# Table of Contents

**Introduction** ..................................................................................................................... 1  
  Background on Substance Prevention ................................................................................. 1 
  Problem Statement ............................................................................................................... 2 
  Goal of Prevention Resource Centers .................................................................................. 3 
  Goal of Data Coordinators .................................................................................................. 4 
  Steps to Achieve Goals ....................................................................................................... 5 

**Purpose** ............................................................................................................................... 6  
  Regional Needs Assessment ............................................................................................... 6 
  Social Determinants of Health ............................................................................................ 7 
  Risk and Protective Factors ................................................................................................. 8 
  Adverse Childhood Experiences .......................................................................................... 9 
  Adverse Community Environments ..................................................................................... 9 
  Quantitative and Qualitative Data ....................................................................................... 10 
  Key Informant Interviews and Regional Epidemiological Workgroups ......................... 11 
  Twelve Sectors of a Community .......................................................................................... 11 

**Methods** ............................................................................................................................. 13  
  Strategic Prevention Framework ......................................................................................... 13 
  Socio-Ecological Model ....................................................................................................... 14 
  Key Informant Interviews ................................................................................................... 15 
   Participants ....................................................................................................................... 15 
   Procedures ......................................................................................................................... 16 
   Analysis Plan ..................................................................................................................... 17 
  Regional Epidemiological Workgroups ............................................................................ 19 
   Participants ....................................................................................................................... 19 
   Procedures ......................................................................................................................... 20 
   Analysis Plan ..................................................................................................................... 22 

**Results** ............................................................................................................................... 23  
  Key Informant Interviews ................................................................................................... 23 
   Substance Use Concerns ................................................................................................. 23 
   Contributing Factors ........................................................................................................ 24 
   Consequences .................................................................................................................. 24 
   Effect on Sector ............................................................................................................... 25 
  Lacking Substance Use/Misuse Prevention Resources ....................................................... 27 
  Lacking Mental/Emotional Wellbeing Resources ............................................................... 27
Introduction

Background on Substance Prevention
Progress has been made over the years to address substance use, misuse, and substance use disorders and the effects it has on individuals, families, and communities. Progress can be marked through the advancements in neurobiology and the chemistry of substances and the brain, the creation and implementation of prevention, treatment, and recovery programs, and governmental and private sector promotion of prevention information and services (U.S. Department of HHS).

The East Texas Council on Alcoholism and Drug Abuse (ETCADA) has a rich history of providing substance use/misuse services throughout East Texas. Founded in 1960, ETCADA services consisted of volunteers counseling those with alcohol problems, distributing promotional pamphlets, and facilitating educational programs.

Over the next sixty-two years, the following services were added:

- **Substance Abuse Screening Assessment and Referral Services** - Licensed Chemical Dependency Counselors provide substance use screening and assessment to those seeking state-funded treatment. Supportive services are provided for participants waiting for available treatment services. 24/7 After-Hours Crisis Line.

- **Substance Abuse Subtle Screening Inventory** - Brief and accurate screening questionnaire that provides a consistent substance abuse scoring measure. Generally required by the judicial system.

- **Education/Prevention School Based Programs** - Evidenced-based interactive curriculum facilitated by certified instructors to elementary through high school students to provide life skills needed to make healthy choices, resist negative peer pressure, increase protective factors, and increase self-image.

- **Region 4 Prevention Resource Center** - Provides data and information related to behavioral health, training, support and resources for community programs, and tobacco compliance checks.
• **Burgess Recovery Center** - Recovery Support Peer Specialists provide peer-driven and person-centered recovery support services that encourage and assist individuals and their supportive allies achieve long-term recovery from substance use disorders.

• **Recovery Support Services** - Confidential support and encouragement led by a certified Recovery Support Peer Specialist for those struggling with addiction.
  - Men's Support Group: Recovery support group for men.
  - Winners Circle: Recovery support group for those striving to remain free from past substance use and criminal justice involvement and their supportive allies.

• **Youth Transition Center** – Connects young people ages 15 to 25 years old with a myriad of services to address and overcome barriers to achieve a successful future.

• **Training Entity** - Certified training entity approved by the Texas Health and Human Services Commission as a certified provider of continuing education for certification and recertification for alcoholism and drug abuse providers in the state of Texas.

Problem Statement
The Region 4 PRC recognizes the need for collaboration and awareness between organizations and providers to maximize their capacity and reach of services for all stakeholders in Region 4. Having a broader and overlapping view of organizations and providers in Region 4, allows the PRC the ability to illuminate service and data gaps and facilitate active discussion to formulate solutions with participation across all sectors and counties.

Substance misuse is a complex behavioral health problem, and to address it requires the energy, expertise, and experience of multiple players, working together across disciplines. Prevention planners need diverse partners—from neighborhood residents to service providers to community leaders—to share information and resources, raise awareness about critical substance use/misuse problems, build support for prevention, and ensure that prevention activities reach multiple populations with multiple strategies in multiple settings.

By involving community members in all aspects of prevention planning, implementation, and evaluation, planners demonstrate respect for the people they serve and are more likely to develop prevention services that meet genuine needs, build on strengths, and produce positive outcomes.
**Goal of Prevention Resource Centers**

PRCs are funded by the Texas Health and Human Services Commission (HHSC) to maintain and serve as the primary resource for substance use/misuse and related behavioral health data and to support prevention collaboration efforts for the region.

PRCs provide technical assistance and consultation to providers, community groups, and other stakeholders to identify data related to substance use and behavioral health in general. PRCs work to promote and educate the community on substance use and misuse and associated consequences through various data products, media awareness activities, regionwide events, and an annual Regional Needs Assessment (RNA).

In this way, PRCs 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/misuse and behavioral health. The program also helps to identify community strengths, gaps in services, and areas for improvement.

### Health Services Regions

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

Map of Health Service Regions serviced by a Prevention Resource Center
There is one PRC located in each of the eleven Texas Health Service Regions to provide support to prevention providers located in their region with substance use/misuse and behavioral health data, trainings, media activities, and regional workgroups. PRCs seek to promote behavioral health and reduce use/misuse of substances, prioritizing the following: underage alcohol use, marijuana and cannabinoid use, tobacco and other nicotine product use/misuse, and prescription drug use/misuse.

PRCs have four fundamental objectives:

- Collect data relevant to the state’s prevention priorities and share findings with community partners.
- Ensure sustainability of a Regional Epidemiological Workgroup focused on identifying strategies related to data collection, gaps in data, and prevention needs.
- Coordinate regional prevention trainings and conduct media awareness activities related to risks and consequences of alcohol, tobacco, and other drugs use/misuse.
- Conduct voluntary compliance checks and education on state tobacco laws to retailers.

**Goal of Data Coordinators**
The PRC Data Coordinators serve as a primary resource for substance use/misuse and behavioral health data for their region and engage in building collaborative partnerships with key community members who aid in securing access to information.

Data Coordinators:

- Develop and maintain the Regional Epidemiological Workgroup (REW).
- Conduct Key Informant Interviews (KII).
- Develop and facilitate at least one regionwide event based on RNA data findings.
- Conduct and attend meetings with community stakeholders to raise awareness and generate support to enhance data collection efforts of substance use/misuse and behavioral health data.
- Compile and synthesize data to develop an RNA to provide community organizations and stakeholders with region-specific substance use/misuse, behavioral health, and Social Determinants of Health (SDoH) information.
- Direct stakeholders to resources regarding data collection strategies and evaluation activities.
- Disseminate findings to the community.
**Steps to Achieve Goals**

The steps needed to achieve the goals of the Region 4 PRC:

- Conduct KIIs, REWs, and regionwide events that focus on the trends, gaps, consequences, and solutions in services pertaining to substance use/misuse and behavioral health found through data gathering for Region 4.
- Attend and facilitate meetings with a wide range of community stakeholders in all areas of Region 4 to raise awareness and generate support for collaboration across organizations and sectors to provide prevention services for the substances, consequences, and gaps in services found through data gathering.
- Dedicate time and space for stakeholders to address current, gaps in, or suggestions for services, organizations, and resources based on need in Region 4 found through data gathering.
- Actively promote participation in KIIs, REWs, and regionwide events for the purpose of data gathering, collaboration, and actively seeking solutions.
- Attend trainings pertaining to data gathering, analysis, and presentation.
- Attend trainings pertaining to the latest behavioral health trends, solutions, and outcomes.
- Disseminate findings to the community and request input for solutions and/or steps to solutions.
- Request information on data gathering by other organizations and providers in Region 4.
- Have an active presence at all Region 4 activities and on social media pertaining to substance use/misuse and behavioral health.
- Ensure accessibility to information, requests, and invitations by organizations, providers, and all stakeholders through a variety of means (webpage, social media, etc.).
- Ensure all deliverables are accessible, inclusive, Americans with Disabilities Act (ADA) visually compliant, and culturally and linguistically appropriate and competent.
Purpose

Regional Needs Assessment
The PRC’s Regional Needs Assessment (RNA) is a document providing community organizations and stakeholders with region-specific substance use/misuse and related behavioral health and SDoH information created by the PRC in Region 4 along with Data Coordinators from PRCs across the State of Texas and supported by HHSC. The PRC 4 serves 23 counties in Northeast Texas, often referred to as the Upper East Texas Region.

The 23 counties in Region 4 are:

A needs assessment is a process of determining and addressing the “gaps” between the current conditions and desired conditions in a set environment or demographic. This needs assessment is a review of data on substance use/misuse, substance use disorders, behavioral health, and related variables that will aid in substance use/misuse prevention and behavioral health decision making at the county, regional, and state level.
Underlying factors, including those related to the SDoH, risk and protective factors, adverse childhood experiences (ACEs), and public health consequences, were examined as they associate with substance use/misuse and behavioral health challenges.

**Social Determinants of Health**
The Social Determinants of Health (SDoH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. SDoH have a major impact on health, well-being, and quality of life and contribute to health disparities and inequities (CDC).

The SDoH are grouped into five domains:

- Economic Stability
- Education Access
- Health Care Access
- Neighborhood and Built Environment
- Social and Community Context
**Risk and Protective Factors**

Many factors influence an individual’s likelihood of developing a mental health and/or substance use disorder. Effective prevention focuses on reducing risk factors and strengthening protective factors that are most closely related to the problem being addressed. Risk and protective factors are shaped by biological, psychological, family, community, and cultural aspects (SAMHSA).

- Risk factors are any attribute, characteristic, or exposure of an individual that increases the likelihood of developing a disease or injury. These factors have an overall negative impact on human development.
- Protective factors are individual or environmental characteristics, conditions, or behaviors that reduce the effects of stressful life events. Such factors provide a safeguard to minimize the effect of harmful risks.

<table>
<thead>
<tr>
<th></th>
<th>Risk Factors</th>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Society</td>
<td>Impoverishment, Unemployment and underemployment, Discrimination, Pro-AOD-use messages in the media</td>
<td>Media literacy (resistance to pro-use messages), Decreased accessibility, Increased pricing through taxation, Raised purchasing age and enforcement, Stricter driving-under-the-influence laws</td>
</tr>
<tr>
<td>Community</td>
<td>Availability of Alcohol and Other Drugs (AOD), Community laws, norms favorable toward AOD, Extreme economic and social deprivation, Transition and mobility, Low neighborhood attachment and community disorganization</td>
<td>Opportunities for participation as active members of the community, Decreasing AOD accessibility, Cultural norms that set high expectations for youth, Social networks and support systems within the community</td>
</tr>
<tr>
<td>School</td>
<td>Academic failure beginning in elementary school, Low commitment to school</td>
<td>Opportunities for prosocial involvement, Rewards/recognition for prosocial involvement, Healthy beliefs and clear standards for behavior, Caring and support from teachers and staff, Positive instructional climate</td>
</tr>
<tr>
<td>Family</td>
<td>Family history of AOD use, Family management problems, Family conflict, Parental beliefs about AOD</td>
<td>Bonding (positive attachments), Healthy beliefs and clear standards for behavior, High parental expectations, A sense of basic trust, Positive family dynamics</td>
</tr>
<tr>
<td>Peer</td>
<td>Association with peers who use or value AOD use, Association with peers who reject mainstream activities and pursuits, Susceptibility to negative peer pressure, Easily influenced by peers</td>
<td>Association with peers who are involved in school, recreation, service, religion, or other organized activities, Resistance to negative peer pressure, Not easily influenced by peers</td>
</tr>
<tr>
<td>Individual</td>
<td>Biological and psychological dispositions, Positive beliefs about AOD use, Early initiation of AOD use, Negative relationships with adults, Risk-taking propensity/impulsivity</td>
<td>Opportunities for prosocial involvement, Rewards/recognition for prosocial involvement, Healthy beliefs and clear standards for behavior, Positive sense of self, Negative beliefs about AOD, Positive relationships with adults</td>
</tr>
</tbody>
</table>
Adverse Childhood Experiences
Adverse childhood experiences (ACEs), are potentially traumatic events that occur in childhood, 0-17 years of age. ACEs can have lasting, negative effects on health, well-being, and life opportunities (CDC).

Adverse Community Environments
Adverse community environments are those communities that have a high concentration of poverty and violence and/or low access to resources, such as food retail, public transportation, and services like education, health care, behavioral health, employment opportunities, economic development, and limited social supports (CDC).
Quantitative and Qualitative Data
The information obtained through these partnerships has been analyzed and synthesized in the form of this RNA.

- Quantitative data refers to any information that can be quantified, counted or measured, and given a numerical value. Quantitative data tells how many, how much, or how often and is gathered by measuring and counting then analyzed by using statistical analysis.
  - Quantitative data has been extrapolated from federal and state agencies to ensure reliability and accuracy. The quantitative data collected is the most recent data available within the last five years; however, older data might be provided for comparison purposes.
  - The criteria used for including quantitative data sets are their relevance, timeliness, methodological soundness, representativeness, and accuracy. The data used is gathered through valid and reliable data collection tools with well-documented methodology.

- Qualitative data is descriptive in nature and expressed in terms of language rather than numerical values. It is descriptive and categorized based on traits and characteristics. Qualitative data tells the why or how behind certain behaviors by describing certain attributes and is gathered through observation and interviews then analyzed by grouping the data into meaningful themes or categories.
  - Data Coordinators conduct focus groups, REWs, surveys, and KIIs with community members about what they believe their greatest needs to be.
Key Informant Interviews and Regional Epidemiological Workgroups

Data Coordinators conduct KIIs and REWs with stakeholders that represent the twelve community sectors across Region 4. The purpose is to collect primary data to identify the current needs and conditions to determine the gaps in substance use/misuse and behavioral health prevention in Region 4. Participants discuss their perceptions of how their communities are affected by substance use/misuse and behavioral health challenges. This qualitative data collection method often reveals additional sources of data. Data Coordinators are then to develop and facilitate at least one regionwide event based on RNA data findings to bring targeted communities and stakeholders together to educate and promote collaboration on substance use/misuse and behavioral health related issues (SAMHSA).

Twelve Sectors of a Community
- Youth and Young Adults
- Parents
- Business Communities
- Media
- Schools
- Organizations Serving Youth or Young Adults
- Law Enforcement Agencies
- Religious or Fraternal Organizations
- Civic or Volunteer Groups
- Healthcare Professionals
- State and Local Government
- Recovery Community, Education Service Centers, and Local Mental Health Authorities
The RNA can serve in the following capacities to:

- Determine patterns of substance use/misuse and behavioral health.
- Monitor changes in substance use/misuse and behavioral health trends.
- Identify gaps in data where critical substance use/misuse and behavioral health information is missing.
- Determine county-level differences and disparities.
- Determine region-level differences and disparities.
- Identify substance use/misuse and behavioral health issues that are unique to specific communities.
- Provide a comprehensive tool for local providers to design relevant, data-driven prevention and intervention programs targeted to needs.
- Provide data to local providers to support their grant-writing activities and provide justification for funding requests.
- Assist policymakers in program planning and policy decisions regarding substance use/misuse and behavioral health prevention, intervention, and treatment at the region and state level.
Methods

PRCs follow the Substance Abuse and Mental Health Services Administration’s (SAMSHA) Strategic Prevention Framework (SPF) and socio-ecological model when delivering prevention and behavioral health promotion services.

**Strategic Prevention Framework**

The SPF assists communities in understanding and addressing the complex issues of substance misuse and related behavioral health problems facing their communities. The model is widely used to identify prevention strategies and programs that will best meet local needs (SAMSHA).

The SPF has five steps:

- **Assessment** - profile population needs
- **Resources, and readiness to address needs and gaps**
- **Capacity** - mobilize and/or build capacity to address needs
- **Planning** - develop a comprehensive strategic plan
- **Implementation** - implement the strategic plan and evidence-based prevention strategies
- **Evaluation** - monitor, evaluate, sustain, and improve or replace those that fail

With two core guiding principles:

- **Sustainability** – process of achieving and maintaining long-term results
- **Cultural Competence** – the ability to interact effectively with diverse populations
**Socio-Ecological Model**

The socio-ecological model is a multi-level framework that considers the different contexts in which risk and protective factors exist in relation to individual, relationship, community, and societal factors. The four overlapping levels in the model illustrate how human development and behavior differ based on the person’s influences and surrounding environment. It is necessary to address the multiple levels at the same time to sustain prevention efforts over time and achieve population impact (SAMHSA).

The four levels of the socio-ecological model are:

- **Individual** – factors specific to the individual, such as age, education, income, and psychosocial issues
- **Relationship** – factors specific to the individual’s closest social circle, such as family members, peers, and teachers
- **Community** – factors specific to the settings in which social relationships occur, such as schools, workplaces, and neighborhoods.
- **Society** – factors specific to the broad societal and cultural norms, such as health, economic, educations, and social policies
Key Informant Interviews
Data Coordinators conduct Key Informant Interviews (KII) with stakeholders to discuss their perceptions of their communities' greatest resources and needs to collect primary data to determine the gaps in substance use prevention in Region 4.

Participants
The Region 4 Data Coordinator conducted sixteen KIIs for the FY22 RNA. Of the 16 interviewees:

- 8 identify as male
- 8 identify as female
- 10 identify as white
- 4 identify as black
- 2 identify as Hispanic
- 2 identify as 25 to 30 years of age
- 2 identify as 30 to 35 years of age
- 3 identify as 35 to 40 years of age
- 2 identify as 40 to 45 years of age
- 2 identify as 45 to 50 years of age
- 1 identifies as 50 to 55 years of age
- 1 identifies as 55 to 60 years of age
- 1 identifies as 60 to 65 years of age
- 2 identify as 70 to 75 years of age

The interviewees covered all sectors except for youth or young adult and media and many covered more than one sector because of employment, volunteer work, and family choices. All twenty-three counties in Region 4 were represented by interviewees through their employment or home community.

The stakeholders that participated in the KII were all individuals the Data Coordinator had met through coalition meetings, data presentations, community-wide events, and behavioral health trainings within Region 4.
Procedures
The Data Coordinators received the questions and instructions on recording, transcribing, and purpose of the key informant interviews in February with the template for the individual summaries in May. The Region 4 Data Coordinator used the contact list compiled from coalition meetings, data presentations, community-wide events, trainings, REWs, and governmental and law agency websites to reach out to individuals through phone calls, emails, packet delivery, and face-to-face meetings to request KII.

Once an individual agreed to participant in an interview, the Data Coordinator would schedule a Zoom meeting to record the audio for transcription purposes. When the Zoom invitation was sent to the interviewee, a list of the questions and a consent to record form was included. Each participant was asked the questions given by HHSC to the Data Coordinators. Other questions inevitably arose during the interviews, but these were asked of each participant.

Each participant was asked the following questions:

1. What substance use concerns do you see in your community?
   a. What do you think are the greatest contributing factors, and what leads you to this conclusion?
   b. What do you believe are the most harmful consequences of substance use/misuse, and what leads you to this conclusion?
2. How specifically does substance use affect the (insert sector here) sector?
3. What substance use and misuse prevention services and resources are you aware of in your community?
   a. What do you see as the best resources in your community?
   b. What services and resources does your community lack?
4. What services and resources specifically dedicated to promoting mental and emotional wellbeing are you aware of in your community?
   a. What do you see as the best resources in your community?
   b. What services and resources does your community lack?
5. What information does the (insert sector here) sector need to better understand substance use/misuse and mental and emotional health in your community?
6. What other questions should we be asking experts in this area?
Analysis Plan
PRCs are to maintain and serve as the primary resource for substance use/misuse and related behavioral health data and to support prevention programs and collaboration efforts for the region.

The two main methods of primary data collection for the PRCs are direct personal interviews, KIIs, and focus groups, REW.

FOCUS GROUPS VS. INTERVIEWS

<table>
<thead>
<tr>
<th>PROS</th>
<th>CONS</th>
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<tbody>
<tr>
<td>Diversity &amp; enrichment of interviewees’ profiles and responses</td>
<td>More complicated to organize</td>
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<tr>
<td>Cheaper light analysis of answers</td>
<td>More complex to interpretate</td>
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<tr>
<td>Confirms insights obtained through other qualitative methodologies</td>
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<td>Easy to organize in a B2C setting</td>
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<td>In-depth analysis</td>
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<td>Higher potential for insights</td>
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<tr>
<td>Possibility to use coding and perform statistical analysis</td>
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<td>Use of robust insights as the fundamental of a quantitative survey</td>
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<td>Less bias than with a focus group</td>
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Key Informants are individuals with specific knowledge about certain aspects of the community because of their professional background, leadership responsibilities, or particular personal experience. KIIs give those who have first-hand knowledge about the community the opportunity to have their voice heard.

The format for KIIs allow more time for the individual to speak which allows more insights to be collected. It also allows for extended questions to explore more in-depth understanding and clarification.
Once the KIIs were complete, the Data Coordinator transcribed the audio from the interviews and then used quantitative coding to categorize the information by topic. Two approaches to coding were done for each interview.

The first parameters for coding were the key words in the questions provided by HHSC. The categories are as follows:

- Substance Use Concerns
- Contributing Factors
- Consequences
- Affect Sector
- Substance Use/Misuse
- Mental Health
- Resource
- Best Resource
- Lacking Resource
- Info to Understand

The second approach to coding the interviews was a pyramid level filter of categories. The categories are as follows:

Using these filters for coding helped the Data Coordinator be aware of influences that might direct the key informant’s answers. When coding was complete, the Data Coordinator collected the data into summaries and used the FY21 RNA and the qualitative data to draw logical conclusions.
Regional Epidemiological Workgroups
The purpose of the Regional Epidemiological Workgroup (REW) is to identifying substance use patterns focused on the State’s four prevention priorities at the regional, county, and local level. The REW must also work to identify regional data sources, data partners, and relevant risk and protective factors to provide information relevant to identification of data gaps, analysis of community resources and readiness, collaboration on region-wide efforts, and recommendations and/or development of other forms of prevention infrastructure support.

Participants
The Region 4 REW averages twenty to twenty-five individuals at the quarterly meetings; however, they are not always the same twenty to twenty-five individuals. There are sixty individuals on the email invitation list. Approximately fifteen attendees are consistent and attend every meeting. Those individuals are predominantly substance use/misuse and mental health providers, prevention organizations, health professionals, one pastor, and one parent. The participants cover all sectors except for youth or young adult, and many cover more than one sector because of employment, volunteer work, and family choices. All twenty-three counties in Region 4 are represented by participants through their employment or home community.
Procedures
The stakeholders invited to participate in the REW are all individuals the Data Coordinator has met and established a working relationship with through coalition meetings, data presentations, community-wide events, and behavioral health trainings within Region 4. Initially due to the pandemic, and then for convenience and higher attendance, the Region 4 REW is held via Zoom once a quarter. Calendar invitations with the agenda, Zoom link, and other pertinent information go out a month in advance with follow-up reminders the week before the meeting.

The following are the questions given by HHSC to guide the REWs:

1. Please share what was discussed. (In addition, which, if any, of the following topics were discussed?):
   - Identification of data gaps
   - Analysis of community resources and readiness
   - Collaboration on region-wide prevention efforts
   - Recommendations and/or development of other forms of prevention infrastructure support
2. What were the takeaways from the discussion?
3. Were solutions recommended? If not, what would be your recommended solutions?
4. How can the information discussed through this REW inform future RNAs (i.e., identifying the gaps between current and desired substance use prevention strategies and outcomes)?
5. How can we better promote the workgroups and gain new perspectives delivered during the meetings?
The Region 4 meetings beginning with a brief welcome and introductions. The majority of the meeting involves the presentation of topics picked from previous meetings suggestions, RNA data, and current substance use/misuse and behavioral health trends. Once the speaker is done presenting, the floor is open for questions and discussion. Ten to fifteen minutes are reserved for discussion of upcoming events or the need for more events in the region. The meeting is closed by the Data Coordinator briefly summarizing the meetings main points, the posting of the evaluation for participants, and confirming that a follow-up email will be sent out.

The evaluations for the REW consists of two to three questions about the topic and speaker, if they would recommend this workgroup to a colleague, and the following questions:

- What topic(s) of discussion need to be explored in future REW meetings?
- What topic(s) would benefit the communities of Region 4 at a regionwide event based on data findings?
- What data gaps have you noticed that need to be addressed to benefit our stakeholders and communities in Region 4?
- What specific data would you like to see in an RNA data supplement?
- Would you or someone in your organization be willing to participate in a KII? If so, please provide your email.
Analysis Plan
PRCs are to maintain and serve as the primary resource for substance use/misuse and related behavioral health data and to support prevention collaboration efforts for the region. The two main methods of primary data collection for the PRCs are direct personal interviews, KIIs, and focus groups, REW. Data Coordinators conduct the REW with stakeholders that represent the twelve community sectors across Region 4.

In Region 4, even though the REWs are held via Zoom, they are not recorded; therefore, transcription was not attainable. The Data Coordinator and the Public Relations Coordinator take detailed notes and the chat is saved for reference. Quantitative coding was used to categorize the information by topic.

The parameters for coding were the key words in the questions provided by HHSC. The categories are as follows:

- Information Covered
- Takeaways
- Solutions
- Apply to RNA
- Promotion of REW
Results

Key Informant Interviews
Through the collection of quantitative data, the majority of Region 4’s substance use/misuse issues involve alcohol, methamphetamines, marijuana, and vaping caused by poverty, mental health issues, and the pandemic leading to the destruction of families and relationships, poverty, and permeant health damage, which is exacerbated by the lack of providers available to those without insurance and without the ability to pay for services.

Substance Use Concerns
- Every key informant listed methamphetamine as a specific substance concern.
- Key informants that work directly with youth and young adults listed vaping of nicotine, THC, and other substances.
- The key informants that are healthcare professionals providing direct services did not mention marijuana, high potency, as a concern; however, all other key informants did.
- The key informants that listed opioids as a concern all specified that prescription opioids are what is being used/misused.
- Several key informants listed alcohol as a concern and that it is typically forgotten or undervalued as a health and substance concern due to alcohol being legal for those 21 years of age and older, social norms, and environmental saturation of advertising and availability.
- Many key informants mentioned the “lacing” of substances with unknown, illicit, or synthetic substances that can be unknown to the person ingesting the substance.
- The key informants that are healthcare professionals providing direct services all said that fentanyl had not been an issue in Region 4 until recently; specifically, the last eight to ten months.
**Contributing Factors**

- Poverty, lack of employment or employment opportunities, and mental health issues were given as both contributing factors and as consequences by all key informants.
- Trauma, especially childhood trauma, was listed by the majority of the key informants.
- Many key informants listed social norms, such as family normalization or generational use, legalization of use for those of legal age or living in a state where consumption is legal, community norms associated with alcohol and nicotine products for adolescents as part of their maturation process, societal norms associated with alcohol use especially in the southern states by young men passed down by father figures or by women at events targeted at female audiences, and community social events associated with alcohol like football, family reunions, and holidays.
- Many key informants listed substance use/misuse as coping mechanism.
- Many key informants listed issues arising or related to the pandemic, such as isolation, loss of employment, health concerns, loss of loved ones, change in routine, and anxiety.
- Availability was listed as a factor for methamphetamines because of high prevalence and ease for anyone to get meth.
- Availability was listed as a factor for vapes, even for youth, because they are legal for those twenty-one years of age and older, sold at the majority of convenience stores, and perception of harm is low.
- Key informants mentioned that perception of harm is low for vapes because both youth and adults are unaware of the dangers.

**Consequences**

- Every key informant listed the breaking down, destruction, or separation of families with several sharing personal and/or painful life experiences associated with substance use/misuse and the demise of the family unit.
- The majority of key informants listed health concerns, damaged organs, addiction, and death.
- Poverty, lack of employment or limited employment opportunities, and mental health issues were given as both contributing factors and as consequences.
- Several key informants listed child abuse and neglect, stigma, criminal activity, and homelessness.
Effect on Sector

- **All key informants** stated that there is a direct effect on their sector.

  - **Parents** – exposure to their children from others; victims of crime
  
  - **Business Communities** – crime rates; domestic violence; increase cost because of loss due to theft, employee time off on related issues, healthcare costs; safety measures for employees and customers; labor force shortage
  
  - **Schools** – students giving up or making no plans after high school; students having low perception of harm because of family use or social norms; marijuana is legal in other states so perception is that it is not harmful; lack of time, staff, and ability
  
  - **Organizations Serving Youth or Young Adults** - students giving up; no plans after high school; students have low perception of harm because family use or social norms; marijuana is legal in other states so perception is that it is not harmful; low perception of harm by youth/young adults because they are unaware of dangers; feel it could not happen to them; compassion fatigue
  
  - **Law Enforcement Agencies** – majority of CPS court cases are drug related; domestic calls; family violence; crime – theft and larceny; safety to officers with pat-downs and drug paraphernalia and testing substances in the field; frustration from community members that are victims of crime due to substance use/misuse which can perpetuate stigma; cost of services for treatment, housing, and rehabilitation; compassion fatigue
  
  - **Religious or Fraternal Organizations** – religion has rules that sometimes differ from social norms; advocating for prayer and professional help not just prayer alone; combating stigma; parishioners ignoring fact that it is in their community or family to not be looked down upon so services are not sought; community unaware of services; cultural communities not targeted with prevention messages and resources; churches having to intercede for so many that cannot pay for services; compassion fatigue
  
  - **Civic or Volunteer Groups** – increase cost of services; reducing workforce/number of volunteers; organization needs to expand services; need collaboration with other organizations and law enforcement; funding is limited/more is needed; lack of funding for those without the ability to pay; compassion fatigue
○ **Healthcare Professionals** – not enough beds that are state-funded for detox; public health concern; those using/misusing substances do not go to preventative doctor visits leading to an increase in tuberculosis cases in those that use/misuse substances; significant medical cost; lack of funding for those without insurance or ability to pay; compassion fatigue

○ **State and Local Government** – majority of CPS cases are drug related; medical costs due to inmates with needs; cannot use programs/providers with religious affiliations as a judicial resource; recidivism; increased case load involving dual diagnosis; lack of funding to assist communities in making behavioral health a priority

○ **Recovery Community, Education Service Centers, and Local Mental Health Authorities** – reason for job; powerful work to do; daily encounters; dual diagnosis; need funding for providers to serve those without insurance or ability to pay; long wait times for services especially those without insurance or ability to pay; high level of calls and requests for counseling for children and adolescents because of trauma and for adults based on childhood trauma; mental health issues and substance use/misuse were connected and cyclical while including homelessness, poverty, and many other negative social determinants of health; few providers take Medicaid or have state funding causing a shortage in service providers; compassion fatigue
Lacking Substance Use/Misuse Prevention Resources

- The majority of the key informant interviewees listed the need for more funding for services for those without insurance or funds, especially detox inpatient facilities funded by the state.
- All of the key informant interviewees listed accessibility issues due to payment, wait time, transportation, and availability.
- Several key informant interviewees listed the need for facilities for co-occurring diagnosis, resources for males, especially young males, and funding for intervention at schools and jails/prisons.
- The key informant interviewees pointed out that kids in poverty have Medicaid and providers do not take Medicaid because the reimbursement is so low and that most community members lack of understanding on how to get resources.
- The key informant interviewees that are in the healthcare professional field listed that medical personnel should have more training and exposure to procedures and treatment of individuals with substance use disorders and those with dual diagnosis.
- The key informant interviewees that are in the recovery community, Education Service Centers, and Local Mental Health Authorities sector listed the lack of support groups specific to substances other than alcohol and recovery housing in Region 4.

Lacking Mental/Emotional Wellbeing Resources

- The majority of the key informant interviewees listed the need for more funding for services for those without insurance or funds, especially youth and adolescents.
- The majority of the key informant interviewees listed accessibility issues due to payment, wait time, transportation, and availability.
- Several key informant interviewees listed the need for facilities for co-occurring diagnosis and funding for intervention at schools and jails/prisons.
- Many key informant interviewees listed the need for mobile service providers to bring services to community members where they live, attend school, worship, and work.
- Several key informant interviewees listed the need for promotion of information and services for substance use/misuse and behavioral health through cultural and religious organizations and communities to reach underserved populations.
**Regional Epidemiological Workgroups**
The Region 4 PRC REW met four times, one a quarter, using the Zoom platform to identify regional data sources, data partners, and relevant risk and protective factors to provide information relevant to identification of data gaps, analysis of community resources and readiness, collaboration on region-wide efforts, and recommendations and/or development of other forms of prevention infrastructure support.

**Information Covered**
The information covered by the REW for FY22 were:
- FY21 RNA data, findings, and methodology
- Goals of Region 4 PRC
- Other data sources in Region 4
- Defining what is a data gap
- Data gaps in Region 4
- Regionwide event
- 988
- Database of services for Region 4
- New direction and vision of the FY22 RNA
- New direction and vision of the REW
- KII and REW

**Takeaways**
The takeaways from the discussions at the REW for FY22 were:
- Explore other organizations community assessments and many are on hold because of the pandemic.
- When presenting data, provide resources/links to providers associated with data.
- Be as specific as possible with data especially demographic information.
- Compile data into 3 to 4 key findings to choose the topic for the regionwide event.
- Explore and bring attention to data gaps and what defines a data gap.
- Verify that data gaps are “true” data gaps and seek solutions for those.
- Recommend those willing to be panelists for the regionwide event.
- Find a location, date, and speakers for the FY23 regionwide event.
Proposed Solutions
Proposed solutions recommended at the REW for FY22 were:

- Be as specific as possible with data especially demographic information to highlight data gaps.
- Topics for the regionwide event were drug trends, dual diagnosis, family outcomes of substance use/misuse, and presentations by service providers.

Application of Information to Regional Needs Assessments
Information discussed through the REW can inform future RNAs the following ways:

- Show gaps in services.
- Provide opportunities for discussion and collaboration to add information, services, and data to the RNA.
- Evaluate services.
- Enhance and develop the methodology and data collection.
- Use and apply data and information gained from regionwide event.

Promotion of Regional Epidemiological Workgroups
The REW can be better promoted in the following ways:

- Include QR code links to information about REW on all deliverables, presentations, and emails.
- Include invitation in monthly newsletter sent out to the region by the Public Relations coordinator
- Mention REW in all coalition, organizational, service, and community meetings with information also included in the chat feature of virtual meetings.
Regionwide Event
The Region 4 PRC was tasked by HHSC to Develop and facilitate at least one region-wide event based on RNA data findings to bring targeted communities and stakeholders together to educate and promote collaboration on substance use related issues. On June 15, 2022, the Region 4 PRC hosted the Data-Driven Dialogue & Discovery Symposium. This was an in-person event with three one-hour sessions with continuing education hours available.
Session 1: Data Discovery and Drug Trends
This interactive workshop will discuss the latest developments and information regarding emerging drug trends with relative and reflective data for Region 4 specifically. Applied outcomes from Regional Epidemiological Workgroups, Key Informant Interviews, coalition meetings, and regional trainings will aid in outlining the current statistical behavioral health concerns for Region 4. The speakers are the Region 4 PRC Data Coordinator and Supervisor over the County Organized Drug Enforcement Unit in Gregg County.

The participant will:

- Outline recent qualitative and quantitative data on substance use/misuse and behavioral health trends and Social Determinants of Health in Region 4
- Know where to find information about the effects, risks, and information about commonly used/misused substances
- Identify various substances of use/misuse, related paraphernalia, and methods of ingestion seen commonly and currently in Region 4
- Improve confidence in discussing commonly used/misused substances

Session 2: Drug Enforcement Agency
This interactive workshop will discuss the latest developments and information regarding current trends in drug use/misuse that have been elevated recently according to the United States Drug Enforcement Agency. Epidemiologic trends in drug abuse in both youth and adults will be discussed as will the latest trends both on the national and local levels. Discussion will also include the most commonly used drugs for Region 4 and explore ways of working with people currently using/misusing substances. The speaker is the senior supervisor Assistant Special Agent in Charge at the United States Drug Enforcement Administration’s Dallas Field Division.

The participant will:

- Identify current drug trends origin, reasoning, evolution, shift, outcomes, and risks concerning the nation, Texas, and Region 4
- Have a better understanding of the “new synthetic drugs” that are replacing the traditional drugs and their risks
- Explain the short- and long-term impact of substance use/misuse
- Know where to find information about the effects, risks, and information about commonly used/misused drugs
Session 3: Panel of Professionals
The goal of this interactive workshop will discuss the latest developments and information regarding emerging trends in behavioral health, substance use/misuse and mental health resources and services, and gaps in resources and services for individuals experiencing behavioral health issues/needs in Region 4.

The participant will:

- Identify current trends, needs, resources, services, and gaps in services for those experiencing behavioral health issues/needs in Region 4
- Have a better understanding of the overall view for individuals experiencing behavioral health issues/needs in Region 4
- Have a better understanding of the stigma associated with those individuals experiencing behavioral health issues/needs in Region 4
- Explain the short- and long-term impact of substance use.
- Know where to signpost those individuals experiencing behavioral health issues/needs

The panelists are:

- Amanda Veasy is the Founder and Executive Director of One Love Longview
- Courtney Kale is a Case Manager working with young adults in the Youth Transitional Program
- Megan Johnson serves as the Outreach Coordinator at the Women's Center of East Texas
- Spencer Wright is a person in long-term recovery and a Recovery Support Peer Specialist in Region 4

Questions for panel:
1. What behavioral health concerns do you see in your community?
2. What are the greatest contributing factors, and what leads you to this conclusion?
3. What are the most harmful consequences, and what leads you to this conclusion?
4. What behavioral health services and resources are lacking in your community?
5. What do you see as the best solution or steps toward solutions for lack of behavioral health services and resources in your community?
Evaluations

Each attendee completed an evaluation at the end of each session. The evaluation for each session asked if the facilities were adequate and comfortable, the speakers were knowledgeable about their topic, the objectives were clearly defined and met, the training was relevant to their job or role within the community, they would recommend the training, and space was given for comments/suggestions.

All of the responses to the questions for all three sessions were positive. Several attendees gave comments and/or suggestions that were reviewed and taken into consideration at the last REW.

Comments from attendees:

• Very informative. Interesting and knowledgeable. This was very interesting.
• I learned a lot. I always learn something new!
• Great information and data presented!
• Grateful for the knowledge presented. Very much relevant.
• Everything was great. Awesome job! Excellent. Thanks. Phenomenal Job!
• All employees at my organization could benefit from this.
• Need more of these trainings.
• Need larger room for next year, however adequate and comfortable.
• Longer sessions with more topics. More time for sessions. Longer.
• Thank you for all you do. Thanks for breaking up the training into 3 segments.
Quantitative Demographic Snapshot

The following are brief demographic snapshots of each county in Region 4 and Region 4 as a whole. Topics covered in the snapshots are population, population density, race, ethnicity, age, median household income, unemployment rate, persons in poverty, ratio of healthcare providers, crime rate, and death rates for alcohol-induced, drug-induced, and suicide.

Region 4

Region 4 is considered predominantly rural, nonmetro, with a 2022 population of 1,167,806 and population density of 75.7 per square mile. The racial and ethnic breakdown for the region is 1% Non-Hispanic Asian, 14% Non-Hispanic Black, 15% Hispanic, 3% Non-Hispanic Other, and 68% Non-Hispanic White. The age grouping breakdown for the region is 23% ages 0 to 17, 8% ages 18 to 24, 25% ages 25 to 44, 23% ages 45 to 64, and 19% ages 65 and older. Economic predictors for Region 4 have the median household income at $49,209, unemployment rate at 7%, total persons in poverty at 15.4%, persons 65 years old and older in poverty at 10.4%, and children under 18 years of age in poverty at 22.0% (data.census.gov). Access to healthcare shows ratios of 1,235:1 for mental health providers, 1,840:1 for primary care physicians, and 2,217:1 for dentists in Region 4 (countyhealthrankings.org). The crime rate is 1,924.6 per 100k population with property crime at 1,644.8 per 100k population and violent crime at 304.8 per 100k population (txucr.nibrs.com). Region 4’s age adjusted death rates per 100k population are alcohol-induced at 6.4, drug-induced at 10.6, and suicide at 16.9 (wonder.cdc.gov).
Anderson County
Anderson County is considered rural, nonmetro, with a 2022 population of 58,094 and population density of 54.7 per square mile. The racial and ethnic breakdown for the county is 1% Non-Hispanic Asian, 21% Non-Hispanic Black, 20% Hispanic, 2% Non-Hispanic Other, and 57% Non-Hispanic White. The age grouping breakdown for the county is 18% ages 0 to 17, 9% ages 18 to 24, 33% ages 25 to 44, 24% ages 45 to 64, and 16% ages 65 and older. Economic predictors for Anderson County have the median household income at $45,847, unemployment rate at 6%, total persons in poverty at 14.1%, persons 65 years old and older in poverty at 9.9%, and children under 18 years of age in poverty at 21.5% (data.census.gov). Access to healthcare shows ratios of 2,310:1 for mental health providers, 3,060:1 for primary care physicians, and 2,510:1 for dentists in Anderson County (countyhealthrankings.org). The crime rate is 1,491.4 per 100k population with property crime at 1,271.3 per 100k population and violent crime at 234.1 per 100k population (txucr.nibrs.com). Anderson County’s age adjusted death rates per 100k population are alcohol-induced at 5.8, drug-induced at 14.5, and suicide at 20.7 (wonder.cdc.gov).

Bowie County
Bowie County is considered urban, metro, with a 2022 population of 92,441 and population density of 76.4 per square mile. The racial and ethnic breakdown for the county is 1% Non-Hispanic Asian, 24% Non-Hispanic Black, 8% Hispanic, 3% Non-Hispanic Other, and 63% Non-Hispanic White. The age grouping breakdown for the county is 21% ages 0 to 17, 8% ages 18 to 24, 28% ages 25 to 44, 24% ages 45 to 64, and 19% ages 65 and older. Economic predictors for Bowie County have the median household income at $51,796, unemployment rate at 7%, total persons in poverty at 16.8%, persons 65 years old and older in poverty at 10.7%, and children under 18 years of age in poverty at 24.2% (data.census.gov). Access to healthcare shows ratios of 950:1 for mental health providers, 1,492:1 for primary care physicians, and 1,780:1 for dentists in Bowie County (countyhealthrankings.org). The crime rate is 2,261.0 per 100k population with property crime at 1,824.5 per 100k population and violent crime at 403.4 per 100k population (txucr.nibrs.com). Bowie County’s age adjusted death rates per 100k population are alcohol-induced at 5.3, drug-induced at 7.9, and suicide at 15.9 (wonder.cdc.gov).
Camp County
Camp County is considered rural, nonmetro, with a 2022 population of 13,515 and population density of 69.0 per square mile. The racial and ethnic breakdown for the county is 1% Non-Hispanic Asian, 16% Non-Hispanic Black, 5% Hispanic, 2% Non-Hispanic Other, and 76% Non-Hispanic White. The age grouping breakdown for the county is 25% ages 0 to 17, 8% ages 18 to 24, 25% ages 25 to 44, 23% ages 45 to 64, and 19% ages 65 and older. Economic predictors for Camp County have the median household income at $49,539, unemployment rate at 7%, total persons in poverty at 20.1%, persons 65 years old and older in poverty at 14.8%, and children under 18 years of age in poverty at 28.6% (data.census.gov). Access to healthcare shows ratios of 2,180:1 for mental health providers, 1,169:1 for primary care physicians, and 2,607:1 for dentists in Camp County (countyhealthrankings.org). The crime rate is 1,268.6 per 100k population with property crime at 943.8 per 100k population and violent crime at 353.0 per 100k population (txucr.nibrs.com). Camp County’s age adjusted death rates per 100k population are alcohol-induced at 10.1, drug-induced at 9.2, and suicide at 13.6 (wonder.cdc.gov).

Cass County
Cass County is considered rural, nonmetro, with a 2022 population of 30,203 and population density of 32.2 per square mile. The racial and ethnic breakdown for the county is 0% Non-Hispanic Asian, 16% Non-Hispanic Black, 5% Hispanic, 2% Non-Hispanic Other, and 76% Non-Hispanic White. The age grouping breakdown for the county is 22% ages 0 to 17, 7% ages 18 to 24, 22% ages 25 to 44, 25% ages 45 to 64, and 25% ages 65 and older. Economic predictors for Cass County have the median household income at $47,539, unemployment rate at 8%, total persons in poverty at 17.5%, persons 65 years old and older in poverty at 8.4%, and children under 18 years of age in poverty at 27.5% (data.census.gov). Access to healthcare shows ratios of 3,750:1 for mental health providers, 3,752:1 for primary care physicians, and 3,347:1 for dentists in Cass County (countyhealthrankings.org). The crime rate is 1,467.3 per 100k population with property crime at 1,352.7 per 100k population and violent crime at 156.0 per 100k population (txucr.nibrs.com). Cass County’s age adjusted death rates per 100k population are alcohol-induced at 6.1, drug-induced at 9.2, and suicide at 18.5 (wonder.cdc.gov).
**Cherokee County**

Cherokee County is considered rural, nonmetro, with a 2022 population of 52,350 and population density of 49.7 per square mile. The racial and ethnic breakdown for the county is 1% Non-Hispanic Asian, 13% Non-Hispanic Black, 24% Hispanic, 2% Non-Hispanic Other, and 60% Non-Hispanic White. The age grouping breakdown for the county is 25% ages 0 to 17, 8% ages 18 to 24, 24% ages 25 to 44, 24% ages 45 to 64, and 18% ages 65 and older. Economic predictors for Cherokee County have the median household income at $50,199, unemployment rate at 8%, total persons in poverty at 14.6%, persons 65 years old and older in poverty at 11.9%, and children under 18 years of age in poverty at 20.1% (data.census.gov). Access to healthcare shows ratios of 1,070:1 for mental health providers, 2,488:1 for primary care physicians, and 3,287:1 for dentists in Cherokee County (countyhealthrankings.org). The crime rate is 1,661.6 per 100k population with property crime at 1,454.0 per 100k population and violent crime at 202.5 per 100k population (txucr.nibrs.com). Cherokee County’s age adjusted death rates per 100k population are alcohol-induced at 7.3, drug-induced at 11.2, and suicide at 16.5 (wonder.cdc.gov).

**Delta County**

Delta County is considered rural, nonmetro, with a 2022 population of 5,375 and population density of 20.9 per square mile. The racial and ethnic breakdown for the county is 1% Non-Hispanic Asian, 9% Non-Hispanic Black, 8% Hispanic, 4% Non-Hispanic Other, and 79% Non-Hispanic White. The age grouping breakdown for the county is 21% ages 0 to 17, 6% ages 18 to 24, 21% ages 25 to 44, 25% ages 45 to 64, and 27% ages 65 and older. Economic predictors for Delta County have the median household income at $49,868, unemployment rate at 6%, total persons in poverty at 16.2%, persons 65 years old and older in poverty at 13.0%, and children under 18 years of age in poverty at 23.4% (data.census.gov). Access to healthcare shows ratios of 1,780:1 for mental health providers, 5,298:1 for primary care physicians, and 0:1 for dentists in Delta County (countyhealthrankings.org). The crime rate is 279.5 per 100k population with property crime at 243.9 per 100k population and violent crime at 37.5 per 100k population (txucr.nibrs.com). Delta County’s age adjusted death rates per 100k population for alcohol-induced, drug-induced, and suicide are all listed as unreliable (wonder.cdc.gov).
Franklin County
Franklin County is considered rural, nonmetro, with a 2022 population of 10,977 and population density of 38.6 per square mile. The racial and ethnic breakdown for the county is 1% Non-Hispanic Asian, 4% Non-Hispanic Black, 16% Hispanic, 2% Non-Hispanic Other, and 77% Non-Hispanic White. The age grouping breakdown for the county is 25% ages 0 to 17, 7% ages 18 to 24, 23% ages 25 to 44, 24% ages 45 to 64, and 20% ages 65 and older. Economic predictors for Franklin County have the median household income at $59,632, unemployment rate at 5%, total persons in poverty at 8.2%, persons 65 years old and older in poverty at 2.6%, and children under 18 years of age in poverty at 13.5% (data.census.gov). Access to healthcare shows ratios of 2,680:1 for mental health providers, 3,589:1 for primary care physicians, and 3,589:1 for dentists in Franklin County (countyhealthrankings.org). The crime rate is 622.5 per 100k population with property crime at 489.0 per 100k population and violent crime at 189.6 per 100k population (txucr.nibrs.com). Franklin County’s age adjusted death rates per 100k population for alcohol-induced and drug-induced are both listed at unreliable and suicide at 16.1 (wonder.cdc.gov).

Gregg County
Gregg County is considered urban, metro, with a 2022 population of 126,321 and population density of 462.2 per square mile. The racial and ethnic breakdown for the county is 1% Non-Hispanic Asian, 21% Non-Hispanic Black, 20% Hispanic, 2% Non-Hispanic Other, and 56% Non-Hispanic White. The age grouping breakdown for the county is 25% ages 0 to 17, 9% ages 18 to 24, 26% ages 25 to 44, 23% ages 45 to 64, and 17% ages 65 and older. Economic predictors for Gregg County have the median household income at $50,180, unemployment rate at 8%, total persons in poverty at 17.6%, persons 65 years old and older in poverty at 8.9%, and children under 18 years of age in poverty at 26.0% (data.census.gov). Access to healthcare shows ratios of 600:1 for mental health providers, 1,153:1 for primary care physicians, and 1,066:1 for dentists in Gregg County (countyhealthrankings.org). The crime rate is 3,012.8 per 100k population with property crime at 2,550.2 per 100k population and violent crime at 337.7 per 100k population (txucr.nibrs.com). Gregg County’s age adjusted death rates per 100k population are alcohol-induced at 6.8, drug-induced at 9.1, and suicide at 15.1 (wonder.cdc.gov).
Harrison County
Harrison County is considered rural, nonmetro, with a 2022 population of 68,736 and population density of 76.4 per square mile. The racial and ethnic breakdown for the county is 1% Non-Hispanic Asian, 21% Non-Hispanic Black, 15% Hispanic, 2% Non-Hispanic Other, and 62% Non-Hispanic White. The age grouping breakdown for the county is 25% ages 0 to 17, 8% ages 18 to 24, 25% ages 25 to 44, 23% ages 45 to 64, and 18% ages 65 and older. Economic predictors for Harrison County have the median household income at $54,234, unemployment rate at 8%, total persons in poverty at 16.8%, persons 65 years old and older in poverty at 9.9%, and children under 18 years of age in poverty at 24.9% (data.census.gov). Access to healthcare shows ratios of 2,500:1 for mental health providers, 3,508:1 for primary care physicians, and 4,448:1 for dentists in Harrison County (countyhealthrankings.org). The crime rate is 1,740.7 per 100k population with property crime at 1,517.2 per 100k population and violent crime at 325.8 per 100k population (txucr.nibrs.com). Harrison County’s age adjusted death rates per 100k population are alcohol-induced at 7.9, drug-induced at 8.0, and suicide at 14.8 (wonder.cdc.gov).

Henderson County
Henderson County is considered rural, nonmetro, with a 2022 population of 81,548 and population density of 93.3 per square mile. The racial and ethnic breakdown for the county is 0% Non-Hispanic Asian, 7% Non-Hispanic Black, 14% Hispanic, 2% Non-Hispanic Other, and 76% Non-Hispanic White. The age grouping breakdown for the county is 21% ages 0 to 17, 7% ages 18 to 24, 23% ages 25 to 44, 26% ages 45 to 64, and 24% ages 65 and older. Economic predictors for Henderson County have the median household income at $49,469, unemployment rate at 6%, total persons in poverty at 17.0%, persons 65 years old and older in poverty at 8.9%, and children under 18 years of age in poverty at 27.9% (data.census.gov). Access to healthcare shows ratios of 1,760:1 for mental health providers, 3,243:1 for primary care physicians, and 2,939:1 for dentists in Henderson County (countyhealthrankings.org). The crime rate is 1,272.5 per 100k population with property crime at 1,081.9 per 100k population and violent crime at 234.5 per 100k population (txucr.nibrs.com). Henderson County’s age adjusted death rates per 100k population are alcohol-induced at 8.7, drug-induced at 14.0, and suicide at 19.1 (wonder.cdc.gov).
Hopkins County
Hopkins County is considered rural, nonmetro, with a 2022 population of 37,334 and population density of 48.7 per square mile. The racial and ethnic breakdown for the county is 1% Non-Hispanic Asian, 7% Non-Hispanic Black, 18% Hispanic, 2% Non-Hispanic Other, and 72% Non-Hispanic White. The age grouping breakdown for the county is 23% ages 0 to 17, 8% ages 18 to 24, 24% ages 25 to 44, 24% ages 45 to 64, and 21% ages 65 and older. Economic predictors for Hopkins County have the median household income at $54,600, unemployment rate at 5%, total persons in poverty at 11.8%, persons 65 years old and older in poverty at 9.9%, and children under 18 years of age in poverty at 15.2% (data.census.gov). Access to healthcare shows ratios of 1,430:1 for mental health providers, 4,055:1 for primary care physicians, and 3,681:1 for dentists in Hopkins County (countyhealthrankings.org). The crime rate is 847.7 per 100k population with property crime at 666.1 per 100k population and violent crime at 187.6 per 100k population (txucr.nibrs.com). Hopkins County’s age adjusted death rates per 100k population are alcohol-induced at 4.4, drug-induced at 9.3, and suicide at 15.0 (wonder.cdc.gov).

Lamar County
Lamar County is considered rural, nonmetro, with a 2022 population of 49,957 and population density of 55.1 per square mile. The racial and ethnic breakdown for the county is 1% Non-Hispanic Asian, 12% Non-Hispanic Black, 10% Hispanic, 4% Non-Hispanic Other, and 73% Non-Hispanic White. The age grouping breakdown for the county is 23% ages 0 to 17, 7% ages 18 to 24, 24% ages 25 to 44, 25% ages 45 to 64, and 22% ages 65 and older. Economic predictors for Lamar County have the median household income at $48,036, unemployment rate at 7%, total persons in poverty at 18.4%, persons 65 years old and older in poverty at 14.2%, and children under 18 years of age in poverty at 26.6% (data.census.gov). Access to healthcare shows ratios of 960:1 for mental health providers, 1,983:1 for primary care physicians, and 1,658:1 for dentists in Lamar County (countyhealthrankings.org). The crime rate is 2,343.3 per 100k population with property crime at 1,807.5 per 100k population and violent crime at 564.7 per 100k population (txucr.nibrs.com). Lamar County’s age adjusted death rates per 100k population are alcohol-induced at 5.7, drug-induced at 9.9, and suicide at 17.1 (wonder.cdc.gov).
Marion County
Marion County is considered rural, nonmetro, with a 2022 population of 10,199 and population density of 26.8 per square mile. The racial and ethnic breakdown for the county is 1% Non-Hispanic Asian, 23% Non-Hispanic Black, 5% Hispanic, 3% Non-Hispanic Other, and 69% Non-Hispanic White. The age grouping breakdown for the county is 19% ages 0 to 17, 6% ages 18 to 24, 21% ages 25 to 44, 28% ages 45 to 64, and 26% ages 65 and older. Economic predictors for Marion County have the median household income at $39,093, unemployment rate at 8%, total persons in poverty at 18.5%, persons 65 years old and older in poverty at 10.0%, and children under 18 years of age in poverty at 30.3% (data.census.gov). Access to healthcare shows ratios of 9,850:1 for mental health providers, 9,850:1 for primary care physicians, and 9,850:1 for dentists in Marion County (countyhealthrankings.org). The crime rate is 1,292.0 per 100k population with property crime at 1,143.1 per 100k population and violent crime at 214.3 per 100k population (txucr.nibrs.com). Marion County’s age adjusted death rates per 100k population are alcohol-induced at 10.1, drug-induced at 13.7, and suicide at 19.6 (wonder.cdc.gov).

Morris County
Morris County is considered rural, nonmetro, with a 2022 population of 12,328 and population density of 48.9 per square mile. The racial and ethnic breakdown for the county is 0% Non-Hispanic Asian, 22% Non-Hispanic Black, 11% Hispanic, 3% Non-Hispanic Other, and 64% Non-Hispanic White. The age grouping breakdown for the county is 22% ages 0 to 17, 7% ages 18 to 24, 22% ages 25 to 44, 24% ages 45 to 64, and 25% ages 65 and older. Economic predictors for Morris County have the median household income at $43,995, unemployment rate at 11%, total persons in poverty at 17.8%, persons 65 years old and older in poverty at 9.5%, and children under 18 years of age in poverty at 22.7% (data.census.gov). Access to healthcare shows ratios of 3,100:1 for mental health providers, 6,234:1 for primary care physicians, and 2,057:1 for dentists in Morris County (countyhealthrankings.org). The crime rate is 1,301.4 per 100k population with property crime at 984.8 per 100k population and violent crime at 344.7 per 100k population (txucr.nibrs.com). Morris County’s age adjusted death rates per 100k population are alcohol-induced is listed as unreliable, drug-induced at 12.6, and suicide at 19.0 (wonder.cdc.gov).
Panola County
Panola County is considered rural, nonmetro, with a 2022 population of 24,714 and population density of 30.8 per square mile. The racial and ethnic breakdown for the county is 0% Non-Hispanic Asian, 16% Non-Hispanic Black, 11% Hispanic, 2% Non-Hispanic Other, and 71% Non-Hispanic White. The age grouping breakdown for the county is 24% ages 0 to 17, 8% ages 18 to 24, 25% ages 25 to 44, 23% ages 45 to 64, and 21% ages 65 and older. Economic predictors for Panola County have the median household income at $51,297, unemployment rate at 8%, total persons in poverty at 14.1%, persons 65 years old and older in poverty at 10.3%, and children under 18 years of age in poverty at 14.5% (data.census.gov). Access to healthcare shows ratios of 7,730:1 for mental health providers, 2,905:1 for primary care physicians, and 3,858:1 for dentists in Panola County (countyhealthrankings.org). The crime rate is 2,022.3 per 100k population with property crime at 1,901.0 per 100k population and violent crime at 291.1 per 100k population (txucr.nibrs.com). Panola County’s age adjusted death rates per 100k population are alcohol-induced at 6.3, drug-induced at 8.8, and suicide at 13.6 (wonder.cdc.gov).

Rains County
Rains County is considered rural, nonmetro, with a 2022 population of 11,455 and population density of 49.9 per square mile. The racial and ethnic breakdown for the county is 1% Non-Hispanic Asian, 3% Non-Hispanic Black, 10% Hispanic, 2% Non-Hispanic Other, and 84% Non-Hispanic White. The age grouping breakdown for the county is 20% ages 0 to 17, 6% ages 18 to 24, 21% ages 25 to 44, 28% ages 45 to 64, and 26% ages 65 and older. Economic predictors for Rains County have the median household income at $52,612, unemployment rate at 5%, total persons in poverty at 12.0%, persons 65 years old and older in poverty at 8.3%, and children under 18 years of age in poverty at 11.6% (data.census.gov). Access to healthcare shows ratios of 2,500:1 for mental health providers, 5,881:1 for primary care physicians, and 11,425:1 for dentists in Rains County (countyhealthrankings.org). The crime rate is 606.4 per 100k population with property crime at 416.5 per 100k population and violent crime at 147.0 per 100k population (txucr.nibrs.com). Rains County’s age adjusted death rates per 100k population are alcohol-induced is unreliable, drug-induced at 14.1, and suicide at 17.9 (wonder.cdc.gov).
Red River County
Red River County is considered rural, nonmetro, with a 2022 population of 12,515 and population density of 12.1 per square mile. The racial and ethnic breakdown for the county is 0% Non-Hispanic Asian, 18% Non-Hispanic Black, 9% Hispanic, 3% Non-Hispanic Other, and 70% Non-Hispanic White. The age grouping breakdown for the county is 21% ages 0 to 17, 6% ages 18 to 24, 22% ages 25 to 44, 25% ages 45 to 64, and 26% ages 65 and older. Economic predictors for Red River County have the median household income at $37,135, unemployment rate at 6%, total persons in poverty at 20.2%, persons 65 years old and older in poverty at 16.9%, and children under 18 years of age in poverty at 26.4% (data.census.gov). Access to healthcare shows ratios of 3,010:1 for mental health providers, 6,115:1 for primary care physicians, and 4,058:1 for dentists in Red River County (countyhealthrankings.org). The crime rate is 1,157.8 per 100k population with property crime at 932.2 per 100k population and violent crime at 283.0 per 100k population (txucr.nibrs.com). Red River County’s age adjusted death rates per 100k population are alcohol-induced at 6.2, drug-induced at 10.2, and suicide at 16.9 (wonder.cdc.gov).

Rusk County
Rusk County is considered rural, nonmetro, with a 2022 population of 52,648 and population density of 57.0 per square mile. The racial and ethnic breakdown for the county is 0% Non-Hispanic Asian, 16% Non-Hispanic Black, 19% Hispanic, 2% Non-Hispanic Other, and 62% Non-Hispanic White. The age grouping breakdown for the county is 21% ages 0 to 17, 9% ages 18 to 24, 27% ages 25 to 44, 24% ages 45 to 64, and 18% ages 65 and older. Economic predictors for Rusk County have the median household income at $56,223, unemployment rate at 7%, total persons in poverty at 11.2%, persons 65 years old and older in poverty at 9.6%, and children under 18 years of age in poverty at 15.0% (data.census.gov). Access to healthcare shows ratios of 3,890:1 for mental health providers, 4,803:1 for primary care physicians, and 3,630:1 for dentists in Rusk County (countyhealthrankings.org). The crime rate is 2,387.9 per 100k population with property crime at 2,175.3 per 100k population and violent crime at 289.5 per 100k population (txucr.nibrs.com). Rusk County’s age adjusted death rates per 100k population are alcohol-induced at 4.9, drug-induced at 8.2, and suicide at 14.7 (wonder.cdc.gov).
Smith County
Smith County is considered urban, metro, with a 2022 population of 239,994 and population density of 260.4 per square mile. The racial and ethnic breakdown for the county is 2% Non-Hispanic Asian, 17% Non-Hispanic Black, 21% Hispanic, 2% Non-Hispanic Other, and 58% Non-Hispanic White. The age grouping breakdown for the county is 24% ages 0 to 17, 9% ages 18 to 24, 26% ages 25 to 44, 23% ages 45 to 64, and 18% ages 65 and older. Economic predictors for Smith County have the median household income at $59,450, unemployment rate at 7%, total persons in poverty at 14.0%, persons 65 years old and older in poverty at 10.4%, and children under 18 years of age in poverty at 18.2% (data.census.gov). Access to healthcare shows ratios of 810:1 for mental health providers, 982:1 for primary care physicians, and 1,693:1 for dentists in Smith County (countyhealthrankings.org). The crime rate is 2,528.7 per 100k population with property crime at 2,195.0 per 100k population and violent crime at 375.7 per 100k population (txucr.nibrs.com). Smith County’s age adjusted death rates per 100k population are alcohol-induced at 5.0, drug-induced at 9.4, and suicide at 15.8 (wonder.cdc.gov).

Titus County
Titus County is considered rural, nonmetro, with a 2022 population of 33,005 and population density of 81.3 per square mile. The racial and ethnic breakdown for the county is 1% Non-Hispanic Asian, 10% Non-Hispanic Black, 44% Hispanic, 2% Non-Hispanic Other, and 43% Non-Hispanic White. The age grouping breakdown for the county is 27% ages 0 to 17, 9% ages 18 to 24, 24% ages 25 to 44, 23% ages 45 to 64, and 16% ages 65 and older. Economic predictors for Titus County have the median household income at $53,406, unemployment rate at 7%, total persons in poverty at 15.8%, persons 65 years old and older in poverty at 10.3%, and children under 18 years of age in poverty at 23.6% (data.census.gov). Access to healthcare shows ratios of 1,560:1 for mental health providers, 1,828:1 for primary care physicians, and 2,360:1 for dentists in Titus County (countyhealthrankings.org). The crime rate is 2,002.9 per 100k population with property crime at 1,607.8 per 100k population and violent crime at 398.1 per 100k population (txucr.nibrs.com). Titus County’s age adjusted death rates per 100k population are alcohol-induced at 3.3, drug-induced at 6.1, and suicide at 15.2 (wonder.cdc.gov).
**Upshur County**
Upshur County is considered rural, nonmetro, with a 2022 population of 42,145 and population density of 72.3 per square mile. The racial and ethnic breakdown for the county is 0% Non-Hispanic Asian, 8% Non-Hispanic Black, 11% Hispanic, 3% Non-Hispanic Other, and 77% Non-Hispanic White. The age grouping breakdown for the county is 22% ages 0 to 17, 8% ages 18 to 24, 25% ages 25 to 44, 26% ages 45 to 64, and 20% ages 65 and older. Economic predictors for Upshur County have the median household income at $54,330, unemployment rate at 8%, total persons in poverty at 14.9%, persons 65 years old and older in poverty at 13.1%, and children under 18 years of age in poverty at 20.7% (data.census.gov). Access to healthcare shows ratios of 2,610:1 for mental health providers, 3,440:1 for primary care physicians, and 8,252:1 for dentists in Upshur County (countyhealthrankings.org). The crime rate is 1,380.4 per 100k population with property crime at 1,279.2 per 100k population and violent crime at 237.4 per 100k population (txucr.nibrs.com). Upshur County’s age adjusted death rates per 100k population are alcohol-induced at 7.8, drug-induced at 10.6, and suicide at 18.3 (wonder.cdc.gov).

**Van Zandt County**
Van Zandt County is considered rural, nonmetro, with a 2022 population of 56,056 and population density of 66.5 per square mile. The racial and ethnic breakdown for the county is 0% Non-Hispanic Asian, 3% Non-Hispanic Black, 13% Hispanic, 3% Non-Hispanic Other, and 82% Non-Hispanic White. The age grouping breakdown for the county is 23% ages 0 to 17, 7% ages 18 to 24, 23% ages 25 to 44, 25% ages 45 to 64, and 23% ages 65 and older. Economic predictors for Van Zandt County have the median household income at $57,203, unemployment rate at 6%, total persons in poverty at 12.7%, persons 65 years old and older in poverty at 8.3%, and children under 18 years of age in poverty at 17.3% (data.census.gov). Access to healthcare shows ratios of 2,980:1 for mental health providers, 5,518:1 for primary care physicians, and 4,309:1 for dentists in Van Zandt County (countyhealthrankings.org). The crime rate is 746.4 per 100k population with property crime at 564.2 per 100k population and violent crime at 194.2 per 100k population (txucr.nibrs.com). Van Zandt County’s age adjusted death rates per 100k population are alcohol-induced at 4.7, drug-induced at 13.3, and suicide at 20.4 (wonder.cdc.gov).
Wood County
Wood County is considered rural, nonmetro, with a 2022 population of 45,896 and population density of 71.1 per square mile. The racial and ethnic breakdown for the county is 0% Non-Hispanic Asian, 5% Non-Hispanic Black, 12% Hispanic, 2% Non-Hispanic Other, and 80% Non-Hispanic White. The age grouping breakdown for the county is 20% ages 0 to 17, 8% ages 18 to 24, 20% ages 25 to 44, 24% ages 45 to 64, and 28% ages 65 and older. Economic predictors for Wood County have the median household income at $56,749, unemployment rate at 7%, total persons in poverty at 12.9%, persons 65 years old and older in poverty at 8.8%, and children under 18 years of age in poverty at 18.4% (data.census.gov). Access to healthcare shows ratios of 2,850:1 for mental health providers, 2,110:1 for primary care physicians, and 3,009:1 for dentists in Wood County (countyhealthrankings.org). The crime rate is 964.9 per 100k population with property crime at 850.9 per 100k population and violent crime at 100.1 per 100k population (txucr.nibrs.com). Wood County’s age adjusted death rates per 100k population are alcohol-induced at 6.6, drug-induced at 12.7, and suicide at 17.2 (wonder.cdc.gov).
Conclusions

Qualitative and quantitative data have independent purpose and value; however, the combining of the two creates a deeper picture of what is trying to be told by the collection of data. Quantitative data is measurable and can show need, improvement, decline, and create a base for qualitative data to evolve from questions, discussions, and observations. The information gathered for this RNA was illuminating and fostered collaboration and understanding across organizations and service providers throughout Region 4 and beyond.

Through the collection of quantitative data, the majority of Region 4’s substance use/misuse issues involve alcohol, methamphetamines, marijuana, and vaping caused by poverty, mental health issues, and the pandemic leading to the destruction of families and relationships, poverty, and permeant health damage, which is exacerbated by the lack of providers available to those without insurance and without the ability to pay for services.

The Region 4 PRC encourages all community members to reach out for more information or to actively participate by being a member of the REW or KIIs. Inquires can be made by emailing intake@etcada.com or calling 903-753-7633.
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