



Drug Laws and Policies in Texas

A Study by the League of Women Voters of Texas Education Fund

INTRODUCTION

The League of Women Voters of Texas (LWV-TX) adopted a study of Drug Laws and Policies in Texas. There is continued public debate whether the use of certain mind-altering drugs should be treated as a criminal offense, a civil infraction, or a personal matter and whether drug abuse is a criminal or public health issue.

Focus: To examine drug laws and policies in Texas.

The scope of the study is to review and evaluate:

- History of drug laws in Texas.
- Current laws and policies governing the sale and use of illegal drugs, including their effects on young people, communities of color, and medical care and public health.
- Social and economic costs of relying on prohibition, law enforcement, and imprisonment to solve drug-related problems.
- Possible alternatives to current policies.

HISTORY OF DRUG USE

Drug use by human societies has been in existence since ancient times. Only the Inuit Eskimos have no traditional history of drug use, but that changed following contact with Europeans. Before the 19th Century, mind-altering substances were legal.

A Brief History of Drug Laws in the U.S.

The earliest laws prohibiting drug use varied from state to state. In 1860, Pennsylvania enacted an anti-morphine law. In 1881, California enacted a similar anti-opium law focused on opium smoking dens commonly frequented by Chinese immigrants. Following state laws, early federal drug laws centered on “social groups using certain drugs rather than the drugs themselves.” An 1887 federal law prohibited the import of opium into the United States by any subject of China. It was followed by an 1890 federal law that permitted only Americans to manufacture opium for smoking.

The Pure Food and Drug Act of 1906, the first federal law regulating drug use, required manufacturers to list the ingredients of medicines on the label and include warnings about dangerous products. It did not impose prohibitions on any substance. Matters of public health and safety were considered the exclusive right of states.

The Harrison Narcotics Act of 1914 made it illegal for physicians to prescribe narcotics to addicts. It was zealously en-

forced by the Treasury Department.

In 1921, the 18th Amendment to the U.S. Constitution was passed prohibiting the manufacture, sale, and transport of alcohol. By this time, 39 states, including Texas, had enacted alcohol prohibition laws, while fourteen states prohibited cigarettes. National alcohol prohibition was repealed in 1933 leaving regulation of alcohol sales to the states.

On January 1, 1932, the newly established Federal Bureau of Narcotics, a unit of the Treasury Department, took over the enforcement of the federal anti-opiate and anti-cocaine laws. This department encouraged states to adopt laws criminalizing the use of marijuana. The media also began to report heinous crimes committed by persons under the influence of marijuana. By 1937, forty-six of the forty-eight states, as well as the District of Columbia, had laws against marijuana. Under most of these state laws, marijuana was subject to the same rigorous penalties applicable to morphine, heroin, and cocaine and was often erroneously designated a narcotic.

The Federal Marijuana Tax Act of 1937, modeled on the Harrison Narcotic Act of 1914, recognized the medicinal usefulness of the substance; although, a fee on prescribing, dispensing, growing, or importing marijuana was implemented. The *non-medicinal, untaxed* possession or sale of marijuana was outlawed. The only physician to testify at the 1937 Congressional hearings was Dr. William C. Woodward, who representing the American Medical Association. He testified that marijuana was a recognized medicine in good standing, distributed by leading pharmaceutical firms, and sold at many pharmacies. At least twenty-eight medicinal products containing marijuana were on the market in 1937, but it were dropped from the *U.S. Pharmacopeia* in 1941.

In 1970 the Comprehensive Drug Abuse Prevention Act put all drugs except alcohol and tobacco under federal control.□ Congress created the Drug Enforcement Agency (DEA) in 1972 to enforce federal drug laws.□ In the late 1970s law enforcement agencies began using□civil forfeiture in the drug war meaning no arrest or criminal sanction is required to seize money or other property that is suspected of being involved in a crime or purchased with drug money.

□

The Omnibus Drug Act of 1988 placed heavier penalties for drug-related felonies and toughened the penalties for users.

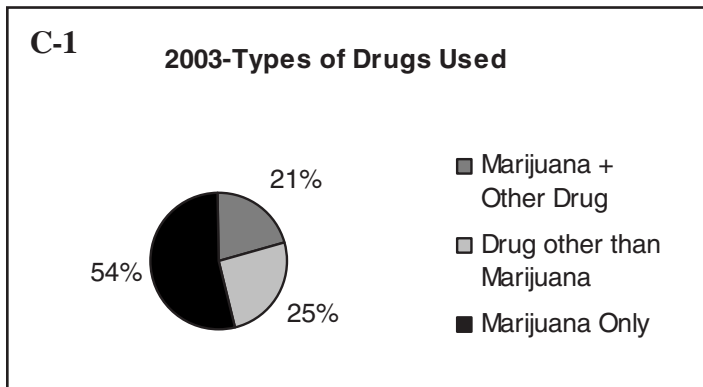
Texas Drug Laws

Texas drug laws have paralleled federal laws. Current state laws are found in the Health and Safety Code, subtitle C. Substance Abuse Regulation and Crimes, Chapter 481, Texas Controlled Substance Act, 2004-2005 Texas Criminal Codes and Rules. Substances are categorized into separate penalty groups for possession, manufacture and/or delivery. Punishment depends on the penalty group and amount of substance possessed by the person charged.

DRUG USE

The National Survey on Drug Use and Health (NSDUH) is a major household survey completed each year for the Substance Abuse and Mental Health Services Administration (SAMHSA), part of the U.S. Department of Health and Human Services. The following statistical data on drug use, abuse, and dependency is from their latest NSDUH (2003).

Below, Chart C-1 reports drug use by type for the 19.5 million illicit drug users in 2003 (6.7% of the U.S. population).

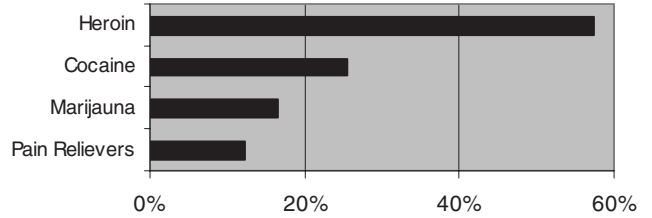


An estimated 2.3 million persons (1.0%) were cocaine users, 604,000 of whom used crack during the same time period (0.3%). Hallucinogens were used by 1.0 million persons (0.4%). There were an estimated 119,000 current heroin users (0.1%). All of these estimates are similar to estimates for 2002.

An estimated 18.2% of unemployed adults aged 18 or older were current illicit drug users compared with 7.9% of those employed full time and 10.7% of those employed part time. However, of the 16.7 million illicit drug users aged 18 or older in 2003, 12.4 million (74.3%) were employed either full or part time.

As Chart C-2 (next column) indicates, a larger percentage of heroin users are dependent or abusers. It is unclear from the statistics whether this is because of the drug or the type of person who chooses to use the drug.

C-2 Percent of Drug Users Who Are Dependent



As shown below in Table T-1, drug use is more wide-spread in the American Indian-Alaskan Natives, Pacific Islanders, and persons of 2+ races than it is for the four other racial and ethnic groups.

Racial/Ethnic Category	Use	Abuse
Am Indians & Alaskan Natives	12.1%	17.2%
Persons 2+ races	12.0%	11.3%
Pacific Islanders	11.1%	12.9%
Whites	8.3%	9.2%
Hispanics	8.0%	9.8%
Blacks	8.7%	8.1%
Asians	3.8%	6.3%

In 2003 adults who had first used substances at a younger age were more likely to be classified with dependence or abuse than adults who initiated use at a later age. For example, among adults aged 18 or older who first tried marijuana at age 14 or younger, 13.3% were classified with illicit drug dependence or abuse compared with only 2.2% of adults first using marijuana at age 18 or older. This pattern of higher rates of dependence or abuse among persons initiating their use of marijuana at younger ages was observed among all demographic subgroups analyzed.

Drug Use and Youth

The NSDUH found that the rate of illicit drug use among youths aged 12 to 17 did not change significantly between 2002 (11.6%) and 2003 (11.2%). The rates of use of the following drugs declined slightly: marijuana from 8.2% in 2002 to 7.9% in 2003, LSD (1.3 to 0.6%), Ecstasy (2.2 to 1.3%), and methamphetamine (0.9 to 0.7%).

Rates of use were highest for the young adult age group (18 to 25 years) at 20.3%, with 17.0% using marijuana, 6.0% using prescription-type drugs non-medically, 2.2% using cocaine, and 1.7% using hallucinogens

The National Office of Drug Control Policy reported that in 2002 about 34% of Texas high school students had used an illegal drug. According to the Texas Commission on Alcohol and Drug Abuse, the highest drug-using age among adults is

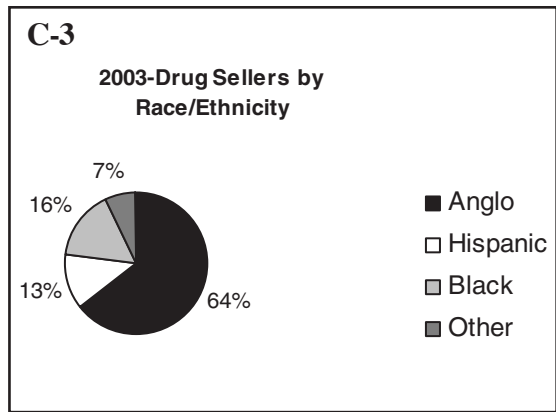
18-24. As stated in the Overview Notes from The Drug Policy Forum of Texas website, “about 75% of our young have already tried an illegal drug by age 22 years. Anyone who really wants drugs gets them.”

The survey also reported that slightly more than half of youths aged 12 to 17 indicated “it would be fairly or very easy to obtain marijuana” (53.6%). However, the ease of obtaining marijuana varied greatly by age among youths aged 12 to 17. Only 25.2% of 12 or 13 year olds indicated “it would be fairly or very easy to obtain marijuana;” on the other hand, the rate for 16 or 17 year olds was 77.2%.

In addition, the results of a comparison of factors influencing a youth’s propensity to use illicit drugs including whether the kid had a parent talk, liked school or had been exposed to a drug prevention message at school and/or out of school were reported. The only significant comparison was if a child liked school he/she was half as likely to use drugs as a child who hated school. A parent talk had no significant difference.

Incarceration Statistics for Drug Offenses

As shown in Tables T-2 and T-3 (below), Blacks represent 11.1% of the Texas population and 50% of persons incarcerated for drug offenses. The 2003 NSDUH survey results (shown above) report very little difference in drug use or drug abuse between Whites (Anglos), Blacks, and Hispanics. And the same survey, shown in the next column (C-3) reports only 16% of all persons who report selling drugs are Black and 13% are Hispanic.



According to the NSDUH, 24.3% of the 1.4 million adults on parole or other supervised release from prison reported current illicit drug use. Twenty-eight percent of the 4.8 million adults on probation reported current illicit drug use.

The Texas Department of Criminal Justice (TDCJ) has a fiscal 2006-07 budget of \$5 billion which includes \$10 million for substance abuse treatment for offenders released from prison. The total budgeted amount for substance abuse treatment was \$72 million (1.4% of the total budget) roughly the same as budgeted in fiscal years 2004-05. The notes to the budget say that current funding levels are approximately \$32 million below 2002-03 levels. The reductions eliminated the state jail substance abuse program, substance abuse education and counseling programs at institutional prisons, and parole field referral programs.

The Governor’s Criminal Justice Division (CJD) distributes over \$30 million from the federal Byrne grant program. The CJD can spend the Byrne funds on substance abuse treatment programs, drug courts, prison diversion programs and/or other programs that work to reduce crime. The CJD has given almost all of this money to the Regional Narcotics Task Forces whose goal is to put more people in prison for drug offenses.

Disparities by Sex and Age

Among pregnant women aged 15 to 44 years, 4.3% reported using illicit drugs in the month prior to their interview during 2002 and 2003. This rate was significantly lower than the rate among women aged 15 to 44 who were not pregnant (10.4%). These estimates are based on combined 2002 and 2003 NSDUH data.

In 2003 males were almost twice as likely to be classified with substance dependence or abuse as females (12.2 vs. 6.2%). However, among youths aged 12 to 17 the rate of substance dependence or abuse among females (9.1%) was higher than the

Category	Total	% Pop
Anglo	11,169,231	50.5%
Hispanic	7,556,869	34.2%
Black	2,462,746	11.1%
Other*	929,663	4.2%
Total	22,118,509	100.0%

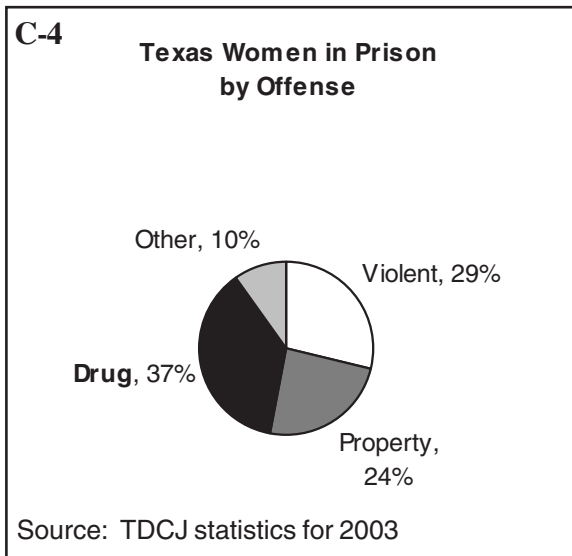
*Includes persons of two or more races.

	Male		Female		Total	
Black	12,903	44%	1,573	5%	14,476	50%
Hispanic	6,838	23%	564	2%	7,402	25%
White	1,338	5%	938	3%	2,276	8%
Other	4,496	15%	579	2%	5,075	17%
Total	25,575	87%	3,654	13%	29,229	100%

Source: Texas Department of Criminal Justice

rate among males (8.7%). Males 12 or older in 2003 were more likely than females to receive treatment for an alcohol or illicit drug problem in the past year (2.0 vs. 0.9%, respectively). Males aged 12 to 17 also were more likely to receive treatment than females (1.7 vs. 1.2%, respectively).

As shown in Chart C-4 below, a higher percentage of women are imprisoned for drug offenses than any other type of offense.



Social and Economic Costs of Criminalizing Drug Sales and Use

A variety of sources have found dramatic costs associated with the criminalization of drug use and abuse:

(1) The Stewart Research Group (SRG) estimates that lost economic productivity due to incarceration in the Texas African American community equals \$1.265 billion per year. Using a cost benefit model, the SRG estimates savings of \$183 million annually would be possible by investing in drug treatment over incarceration and associated costs. The NAACP of Texas funded this research.

(2) In “The Budgetary Implications of Marijuana Prohibition,” Jeffrey A. Miron, Ph.D., estimates legalizing marijuana would save Texas an estimated \$273.71 million in enforcement costs. This estimate is based on total expenditures for all drug enforcement cases times the fraction of these cases attributed to marijuana violations. If marijuana were taxed like other goods, Texas tax revenues could be expected to total between \$46.6 and \$59.3million per year depending upon the number of users. The research for the study was funded by the Marijuana Policy Project, a group that supports legalization. The study does not estimate the costs to society of a potential increase in marijuana users due to legalization. It also does

not quantify the benefit to society of having fewer persons incarcerated.

(3) The following table is from “Economic Costs of Alcohol and Drug Abuse in Texas in 2000” funded by the Texas Commission on Drug and Alcohol Abuse. Morbidity equals lost productivity. Mortality is premature death at a discount rate of 4 percent. Direct costs include crime, motor vehicle crashes,

T-4 “Economic Costs of Alcohol and Drug Abuse in Texas in 2000”

Type of Cost	Cost in millions
Treatment	\$393
Prevention	\$74
Medical	\$12
Morbidity	\$2,375
Mortality	\$1,450
Direct Costs	\$2,410
Indirect Costs	\$2,529
Drug-Exposed Infants	\$100
AIDS	\$182
Hepatitis B/C	\$4
Tuberculosis	\$2
Total	\$9,531

Source: Texas Commission on Drug and Alcohol Abuse

social welfare administration, and fire destruction. Indirect costs include victims of crime, incarceration, and crime careers. These costs equal \$457 for every man, woman, and child in Texas.

(4) According to the Texas LULAC Criminal Justice Policy Brief (2004), Texas has over 100 state laws that forbid a felon working certain types of jobs. Ex-felons cannot receive Temporary Assistance for Needy Families (TANF) and food stamps, particularly onerous policies for female felons. More than half of the people in Texas prisons are parents. Studies indicate that children who have a parent in prison get lower grades in school, drop out of school, become delinquent more often, and are 6-8 times more likely to end up in prison themselves. Children with parents in prison often end up living with grandparents or in the state foster care system. Parents who are currently in Texas prisons owe \$2.5 billion in unpaid child support to children who live in Texas.

DRUG TREATMENT AND ITS FUNDING

Treatment for substance abuse is widely considered a cost-effective approach to combating the problems associated with substance abuse. According to the California Drug and Alcohol Treatment Assessment (CALDATA), every \$1 invested in substance abuse treatment has a return of \$7 in cost savings from reduced health costs, crime, lost productivity, etc. The Texas Criminal Justice Policy Council’s 1995 study esti-

mated that for every \$1 of treatment, the state saved \$2.86 in incarceration costs alone.

Despite the cost effectiveness of substance abuse treatment programs, a substantial gap exists between the number of people who need treatment and the number who receive treatment. According to the NHSDA, the number of people in the United States over age 12 who abused alcohol or illicit drugs in 2003 grew to 22.2 million. In 2003, only an estimated 3.3 million persons aged 12 or older received treatment for alcohol or illicit drugs. There was a decrease in specialty treatment for an illicit drug problem among adults aged 26 or older, from 1.0 million in 2002 to 0.6 million in 2003.

In the year 2002-2003 the NHSDA estimated that 2.73% of Texans 12 years and older were dependent on illicit drugs compared to a nation-wide average of 2.95%. An estimated 2.47% of Texans who needed drug treatment were not receiving it compared to 2.66% for the U.S.

The treatment gap is due at least in part to the financing of substance abuse treatment programs. Unlike other health expenditures, the majority of mental health and substance abuse treatment programs are financed with public funds. Public and private insurers pay for most health care in the country; however, drug treatment programs often are not covered by these plans. Medicaid and Medicare offer limited coverage options, and many private plans simply do not cover substance abuse treatment. From 1987-1997 private insurance plans, out-of-pocket expenditures, and charity groups paid about 35 percent of substance abuse treatment costs, while the public paid approximately 65 percent. In contrast, the public funds only 46 percent of all other health care costs, with private payers covering the majority of the costs.

Among those who perceived an unmet treatment need, the primary reasons for not getting treatment were: (1) not being ready to stop using illicit drugs, (2) thinking the cost of treatment would be too high, (3) stigma associated with receiving treatment, and (4) not knowing where to get treatment (NHSDA survey).

In fiscal year 2004-05, the U.S. Substance Abuse and Mental Health Services Administration provided \$177,501,146 to Texas. The Substance Abuse Prevention and Treatment Block Grant, which makes up 77% of the funding, were not broken down between treatment and prevention. However, almost 65% of the discretionary funding is for treatment.

Harm Reduction

Proponents of the harm reduction philosophy do not support the use of mind-altering drugs. However, they feel that ef-

forts should be taken to minimize the health risks of those who do use such drugs. One such harm reduction effort is needle and syringe exchange programs for intravenous drug users.

The Center for Disease Control (CDC) has reported that needle and syringe exchange programs are effective in controlling blood-borne diseases such as human immunodeficiency virus (HIV), and hepatitis B and C. These programs did not increase drug use. According to "Substance Abuse Trends in Texas, January 2005," 41% of persons testing positive for hepatitis C were exposed through intravenous drug use. The Texas Medical Association, the Texas Pharmaceutical Association, and the Texas Sheriffs' Association support the creation of legal access to sterile needles and syringes for addicts.

Australia, which has a population slightly less than Texas, reported the avoidance of 25,000 cases of HIV and 21,000 cases of hepatitis C over the decade of the 1990's due to sterile needle and syringe programs. They calculated that an investment of approximately \$71.8 million (US) in such programs would result in a savings of between \$1.3 and \$4.1 billion.

In Texas, possession of needles and syringes is illegal for illicit drug use through tough drug paraphernalia laws. Legislation was introduced in the 79th legislative session (2005) to allow for needle and syringe exchange programs, but it did not pass.

Some concerns about enhanced needle and syringe access are as follows: (1) Allowing access to clean needles and syringes will increase drug use and the amount of dirty needles and syringes discarded in public areas. (2) Easier access sends a mixed or confusing message about drug use to children. (3) Tax dollars should not be spent to help individuals acquire the objects necessary for the injection of illegal substances.

DRUG EDUCATION

Most existing drug education programs for youth or adults stress that controlled substances are illegal because of their danger to the user and society at large. The basic idea is "just say no." However, as indicated above, these substances are readily available. Since youth is a time of experimentation, a majority try at least one of these substances before they are 22.

The "Safety First" drug education program recommends that the subject of drugs be integrated into a variety of high school courses and curricula, including physiology and biology (how drugs affect the body), psychology (how drugs affect the mind), chemistry (what's contained in drugs), history and civics (how drugs have been handled by the government), and social studies (who uses which drugs and why). The program discourages young people from experimenting with mind altering drugs including alcohol. But it also tries to foster safer use among those who choose to use drugs despite the warnings. Critics

of this approach say that learning about illegal drugs would glamorize them and encourage more youth to experiment with them. Proponents counter that the real goal should be to reduce the number of persons abusing drugs.

POSSIBLE ALTERNATIVES TO CURRENT LAWS AND POLICIES

- Change Texas law to allow safe and legal access to marijuana for those who have a doctor’s recommendation. Proponents hope to allow patients access to the herb and reduce purchases from the criminal market. Most of the states that have such laws restrict use to seriously ill people to treat pain, extreme nausea, glaucoma, or other listed conditions. Opponents say that allowing the use of marijuana by any group, however controlled, would lead to more use and abuse of this mind-altering substance to the detriment of users and society.
- Penalty reduction (sometimes referred to as decriminalization) would make drug possession and use a non-criminal offense punishable by a ticket, fine or mandatory treatment. Proponents of this approach hope to save police time, reduce the prison population, and shrink the number of people with criminal records. Penalty reduction would not affect the illegal supply-side of the market or the violence that goes with it. The source of drugs would still be the illegal market. Opponents say this would encourage more people to use and abuse illegal drugs since there would no longer be any real legal sanctions for their use.
- Regulated possession and sales of just marijuana or all illegal drugs, sometimes referred to as legalization, seeks to address the supply-side of the drug market. Proponents say regulation (1) eliminates arrests for trafficking; (2) saves prosecutorial, judicial, and incarceration expenses; (3) improves drug safety by regulating purity and by requiring labeling about the recommended dose and side effects; and (4) allows taxation of marijuana production and sale. Opponents say this policy would dramatically increase drug use especially among youth, increase violent crime, destroy families, and reduce worker productivity.
- Treat the abuse of mind-altering drugs of all kinds including alcohol as a public health issue rather than a criminal issue and require all those found abusing drugs to attend a drug treatment program. This could be coupled with reduction in penalties for all drug offenses and/or legalization of drugs. Opponents say this approach would increase drug usage and require additional tax revenue to pay for treatment programs.

- Retain the existing drug laws and policies with fairly light sentences for possession of small amounts of marijuana and longer sentences for possession of larger amounts of marijuana or even small amounts of the illegal drugs. This also retains stiff penalties for the sale of illegal drugs. Opponents say the current policy isn’t working. Texas has over 29,000 persons in its prisons and state jails for drug law violations, 84.7 of whom are Black or Hispanic.

- Strengthen mandatory minimum sentencing drug laws with the goal of eliminating the availability and use of all illegal drugs. Proponents think if criminal penalties are made harsh enough, people will stop selling and using drugs. They say controlled substances were made illegal because they are dangerous and harmful to the user and the society at large. Opponents say that this approach has been used for 35 years. During that time, the prison population has grown to the largest per capita in the world, drug prices have decreased, drug purity has increased, and the number of drug users has remained constant.

GLOSSARY

Drug—a substance that in relatively small amounts produces significant changes in the body, mind, or both. The effects of most mind-altering substances vary with the dosage, purity, method of use, and the mood and personality of the user. Typically, taking the substance orally or in a less refined state causes fewer problems than smoking, injecting, or snorting the substance.

Drug abuse—a disease characterized by continued misuse of a drug even when faced with drug-related job, legal or family difficulties” (Wood-Aurora Health Care)

Drug addiction—a brain disease characterized by elevated dopamine levels that create a compulsive use, craving, sensitization, tolerance and undesirable symptoms of withdrawal.

Drug dependence—physical dependence on a drug to maintain good health, such as medication to control high blood pressure, or drug addiction depending on the context.

Pharmacopeia—the official public standards-setting authority for all prescription and over-the-counter medicines.

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