,179	7,572,679	7,724,383	991,204	14.7	151,704	2.0
Region 4	1,111,696	1,137,502	1,144,106	32,410	2.9	6,604	0.6
Region 5	767,222	778,574	782,269	15,047	2.0	3,695	0.5
Region 6	6,087,133	6,969,489	7,064,712	977,579	16.1	95,223	1.4
Region 7	2,948,364	3,370,065	3,444,710	496,346	16.8	74,645	2.2
Region 8	2,604,647	2,910,042	2,958,133	353,486	13.6	48,091	1.7
Region 9	571,871	637,954	635,912	64,041	11.2	-2,042	-0.3
Region 10	825,913	862,043	865,822	39,909	4.8	3,779	0.4
Region 11	2,105,700	2,248,371	2,262,373	156,673	7.4	14,002	0.6
Source: U.S. Census Bureau, 2010 Census Count, 2010 - 2017 Population Estimates							

Appendix A, Table 2, 2010 – 2017 Population Change by County

2010 - 2017 Populatioin Change by County							
Geography	**April 1, 2010 - Census**	**Population Estimate (as of July 1) - 2016**	**Population Estimate (as of July 1) - 2017**	**Number Change 2010-2017**	**Percent Change 2010-2017**	**Number Change 2016-2017**	**Percent Change 2016-2017**
United States	308,745,538	323,405,935	325,719,178	16,973,640	5.5	2,313,243	0.7
Texas	25,145,561	27,904,862	28,304,596	3,159,035	12.6	399,734	1.4
Region 8	2,604,647	2,910,042	2,958,133	353,486	13.6	48,091	1.7
Atascosa	44,911	48,666	48,981	4,070	9.1	315	0.6
Bandera	20,485	21,710	22,351	1,866	9.1	641	3.0
Bexar	1,714,773	1,927,747	1,958,578	243,805	14.2	30,831	1.6
Calhoun	21,381	21,942	21,744	363	1.7	**-198**	**-0.9**
Comal	108,472	134,142	141,009	32,537	30.0	6,867	5.1
DeWitt	20,097	20,618	20,226	129	0.6	**-392**	**-1.9**
Dimmit	9,996	10,784	10,418	422	4.2	**-366**	**-3.4**
Edwards	2,002	1,918	1,953	-49	-2.4	35	1.8
Frio	17,217	19,385	19,600	2,383	13.8	215	1.1
Gillespie	24,837	26,305	26,646	1,809	7.3	341	1.3
Goliad	7,210	7,521	7,562	352	4.9	41	0.5
Gonzales	19,807	20,863	20,893	1,086	5.5	30	0.1
Guadalupe	131,533	154,596	159,659	28,126	21.4	5,063	3.3
Jackson	14,075	14,851	14,805	730	5.2	**-46**	**-0.3**
Karnes	14,824	15,264	15,187	363	2.4	**-77**	**-0.5**
Kendall	33,410	41,964	44,026	10,616	31.8	2,062	4.9
Kerr	49,625	51,296	51,720	2,095	4.2	424	0.8
Kinney	3,598	3,640	3,745	147	4.1	105	2.9
La Salle	6,886	7,619	7,584	698	10.1	**-35**	**-0.5**
Lavaca	19,263	19,910	20,062	799	4.1	152	0.8
Maverick	54,258	57,989	58,216	3,958	7.3	227	0.4
Medina	46,006	49,196	50,066	4,060	8.8	870	1.8
Real	3,309	3,397	3,429	120	3.6	32	0.9
Uvalde	26,405	27,106	27,132	727	2.8	26	0.1
Val Verde	48,879	48,953	49,205	326	0.7	252	0.5
Victoria	86,793	92,379	92,084	5,291	6.1	**-295**	**-0.3**
Wilson	42,918	48,190	49,304	6,386	14.9	1,114	2.3
Zavala	11,677	12,091	11,948	271	2.3	**-143**	**-1.2**
Source: U.S. Census Bureau, 2010 Census Count, 2010 - 2017 Population Estimates							

Appendix A, Table 3, 2018 Population by Age by County

2018 Region 8 Percent of Population by Age by County										
Area	**00-09**	**10-19**	**20-29**	**30-39**	**40-49**	**50-59**	**60-69**	**70-79**	**80-85+**	**Total**
Texas	14.0	14.8	14.4	14.0	12.9	12.0	9.7	5.5	2.7	100.0
Region 8	13.6	14.6	14.4	13.0	12.3	12.4	10.5	6.2	3.1	100.0
Atascosa	13.2	15.6	12.0	11.1	12.2	13.0	12.0	7.3	3.5	100.0
Bandera	8.0	10.3	8.8	7.1	10.1	17.9	19.9	13.2	4.7	100.0
Bexar	14.3	14.7	15.4	14.3	12.4	11.8	9.3	5.1	2.7	100.0
Calhoun	13.4	14.6	12.8	11.7	10.6	12.9	11.9	7.8	4.3	100.0
Comal	10.0	13.3	10.0	9.5	13.1	15.5	15.6	9.1	3.9	100.0
DeWitt	12.0	12.3	12.4	11.1	11.7	13.5	12.9	8.5	5.6	100.0
Dimmit	15.2	15.2	13.0	9.6	10.7	11.8	12.2	7.8	4.5	100.0
Edwards	12.6	11.1	10.4	8.4	8.7	12.6	15.1	14.3	6.9	100.0
Frio	12.8	12.8	18.2	14.9	11.5	11.3	9.6	5.7	3.1	100.0
Gillespie	9.6	11.3	9.2	8.0	9.8	14.1	17.0	13.9	7.1	100.0
Goliad	9.4	12.5	11.4	8.4	11.2	14.7	16.5	10.9	5.1	100.0
Gonzales	14.4	14.6	12.6	10.7	10.8	13.0	12.0	7.9	4.0	100.0
Guadalupe	11.7	16.3	12.4	11.4	14.8	13.9	10.3	6.2	2.9	100.0
Jackson	14.0	13.2	12.6	10.9	10.1	13.0	12.9	8.3	4.9	100.0
Karnes	9.5	11.1	16.1	14.4	12.2	12.9	12.5	7.0	4.2	100.0
Kendall	9.1	14.1	10.4	8.2	12.4	16.1	15.2	9.8	4.5	100.0
Kerr	10.5	10.9	10.9	8.4	9.5	13.2	16.6	13.3	6.8	100.0
Kinney	11.4	8.9	12.7	10.2	11.1	12.0	13.6	12.5	7.7	100.0
La Salle	12.5	11.2	18.7	17.0	9.8	10.2	9.2	7.9	3.5	100.0
Lavaca	10.6	12.8	10.5	8.8	10.5	13.8	15.8	10.7	6.5	100.0
Maverick	17.7	17.3	14.7	10.8	11.5	10.4	8.9	5.7	3.1	100.0
Medina	11.5	14.6	13.0	10.6	11.7	14.4	12.8	7.7	3.6	100.0
Real	10.7	9.0	12.1	6.4	8.4	13.2	17.6	14.8	7.7	100.0
Uvale	15.6	16.0	15.3	8.7	10.4	11.4	10.9	7.6	4.2	100.0
Val Verde	17.0	15.4	13.3	12.1	11.6	11.1	9.3	6.5	3.7	100.0
Victoria	14.5	14.2	13.9	12.4	10.7	12.1	11.4	6.9	3.8	100.0
Wilson	9.8	15.5	11.4	9.5	13.8	16.2	13.4	7.2	3.3	100.0
Zavala	18.0	15.7	14.6	11.7	10.0	10.5	10.0	6.0	3.6	100.0
Source: Texas Demographic Center, Population Estimates, 2018										

Appendix A, Table 4, 2018 Population by Sex by County

2018 Region 8 Population Sex by County					
Area	**Total Pop**	**Total Male**	**Percent Male**	**Total Female**	**Percent Female**
Texas	29,366,479	14,620,675	49.8	14,745,804	50.2
Region 8	3,034,265	1,505,424	49.6	1,528,841	50.4
Atascosa	53,655	26,297	49.0	27,358	51.0
Bandera	24,187	11,938	49.4	12,249	50.6
Bexar	1,988,364	984,997	49.5	1,003,367	50.5
Calhoun	24,472	12,368	50.5	12,104	49.5
Comal	141,332	69,704	49.3	71,628	50.7
DeWitt	20,770	10,984	52.9	9,786	47.1
Dimmit	10,719	5,257	49.0	5,462	51.0
Edwards	2,153	1,108	51.5	1,045	48.5
Frio	19,512	11,441	58.6	8,071	41.4
Gillespie	28,827	13,900	48.2	14,927	51.8
Goliad	8,255	4,089	49.5	4,166	50.5
Gonzales	21,871	11,171	51.1	10,700	48.9
Guadalupe	171,409	82,916	48.4	88,493	51.6
Jackson	14,291	7,156	50.1	7,135	49.9
Karnes	15,976	9,497	59.4	6,479	40.6
Kendall	42,562	20,305	47.7	22,257	52.3
Kerr	55,505	26,998	48.6	28,507	51.4
Kinney	3,778	2,076	54.9	1,702	45.1
La Salle	7,957	4,714	59.2	3,243	40.8
Lavaca	19,717	9,856	50.0	9,861	50.0
Maverick	61,696	30,536	49.5	31,160	50.5
Medina	54,632	27,676	50.7	26,956	49.3
Real	3,430	1,704	49.7	1,726	50.3
Uvalde	28,161	13,890	49.3	14,271	50.7
Val Verde	52,475	26,528	50.6	25,947	49.4
Victoria	91,624	44,958	49.1	46,666	50.9
Wilson	54,265	27,032	49.8	27,233	50.2
Zavala	12,670	6,328	49.9	6,342	50.1

Source: Texas Demographic Center, Population Estimates, 2018

Appendix A, Table 5, 2018 Region 8 Race/Ethnicity

2018 Region 8 Population by Race/Ethnicity by County									
Area Name	**Total Pop**	**Angle**	**Percent Anglo**	**Black**	**Percent Black**	**Hispanic**	**Percent Hispaic**	**Other**	**Percent Other**
Texas	29,366,479	11,826,470	40.3	3,348,098	11.4	12,181,167	41.5	2,010,744	6.8
Region 8	3,034,265	1,020,855	33.6	169,761	5.6	1,713,966	56.5	129,683	4.3
Atascosa	53,655	18,060	33.7	295	0.5	34,620	64.5	680	1.3
Bandera	24,187	18,973	78.4	90	0.4	4,666	19.3	458	1.9
Bexar	1,988,364	521,289	26.2	138,307	7.0	1,224,470	61.6	104,298	5.2
Calhoun	24,472	9,831	40.2	560	2.3	12,670	51.8	1,411	5.8
Comal	141,332	98,103	69.4	2,356	1.7	36,931	26.1	3,942	2.8
DeWitt	20,770	10,772	51.9	1,890	9.1	7,684	37.0	424	2.0
Dimmit	10,719	1,261	11.8	88	0.8	9,273	86.5	97	0.9
Edwards	2,153	950	44.1	10	0.5	1,175	54.6	18	0.8
Frio	19,512	2,920	15.0	513	2.6	15,467	79.3	612	3.1
Gillespie	28,827	21,797	75.6	53	0.2	6,578	22.8	399	1.4
Goliad	8,255	4,772	57.8	310	3.8	3,064	37.1	109	1.3
Gonzales	21,871	8,633	39.5	1,456	6.7	11,461	52.4	321	1.5
Guadalupe	171,409	87,472	51.0	10,823	6.3	66,026	38.5	7,088	4.1
Jackson	14,291	8,471	59.3	995	7.0	4,606	32.2	219	1.5
Karnes	15,976	6,233	39.0	1,370	8.6	8,219	51.4	154	1.0
Kendall	42,562	31,639	74.3	149	0.4	9,830	23.1	944	2.2
Kerr	55,505	38,443	69.3	824	1.5	14,867	26.8	1,371	2.5
Kinney	3,778	1,375	36.4	38	1.0	2,307	61.1	58	1.5
La Salle	7,957	944	11.9	18	0.2	6,937	87.2	58	0.7
Lavaca	19,717	14,261	72.3	1,361	6.9	3,788	19.2	307	1.6
Maverick	61,696	1,693	2.7	79	0.1	59,029	95.7	895	1.5
Medina	54,632	24,075	44.1	973	1.8	28,584	52.3	1,000	1.8
Real	3,430	2,366	69.0	24	0.7	957	27.9	83	2.4
Uvalde	28,161	7,367	26.2	121	0.4	20,287	72.0	386	1.4
Val Verde	52,475	8,224	15.7	630	1.2	42,911	81.8	710	1.4
Victoria	91,624	39,363	43.0	5,642	6.2	44,011	48.0	2,608	2.8
Wilson	54,265	30,912	57.0	752	1.4	21,600	39.8	1,001	1.8
Zavala	12,670	656	5.2	34	0.3	11,948	94.3	32	0.3

Source: Texas Demographic Center, Population Estimates, 2018

Appendix A, Table 6, 2017 Population Density by County

2017 Population Density by County					
County	Land Area (Sq. Mi.)*	2010 Population	2010 Population Density	2017 Population	2017 Population Density
United States	3,531,905.4	308,758,105	87.4	325,719,178	92.2
Texas	261,231.7	25,146,100	96.3	28,304,596	108.4
Region 8	31,057.8	2,604,655	83.86	2,958,133	95.24
Atascosa	1,219.5	44,911	36.8	48,981	40.2
Bandera	791.0	20,485	25.9	22,351	28.3
Bexar	1,239.8	1,714,774	1,383.1	1,958,578	1,579.8
Calhoun	506.8	21,381	42.2	21,744	42.9
Comal	559.5	108,471	193.9	141,009	252.0
DeWitt	909.0	20,097	22.1	20,226	22.3
Dimmit	1,328.9	9,996	7.5	10,418	7.8
Edwards	2,117.9	2,002	0.9	1,953	0.9
Frio	1,133.5	17,217	15.2	19,600	17.3
Gillespie	1,058.2	24,837	23.5	26,646	25.2
Goliad	852.0	7,210	8.5	7,562	8.9
Gonzales	1,066.7	19,807	18.6	20,893	19.6
Guadalupe	711.3	131,537	184.9	159,659	224.5
Jackson	829.4	14,075	19.0	14,805	17.9
Karnes	747.6	14,824	19.8	15,187	20.3
Kendall	662.5	33,419	50.4	44,026	66.5
Kerr	1,103.3	49,625	45.0	51,720	46.9
Kinney	1,360.1	3,598	2.6	3,745	2.8
La Salle	907.2	6,886	4.6	7,584	8.4
Lavaca	969.7	19,263	19.9	20,062	20.7
Maverick	1,279.3	54,258	42.4	58,216	45.5
Medina	1,325.4	46,006	34.7	50,066	37.8
Real	699.2	3,309	4.7	3,429	4.9
Uvalde	1,552.0	26,405	17.0	27,132	17.5
Val Verde	3,144.8	48,879	15.5	49,205	15.6
Victoria	882.1	86,793	98.4	92,084	104.4
Wilson	803.7	42,913	53.4	49,304	61.3
Zavala	1,297.4	11,677	9.0	11,948	9.2
U.S. Census Bureau, QuickFacts, Population Estimates, (V2017), 2010					

Appendix A, Table 7, 2016 Languages Spoken at Home by Region

2016 Languages Spoken at Home Ages 5 and Older by Region									
Public Health Region	Population 5 years and over	Speaks English only	% Speak English Only	Speaks Spanish	% Speak Spanish	All Other Languages	% All Other Languages	Speaks English less than "very well"	% Speaks English less than "very well"
1	800,336	589,533	73.66	188,604	23.57	22,199	2.77	70,372	8.79
2	515,167	439,600	85.33	65,376	12.69	10,191	1.98	26,861	5.21
3	6,748,798	4,727,605	70.05	1,512,786	22.15	508,407	7.53	897,116	13.29
4	1,055,238	918,843	87.07	121,540	11.52	14,855	1.41	56,996	5.40
5	722,184	617,877	85.56	85,735	11.87	18,572	2.57	40,269	5.58
6	6,152,106	3,827,444	62.21	1,774,837	28.85	549,825	8.94	1,022,719	16.62
7	3,002,156	2,278,346	75.89	564,961	18.82	158,849	5.29	265,361	8.84
8	2,611,832	1,622,187	62.11	908,543	34.79	81,102	3.11	305,133	11.68
9	571,749	362,422	63.39	195,185	34.14	14,142	2.47	65,315	11.42
10	789,870	222,269	28.14	550,783	69.73	16,818	2.13	242,320	30.68
11	2,016,313	585,969	29.06	1,405,447	69.70	24,897	1.23	526,510	26.11
Texas	24,985,749	16,192,095	64.81	7,373,797	29.51	1,419,857	5.68	3,518,972	14.08
U.S.	298,691,202	235,519,143	78.85	39,145,066	13.11	24,026,993	8.04	16,268,850	5.45
Source: U.S. Census Bureau. 2016 American Community Survey 5-year estimates									

Appendix A, Table 8, 2016 Languages Spoken at Home Ages Five and Older by County

2016 Languages Spoken at Home for Ages 5 and Older							
County Name	Population 5 years and over	Speaks English only	% Speak English Only	Speaks Spanish	% Speak Spanish	All Other Languages	% All Other Languages
United States	298,691,202	235,519,143	78.85	39,145,066	13.11	24,026,993	8.04
Texas	24,985,749	16,192,095	64.81	7,373,797	29.51	1,419,857	5.68
Region 8	2,611,832	1,622,187	62.11	908,543	34.79	81,102	3.11
Atascosa County, Texas	44,284	26,342	59.48	17,510	39.54	432	0.98
Bandera County, Texas	20,135	18,081	89.80	1,833	9.10	221	1.10
Bexar County, Texas	1,723,161	1,025,295	59.50	632,787	36.72	65,079	3.78
Calhoun County, Texas	20,351	14,521	71.35	4,797	23.57	1,033	5.08
Comal County, Texas	117,121	96,030	81.99	18,511	15.81	2,580	2.20
DeWitt County, Texas	19,298	15,673	81.22	3,304	17.12	321	1.66
Dimmit County, Texas	9,774	3,191	32.65	6,560	67.12	23	0.24
Edwards County, Texas	1,911	1,038	54.32	873	45.68	0	0.00
Frio County, Texas	17,319	6,937	40.05	10,173	58.74	209	1.21
Gillespie County, Texas	24,500	19,335	78.92	4,064	16.59	1,101	4.49
Goliad County, Texas	7,108	5,978	84.10	1,074	15.11	56	0.79
Gonzales County, Texas	18,882	11,791	62.45	6,958	36.85	133	0.70
Guadalupe County, Texas	137,690	105,559	76.66	28,827	20.94	3,304	2.40
Jackson County, Texas	13,634	10,770	78.99	2,757	20.22	107	0.78
Karnes County, Texas	14,166	9,991	70.53	3,980	28.10	195	1.38
Kendall County, Texas	37,008	31,888	86.17	4,459	12.05	661	1.79
Kerr County, Texas	47,976	39,437	82.20	7,910	16.49	629	1.31
Kinney County, Texas	3,489	1,559	44.68	1,846	52.91	84	2.41
La Salle County, Texas	6,720	1,870	27.83	4,812	71.61	38	0.57
Lavaca County, Texas	18,482	15,214	82.32	2,502	13.54	766	4.14
Maverick County, Texas	51,697	3,453	6.68	47,762	92.39	482	0.93
Medina County, Texas	45,083	30,154	66.89	14,491	32.14	438	0.97
Real County, Texas	3,141	2,705	86.12	424	13.50	12	0.38
Uvalde County, Texas	24,941	12,186	48.86	12,500	50.12	255	1.02
Val Verde County, Texas	44,701	13,244	29.63	31,005	69.36	452	1.01
Victoria County, Texas	84,422	64,204	76.05	18,343	21.73	1,875	2.22
Wilson County, Texas	43,772	33,253	75.97	9,927	22.68	592	1.35
Zavala County, Texas	11,066	2,488	22.48	8,554	77.30	24	0.22

Source: U.S. Census Bureau. 2012-2016 American Community Survey 5-year estimates: Language Spoken at Home. American FactFinder - Results.

Appendix A, Table 9 – 2016 Limited English Speaking Households by County

2016 Limited English Speaking Households							
Geography	Total; Estimate; All households	Limited English-speaking households; Estimate; All households	Percent limited English-speaking households; Estimate; All households	Total; Estimate; Households speaking -- - Spanish	Percent; Estimate; Households speaking -- - Spanish	Limited English-speaking households; Estimate; Households speaking -- - Spanish	Percent limited English-speaking households; Estimate; Households speaking -- - Spanish
Atascosa County, Texas	15343	1410	9.2	6932	45.2	1375	19.8
Bandera County, Texas	8256	57	0.7	889	10.8	22	2.5
Bexar County, Texas	623321	43196	6.9	271103	43.5	37628	13.9
Calhoun County, Texas	7800	553	7.1	2233	28.6	373	16.7
Comal County, Texas	45338	1092	2.4	7771	17.1	952	12.3
DeWitt County, Texas	7105	175	2.5	1347	19	153	11.4
Dimmit County, Texas	3457	613	17.7	2936	84.9	613	20.9
Edwards County, Texas	718	88	12.3	397	55.3	88	22.2
Frio County, Texas	4660	532	11.4	3333	71.5	532	16
Gillespie County, Texas	10498	288	2.7	1441	13.7	248	17.2
Goliad County, Texas	2798	58	2.1	567	20.3	53	9.3
Gonzales County, Texas	6611	369	5.6	2380	36	369	15.5
Guadalupe County, Texas	49930	1998	4	13286	26.6	1824	13.7
Jackson County, Texas	5164	105	2	958	18.6	95	9.9
Karnes County, Texas	4288	278	6.5	1476	34.4	240	16.3
Kendall County, Texas	13390	287	2.1	1945	14.5	287	14.8
Kerr County, Texas	20476	654	3.2	3150	15.4	564	17.9
Kinney County, Texas	1139	48	4.2	564	49.5	48	8.5
La Salle County, Texas	2101	651	31	1757	83.6	651	37.1
Lavaca County, Texas	7741	267	3.4	995	12.9	224	22.5
Maverick County, Texas	16221	5119	31.6	15524	95.7	5109	32.9
Medina County, Texas	15104	661	4.4	6090	40.3	661	10.9
Real County, Texas	1192	24	2	144	12.1	24	16.7
Uvalde County, Texas	8512	848	10	4745	55.7	848	17.9
Val Verde County, Texas	14977	2139	14.3	10883	72.7	2127	19.5
Victoria County, Texas	32513	1059	3.3	8089	24.9	969	12
Wilson County, Texas	15474	719	4.6	4024	26	673	16.7
Zavala County, Texas	3638	771	21.2	3155	86.7	771	24.4
Region 8	947765	64059	6.76	378114	39.90	57521	15.21
Texas	9289554	734648	7.9	2665398	28.7	623533	23.4
United States	117,716,237	5,283,060	4.5	14,077,413	12	3,186,361	22.6
Source: U.S. Census Bureau, 2012-2016 American Community Survey 5-Year Estimates							

Appendix A, Table 10, 2016 Poverty by County and Median Household Income

2016 Poverty by County

Year	State / County Name	All Ages SAIPE Poverty Universe	All Ages in Poverty Count	All Ages in Poverty Percent	Under Age 18 SAIPE Poverty Universe	All	Under Age 18 in Poverty Percent	Ages 5 to 17 in Families SAIPE Poverty Universe	Ages 5 to 17 in Families in Poverty Count	Ages 5 to 17 in Families in Poverty Percent	Under Age 5 SAIPE Poverty Universe	Under Age 5 in Poverty Count	Under Age 5 in Poverty Percent	Median Household Income in Dollars
2016	United States	315,165,470	44,268,996	14.0	72,452,603	14,115,713	19.5	52,644,648	9,648,486	18.3	19473767	4156949	21.3	$57,617.00
2016	Texas	27,236,431	4,261,291	15.6	7,212,532	1,616,085	22.4	5,202,578	1,111,489	21.4	1984517	481319	24.3	$56,583.00
2016	Region 8	2,841,513	444,990	15.7	735,037	161,691	22.0	531,186	110,479	20.8		NA	NA	$49,732.00
2016	Atascosa County (TX)	48,345	7,867	16.3	13,347	3,316	24.8	9,795	2,293	23.4	NA	NA	NA	$53,622.00
2016	Bandera County (TX)	21,443	3,138	14.6	3,474	844	24.3	2,588	577	22.3	NA	NA	NA	$55,885.00
2016	Bexar County (TX)	1,884,633	306,859	16.3	494,371	108,689	22.0	355,058	74,149	20.9	NA	NA	NA	$53,170.00
2016	Calhoun County (TX)	21,733	3,420	15.7	5,440	1,366	25.1	3,969	924	23.3	NA	NA	NA	$52,916.00
2016	Comal County (TX)	133,515	11,496	8.6	30,311	3,954	13.0	22,378	2,691	12.0	NA	NA	NA	$76,296.00
2016	DeWitt County (TX)	18,979	3,462	18.2	4,677	1,253	26.8	3,278	880	26.8	NA	NA	NA	$46,915.00
2016	Dimmit County (TX)	10,671	2,940	27.6	3,185	1,215	38.1	2,244	866	38.6	NA	NA	NA	$38,275.00
2016	Edwards County (TX)	1,904	443	23.3	407	160	39.3	279	112	40.1	NA	NA	NA	$36,539.00
2016	Frio County (TX)	15,534	4,005	25.8	4,567	1,521	33.3	3,267	1,051	32.2	NA	NA	NA	$39,193.00
2016	Gillespie County (TX)	26,110	2,563	9.8	5,132	860	16.8	3,816	594	15.6	NA	NA	NA	$58,787.00
2016	Goliad County (TX)	7,407	1,059	14.3	1,592	396	24.9	1,207	273	22.6	NA	NA	NA	$55,264.00
2016	Gonzales County (TX)	20,523	3,519	17.1	5,635	1,441	25.6	4,060	1,012	24.9	NA	NA	NA	$45,491.00
2016	Guadalupe County (TX)	153,024	15,051	9.8	39,424	5,359	13.6	29,459	3,563	12.1	NA	NA	NA	$67,683.00
2016	Jackson County (TX)	14,592	1,966	13.5	3,729	713	19.1	2,716	500	18.4	NA	NA	NA	$53,143.00
2016	Karnes County (TX)	12,268	2,677	21.8	3,173	836	26.3	2,289	553	24.2	NA	NA	NA	$47,608.00
2016	Kendall County (TX)	42,045	3,119	7.4	9,781	1,066	10.9	7,621	730	9.6	NA	NA	NA	$83,805.00
2016	Kerr County (TX)	49,576	7,348	14.8	9,736	2,674	27.5	7,074	1,816	25.7	NA	NA	NA	$50,461.00
2016	Kinney County (TX)	3,253	652	20.0	662	181	27.3	507	127	25.0	NA	NA	NA	$40,612.00
2016	La Salle County (TX)	5,949	1,561	26.2	1,527	533	34.9	1,054	371	35.2	NA	NA	NA	$39,926.00
2016	Lavaca County (TX)	19,352	2,418	12.5	4,625	813	17.6	3,452	566	16.4	NA	NA	NA	$48,975.00
2016	Maverick County (TX)	56,638	13,759	24.3	18,346	6,390	34.8	12,900	4,358	33.8	NA	NA	NA	$35,654.00
2016	Medina County (TX)	46,919	6,746	14.4	11,466	2,348	20.5	8,556	1,643	19.2	NA	NA	NA	$51,304.00
2016	Real County (TX)	3,305	609	18.4	570	205	36.0	404	147	36.4	NA	NA	NA	$36,744.00
2016	Uvalde County (TX)	26,761	6,761	25.3	7,444	2,983	40.1	5,414	1,980	36.6	NA	NA	NA	$36,913.00
2016	Val Verde County (TX)	46,936	9,703	20.7	13,826	4,175	30.2	9,652	2,905	30.1	NA	NA	NA	$42,104.00
2016	Victoria County (TX)	90,681	12,900	14.2	23,314	5,024	21.5	16,787	3,492	20.8	NA	NA	NA	$53,659.00
2016	Wilson County (TX)	47,826	4,958	10.4	11,673	1,677	14.4	8,759	1,165	13.3	NA	NA	NA	$66,045.00
2016	Zavala County (TX)	11,591	3,991	34.4	3,603	1,699	47.2	2,603	1,141	43.8	NA	NA	NA	$25,507.00

Small Area Income and Poverty Estimates (SAIPE)

Appendix A, Table 11. 2016 Median Household Income and Poverty by County

2016 Median Household Income and Poverty by County					
Area/County	All Ages in Poverty Percent	Under Age 18 in Poverty Percent	Ages 5 to 17 in Families in Poverty Percent	Under Age 5 in Poverty Percent	Median Household Income in Dollars
United States	14.0	19.5	18.3	21.3	$57,617
Texas	15.6	22.4	21.4	24.3	$56,583
Region 8	15.7	22.0	20.8	NA	$49,732
Atascosa	16.3	24.8	23.4	NA	$53,622
Bandera	14.6	24.3	22.3	NA	$55,885
Bexar	16.3	22.0	20.9	NA	$53,170
Calhoun	15.7	25.1	23.3	NA	$52,916
Comal	8.6	13.0	12.0	NA	$76,296
DeWitt	18.2	26.8	26.8	NA	$46,915
Dimmit	27.6	38.1	38.6	NA	$38,275
Edwards	23.3	39.3	40.1	NA	$36,539
Frio	25.8	33.3	32.2	NA	$39,193
Gillespie	9.8	16.8	15.6	NA	$58,787
Goliad	14.3	24.9	22.6	NA	$55,264
Gonzales	17.1	25.6	24.9	NA	$45,491
Guadalupe	9.8	13.6	12.1	NA	$67,683
Jackson	13.5	19.1	18.4	NA	$53,143
Karnes	21.8	26.3	24.2	NA	$47,608
Kendall	7.4	10.9	9.6	NA	$83,805
Kerr	14.8	27.5	25.7	NA	$50,461
Kinney	20.0	27.3	25.0	NA	$40,612
La Salle	26.2	34.9	35.2	NA	$39,926
Lavaca	12.5	17.6	16.4	NA	$48,975
Maverick	24.3	34.8	33.8	NA	$35,654
Medina	14.4	20.5	19.2	NA	$51,304
Real	18.4	36.0	36.4	NA	$36,744
Uvalde	25.3	40.1	36.6	NA	$36,913
Val Verde	20.7	30.2	30.1	NA	$42,104
Victoria	14.2	21.5	20.8	NA	$53,659
Wilson	10.4	14.4	13.3	NA	$66,045
Zavala	34.4	47.2	43.8	NA	$25,507

Source: SAIPE

Appendix A, Table 12 – 2015-2016 Median Household Income Percent Change by County

2015-2016 Median Household Income Percent Change by County				
State / County Name	**2015**	**2016**	**Difference**	**(+ or -) % Change**
United States	$55,775	$57,617	1,842	3.3
Texas	$55,668	$56,583	915	1.6
Region 8	$48,805	$49,732	927	1.9
Zavala County (TX)	$27,711	$25,507	-2,204	-8.0
Maverick County (TX)	$34,687	$35,654	967	2.8
Edwards County (TX)	$37,567	$36,539	-1,028	-2.7
Real County (TX)	$34,031	$36,744	2,713	8.0
Uvalde County (TX)	$37,700	$36,913	-787	-2.1
Dimmit County (TX)	$40,040	$38,275	-1,765	-4.4
Frio County (TX)	$38,809	$39,193	384	1.0
La Salle County (TX)	$42,500	$39,926	-2,574	-6.1
Kinney County (TX)	$40,840	$40,612	-228	-0.6
Val Verde County (TX)	$42,465	$42,104	-361	-0.9
Gonzales County (TX)	$43,519	$45,491	1,972	4.5
DeWitt County (TX)	$47,365	$46,915	-450	-1.0
Karnes County (TX)	$47,129	$47,608	479	1.0
Lavaca County (TX)	$49,752	$48,975	-777	-1.6
Kerr County (TX)	$47,389	$50,461	3,072	6.5
Medina County (TX)	$52,831	$51,304	-1,527	-2.9
Calhoun County (TX)	$50,873	$52,916	2,043	4.0
Jackson County (TX)	$53,667	$53,143	-524	-1.0
Bexar County (TX)	$52,230	$53,170	940	1.8
Atascosa County (TX)	$49,047	$53,622	4,575	9.3
Victoria County (TX)	$55,406	$53,659	-1,747	-3.2
Goliad County (TX)	$52,612	$55,264	2,652	5.0
Bandera County (TX)	$53,662	$55,885	2,223	4.1
Gillespie County (TX)	$54,180	$58,787	4,607	8.5
Wilson County (TX)	$68,805	$66,045	-2,760	-4.0
Guadalupe County (TX)	$64,252	$67,683	3,431	5.3
Comal County (TX)	$68,362	$76,296	7,934	11.6
Kendall County (TX)	$79,108	$83,805	4,697	5.9
Source: SAIPE 2015-2016				

Appendix A, Table 13, 2018 Single Parent Homes by County

Percent of Single-Parent Homes			
County	**% Single-Parent Households**	**# Households**	**# Single-Parent Households**
Atascosa	38	13,358	5,108
Bandera	28	3,576	1,016
Bexar	38	483,323	183,786
Calhoun	35	5,555	1,926
Comal	26	28,402	7,336
DeWitt	42	4,606	1,928
Dimmit	41	3,245	1,318
Edwards	32	333	108
Frio	36	4,522	1,648
Gillespie	26	5,047	1,304
Goliad	42	1,605	672
Gonzales	35	5,433	1,925
Guadalupe	29	38,360	11,027
Jackson	24	3,738	915
Karnes	47	2,967	1,392
Kendall	22	9,136	2,044
Kerr	37	9,510	3,524
Kinney	10	678	68
La Salle	38	1,826	690
Lavaca	24	4,597	1,124
Maverick	32	18,320	5,893
Medina	29	11,422	3,333
Real	67	628	423
Uvalde	41	7,464	3,097
Val Verde	30	14,240	4,333
Victoria	35	23,181	8,151
Wilson	28	11,316	3,156
Zavala	58	3,687	2,152
Region 8	36	720,075	259,397
Texas	33	7,076,774	2,358,262
United States	20	72,452,603	14,115,713
Source: County Health Rankings, 2018			

Appendix A, Table 14 – 2017 Unemployment Rate by Region

2017 Unemployment Rate by Region						
Year	**Region**	**Area**	**Unemployment Rate %**	**Labor Force**	**Employed**	**Unemployed**
2017	US	United States	4.4	160,588,786	153,594,231	6,994,555
2017	Texas	Texas	4.3	13,538,411	12,960,611	577,800
2017	1	Region 1	3.4	417,719	403,666	14,053
2017	2	Region 2	3.8	237,371	228,275	9,096
2017	3	Region 3	3.6	3,948,817	3,805,063	143,754
2017	4	Region 4	4.6	502,474	479,569	22,905
2017	5	Region 5	6.3	322,498	302,051	20,447
2017	6	Region 6	5.0	3,397,842	3,229,430	168,412
2017	7	Region 7	3.4	1,734,065	1,675,751	58,314
2017	**8**	**Region 8**	**3.7**	**1,380,788**	**1,329,486**	**51,302**
2017	9	Region 9	3.7	305,494	294,337	11,157
2017	10	Region 10	4.6	363,834	346,981	16,853
2017	11	Region 11	6.6	927,509	866,002	61,507
Source: Local Area Unemployment Statistics						

Appendix A, Table 15 – 2017 Unemployment Rate by County

2017 Unemployment Rate by County				
Area	Unemployment Rate %	Labor Force	Employed	Unemployed
United States	4.4			
Texas	4.3			
Region 8	3.7	2,761,576	2,658,972	102,604
Atascosa County, TX	4.2	21,181	20,295	886
Bandera County, TX	3.6	9,639	9,293	346
Bexar County, TX	3.5	924,590	892,277	32,313
Calhoun County, TX	5.8	10,424	9,818	606
Comal County, TX	3.4	66,826	64,580	2,246
DeWitt County, TX	4.4	9,586	9,160	426
Dimmit County, TX	5.1	6,480	6,150	330
Edwards County, TX	3.2	904	875	29
Frio County, TX	3.8	9,300	8,942	358
Gillespie County, TX	2.6	13,193	12,853	340
Goliad County, TX	4.9	3,244	3,084	160
Gonzales County, TX	3.5	9,361	9,035	326
Guadalupe County, TX	3.3	77,510	74,946	2,564
Jackson County, TX	4	7,366	7,072	294
Karnes County, TX	3.5	6,424	6,200	224
Kendall County, TX	3.1	20,705	20,070	635
Kerr County, TX	3.4	21,290	20,564	726
Kinney County, TX	5.5	1,150	1,087	63
La Salle County, TX	3.7	4,203	4,048	155
Lavaca County, TX	3.6	8,712	8,400	312
Maverick County, TX	9.3	23,860	21,651	2,209
Medina County, TX	3.8	21,273	20,459	814
Real County, TX	5.7	1,049	989	60
Uvalde County, TX	4.7	11,714	11,168	546
Val Verde County, TX	5.1	20,007	18,991	1,016
Victoria County, TX	4.8	42,923	40,853	2,070
Wilson County, TX	3.5	24,155	23,320	835
Zavala County, TX	11.1	3,719	3,306	413
Region 8		1,380,788	1,329,486	51,302
Source: Bureau of Labor Statistics, 2017				

Appendix A, Table 16 – 2014 – 2017 Supplemental Nutrition Assistance Program (SNAP)

2014 - 2017 Supplemental Nutritioin Assistance Program (SNAP)												
	2017 Population	2017 # of Recipients	2017 Percent of Recipients	2016 Population	2016 # of Recipients	2016 Percent of Recipients	2015 Population	2015 # of Recipients	2015 Percent of Recipients	2014 Population	2014 # of Recipients	2014 Percent of Recipients
US	325,719,178	42,101,365	12.9	323,405,935	44,219,363	13.7	321,039,839	45,766,672	14.3	318,622,525	46,535,888	14.6
Texas	28,304,596	3,943,512	13.9	27,904,862	3,867,476	13.9	27,454,880	3,784,329	13.8	26,954,436	3,489,144	12.9
Region 8	2,958,133	446,014	15.1	2,910,042	433,898	14.9	2,860,832	429,959	15.0	2,806,021	399,644	14.2
Atascosa	48,981	9,400	19.2	48,666	9,110	18.7	48,349	8,551	17.7	47,700	8,221	17.2
Bandera	22,351	2,161	9.7	21,710	2,135	9.8	21,146	2,148	10.2	20,814	2,028	9.7
Bexar	1,958,578	306,086	15.6	1,927,747	298,590	15.5	1,894,811	300,406	15.9	1,857,635	279,431	15.0
Calhoun	21,744	4,126	19.0	21,942	3,266	14.9	21,881	3,132	14.3	21,805	2,808	12.9
Comal	141,009	9,733	6.9	134,142	9,293	6.9	128,653	9,139	7.1	123,120	8,641	7.0
DeWitt	20,226	3,659	18.1	20,618	3,147	15.3	20,630	2,898	14.0	20,516	2,691	13.1
Dimmit	10,418	2,910	27.9	10,784	3,056	30.2	10,981	2,875	26.2	11,021	2,652	24.1
Edwards	1,953	295	15.1	1,918	295	15.4	1,910	306	16.0	1,902	258	13.6
Frio	19,600	3,865	19.7	19,385	3,940	20.3	19,260	3,646	18.0	18,924	3,425	18.1
Gillespie	26,646	1,684	6.3	26,305	1,739	6.6	25,959	1,741	6.7	25,465	1,676	6.6
Goliad	7,562	1,015	13.4	7,521	884	11.8	7,510	814	10.8	7,504	731	9.7
Gonzales	20,893	3,923	18.8	20,863	3,540	17.0	20,538	3,422	16.7	20,357	3,097	15.2
Guadalupe	159,659	14,549	9.1	154,596	14,217	9.2	150,585	14,205	9.4	146,765	13,523	9.2
Jackson	14,805	1,970	13.3	14,851	1,841	12.4	14,792	1,716	11.6	14,721	1,582	10.7
Karnes	15,187	3,008	19.8	15,264	2,483	16.3	15,247	2,185	14.3	14,833	1,979	13.3
Kendall	44,026	1,825	4.1	41,964	1,959	4.7	39,968	2,031	5.1	38,408	1,830	4.8
Kerr	51,720	5,603	10.9	51,296	5,754	11.2	50,753	5,818	11.5	50,275	5,480	10.9
Kinney	3,745	464	12.4	3,640	473	13.0	3,593	504	14.0	3,548	457	12.9
La Salle	7,584	1,397	18.4	7,619	1,404	18.4	7,644	1,268	16.6	7,479	1,258	16.8
Lavaca	20,062	2,319	11.6	19,910	1,940	9.7	19,916	1,866	9.4	19,779	1,642	8.3
Maverick	58,216	17,065	29.3	57,989	17,398	30.0	57,658	16,520	28.7	57,031	15,151	26.6
Medina	50,066	6,720	13.4	49,196	6,695	13.6	48,380	6,546	13.5	47,834	6,024	12.6
Real	3,429	470	13.7	3,397	452	13.3	3,297	422	12.8	3,348	424	12.7
Uvalde	27,132	6,410	23.6	27,106	6,342	23.4	26,925	6,078	22.6	27,062	5,468	20.2
Val Verde	49,205	11,321	23.0	48,953	11,391	23.3	48,906	11,069	22.6	48,808	10,204	20.9
Victoria	92,084	15,667	17.0	92,379	14,168	15.3	92,082	12,555	13.6	90,988	11,490	12.6
Wilson	49,304	4,429	9.0	48,190	4,293	8.9	47,162	4,136	8.8	46,143	3,833	8.3
Zavala	11,948	3,941	33.0	12,091	4,093	33.9	12,296	3,965	32.2	12,236	3,642	29.8
Supplemental Nutritional Assistance Program (SNAP) Statistics												

Appendix A, Table 17 – Free/Reduced Lunch by County

2014 - 2015 to 2015- 2016 Students Eligible for Free and/or Reduced Lunches by County						
County Name	**Total Students, All Grades (Excludes AE) [Public School] 2015-16**	**Free and Reduced Lunch Students [Public School] 2015-16**	**2015-2016 Percent Free and Reduced Eligible Students**	**Total Students, All Grades (Excludes AE) [Public School] 2014-15**	**Free and Reduced Lunch Students [Public School] 2014-15**	**2014-2015 Percent Free and Reduced Eligible Students**
Atascosa County, TX	8,232	4,919	59.8	8,684	5,320	61.3
Bandera County, TX	2,502	1,285	51.4	2,549	1,317	51.7
Bexar County, TX	355,644	225,861	63.5	351,598	223,258	63.5
Calhoun County, TX	4,179	2,516	60.2	4,224	2,564	60.7
Comal County, TX	24,629	7,762	31.5	24,075	7,897	32.8
DeWitt County, TX	4,653	2,804	60.3	4,695	2,743	58.4
Dimmit County, TX	2,314	1,311	56.7	2,449	1,805	73.7
Edwards County, TX	386	273	70.7	388	263	67.8
Frio County, TX	3,284	2,581	78.6	3,407	2,398	70.4
Gillespie County, TX	3,770	1,850	48.1	3,637	1,781	49.0
Goliad County, TX	1,368	656	48.0	1,408	643	45.7
Gonzales County, TX	4,275	3,186	74.5	4,193	3,103	74.0
Guadalupe County, TX	26,713	11,105	41.6	26,110	10,967	42.0
Jackson County, TX	3,323	1,754	52.8	3,345	1,712	51.2
Karnes County, TX	2,504	1,542	61.6	‡	‡	‡
Kendall County, TX	8,559	2,077	24.3	8,050	2,059	25.6
Kerr County, TX	6,962	4,186	60.1	6,967	4,223	60.6
Kinney County, TX	615	382	62.1	641	385	60.1
La Salle County, TX	1,361	1,157	85.0	1,353	1,110	82.0
Lavaca County, TX	2,358	878	37.2	2,295	852	37.1
Maverick County, TX	15,093	11,778	78.0	15,076	11,420	75.7
Medina County, TX	10,825	6,442	59.5	10,301	5,939	57.7
Real County, TX	563	399	70.9	542	356	65.7
Uvalde County, TX	5,755	4,177	72.6	5,763	4,094	71.0
Val Verde County, TX	11,090	8,324	75.1	11,261	8,384	74.5
Victoria County, TX	15,765	10,189	64.6	15,749	9,864	62.6
Wilson County, TX	0	‡	‡	0	‡	‡
Zavala County, TX	2,655	1,988	74.9	2,693	2,005	74.5
Region 8	529,377	321,382	60.7	521,453	316,462	60.7
Totals:	5,291,752	3,107,545	58.7	5,222,326	3,058,606	58.6

Appendix A, Table 18 2015-2016 Uninsured/Insured Under Age 65 by County

2015 - 2016 Percent Uninsured/Insured Under Age 65 by County

Name	2015 Population	2015 Number Uninsured	2015 % Uninsured	2015 Number Insured	2015 % Insured	2016 Population	2016 Number Uninsured	2016 % Uninsured	2016 Number Insured	2016 % Insured	Change (+/-)
Texas	23,676,871	4,536,765	19.2	19,140,106	80.8	23,943,499	4,444,791	18.6	19,498,708	81.4	-0.6
Region 8	2,425,173	421,039	17.4	2,004,134	82.638	2,458,492	419,719	17.1	2,038,773	82.927	-0.3
Atascosa County, TX	41,356	7,750	18.7	33,606	81.3	41,543	7,590	18.3	33,953	81.7	-0.4
Bandera County, TX	15,658	2,696	17.2	12,962	82.8	15,915	2,865	18	13,050	82	0.8
Bexar County, TX	1,640,479	274,865	16.8	1,365,614	83.2	1,663,368	276,390	16.6	1,386,978	83.4	-0.2
Calhoun County, TX	18,142	3,625	20	14,517	80	18,146	3,335	18.4	14,811	81.6	-0.6
Comal County, TX	105,473	16,838	16	88,635	84	109,734	15,496	14.1	94,238	85.9	-1.9
DeWitt County, TX	15,217	2,607	17.1	12,610	82.9	15,229	2,576	16.9	12,653	83.1	-0.2
Dimmit County, TX	9,267	1,714	18.5	7,553	81.5	9,044	1,650	18.2	7,394	81.8	-0.3
Edwards County, TX	1,396	436	31.2	960	68.8	1,404	344	24.5	1,060	75.5	-6.7
Frio County, TX	13,243	2,692	20.3	10,551	79.7	13,335	2,674	20.1	10,661	79.9	-0.2
Gillespie County, TX	18,350	4,214	23	14,136	77	18,589	4,392	23.6	14,197	76.4	0.6
Goliad County, TX	5,907	799	13.5	5,108	86.5	5,865	835	14.2	5,030	85.8	0.7
Gonzales County, TX	17,002	4,195	24.7	12,807	75.3	17,271	4,298	24.9	12,973	75.1	0.2
Guadalupe County, TX	129,709	19,226	14.8	110,483	85.2	132,881	19,985	15	112,896	85	0.2
Jackson County, TX	12,198	2,273	18.6	9,925	81.4	12,175	2,272	18.7	9,903	81.3	0.1
Karnes County, TX	10,248	1,628	15.9	8,620	84.1	10,174	1,583	15.6	8,591	84.4	-0.3
Kendall County, TX	32,304	5,262	16.3	27,042	83.7	34,011	4,763	14	29,248	86	-2.3
Kerr County, TX	35,801	7,559	21.1	28,242	78.9	36,049	7,275	20.2	28,774	79.8	-0.9
Kinney County, TX	2,331	494	21.2	1,837	78.8	2,371	489	20.6	1,882	79.4	-0.6
La Salle County, TX	4,955	922	18.6	4,033	81.4	4,910	833	17	4,077	83	-1.6
Lavaca County, TX	15,349	2,731	17.8	12,618	82.2	15,268	2,616	17.1	12,652	82.9	-0.7
Maverick County, TX	49,602	14,293	28.8	35,309	71.2	49,546	13,611	27.5	35,935	72.5	-1.3
Medina County, TX	38,685	7,049	18.2	31,636	81.8	39,327	6,524	16.6	32,803	83.4	-1.6
Real County, TX	2,296	609	26.5	1,687	73.5	2,361	578	24.5	1,783	75.5	-2
Uvalde County, TX	22,328	5,185	23.2	17,143	76.8	22,297	5,022	22.5	17,275	77.5	-0.7
Val Verde County, TX	40,352	8,997	22.3	31,355	77.7	40,064	9,023	22.5	31,041	77.5	0.2
Victoria County, TX	77,257	13,916	18	63,341	82	76,978	14,481	18.8	62,497	81.2	0.8
Wilson County, TX	40,114	6,427	16	33,687	84	40,736	6,225	15.3	34,511	84.7	-0.7
Zavala County, TX	10,154	2,037	20.1	8,117	79.9	9,901	1,994	20.1	7,907	79.9	0

Source: Small Area Health Insurance Estimates (SAHIE) Program, 2015, 2016

Appendix A, Table 19 – 2016 Educational Attainment of Persons 18-24 Years of Age by County

2016 Educational Attainment of Persons 18 to 24 Years of Age by County									
Area	Population	Less Than High School	High School Grad	Some College or Associate's Degree	Bachelor's Degree or Higher	Percent Less Than High School	Percent High School Grad	Percent Some College or Associate's Degree	Percent Bachelor's Degree or Higher
Atascosa	4,249	803	1,691	1,558	197	18.9%	39.8%	36.7%	4.6%
Bandera	1,304	239	547	491	27	18.3%	41.9%	37.7%	2.1%
Bexar	200,276	29,580	65,002	90,665	15,029	14.8%	32.5%	45.3%	7.5%
Calhoun	1,778	455	703	544	76	25.6%	39.5%	30.6%	4.3%
Comal	9,453	1,323	3,806	3,476	848	14.0%	40.3%	36.8%	9.0%
Dewitt	1,497	247	731	447	72	16.5%	48.8%	29.9%	4.8%
Dimmit	1,034	513	320	201	0	49.6%	30.9%	19.4%	0.0%
Edwards	243	62	135	46	0	25.5%	55.6%	18.9%	0.0%
Frio	2,917	1,029	1,371	477	40	35.3%	47.0%	16.4%	1.4%
Gillespie	1,777	346	809	581	41	19.5%	45.5%	32.7%	2.3%
Goliad	607	84	267	240	16	13.8%	44.0%	39.5%	2.6%
Gonzales	1,882	498	864	497	23	26.5%	45.9%	26.4%	1.2%
Guadalupe	13,360	2,128	5,544	4,898	790	15.9%	41.5%	36.7%	5.9%
Jackson	1,094	170	495	329	100	15.5%	45.2%	30.1%	9.1%
Karnes	1,609	653	515	424	17	40.6%	32.0%	26.4%	1.1%
Kendall	2,966	447	1,389	1,091	39	15.1%	46.8%	36.8%	1.3%
Kerr	4,215	865	1,635	1,520	195	20.5%	38.8%	36.1%	4.6%
Kinney	309	92	97	112	8	29.8%	31.4%	36.2%	2.6%
La Salle	709	157	202	294	56	22.1%	28.5%	41.5%	7.9%
Lavaca	1,429	296	489	607	37	20.7%	34.2%	42.5%	2.6%
Maverick	6,629	1,683	2,197	2,494	255	25.4%	33.1%	37.6%	3.8%
Medina	4,693	1,135	1,507	1,955	96	24.2%	32.1%	41.7%	2.0%
Real	223	84	45	94	0	37.7%	20.0%	42.2%	0.0%
Region 8	286,717	47,261	98,671	121,633	19,151	16.5%	34.4%	42.4%	6.7%
Texas	2,738,831	447,119	855,325	1,213,652	222,735	16.3%	31.2%	44.3%	8.1%
U.S.	31,296,577	4,326,831	9,390,475	14,398,370	3,180,901	13.8%	30.0%	46.0%	10.2%
Uvalde	2,895	457	1,104	1,169	165	15.8%	38.1%	40.4%	5.7%
Val Verde	5,465	1,274	1,954	1,847	389	23.3%	35.8%	33.8%	7.1%
Victoria	8,754	1,866	3,396	3,143	349	21.3%	38.8%	35.9%	4.0%
Wilson	3,852	595	1,311	1,706	240	15.4%	34.0%	44.3%	6.2%
Zavala	1,498	180	545	727	46	12.0%	36.4%	48.5%	3.1%
Source: 2012 - 2016 American Community Survey 5-Year Estimates, 2016 Educational Attainment.									

Appendix A, Table 20 – 2016 Dropout Rates by County

2016 Dropout Rates by County					
County Name	**County all students graduation, continuation, or GED rate 2016**	**County all students graduation rate 2016**	**County all students continuation rate 2016**	**County all students GED rate 2016**	**County all students dropout rate 2016**
ATASCOSA COUNTY	95.6	93.9	1.6	0.2	4.4
BANDERA COUNTY	94.7	94.3	0.5	0	5.3
BEXAR COUNTY	92.3	88.3	3.6	0.4	7.7
CALHOUN COUNTY	96.3	91.6	3	1.7	3.7
COMAL COUNTY	96.2	93.5	2.3	0.4	3.8
DEWITT COUNTY	97.9	93.4	4.2	0.3	2.1
DIMMIT COUNTY	85.1	82.9	2.2	0	14.9
EDWARDS COUNTY	96.3	96.3	0	0	3.7
FRIO COUNTY	88.2	84.6	2.6	0.9	11.8
GILLESPIE COUNTY	96.6	94.9	1.7	0	3.4
GOLIAD COUNTY	100	99	1	0	0
GONZALES COUNTY	88.8	84.5	3.9	0.4	11.2
GUADALUPE COUNTY	97.7	94.2	3.3	0.3	2.3
JACKSON COUNTY	97.9	96.3	1.6	0	2.1
KARNES COUNTY	95.5	94.9	0.6	0	4.5
KENDALL COUNTY	99.4	97.9	1.3	0.1	0.6
KERR COUNTY	98.5	94	2.8	1.7	1.5
KINNEY COUNTY	95.3	93	2.3	0	4.7
LA SALLE COUNTY	96.4	93.8	2.5	0	3.6
LAVACA COUNTY	98.6	96.5	2.1	0	1.4
MAVERICK COUNTY	91.8	86.9	4.4	0.6	8.2
MEDINA COUNTY	95.3	93.5	1.5	0.3	4.7
REAL COUNTY	77.4	71	3.2	3.2	22.6
UVALDE COUNTY	86.8	77.5	8.2	1.1	13.2
VAL VERDE COUNTY	92.6	86.1	6.3	0.3	7.4
VICTORIA COUNTY	87.7	81.4	4.8	1.5	12.3
WILSON COUNTY	97.4	96.3	1.1	0	2.6
ZAVALA COUNTY	92.8	90.4	0.6	1.8	7.2
TEA Division of Research and Analysis					

Appendix A, Table 21 UCR Crime Rates by County

2016 Uniform Crime by County											
Year	**County**	**Agency**	**Population**	**Murder**	**Rape**	**Robbery**	**Assault**	**Burglary**	**Larceny**	**Auto Theft**	**Total**
2016	Atascosa	Population	49,596								
2016	Atascosa	**Number Offenses**		3	8	17	81	319	915	92	1,435
2016	Atascosa	Rate Per 100,000		6.0	16.1	34.3	163.3	643.2	1,844.9	185.5	2,893.4
2016	Atascosa	**Number Clearances**		2	4	5	34	25	89	18	177
2016	Atascosa	Percent Cleared		67	50	30	42	8	10	20	13
2016	Atascosa	**Number of Arrests**		4	3	4	31	44	123	35	244
2016	Bandera	Population	21,352								
2016	Bandera	**Number Offenses**		0	11	1	26	75	146	25	284
2016	Bandera	Rate Per 100,000		0.0	51.5	4.7	121.8	351.3	683.8	117.1	1,330.1
2016	Bandera	**Number Clearances**		0	5	0	18	0	6	10	39
2016	Bandera	Percent Cleared		0	46	0	70	0	5	40	14
2016	Bandera	**Number of Arrests**		0	0	0	9	0	5	5	19
2016	Bexar	Population	1,932,033								
2016	Bexar	**Number Offenses**		173	1369	2445	7758	14339	67692	8141	101917
2016	Bexar	Rate Per 100,000		9.0	70.9	126.6	401.5	742.2	3,503.7	421.4	5,275.1
2016	Bexar	**Number Clearances**		113	177	291	1,843	404	6,623	343	9,794
2016	Bexar	Percent Cleared		66	13	12	24	3	10	5	10
2016	Bexar	**Number of Arrests**		136	132	636	1,104	741	4,708	181	7,638
2016	Calhoun	Population	19,728								
2016	Calhoun	**Number Offenses**		2	21	6	100	201	370	24	724
2016	Calhoun	Rate Per 100,000		10.1	106.4	30.4	506.9	1,018.9	1,875.5	121.7	3,669.9
2016	Calhoun	**Number Clearances**		2	7	2	61	30	64	10	176
2016	Calhoun	Percent Cleared		100	34	34	61	15	18	42	25
2016	Calhoun	**Number of Arrests**		2	8	3	55	33	76	12	189
2016	Comal	Population	144,356								
2016	Comal	**Number Offenses**		2	74	34	256	470	1909	239	2984
2016	Comal	Rate Per 100,000		1.4	51.3	23.6	177.3	325.6	1,322.4	165.6	2,067.1
2016	Comal	**Number Clearances**		2	12	12	93	28	267	19	433
2016	Comal	Percent Cleared		100	17	36	37	6	14	8	15
2016	Comal	**Number of Arrests**		4	14	14	58	42	329	28	489
2016	Dewitt	Population	18,669								
2016	Dewitt	**Number Offenses**		1	10	3	91	112	218	10	445
2016	Dewitt	Rate Per 100,000		5.4	53.6	16.1	487.4	599.9	1,167.7	53.6	2,383.6
2016	Dewitt	**Number Clearances**		1	3	2	44	32	33	3	118
2016	Dewitt	Percent Cleared		100	30	67	49	29	16	30	27
2016	Dewitt	**Number of Arrests**		1	3	1	35	34	30	5	109
2016	Dimmit	Population	11,148								
2016	Dimmit	**Number Offenses**		0	1	0	2	39	135	8	185
2016	Dimmit	Rate Per 100,000		0.0	9.0	0.0	17.9	349.8	1,211.0	71.8	1,659.5
2016	Dimmit	**Number Clearances**		0	1	0	2	3	52	1	59
2016	Dimmit	Percent Cleared		0	100	0	100	8	39	13	32
2016	Dimmit	**Number of Arrests**		0	0	0	3	6	49	1	59
2016	Edwards	Population	1,868								
2016	Edwards	**Number Offenses**		0	0	0	4	4	11	3	22
2016	Edwards	Rate Per 100,000		0.0	0.0	0.0	214.1	214.1	588.9	160.6	1,177.7
2016	Edwards	**Number Clearances**		0	0	0	4	1	0	0	5
2016	Edwards	Percent Cleared		0	0	0	100	25	0	0	23
2016	Edwards	**Number of Arrests**		0	0	0	3	1	8	0	12

Continued Appendix A, Table 21 - 2016 UCR Crime Rates

2016 Uniform Crime by County											
Year	**County**	**Agency**	**Population**	**Murder**	**Rape**	**Robbery**	**Assault**	**Burglary**	**Larceny**	**Auto Theft**	**Total**
2016	Frio	Population	19,062								
2016	Frio	**Number Offenses**		0	2	7	25	120	208	14	376
2016	Frio	Rate Per 100,000		0	10.5	36.7	131.2	629.5	1,091.2	73.4	1,972.5
2016	Frio	**Number Clearances**		0	1	0	18	21	61	2	103
2016	Frio	Percent Cleared		0	50	0	72	18	30	15	28
2016	Frio	**Number of Arrests**		0	0	0	14	15	45	3	77
2016	Gillespie	Population	26,108								
2016	Gillespie	**Number Offenses**		0	0	1	12	53	205	13	284
2016	Gillespie	Rate Per 100,000		0.0	0.0	3.8	46.0	203.0	785.2	49.8	1,087.8
2016	Gillespie	**Number Clearances**		0	0	1	10	10	48	3	72
2016	Gillespie	Percent Cleared		0	0	100	84	19	24	24	26
2016	Gillespie	**Number of Arrests**		0	0	0	5	7	22	1	35
2016	Goliad	Population	7,571								
2016	Goliad	**Number Offenses**		0	2	2	12	38	51	3	108
2016	Goliad	Rate Per 100,000		0	26.4	26.4	158.5	501.9	673.6	39.6	1,426.5
2016	Goliad	**Number Clearances**		0	0	1	3	2	0	1	7
2016	Goliad	Percent Cleared		0	0	50	25	6	0	34	7
2016	Goliad	**Number of Arrests**		0	0	1	3	4	0	1	9
2016	Gonzales	Population	20,679								
2016	Gonzales	**Number Offenses**		0	19	3	90	87	249	15	463
2016	Gonzales	Rate Per 100,000		0	91.9	14.5	435.2	420.7	1,204.1	72.5	2,239.0
2016	Gonzales	**Number Clearances**		0	16	3	76	14	65	4	178
2016	Gonzales	Percent Cleared		0	85	100	85	17	27	27	39
2016	Gonzales	**Number of Arrests**		0	7	0	43	12	16	1	79
2016	Guadalupe	Population	142,459								
2016	Guadalupe	**Number Offenses**		5	79	35	161	483	2039	169	2971
2016	Guadalupe	Rate Per 100,000		3.5	55.5	24.6	113.0	339.0	1,431.3	118.6	2,085.5
2016	Guadalupe	**Number Clearances**		4	55	25	89	70	397	39	679
2016	Guadalupe	Percent Cleared		80	70	72	56	15	20	24	23
2016	Guadalupe	**Number of Arrests**		2	38	16	63	60	224	25	428
2016	Jackson	Population	14,925								
2016	Jackson	**Number Offenses**		0	7	3	26	53	140	9	238
2016	Jackson	Rate Per 100,000		0	46.9	20.1	174.2	355.1	938.0	60.3	1,594.6
2016	Jackson	**Number Clearances**		0	6	1	23	8	64	6	108
2016	Jackson	Percent Cleared		0	86	34	89	16	46	67	46
2016	Jackson	**Number of Arrests**		0	7	2	21	14	69	6	119
2016	Karnes	Population	14,954								
2016	Karnes	**Number Offenses**		1	4	6	34	80	259	13	397
2016	Karnes	Rate Per 100,000		6.7	26.7	40.1	227.4	535.0	1,732.0	86.9	2,654.8
2016	Karnes	**Number Clearances**		1	1	4	21	14	51	4	96
2016	Karnes	Percent Cleared		100	25	67	62	18	20	31	25
2016	Karnes	**Number of Arrests**		1	0	5	13	15	60	5	99
2016	Kendall	Population	39,764								
2016	Kendall	**Number Offenses**		1	14	4	20	79	425	39	582
2016	Kendall	Rate Per 100,000		2.5	35.2	10.1	50.3	198.7	1,068.8	98.1	1,463.6
2016	Kendall	**Number Clearances**		0	2	0	8	6	27	12	55
2016	Kendall	Percent Cleared		0	15	0	40	8	7	31	10
2016	Kendall	**Number of Arrests**		0	0	0	9	5	22	9	45

Continued Appendix A, Table 21 – 2016 UCR Crime Rates

2016 Uniform Crime by County											
Year	County	Agency	Population	Murder	Rape	Robbery	Assault	Burglary	Larceny	Auto Theft	Total
2016	Kerr	Population	51,069								
2016	Kerr	**Number Offenses**		8	28	7	81	180	715	46	1065
2016	Kerr	Rate Per 100,000		15.7	54.8	13.7	158.6	352.5	1,400.1	90.1	2,085.4
2016	Kerr	**Number Clearances**		7	12	7	51	32	200	22	331
2016	Kerr	Percent Cleared		88	43	100	63	18	28	48	32
2016	Kerr	**Number of Arrests**		6	4	7	38	32	170	16	273
2016	Kinney	Population	1,880								
2016	Kinney	**Number Offenses**		0	0	0	1	10	0	1	12
2016	Kinney	Rate Per 100,000		0	0	0	53.2	531.9	0	53.2	638.3
2016	Kinney	**Number Clearances**		0	0	0	1	0	0	0	1
2016	Kinney	Percent Cleared		0	0	0	100	0	0	0	9
2016	Kinney	**Number of Arrests**		0	0	0	2	2	0	0	4
2016	La Salle	Population	7,763								
2016	La Salle	**Number Offenses**		0	1	0	6	5	49	1	62
2016	La Salle	Rate Per 100,000		0	12.9	0	77.3	64.4	631.2	12.9	798.7
2016	La Salle	**Number Clearances**		0	1	0	5	0	1	0	7
2016	La Salle	Percent Cleared		0	100	0	84	0	2	0	12
2016	La Salle	**Number of Arrests**		0	1	0	10	3	11	0	25
2016	Lavaca	Population	22,115								
2016	Lavaca	**Number Offenses**		0	4	6	28	109	135	6	288
2016	Lavaca	Rate Per 100,000		0	18.1	27.1	126.6	492.9	610.4	27.1	1,302.3
2016	Lavaca	**Number Clearances**		0	3	1	21	9	37	1	72
2016	Lavaca	Percent Cleared		0	75	17	75	9	28	17	25
2016	Lavaca	**Number of Arrests**		0	0	2	18	10	35	0	65
2016	Maverick	Population	58,200								
2016	Maverick	**Number Offenses**		1	9	10	85	272	855	44	1276
2016	Maverick	Rate Per 100,000		1.7	15.5	17.2	146.0	467.4	1,469.1	75.6	2,192.4
2016	Maverick	**Number Clearances**		1	2	5	22	7	78	8	123
2016	Maverick	Percent Cleared		100	23	50	26	3	10	19	10
2016	Maverick	**Number of Arrests**		0	1	6	14	21	134	6	182
2016	Medina	Population	46,994								
2016	Medina	**Number Offenses**		2	36	4	90	217	617	50	1016
2016	Medina	Rate Per 100,000		4.3	76.6	8.5	191.5	461.8	1,312.9	106.4	2,162.0
2016	Medina	**Number Clearances**		2	12	2	54	19	75	7	171
2016	Medina	Percent Cleared		100	34	50	60	9	13	14	17
2016	Medina	**Number of Arrests**		2	8	4	58	33	80	4	189
2016	Real	Population	3,295								
2016	Real	**Number Offenses**		0	0	0	6	17	20	2	45
2016	Real	Rate Per 100,000		0	0	0	182.1	515.9	607	60.7	1,365.7
2016	Real	**Number Clearances**		0	0	0	2	0	0	0	2
2016	Real	Percent Cleared		0	0	0	34	0	0	0	5
2016	Real	**Number of Arrests**		0	0	0	4	6	4	5	19

Continued Appendix A, Table 21 UCR Crime Rages by County

2016 Uniform Crime by County											
Year	County	Agency	Population	Murder	Rape	Robbery	Assault	Burglary	Larceny	Auto Theft	Total
2016	Uvalde	Population	27,327								
2016	Uvalde	**Number Offenses**		3	9	7	41	124	639	17	840
2016	Uvalde	Rate Per 100,000		11	32.9	25.6	150	453.8	2,338.3	62.2	3,073.9
2016	Uvalde	**Number Clearances**		3	1	2	27	18	278	9	338
2016	Uvalde	Percent Cleared		100	12	29	66	15	44	53	41
2016	Uvalde	**Number of Arrests**		0	1	1	27	16	31	0	76
2016	Val Verde	Population	48,838								
2016	Val Verde	**Number Offenses**		1	6	13	50	240	761	31	1102
2016	Val Verde	Rate Per 100,000		2	12.3	26.6	102.4	491.4	1,558.2	63.5	2,256.4
2016	Val Verde	**Number Clearances**		3	0	3	22	6	182	5	221
2016	Val Verde	Percent Cleared		300	0	24	44	3	24	17	21
2016	Val Verde	**Number of Arrests**		3	0	3	21	25	100	8	160
2016	Victoria	Population	93,252								
2016	Victoria	**Number Offenses**		4	66	63	226	620	1872	122	2973
2016	Victoria	Rate Per 100,000		4.3	70.8	67.6	242.4	664.9	2,007.5	130.8	3,188.1
2016	Victoria	**Number Clearances**		4	7	27	142	51	287	20	538
2016	Victoria	Percent Cleared		100	11	43	63	9	16	17	19
2016	Victoria	**Number of Arrests**		5	3	22	112	28	308	12	490
2016	Wilson	Population	48,311								
2016	Wilson	**Number Offenses**		1	5	5	48	112	350	54	575
2016	Wilson	Rate Per 100,000		2.1	10.3	10.3	99.4	231.8	724.5	111.8	1,190.2
2016	Wilson	**Number Clearances**		1	2	6	35	31	140	23	238
2016	Wilson	Percent Cleared		100	40	120	73	28	40	43	42
2016	Wilson	**Number of Arrests**		2	0	4	31	13	40	12	102
2016	Zavala	Population	12,306								
2016	Zavala	Number Offenses		0	1	2	31	67	90	5	196
2016	Zavala	Rate Per 100,000		0	8.1	16.3	251.9	544.4	731.4	40.6	1,592.7
2016	Zavala	Number Clearances		0	0	2	14	5	8	1	30
2016	Zavala	Percent Cleared		0	0	100	46	8	9	20	16
2016	Zavala	Number of Arrests		0	0	0	9	6	9	1	25
2016	Region 8	Population	2,905,622								
2016	Region 8	Number Offenses		208	1,786	2,684	9,391	18,525	81,075	9,196	122,865
2016	Region 8	Rate Per 100,000		7.2	61.5	92.4	323.2	637.6	2,790.3	316.5	4,228.5
2016	Region 8	Number Clearances		146	330	402	2,743	846	9,133	571	14,171
2016	Region 8	Percent Cleared		70.192	18.477	14.977	29.208	4.566	11.264	6.209	11.533
2016	Region 8	Number of Arrests		168	230	731	1,813	1,228	6,708	382	11,260
2016	Texas	Population	27,821,692								
2016	Texas	Number Offenses		1,473	13,320	33,250	72,609	148,073	548,941	68,523	886,189
2016	Texas	Rate Per 100,000		5.3	47.9	119.5	261.0	532.2	1,973.1	246.3	3,185.2
2016	Texas	Number Clearances		982	4,942	7,914	35,941	15,548	91,673	9,319	166,604
2016	Texas	Percent Cleared		66.7	37.1	23.8	49.5	10.5	16.7	13.6	18.8
2016	Texas	Number of Arrests		907	2,472	7,255	22,307	12,657	79,477	5,973	131,048

Appendix A, Table 22 – 2015-2016 Change in Family Violence Incidents

2015 - 2016 Family Violence Percent Change by County				
County	**2015 Number Incidents**	**2016 Number Incidents**	**Number Change**	**% Change**
Texas	194,872	196,564	1692	0.9%
Region 8	20,948	21,543	595	2.8%
Atascosa	312	301	-11	-3.5%
Bandera	79	94	15	19.0%
Bexar	15,342	16,551	1209	7.9%
Calhoun	176	231	55	31.3%
Comal	1,049	976	-73	-7.0%
DeWitt	76	75	-1	-1.3%
Dimmit	72	73	1	1.4%
Edwards	1	10	9	900.0%
Frio	96	101	5	5.2%
Gillespie	39	30	-9	-23.1%
Goliad	34	33	-1	-2.9%
Gnzales	90	80	-10	-11.1%
Guadalup	791	744	-47	-5.9%
Jackson	52	45	-7	-13.5%
Karnes	63	69	6	9.5%
Kendall	121	101	-20	-16.5%
Kerr	328	340	12	3.7%
Kinney	2	2	0	0.0%
La Salle	21	22	1	4.8%
Lavaca	122	57	-65	-53.3%
Maverick	415	394	-21	-5.1%
Medina	144	152	8	5.6%
Real	10	6	-4	-40.0%
Uvalde	303	48	-255	-84.2%
Val Verde	227	184	-43	-18.9%
Victoria	851	733	-118	-13.9%
Wilson	75	50	-25	-33.3%
Zavala	57	41	-16	-28.1%

Source: Texas Department of Public Safety, Crime in Texas, Chapter 5, 2015, 2016

Appendix A, Table 23 – 2017 CPS Completed Abuse/Neglect Investigations by County

2016-2017 CPS Completed Victim Investigations by County								
County	2016 Confirmed	2016 Not Confirmed	2016 Total	2016 Victims Per 1,000 Child Population	2017 Confirmed	2017 Not Confirmed	2017 Total	2017 Victims Per 1,000 Child Population
Texas			276,763	37.4			289,796	38.6
Region 8	6,944	27,741	34,685	46.4	8,267	30,058	38,325	50.7
Atascosa	202	517	719	53.0	308	730	1,038	75.9
Bandera	47	156	203	52.1	83	192	275	70.6
Bexar	4,550	18,901	23,451	46.4	5,588	20,201	25,789	50.6
Calhoun	91	212	303	50.5	99	199	298	49.1
Comal	382	1,015	1,397	49.3	455	1,150	1,605	55.8
DeWitt	72	260	332	73.3	65	261	326	71.4
Dimmit	60	181	241	82.3	51	173	224	76.5
Edwards	2	7	9	19.8	5	30	35	75.6
Frio	79	266	345	78.6	94	243	337	76.0
Gillespie	34	133	167	31.7	42	153	195	36.6
Goliad	17	89	106	66.9	16	94	110	69.2
Gonzales	46	201	247	46.4	77	282	359	63.0
Guadalup	357	1,335	1,692	41.1	317	1,538	1,855	50.7
Jackson	54	107	161	45.5	42	117	159	44.6
Karnes	31	184	215	73.3	64	216	280	95.6
Kendall	30	222	252	29.5	39	258	297	34.6
Kerr	197	402	599	57.2	182	483	665	62.9
Kinney	10	30	40	59.1	7	23	30	43.4
La Salle	19	104	123	75.6	38	122	160	97.3
Lavaca	21	135	156	37.0	20	143	163	39.0
Maverick	34	321	355	18.6	38	294	332	17.3
Medina	107	486	593	47.7	108	527	635	50.6
Real	10	31	41	68.9	6	46	52	86.2
Uvalde	101	378	479	61.2	120	392	512	64.9
Val Verde	70	481	551	36.1	74	418	492	32.1
Victoria	222	1,083	1,305	55.4	206	1,179	1,385	58.6
Wilson	60	307	367	30.7	87	405	492	40.9
Zavala	39	197	236	61.9	36	189	225	58.5
Source: DFPS, Data Book 2016-2017								

Appendix A, Table 24 – 2013 – 2017 Texas Marijuana/Hashish Seizures

2013-2017 Texas Marijuana/Hashish Seizures							
Year	**Description**	**Solid Pound**	**Solid Ounces**	**Solid Grams**	**Liquid Ounces**	**Dose Units**	**Items**
2013	Marijuana(Packaged)	814,952	14,773	0	0	0	0
2013	Marijuana(Plants)	0	0	0	0	0	599,182
2013	Marijuana(Gardens)	0	0	0	0	0	556
2013	Marijuana(Wild Fields)	0	0	0	0	0	18
2013	Marijuana(Cultivated Fields)	0	0	0	0	0	3,034
2013	Marijuana(Green Houses)	0	0	0	0	0	389
2013	Hashish(Liquid Oil)	0	0	0	129	0	0
2013	Hashish(Solid)	81	234	998	0	0	0
2014	Marijuana(Packaged)	1,502,123	15,353	0	0	0	0
2014	Marijuana(Plants)	0	0	0	0	0	66,289
2014	Marijuana(Gardens)	0	0	0	0	0	186
2014	Marijuana(Wild Fields)	0	0	0	0	0	4
2014	Marijuana(Cultivated Fields)	0	0	0	0	0	26
2014	Marijuana(Green Houses)	0	0	0	0	0	260
2014	Hashish(Liquid Oil)	0	0	0	12,184	0	0
2014	Hashish(Solid)	146	229	1,263	0	0	0
2015	Marijuana(Packaged)	138,001	15,041	0	0	0	0
2015	Marijuana(Plants)	0	0	0	0	0	26,537
2015	Marijuana(Gardens)	0	0	0	0	0	236
2015	Marijuana(Wild Fields)	0	0	0	0	0	1,033
2015	Marijuana(Cultivated Fields)	0	0	0	0	0	5,311
2015	Marijuana(Green Houses)	0	0	0	0	0	75
2015	Hashish(Liquid Oil)	0	0	0	1,075	0	0
2015	Hashish(Solid)	68	371	1,742	0	0	0
2016	Marijuana(Packaged)	276,483	17,039	0	0	0	0
2016	Marijuana(Plants)	0	0	0	0	0	1,111
2016	Marijuana(Gardens)	0	0	0	0	0	188
2016	Marijuana(Wild Fields)	0	0	0	0	0	1
2016	Marijuana(Cultivated Fields)	0	0	0	0	0	16
2016	Marijuana(Green Houses)	0	0	0	0	0	679
2016	Hashish(Liquid Oil)	0	0	0	2,641	0	0
2016	Hashish(Solid)	311	569	2,562	0	0	0
2017	Marijuana(Packaged)	115,745	19,100	0	0	0	0
2017	Marijuana(Plants)	0	0	0	0	0	10,799
2017	Marijuana(Gardens)	0	0	0	0	0	119
2017	Marijuana(Wild Fields)	0	0	0	0	0	14
2017	Marijuana(Cultivated Fields)	0	0	0	0	0	93
2017	Marijuana(Green Houses)	0	0	0	0	0	79
2017	Hashish(Liquid Oil)	0	0	0	11,708	0	0
2017	Hashish(Solid)	796	925	3,585	0	0	0

Source: Texas Department of Public Safety

Appendix A, Table 25 - 2017 Texas Drug Seizures

2017 Texas Drug Seizures								
Year	Description	Solid Pounds	% of Drugs Seized	Solid Ounces	Solid Grams	Liquid Ounces	Dose Units	Items
2017	Marijuana(Packaged)	115,745	80.5%	19,100	0	0	0	0
2017	Other Drugs(Methamphetamines)	4,895	3.4%	3,380	22,155	1,432	1,518,276	0
2017	Cocaine(Solid)	19,814	13.8%	2,449	15,704	0	0	0
2017	Hallucinogens(Designer Drugs)	627	0.4%	1,437	6,478	878	19,604	0
2017	Other Drugs(Amphetamines)	612	0.4%	1,230	10,121	6,530	15,584	0
2017	Opiates(Heroin)	878	0.6%	930	5,998	71	1,044	0
2017	Hashish(Solid)	796	0.1%	925	3,585	0	0	0
2017	Opiates(Codeine)	346	0.2%	519	1,717	1,164,779	19,522	0
2017	Hallucinogens(PCP)	38	0.0%	235	1,376	252	180	0
2017	Hallucinogens(Mushrooms)	47	0.0%	150	1,721	0	64	0
2017	Opiates(Gum Opium)	8		57	595	0	0	0
2017	Opiates(Morphine)	2		48	467	9	3,071	0
2017	Hallucinogens(LSD)	0		36	526	198	7,324	0
2017	Precursor Chemicals	1		34	182	78	0	0
2017	Hallucinogens(Peyote)	2		9	59	0	0	0
2017	Other Drugs(Synthetic Narcotics)	9		0	0	4,977	145,287	0
2017	Marijuana(Plants)	0		0	0	0	0	10,799
2017	Marijuana(Gardens)	0		0	0	0	0	119
2017	Marijuana(Wild Fields)	0		0	0	0	0	14
2017	Marijuana(Cultivated Fields)	0		0	0	0	0	93
2017	Marijuana(Green Houses)	0		0	0	0	0	79
2017	Hashish(Liquid Oil)	0		0	0	11,708	0	0
2017	Cocaine(Liquid)	0		0	0	3,736	0	0
2017	Other Drugs(Barbiturates)	0		0	0	527	77,793	0
2017	Other Drugs(Tranquilizers)	0		0	0	2,699	583,580	0
2017	Clandestine Labs	0		0	0	0	0	59

Source: Texas Department of Public Safety

Appendix A, Table 26 – 2014-2015 Intentional Self-Harm (Suicide)

2014-2015 Intentional Self-Harm (Suicide) (ICD 10 Codes X60-X84, Y87.0)by Region					
Area	# Suicides 2014	# Suicides 2015	# Suicides 2014-2015	Crude Death Rate 2014-2015	Age Adjusted Rate 2014-2015
Texas	3,225	3,368	6,593	12.1	12.2
Region 8	347	331	678	12.1	12.1
Atascosa County	10	6	16		
Bandera County	-99	-99	-99		
Bexar County	188	205	393	10.5	10.6
Calhoun County	-99	-99	-99		
Comal County	25	19	44		
DeWitt County	-99	-99	-99		
Dimmit County	-99	-99	-99		
Edwards	0	0	0		
Frio County	-99	0	-99		
Gillespie County	-99	-99	13		
Goliad County	-99	-99	-99		
Gonzales County	-99	-99	-99		
Guadalupe County	19	15	34	11.3	11.6
Jackson County	-99	-99	-99		
Karnes County	-99	-99	-99		
Kendall County	-99	10	16		
Kerr County	12	15	27	26.3	21.8
Kinney County	-99	-99	-99		
La Salle County	0	-99	-99		
Lavaca County	-99	-99	-99		
Maverick County	-99	-99	-99		
Medina County	-99	-99	15		
Real County	-99	-99	-99		
Uvalde County	-99	-99	-99		
Val Verde County	-99	-99	-99		
Victoria County	18	12	30	16.4	16.9
Wilson County	-99	-99	12		
Zavala County	0	-99	-99		
*-99 Value is less than 9 and masked					
Source: Texas Department of State Health Services, DSHS Center for Health Statistics					

Appendix A, Table 27 – 2015 Medicare Clients Reporting Depression by County

2015 Region 8 Medicare Clients Reporting Depression by County			
County	**Condition**	**Count of Beneficiaries in County**	**Prevelance**
Atascosa	Depression	3,881	17.2
Bandera	Depression	3,808	16.3
Bexar	Depression	130,099	15.4
Calhoun	Depression	3,146	19.4
Comal	Depression	18,614	14.3
De Witt	Depression	3,048	14.1
Dimmit	Depression	1,115	15.2
Edwards	Depression	541	12.6
Frio	Depression	1,579	12.1
Gillespie	Depression	5,953	14.8
Goliad	Depression	1,072	17.2
Gonzales	Depression	2,954	13.1
Guadalupe	Depression	14,568	14.9
Jackson	Depression	1,937	17.0
Karnes	Depression	2,124	14.8
Kendall	Depression	7,446	13.5
Kerr	Depression	12,540	16.4
Kinney	Depression	629	11.9
La Salle	Depression	667	11.7
Lavaca	Depression	4,493	17.1
Maverick	Depression	5,933	13.3
Medina	Depression	4,560	16.3
Real	Depression	883	15.1
Uvalde	Depression	3,404	12.1
Val Verde	Depression	5,509	12.6
Victoria	Depression	12,340	18.1
Wilson	Depression	4,173	16.7
Zavala	Depression	1,165	12.4
The Medicare Chronic Conditions Dashboard:			

Appendix A, Table 28 – Alcohol Permit Density by County

2018 Alcohol Permits by County				
County	**2018 Population**	**Number of Alcohol Permits**	**Permits per 500 Population**	**Permits per 100,000 Population**
Atascosa	53,655	108	1.0	201.3
Bandera	24,187	57	1.2	235.7
Bexar	1,988,364	3,831	1.0	192.7
Calhoun	24,472	74	1.5	306.5
Comal	141,332	430	1.5	304.2
DeWitt	20,770	75	1.8	361.1
Dimmit	10,719	38	1.8	354.5
Edwards	2,153	6	1.4	278.7
Frio	19,512	52	1.3	266.5
Gillespie	28,827	213	3.7	738.9
Goliad	8,255	27	1.6	327.1
Gonzales	21,871	57	1.3	260.6
Guadalupe	171,409	259	0.8	151.1
Jackson	14,291	43	1.5	300.9
Karnes	15,976	57	1.8	356.8
Kendall	42,562	124	1.5	291.3
Kerr	55,505	140	1.3	252.2
Kinney	3,778	11	1.5	291.2
La Salle	7,957	34	2.1	427.3
Lavaca	19,717	78	2.0	395.6
Maverick	61,696	92	0.7	149.1
Medina	54,632	109	1.0	199.5
Real	3,430	20	2.9	583.1
Uvalde	28,161	72	1.3	255.7
Val Verde	52,475	90	0.9	171.5
Victoria	91,624	229	1.2	249.9
Wilson	54,265	86	0.8	158.5
Zavala	12,670	32	1.3	252.6
Region 8	3,034,265	6,444	1.1	212.4
Texas	29,366,479	59,086	1.0	201.2
Source: Texas Alcoholic Beverage Commission				
Source: Texas Demographic Center, Population Estimates, 2018				

Appendix A, Table 29 – 1999 – 2016 Alcohol and Drug Overdose Deaths by County

1999-2016 Alcohol and Drug Induced Deaths				
County Name	Deaths (1999-2016)	Population (1999-2016)	Crude Rate per 100K	Age Adjusted Rate per 100K
Atascosa	110	787,144	14	14.6
Bandera	82	356,058	23	18.2
Bexar	5,638	29,420,227	19.2	19.8
Calhoun	99	380,712	26	26
Comal	336	1,826,969	18.4	17.2
DeWitt	52	364,363	14.3	12.8
Dimmit	25	184,499	13.6	15
Frio	32	309,189	10.3	11.6
Gillespie	63	425,960	14.8	13.6
Gonzales	69	353,188	19.5	19.6
Guadalupe	286	2,153,730	13.3	13.1
Jackson	30	256,371	11.7	10.6
Karnes	32	271,403	11.8	11.2
Kendall	63	564,099	11.2	11.3
Kerr	211	860,858	24.5	24.2
La Salle	21	120,491	17.4	19.7
Lamar	124	887,294	14	14
Lavaca	41	347,750	11.8	10.9
Maverick	75	940,450	8	9.2
Medina	71	797,030	8.9	8.8
Uvalde	58	476,118	12.2	12.7
Val Verde	95	853,672	11.1	11.9
Victoria	251	1,562,732	16.1	16.3
Wilson	85	723,682	11.7	11.1
Zavala	31	211,728	14.6	16.9
Goliad	17	129,516	Unreliable	Unreliable
Real	10	58,091	Unreliable	Unreliable
Region 8	8,007	45,623,324	17.6	
Texas	66,969	433,541,733	15.4	15.8
CDC Wonder, 999-2016				

Appendix A, Table 30 – 2017 DUI Crashes and Fatalities by County

2017 Region 8 Percent DUI Crashes DUI Fatalities by County								
County	**DUI Crashes**	**Crashes NO Alcohol**	**% Crashes DUI**	**Total Crashes**	**DUI Fatalities**	**NO Alcohol Fatalities**	**Total Fatalities**	**Percent DUI Fatalities**
Atascosa	38	747	4.8%	785	1	8	9	11.1%
Bandera	39	294	11.7%	333	2	5	7	28.6%
Bexar	2,016	48,520	4.0%	50,536	53	111	164	32.3%
Calhoun	20	314	6.0%	334	0	1	1	0.0%
Comal	166	1,913	8.0%	2,079	4	13	17	23.5%
DeWitt	12	281	4.1%	293	1	4	5	20.0%
Dimmit	12	175	6.4%	187	1	2	3	33.3%
Edwards	2	49	3.9%	51	0	1	1	0.0%
Frio	7	160	4.2%	167	0	3	3	0.0%
Gillespie	33	487	6.3%	520	3	10	13	23.1%
Goliad	3	91	3.2%	94	0	1	1	0.0%
Gonzales	21	405	4.9%	426	1	11	12	8.3%
Guadalupe	119	2,546	4.5%	2,665	4	15	19	21.1%
Jackson	15	276	5.2%	291	2	1	3	66.7%
Karnes	12	274	4.2%	286	0	4	4	0.0%
Kendall	43	810	5.0%	853	2	2	4	50.0%
Kerr	70	857	7.6%	927	0	3	3	0.0%
Kinney	0	17	0.0%	17	0	0	0	0.0%
La Salle	10	129	7.2%	139	1	6	7	14.3%
Lavaca	19	103	15.6%	122	2	5	7	28.6%
Maverick	41	790	5.2%	831	3	6	9	33.3%
Medina	42	718	5.5%	760	2	15	17	11.8%
Real	1	66	1.5%	67	0	2	2	0.0%
Uvalde	25	385	6.1%	410	0	15	15	0.0%
Val Verde	38	765	4.7%	803	0	1	1	0.0%
Victoria	95	1,128	7.8%	1,223	5	10	15	33.3%
Wilson	32	539	5.6%	571	0	4	4	0.0%
Zavala	4	56	6.7%	60	2	0	2	100.0%
Region 8	2,935	62,875	4.5%	65,810	**89**	259	**348**	**25.6%**
Texas	23,760	514,210	4.4%	537,970	**1,024**	1,361	**3,721**	**27.5%**
Source: Texas Department of Transportation, Texas Peach Officer's Crash Reports (CR-3)								

Appendix A, Table 31 – Percent Change in DUI Fatalities by County

2016 - 2017 Region 8 Percent Change in DUI Fatalities by County				
County	**2016 DUI Fatalities**	**2017 DUI Fatalities**	**Number Change from 2016 to 2017**	**Percent Change from 2016 to 2017**
Atascosa	1	1	0	0.0%
Bandera	0	2	2	200.0%
Bexar	64	53	-11	-17.2%
Calhoun	1	0	-1	-100.0%
Comal	6	4	-2	-33.3%
DeWitt	2	1	-1	-50.0%
Dimmit	0	1	1	100.0%
Edwards	0	0	0	0.0%
Frio	2	0	-2	100.0%
Gillespie	0	3	3	300.0%
Goliad	1	0	-1	100.0%
Gonzales	2	1	-1	-100.0%
Guadalupe	11	4	-7	-63.6%
Jackson	2	2	0	0.0%
Karnes	1	0	-1	-100.0%
Kendall	1	2	1	100.0%
Kerr	3	0	-3	-100.0%
Kinney	1	0	-1	-100.0%
La Salle	1	1	0	0.0%
Lavaca	0	2	2	200.0%
Maverick	2	3	1	50.0%
Medina	5	2	-3	-60.0%
Real	1	0	-1	-100.0%
Uvalde	1	0	-1	100.0%
Val Verde	1	0	-1	100.0%
Victoria	0	5	5	500.0%
Wilson	1	0	-1	-100.0%
Zavala	0	2	2	200.0%
Region 8	110	**89**	-21	-19.1%
Texas	1,018	**1,024**	6	0.6%
Source: Texas Department of Transportation, Texas Peach Officer's Crash Reports (CR-3)				

Appendix A, Table 32 – 2017 DUI Fatalities by Age by County

2017 Region 8 DUI (Alcohol) Related Fatalities by County by Age													
County	**DUI Fatalities**	**<21**	**21-25**	**26-30**	**31-35**	**36-40**	**41-45**	**46-50**	**51-55**	**56-60**	**61-65**	**65+**	**UNK**
Atascosa	1						1						
Bandera	2							1		1			
Bexar	53	5	13	8	8	4	4	5	1	3	0	1	1
Calhoun	0												
Comal	4	0		2		1	1						
DeWitt	1								1				
Dimmit	1				1								
Edwards	0												
Frio	0												
Gillespie	3		1			1					1		
Goliad	0												
Gonzales	1						1						
Guadalupe	4			1		1	1	1					
Jackson	2		1			1							
Karnes	0												
Kendall	2		1						1				
Kerr	0												
Kinney	0												
La Salle	1			1									
Lavaca	2								1		1		
Maverick	3			1						1	1		
Medina	2			1							1		
Real	0												
Uvalde	0												
Val Verde	0												
Victoria	5	1	1	1	1		1						
Wilson	0												
Zavala	2	1			1								
Region 8	89	7	17	15	11	8	9	7	4	5	4	1	1
Texas	1,024	113	178	142	116	87	95	75	79	69	35	32	3
Source: Texas Department of Transportation, Texas Peach Officer's Crash Reports (CR-3)													

Appendix A, Table 33 – 2014-2015 High Risk Substance Misuse Morbidity by County

2014-2015 Region 8 High Risk Substance Misuse Morbidity by County						
Area	**Chronic Liver Disease and Cirrhosis**	**Crude Death Rate Liver**	**Malignant Neoplasms**	**Crude Death Rate Malignant Neoplasms**	**Diseases of the Heart**	**Crude Death Rate Heart**
Atascosa County	11	*	153	158.4	237	245.3
Bandera County	10	*	110	258.7	94	221.1
Bexar County	640	17.1	5,123	137.1	5,994	160.4
Calhoun County	*	*	88	204.6	103	239.4
Comal County	36	14.2	448	176.4	465	183.1
DeWitt County	*	*	100	237.6	141	335.1
Dimmit County	11	*	42	191.3	73	332.6
Edwards County	*	*	14	0.0	11	0.0
Frio Couonty	*	*	40	107.4	91	244.3
Gillespie County	12	*	140	266.5	138	262.7
Goliad County	*	*	42	269.4	34	218.1
Gonzales County	*	*	78	191.2	86	210.9
Guadalupe County	51	17.0	433	144.2	538	179.2
Jackson County	*	*	63	214.5	68	231.5
Karnes County	10	*	57	182.4	67	214.4
Kendall County	*	*	149	187.6	170	214.0
Kerr County	19	*	300	292.5	332	323.7
Kinney County	*	*	21	287.8	20	0.0
La Salle County	0	*	14	0.0	33	216.5
Lavaca County	*	*	110	277.6	129	325.6
Maverick County	28	*	138	121.2	170	149.3
Medina County	17	*	180	183.3	219	223.0
Real County	*	*	23	333.3	25	362.3
Region 8	1010	17.9	8,613	152.0	10,062	177.6
Texas	7504	13.8	77,745	142.8	84,426	155.1
Uvalde County	18	*	93	169.7	109	198.9
Val Verde County	22	*	118	121.9	152	157.0
Victoria County	36	19.6	338	184.4	324	176.8
Wilson County	20	*	152	159.9	197	207.3
Zavala County	14	*	46	188.5	42	172.1
Source: Texas Health Data, Center for Health Statistics						

Appendix A, Table 34 – 2017 Alcohol Related Arrests

2017 Alcohol Related Arrests by County - Updated 10/8/2018								
	Juvenile	Adult	Total			Juvenile	Adult	Total
Texas DUI	70	10,866	10,936		Region 8 DUI	3	9,762	9,765
Texas Drunkenness	118	11,525	11,643		Region 8 Drunkenness	7	4,893	4,900
Texas Liquor Laws	306	1,422	1,728		Region Liquor Laws	26	617	643
Atascosa DUI	0	40	40		Karnes DUI	0	15	15
Atascosa Drunkenness	0	192	192		Karnes Drunkenness	0	79	79
Atascosa Liquor Laws	0	5	5		Karnes Liquor Laws	3	4	7
Bandera DUI	0	30	30		Kendall DUI	0	143	143
Bandera Drunkenness	0	32	32		Kendall Drunkenness	0	93	93
Bandera Liquor Laws	0	2	2		Kendall Liquor Laws	1	8	9
Bexar DUI	1	7405	7406		Kerr DUI	0	205	205
Bexar Drunkenness	0	1837	1837		Kerr Drunkenness	0	387	387
Bexar Liquor Laws	8	331	335		Kerr Liquor Laws	7	95	102
Calhoun DUI	0	81	81		Kinney DUI	0	8	8
Calhoun Drunkenness	0	187	187		Kinney Drunkenness	0	18	18
Calhoun Liquor Laws	0	4	4		Kinney Liquor Laws	0	0	0
Comal DUI	0	530	530		La Salle DUI	0	30	30
Comal Drunkenness	1	452	453		La Salle Drunkenness	0	46	46
Comal Liquor Laws	2	18	20		La Salle Liquor Laws	0	2	2
DeWitt DUI	0	17	17		Lavaca DUI	0	31	31
DeWitt Drunkenness	0	32	32		Lavaca Drunkenness	0	44	44
DeWitt Liquor Laws	0	0	0		Lavaca Liquor Laws	1	3	4
Dimmit DUI	0	7	7		Maverick DUI	0	112	112
Dimmit Drunkenness	0	75	75		Maverick Drunkenness	0	178	178
Dimmit Liquor Laws	0	6	6		Maverick Liquor Laws	0	1	1
Edwards DUI	0	3	3		Medina DUI	0	32	32
Edwards Drunkenness	0	6	6		Medina Drunkenness	3	68	71
Edwards Liquor Laws	0	0	0		Medina Liquor Laws	2	47	49
Frio DUI	0	55	55		Real DUI	0	17	17
Frio Drunkenness	0	62	62		Real Drunkenness	0	0	0
Frio Liquor Laws	0	0	0		Real Liquor Laws	0	0	0
Gillespie DUI	0	145	145		Uvalde DUI	0	54	54
Gillespie Drunkenness	0	121	121		Uvalde Drunkenness	0	89	89
Gillespie Liquor Laws	0	15	15		Uvalde Liquor Laws	0	2	2
Goliad DUI	0	1	1		Val Verde DUI	2	197	199
Goliad Drunkenness	0	3	3		Val Verde Drunkenness	0	72	72
Goliad Liquor Laws	0	0	0		Val Verde Liquor Laws	0	11	11
Gonzales DUI	0	57	57		Victoria DUI	0	194	194
Gonzales Drunkenness	0	66	66		Victoria Drunkenness	0	366	366
Gonzales Liquor Laws	0	5	5		Victoria Liquor Laws	4	46	50
Guadalupe DUI	0	286	286		Wilson DUI	0	7	7
Guadalupe Drunkenness	0	249	249		Wilson Drunkenness	3	59	62
Guadalupe Liquor Laws	0	6	6		Wilson Liquor Laws	0	2	2
Jackson DUI	0	53	53		Zavala DUI	0	7	7
Jackson Drunkenness	0	25	25		Zavala Drunkenness	0	55	55
Jackson Liquor Laws	2	4	6		Zavala Liquor Laws	0	0	0
Source: Texas Department of Public Safety, 2017								

Appendix A, Table 35 – 2013-2014 Texas Public HS Grads Enrolled in Higher Education 2014-2015

Academic Year 2013-2014 Texas Public High School Gruduates Enrolled in Texas Higher Education in Academic Year 2014-2015					
Area	**Enrolled in Texas Public or Independent 4-Year Institution**	**Enrolled in Texas Public or Independent 2 Year College**	**Not Trackable in Texas Higher Education**	**Not Located in Texas Higher Education**	**Total**
Texas	79,171	95,058	15,699	113,181	303,109
Region 8	8,013	9,247	753	13,314	31,379
Atascosa	111	164	2	282	559
Bandera	60	27	1	94	182
Bexar	5,049	6,067	573	8,372	20,061
Calhoun	40	79	10	158	287
Comal	588	383	29	810	1,810
DeWitt	54	91	6	134	285
Dimmit	27	53	1	48	129
Edwards	11	12	0	19	42
Frio	30	33	1	93	157
Gillespie	91	56	6	122	275
Goliad	26	29	2	37	94
Gonzales	40	54	19	112	225
Guadalupe	470	360	29	795	1,654
Jackson	41	91	2	77	211
Karnes	34	52	0	55	141
Kendall	260	146	12	237	655
Kerr	146	61	17	194	418
Kinney	13	14	0	26	53
La Salle	*	*	*	*	52
Lavaca	27	59	0	41	127
Maverick	202	376	8	333	919
Medina	168	171	6	302	647
Real	6	12	0	11	29
Uvalde	56	140	1	93	290
Val Verde	127	224	5	221	577
Victoria	138	290	16	349	793
Wilson	174	147	7	240	568
Zavala	24	56	0	59	139

* College enrollment counts do not include graduates that enrolled in out-of-state institutions of higher education or graduates with ID numbers that were non-trackable or not located.

Source: Academic Year 2013-2014 Texas Public High School Graduates Enrolled in Texas Higher Education, Academic Year 2014-2015. Texas Higher Education Data. http://www.thecb.state.tx.us/reports/PDF/7514.PDF?CFID=80883979&CFTOKEN=56853660. Accessed July 29, 2018

Appendix B - Glossary of Terms

ACS	American Community Survey
Adolescent	An individual between the ages of 12 and 17 years (SAMHSA)
ATOD	Alcohol, tobacco, and other drugs
BAC	Blood Alcohol Concentration
BLS	U.S. Bureau of Labor Statistics
BRFSS	Behavioral Risk Factor Surveillance System
CAPT	Southwest Regional Center for Applied Prevention Technologies
CBD	Cannabinoid
CBP	U.S. Customs and Border Protection
CDC	Centers for Disease Control and Prevention
CHR	County Health Rankings
CSAP	SAMHSA's Center for Substance Abuse Prevention
Epidemiology	Epidemiology is the study of the distribution and determinants of health-related states or events in specified populations, and the application of this study to the control of health problems. (CDC)
Evaluation	Systematic application of scientific and statistical procedures for measuring program conceptualization, design, implementation, and utility; making comparisons based on these measurements; and the use of the resulting information to optimize program outcomes.
EWG	Epidemiological Work Group
FBI UCR	Federal Bureau-Investigation Uniform Crime Reporting
HHSC	Texas Health and Human Service Commission
Incidence	Incidence refers to the occurrence of new cases of disease or injury in a population over a specified period of time. (CDC)
IOM	Institute of Medicine
NCES	National Center for Education Statistics
NIAAA	National Institute on Alcohol Abuse and Alcoholism
NIDA	National Institute on Drug Abuse
OCA	Texas Office of Court Administration
PMP	Prescription Monitoring Program
PPRI	Public Policy Research Institute
PRC	Prevention Resource Center
Prevalence	Prevalence is the proportion of persons in a population who have a particular disease or attribute at a specified point in time or over a specified period of time. Prevalence differs from incidence in that prevalence includes all cases, both new and preexisting, in the population at the specified time, whereas incidence is limited to new cases only. (CDC)
Protective Factor	Protective factors are characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's impact. Protective factors may be seen as positive countering events. (SAMHSA)

RE	Regional Evaluator
Risk Factor	Risk factors are characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes. (SAMHSA)
RNA	Regional Needs Assessment
SAMHSA	Substance Abuse and Mental Health Services Administration
SNAP	Supplemental Nutrition Assistance Program
SPF	Strategic Prevention Framework. SAMHSA's SPF is a planning process for preventing substance use and misuse. The five steps and two guiding principles of the SPF offer prevention professionals a comprehensive process for addressing the substance misuse and related behavioral health problems facing their communities. (SAMHSA)
SUD	Substance Use Disorder. The *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition (DSM-5), no longer uses the terms substance abuse and substance dependence, rather it refers to substance use disorders, which are defined as mild, moderate, or severe to indicate the level of severity, which is determined by the number of diagnostic criteria met by an individual. Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. According to the DSM-5, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria. Disorders include: Alcohol Use Disorder (AUD), Tobacco Use Disorder, Cannabis Use Disorder, Stimulant Use Disorder, Hallucinogen Use Disorder, and Opioid Use Disorder. (SAMHSA)
TANF	Temporary Assistance for Needy Families
TDC	Texas Demographic Center
TEA	Texas Education Agency
TJJD	Texas Juvenile Justice Department
TPII	Texas Prevention Impact Index
TSDC	Texas State Data Center
TSS	Texas School Survey
TxDOT	Texas Department of Transportation
TxDPS	Texas Department of Public Safety
USCB	U.S. Census Bureau
WHO	World Health Organization
YRBSS	Youth Risk Behavior Surveillance System

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