

# Violence and Rural Teens

## Teen Violence, Drug Use, and School-Based Prevention Services in Rural America



*At the Heart of Public Health Policy*

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## Executive Summary

This study had three main purposes: (1) to explore the prevalence of violence-related exposures and drug use among rural teens, (2) to investigate the effects of race and gender on the risk of exposure to violence and drug use, and (3) to compare the policies and mental health care services of rural and urban schools. The sections below summarize the results of this research:

**Exposure to Violence: This study found no evidence to support the common assumption that rural youth are protected from exposure to violence.**

- Of the 15 measures of violence activities, none showed a significantly lower prevalence among rural teens when compared to suburban and urban teens. In fact, rural teens were more likely than urban or suburban teens to have carried a weapon within the last 30 days. These results suggest that rural teens are equally or more likely than suburban and urban teens to be exposed to violent activities.

**Drug Use: Rural teens are at significantly greater risk of using drugs than both suburban and urban teens.**

- Five of the 13 measures of drug use showed a significantly higher prevalence rate among rural teens: chewing tobacco (11.5%), chewing tobacco at school (7.6%), smoking cigarettes at school (14.8%), using crack/cocaine (5.9%), and using steroids (7.4%). Only one measure showed a significantly higher prevalence rate among urban teens (smoking marijuana at school at 6.8%). The remaining seven measures showed no differences by residence.
- Of important note is the prevalence of crystal meth use among rural teens. The proportion of rural teens who reported every using crystal meth (15.5%) was almost double the proportion of urban (8.8%) and suburban teens (9.5%). Crystal meth was the 4<sup>th</sup> most commonly used drug among rural teens after alcohol, cigarettes, and marijuana, making it more popular among rural teens than chewing tobacco.

**Effects of Race: Racial differences for exposure to violence and drug use are negligible among rural teens.**

- Non-white rural teens were no more likely than white rural teens to experience the 15 measures of exposure to violence. This result was similar to comparable comparisons among urban teens but not suburban teens, where non-white teens were more likely than white teens to experience 9 of the violence exposure measures.

### **Exposure to Violence**

#### **Weapons Carrying**

- Carried any weapon
- Carried a gun
- Carried weapon to school

#### **Fear of Violence**

- Feared to attend school
- Threatened with weapon at school

#### **Fighting**

- In a fight
- Injured in a fight
- In a fight at school
- Hit by dating partner
- Coerced into sex

#### **Suicide**

- Considered suicide
- Planned suicide
- Attempted suicide
- Injured in attempt
- Injured who attempted

### **Drug Use**

#### **Outside of School**

- Cigarettes
- Chewing tobacco
- Alcohol
- Marijuana

#### **On School Grounds**

- Cigarettes
- Chewing tobacco
- Alcohol
- Marijuana

#### **Street Drugs**

- Cocaine or crack
- Inhalants
- Heroin
- Crystal meth
- Steroids

- Among rural teens, only one measure of drug use differed by race: rural non-white teens were less likely to report chewing tobacco compared to rural white teens. This pattern was strikingly different from the racial differences found among urban teens (9 differences) and suburban teens (7 differences).

**Effects of Gender: Exposures to violence and drug use vary by gender among rural teens.**

- Among rural teens, females are more likely than males to be coerced into sex or engage in suicide behaviors, while males are more likely than females to use weapons, be threatened at school, or engage in fighting behaviors. Male teens are also more likely than female teens to chew tobacco and smoke marijuana, both on and off school grounds.

**Teen Violence Services: Rural schools offer somewhat fewer teen violence services than rural schools.**

- Rural schools were less likely than urban schools to offer peer counseling and self help services, but just as likely to offer 14 other violence prevention and treatment services.
- There were very few significant differences between rural and urban school in the way these services are delivered. Out of the 66 possible combinations of violence-related services and service delivery option, only 6 showed significantly lower utilization rates for rural schools. The remaining 60 combinations showed no differences by location. (See page 24)

<b><u>Teen Violence Services</u></b>
<b>Mental Health</b>
▪ Violence prevention
▪ Suicide prevention
▪ Crisis intervention
▪ Stress management
▪ Referral for abuse
<b>Drug Use</b>
▪ Alcohol/drug prevention
▪ Tobacco use prevention
▪ Alcohol/drug treatment
▪ Tobacco use treatment
<b>Treatment Modality</b>
▪ Case management
▪ Family counseling
▪ Group counseling
▪ Individual counseling
▪ Comprehensive assessment
▪ Peer counseling
▪ Self help

**Teen Violence Services Personnel: Mental health care staff in rural schools are available for fewer hours, have fewer hiring requirements, and receive training for fewer teen violence services than their counterparts in urban schools.**

- Rural and urban schools were equally likely to have a guidance counselor, a psychologist, and a social worker on staff. However, all three of these professionals were available for significantly fewer hours per week in rural schools.
- Rural and urban schools were equally likely to require a graduate degree, board certification, and a state license for newly hired guidance counselors and for newly hired psychologists. However, rural schools were significantly less likely than urban schools to require a graduate degree or a state license for newly hired school social workers.
- Mental health care staff from rural schools were less likely than their counterparts in urban schools to receive training for certain teen violence services. Specifically, Mental Health Care Coordinators were less likely to receive training in suicide prevention, family counseling, peer counseling, and self help, while Health Education Coordinators in rural schools were less likely to receive training in tobacco use prevention.

**School Environment: Overall, rural schools report fewer policies and security practices that prevent violence and drug use than do urban schools.**

- Rural schools were less likely than urban schools to report using five (5) administrative policies to prevent student violence: prohibiting gang paraphernalia, student education on suicide prevention, violence prevention, and tobacco use prevention, and having a council for school health. The remaining 13 measures showed no differences by school location.
- In response to student fighting, rural schools were less likely than urban schools to encourage or require participation in a student assistance program.
- Rural schools were more likely than urban schools to monitor school hallways and to arm their security staff, but less likely to use a closed campus, prohibit bookbags, require school uniforms, use surveillance cameras, use uniformed police, use undercover police, and use security guards. The remaining seven school security measures did not differ by school location.

***Policy Recommendations***

- **Quality of Violence-Related Services:** Rural schools are just as likely as urban schools to provide mental health services that address violence and drug use activities. However, in rural schools, staff receive less training, have lower hiring requirements, and are available for fewer hours each week. The Rural Health Outreach Grant Program includes many initiatives addressing mental or behavioral health components, but no FY04 grantees specifically address teen violence. ORHP should encourage applicants to address teen violence services in rural areas. It is important, however, to understand why this disparity exists before trying to reduce it. For example, if rural schools have fewer resources available for staff training, then funding would be the priority. But if rural school officials perceive a lower need for these services, then raising awareness of the problem might motivate a re-allocation of training for mental health care staff.
- **School-Based Health Centers and School-Physician Partnerships:** ORHP and State Departments of Health should facilitate physician education regarding (1) teen violence and drug use in rural areas, (2) warning signs and symptoms of violence and drug use, (3) need for communication between medical providers and local schools, particularly mental health

**Violence Prevention Policies**

**Weapons in school**

- Weapons prohibited policy
- Weapons off campus prohibited

**Fighting in school**

- Fighting prohibited policy

**Gangs in school**

- Gangs prohibited policy
- Gang paraphernalia prohibited

**Violence education**

- Emotional or mental health
- Suicide prevention
- Violence prevention
- Alcohol/drug prevention
- Tobacco use prevention

**School policies**

- Have a council for school health
- Council on violence prevention
- Council for school climate
- Council for mental health svcs
- Written violence plan
- Anti-harassment policy
- Alcohol/drug prevention
- Tobacco use prevention

**School Security**

- Closed campus
- Monitored halls
- Monitored bathrooms
- Monitored school grounds
- Conduct bag/locker checks
- Prohibit bags/backpacks
- Required school uniforms
- Required dress code
- Student ID badges
- Surveillance cameras
- Metal detectors
- Uniformed police
- Undercover police
- Security guards
- Armed security staff
- Armed, those w/security staff

care professionals who work for the school system. School Based Health Centers, funded under the Health Centers Consolidation Act of 1996, are potential new access points for service expansion in the areas of mental health and substance abuse services. Rural program planners, particularly in existing Community Health Centers, are encouraged to consider offering violence and drug abuse screening and prevention services to youth through this funding mechanism.

- **Technology:** Technology offers two important avenues for improving mental health care in rural areas. First, telecommunications provides another way for mental health providers to connect with clients. HRSA's existing Telehealth Network Grant Program can be used to encourage research into distance care that includes teen violence prevention and treatment components. Research should also consider outcomes evaluation and financial hurdles to adopting telehealth programs at the local level. Second, telecommunications offers low-cost, flexible-access venues for training current mental health care staff in rural areas. This is an excellent opportunity for a professional organization like the National Rural Health Association or the American Public Health Association to develop on-line training programs for rural mental health providers.
- **Community-Based Programs:** The Model Programs section of this report describes five approaches to teen violence that have been highly rated by several agencies. These models could easily be adopted by individual communities to help address teen violence and drug use. Most of these programs recommend an integrated approach that involves mental health and medical providers, schools, local authorities, and families. Local health clinics could provide the leadership needed to develop and maintain these collaborations, while HRSA and some of the evaluating agencies (i.e., SAMSHA) could provide technical assistance as needed.
- **School Policies:** Rural schools report using more punitive school policies, while urban schools report using more preventive school policies (see School Policies in previous section). Initiatives at the federal or state level could provide guidance to rural schools on how to modify current policies to be more preventive in nature and less punitive. Successful prevention policies can help reduce both the incidence of teen violence/drug use and the need for treatment services.
- **State Offices of Rural Health:** State Offices of Rural Health (SORHs) have a unique opportunity to foster teen violence and drug abuse prevention programs through the Medicare Rural Hospital Flexibility Grant Program. ORHP can ensure that teen violence is addressed in the State Rural Health Plan by making it a priority element in funding decisions. Critical Access Hospitals could require early identification for at-risk youth for EMS and emergency department staff. ORHP, NRHA and SORHs should advocate for rural violence and drug abuse intervention program to potential federal partners, particularly the Centers for Disease Control and Prevention (CDC). CDC programs appear to target urban areas, as in the recent RFA 05042, "Urban Networks to Increase Thriving Youth through Violence Prevention." Based on the findings from the current study, CDC should consider investments in rural communities with regards to teen violence and drug use prevention.