KRONKOSKY CHARITABLE FOUNDATION

RESEARCH BRIEF

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AT RISK YOUTH IN RURAL COUNTIES

Children in families with low socio-economic status are more likely to contend with adverse childhood experiences. The National Advisory Committee on Rural Health and Human Services (NACRHHS) (2009) reported that rural areas have higher rates of childhood poverty and a higher probability of adverse childhood experiences than urban areas. The National Survey of Children's Health (NSCH) (2011) reported that in 2007 there were 13.5 million children living in rural, small or isolated areas. These children were 22 times more likely to have been abused and 44 times more likely to have been neglected than children living in urban areas. These adverse childhood experiences put the child at risk for delayed intellectual, emotional, and social development. The more a child is exposed to adverse experiences, the more vulnerable the child becomes to a variety of health risks as an adult including alcoholism, substance use, mental health illnesses, domestic violence, and higher school dropout rates (NACRHHS, 2009). In addition, "geographic isolation, socio-economic status, health risk behaviors, and limited job opportunities contribute to health disparities in rural communities" (Rural Assistance Center, [RAC], 2011a).

A commonly held misconception is that children in urban environments are more likely to be victims of adverse childhood experiences, and consequently, are more likely to engage in risky behaviors. Recently, research has demonstrated that urban and rural areas experience similar rates of substance use and adverse childhood experiences. The NSCH (2011) report indicated that families with children in large rural areas are more likely to fall below the Federal poverty level than those in urban areas (23.7% and 17.4% respectively).

Health Issues in Rural Areas

Children residing in rural areas are more likely to suffer from particular health and well-being conditions than children in urban areas. According to the NSCH (2011) 83.1% of children living in large rural areas were reported to be in excellent health compared to 84.6% of children living in urban areas. When asked if their child had ever exhibited problems with social behavior, parents of children ages 6 to 17 living in large rural areas reported that 10% exhibited at least one social behavioral problem, while parents of children living in urban areas reported 8.8%. These social behavioral problems included: arguing too much; bullying; being disobedient; and being stubborn, sullen or irritable (NSCH, 2011). Children in rural areas also had higher rates of being overweight and/or obese. In children ages 10 to 17, rural areas reported 34.6% of children suffering from overweight or obesity, while urban areas reported 30.9% (NSCH, 2011). In the two categories of chronic conditions surveyed in the NSCH (2011) (chronic physical conditions and chronic emotional, behavioral, or developmental (EBD) conditions), both had higher rates in children living in large rural areas than in their urban counterparts. Rural parents of children ages 12 to 17 reported 16.7% with chronic physical conditions, while urban areas reported 16.2%. In the same age group, parents reported 6.4% of children suffered from a chronic EBD condition in large rural areas and 4.2% suffered the same conditions in urban areas (NSCH, 2011).

Physical and EBD chronic conditions included:

Physical Conditions
- Asthma
- Diabetes
- Brain Injuries
- Bone, joint or muscle
- Epilepsy
- Hearing
- Vision

Emotional, Behavioral or Developmental Conditions
- ADD/ADHD
- Anxiety
- Autism Spectrum Disorder
- Depression
- Developmental Delay
- Conduct Disorder
- Speech and Learning Disabilities

(NSCH, 2011)

Substance Use

"Today, adults and young teens in rural areas are just as likely to abuse substances as those in larger metropolitan areas. The problems may be the same, but smaller communities have limited resources to deal with the consequences of substance abuse" (RAC, 2011b). Research on at risk youth behavior tends to focus on substance and alcohol use and abuse. One study found that adolescents aged 12 to 17 in rural areas were more likely to have used alcohol, and engaged in binge drinking, heavy drinking, and/or driving under the influence than adolescents in urban areas (Maine Rural Health Research Center [MRHRC], 2012).

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) (2011) 2010 National Survey on Drug Use and Health, substance abuse for persons 12 years or older varied by geographic location (Nonmetropolitan areas, small metropolitan areas, and large metropolitan areas). The use of alcohol in Nonmetropolitan areas was 25.5%, small metropolitan areas at 27.4%, and large metropolitan areas at 25.9%, with past month use being 46.2% in nonmetropolitan areas, 50.6% in small metropolitan areas, and 51.4% in large metropolitan areas. The rate of illicit drug use was 7.5% in nonmetropolitan areas, 8.8% in small metropolitan areas, and 9.4% in large metropolitan areas. The rates of substance abuse and/or dependence were 7.6% in nonmetropolitan areas, 8.9% in small metropolitan areas, and 8.9% in large metropolitan areas (SAMHSA, 2011).

Substance Use in Texas

In another report, SAMHSA (2009b) indicated that Texas had one of the highest prevalence rates of cocaine use for individuals aged 12 to 17 in the nation. This report also indicated that Texas was among the states with the lowest prevalence rates of past month illicit drug use, past month marijuana use, and lifetime marijuana use for individuals aged 12 to 25 (SAMHSA, 2009b).

SAMHSA also reported that in 2010 nearly 10.1% of all adolescents in Texas, aged 12 to 17, reported using an illicit drug at some time in their life. The report also showed marijuana as being the most used illicit drug at 7.4%, with psychotherapeutics drugs next at 3.0%, inhalants 1.1%, hallucinogens 0.9%, and cocaine 0.2% (SAMHSA, 2012). In 2012 the Addiction Research Institute stated that 3.3% of Texas high school students reported ever using heroin, 5.0% had ever used hydrocodone, and 3.0% had ever used oxycodone (both opiate analgesics) (Addiction Research Institute, 2012).

Alcohol continues to be the most widely used substance among Texas secondary school students with 72.7 percent reporting, in 2011, that they had used alcohol at some point in their lives, higher than the national average of 70.8%. Texas adolescents were also reported to be more likely than others to start drinking before age 13, and to drive when drinking alcohol (Center for Disease Control and Prevention, [CDC], 2011a). In addition, 90% of all underage drinking in the U.S. is in the form of binge drinking, with men having a higher prevalence for binge drinking than women (CDC, [n.d.]). Texas reported a total of 23.2% of at risk youth binge drinking, with 21.6% of females and 25.2% of males (CDC 2011b).

Treatment Facilities in Rural Areas

One of the greatest challenges facing at risk youth in rural areas is the limited access to treatment and intervention facilities. In many situations, the lack of resources prevents maltreated children from ever being identified and their needs remain unaddressed. When a child is identified as

maltreated or at risk, there are few resources within the community to provide help. If a child or family needs therapy, they are often expected to travel long distances to obtain the service. The higher poverty rate in rural areas also prevents access for individuals who may need treatment services (NACRHHS, 2009).

In rural areas, one treatment facility may be servicing individuals from a 50 to 100 mile radius. The MRHRC (2009) found that nearly 60% of rural detox providers had a service radius of more than 100 miles. Nearly 90% of detox providers in rural areas are the sole source of service in that area. Because these treatment facilities are expected to service such large areas, they tend to have extensive waiting lists and frequently deny help to individuals in need. For example, approximately one-third of rural detox providers have a formal waiting list and have been unable to admit one or more patients in the past 60 days (MRHRC, 2009).

In addition to the limited treatment facilities, prevention and intervention programs are often nonexistent in rural areas. When funds are available to help at risk youth, they tend to be allocated towards treatment programs. The failure to provide prevention and intervention programs means that children must be identified and diagnosed before they receive treatment, and consequently, the child's development process may have already been interrupted (NACRHHS, 2009).

Treatment Facilities in Texas

As of March 31, 2010 there are 454 substance abuse treatment facilities, treating approximately 33,113 clients. Of these 454 existing facilities 231 (50.9%) are private non-profit, 168 (37.0%) are private for-profit, and 55 (12%) are Local, State, or Federally operated agencies. Some treatment facilities may offer multiple services to patients seeking substance use treatment. In Texas, the majority (375 facilities) offered some form of outpatient treatment, 131 facilities offered some form of residential care, and 61 facilities offered opiate narcotics treatment (SAMHSA, 2011).

Additionally, due to limited access to treatment facilities, many individuals face financial barriers that prevent them from seeking treatment. "Rural citizens have traditionally had less access both to health care providers and private insurance coverage. One out of eight rural nonadjacent residents is underinsured (12%), compared with 10% of rural adjacent and 6% of urban residents" (NACRHHS, 2011). The Texas Department of State Health Services (TDSHS) (2011) reported that in 2010, 25.6% of the nonmetropolitan population in Texas did not have health insurance, compared to 22.1% of individuals in metropolitan areas. Despite the seemingly large amount of treatment facilities in Texas, there are a large number of individuals who needed treatment for substance use problems and did not receive it. The following table indicates the number of adolescents in Texas who had unmet treatment needs from 2003 through 2006.

Unmet Need for Adolescent Substance Abuse Treatment in Texas

	Abused Substance	
	Alcohol	Drugs
Male	55,000 (5.3%)	48,000 (4.5%)
Female	44,000 (4.4%)	41,000 (4.0%)

(SAMHSA, 2009a)

The number of youth programs, whether for treatment or prevention, in Bandera, Comal, and Kendall Counties are inadequate to serve the needs of those counties. The majority of the preventative programs are school related and/or affiliated with national organizations such as the Boy Scouts/Girl Scouts of America. Some of the programs already in place in those counties include:

Youth Programs Available by County

Bexar	Bandera	Comal	Kendall
YMCA		√	√
Boys & Girls Club	√		√
Big Brother/Sister		√	√
Little League	√	√	√
4-H	√	√	√
Boy/Girl Scouts	√	√	√

Programs unique to each outlying county include:

- **Bandera County**: Hill Country Council on Alcohol and Drug Abuse
  - Offers preventative programs and out patient treatment; reduces risk taking behavior and substance abuse
  - Program type: prevention and treatment

- **Comal County**: Communities in Schools of South Central Texas
  - Offers supportive social work services to youth and their families, also a stay-in-school program
  - Program type: prevention
- **Kendall County:** Roy Maas' Youth Alternatives
  - Provides individual and family counseling, crisis intervention, life skills training and parenting classes for at-risk youth and families
  - Program type: treatment and prevention

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