Rural-Urban Differences in Adverse and Positive Childhood Experiences

March 15, 2022

- All attendees are muted
- Today’s session will be recorded
- Submit questions using the chat function
- Q&A will follow the presentation
About Per Ostmo

Per Ostmo is the Program Director of the Rural Health Research Gateway (Gateway), housed at the Center for Rural Health at the University of North Dakota School of Medicine & Health Sciences. Gateway is funded by the Federal Office of Rural Health Policy (FORHP) to disseminate research conducted by the FORHP funded Rural Health Research Centers. Per earned his Master of Public Administration degree from the University of North Dakota with focus areas in grant writing and health care administration. He is originally from rural North Dakota.

Likes: equitable healthcare, bicycling, punk rock
Dislikes: Health Professional Shortage Areas

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Rural Health Research Gateway

Provide access to publications and projects funded through the Federal Office of Rural Health Policy, Health Resources and Services Administration.

Gateway is a resource for:

- Policy makers
- Students
- Rural health researchers
- Health care providers
- Rural health organizations, professionals, associations, and more

ruralhealthresearch.org
Rural-Urban Differences in Adverse and Positive Childhood Experiences

Elizabeth Crouch, PhD, Deputy Director, Rural and Minority Health Research Center, University of South Carolina
Our mission is to illuminate and address the problems experienced by rural and minority populations in order to guide research, policy, and related advocacy.
HEALTH DISPARITY POPULATIONS

- Rural
- Racial/Ethnic Minorities
- Low SES
- Sexual and Gender Minorities
- Sex/Gender
- Disability
- Nativity
- Geographic Region

Source: National Institute on Minority Health and Health Disparities
RURAL CHILDREN’S HEALTH

• Nationally, 12 million children live in rural areas.

• Rural children versus urban (Probst et al, 2018):
  • Higher percent Medicaid covered
  • More likely to miss 1 or more days of school
  • Higher rates of obesity
  • Lower rates of preventive medical and oral health services
  • Higher mortality rates, largely associated with unintentional injuries
WHAT ARE ACES AND WHY ARE THEY IMPORTANT?
WHAT ARE ACES?

• Adverse Childhood Experiences
• ACEs are traumatic events that occur in a child’s life.
  • Abuse
  • Neglect,
  • Household dysfunction.
• Traumatic experiences as a child are associated with negative health and well-being outcomes as an adult.
CHILDREN IN RURAL AREAS: CHILDHOOD ADVERSITY

NSCH ACES
NSCH: Parent/guardian reporting current experience
• Someone in home suicidal or mentally ill
• Alcohol or drugs in home
• Parent in jail
• Divorce
• Witness to domestic violence

NSCH but not BRFSS
• Parental death
• Racial discrimination
• Low income

CDC/BRFSS ACES
BRFSS: Adult reporting remembered experience
• Household mental illness
• Household substance abuse (alcohol)
• Household substance abuse (drugs)
• Household incarceration
• Parental separation/divorce
• Household domestic violence

BRFSS but not NSCH
• Emotional abuse
• Physical Abuse
• Sexual abuse
August 2018 Recommendations

1. “…develop and implement a comprehensive prevention strategy that identifies priority outreach/awareness, programming, research and policy areas to address toxic stress, trauma and the health consequences of ACEs for rural, tribal and other at-risk populations.”

2. “… support research that evaluates long-term economic costs resulting from ACEs and benefits gained from federal investments in ACE-related prevention programming.”

3. HRSA’s MCH should “… establish and include a predefined variable for “Rural-Urban Status” in the National Survey on Children’s Health to allow for standardized analyses of ACE prevalence.”

4. “… seek additional funding for telehealth-supported school-based health centers in rural areas as a way of increasing access to integrated primary and behavioral health care services.”
WHAT ARE PCES AND WHY ARE THEY IMPORTANT?
THE ROLE OF POSITIVE CHILDHOOD EXPERIENCES (PCES)

• Positive Childhood Experiences (PCEs) are positive life events such as having a mentor, or a safe, stable relationship with a caregiver.
• Both positive and traumatic experiences as a child are associated with health and well-being outcomes as an adult.
WE KNOW THAT:

• **Identifying positive experiences** allows people to use their own life experiences to heal and recover.

• **Programs** that support positive childhood experiences promote health development – while avoiding stigma and labeling.

• **Health equity** serves as the foundation for HOPE: Healthy Outcomes from Positive Experiences. It invites us to think of each other’s strengths and connections in ways that go beyond labeling individuals as helpless victims of historical trauma and institutional racism.

• **Policies** that promote positive childhood experiences make life better for all of us and promote our long-term health and well-being.
4 Building Blocks of HOPE

1. Relationships
   - with other children
   - with other adults
   - through interactive activities
4 Building Blocks of HOPE

2 Environment

- Safe, equitable, & stable
- Living, playing, & learning
- Positive school & home environments
4 Building Blocks of HOPE

3 Engagement
- Develop a sense of connectedness
- Social/civic activities
Building Blocks of HOPE

Opportunities for Social Emotional Development
- Playing with peers
- Learning self-reflection
- Collaboration in art, sports, drama, & music
PRIOR RESEARCH
NATIONAL SURVEY OF CHILDREN’S HEALTH

Asks about ACEs (Crouch 2019)

THE JOURNAL OF RURAL HEALTH

ORIGINAL ARTICLE

Rural-Urban Differences in Adverse Childhood Experiences Across a National Sample of Children

Elizabeth Crouch, PhD;1 Elizabeth Radcliff, PhD;1 Janice C. Probst, PhD;1 Kevin J. Bennett, PhD;1,2 & Selina Hunt McKinney, PhD, APRN;1

1 South Carolina Rural Health Research Center, Arnold School of Public Health, University of South Carolina, Columbia, South Carolina
2 School of Medicine, University of South Carolina, Columbia, South Carolina

Asks about seven PCES (Crouch 2020)

THE JOURNAL OF RURAL HEALTH

ORIGINAL ARTICLE

Rural-Urban Differences in Positive Childhood Experiences Across a National Sample

Elizabeth Crouch, PhD;1 Elizabeth Radcliff, PhD;1 Melinda A. Merrell, PhD, MPH;1,2 & Kevin J. Bennett, PhD;1

1 Rural and Minority Health Research Center, Arnold School of Public Health, University of South Carolina, Columbia, South Carolina
2 School of Medicine, University of South Carolina, Columbia, South Carolina
RURAL CHILDREN MORE LIKELY TO EXPERIENCE NEARLY ALL ACES

ACEs among rural and urban children, 2016 NSCH, 35 states

All comparisons except neighborhood violence significant at p<0.001.
DIFFERENCES IN TOTAL EXPOSURE

ACEs have a dose-response relationship. Compared to urban children:

• Rural children more likely to have one to three ACEs (33.3% versus 30.1%, \( p<0.0001 \))
• Rural children more likely to have four or more ACEs (6.9% versus 3.8%, \( p<0.0001 \))
• Rural children less likely to have zero ACEs (59.9% versus 66.1%, \( p<0.0001 \))
2017-2018 STUDY OF PCES

- Rural children, while having higher rates of ACEs, also were more likely to have at least two of the PCEs measured in our adjusted analyses.

- Rural children were more likely to volunteer in their community, school, or church, a measure of an opportunity for constructive social engagement.

- Rural children were more likely to have a mentor outside of their home (school, neighborhood, or community), a measure of being in nurturing, supportive relationships.
FILLING A LITERATURE GAP

• Previous study results on ACEs and PCEs have been limited due to differences in: 1) geographic coverage of studied datasets, 2) measurement of ACEs, and 3) sampling methodologies, as well as limited examination of intra-rural differences among American Indian/Alaska Native (AI/AN) populations.

• Furthermore, rural-urban differences in PCEs have not yet been examined using all fifty states. Previous studies were conducted using data from only 31 states and the District of Columbia (34 states and the District of Columbia for ACEs) due to potential disclosure issues.

• States with relatively few responses in a particular category were not included in analyses and these suppressed states tended to be either highly urban or highly rural.
PURPOSE OF THE STUDY

• Ascertain whether ACE and PCE exposure differs between rural and urban children, by type and by count. This is the first study to estimate rural-urban differences in ACEs and PCEs using all fifty states and the District of Columbia.

• Examine racial/ethnic differences in ACEs and PCEs among rural children

• Focus on the degree to which children exposed to ACEs also have potentially strengthening PCEs.
METHODS
DATA

• 2016-2018 National Survey of Children’s Health (NSCH), using the Research Data Center (RDC) access to obtain geographic information.

• The NSCH is an online and mail survey of U.S. households with children ages 0-17 years; parents or guardians answer questions regarding the child’s physical and emotional health.

• A total of 102,341 samples were collected including 50,212 interviews in 2016, 21,599 in 2017 and 30,530 in 2018.

• Our sample was limited to children who were six years of age or older, as many PCEs are only measured at school age.

• It was further restricted to respondents who had completed the ACE and PCE questions and had complete demographic information.

• The final unweighted rounded sample size was 63,000 children, per the United States Census Bureau Data Review Board (data are rounded for confidentiality purposes). 11% of our sample was rural.
FINDINGS
ACE EXPOSURE

Adverse Childhood Experiences by Type
Among children ages 6-17, National Survey of Children’s Health

Economic hardship* 20.7% 26.2%
Racial/ethnic mistreatment 3.6% 5.1%
Household substance abuse* 9.5% 14.3%
Household mental illness* 8.7% 11.7%
Witness neighborhood violence* 6.2% 4.9%
Witness household violence* 6.4% 9.3%
Household incarceration* 8.4% 12.9%
Parental death 5.1% 4.0%
Parental separation/divorce* 28.8% 35.2%

*Statistically significant

Urban % Rural %
## ACES AMONG CHILDREN, BY COUNT

<table>
<thead>
<tr>
<th>ACE Summary Score</th>
<th>Rural (%)</th>
<th>Urban (%)</th>
<th>All (%)</th>
</tr>
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<tbody>
<tr>
<td>0</td>
<td>44.1</td>
<td>52.5</td>
<td>51.5</td>
</tr>
<tr>
<td>1-3</td>
<td>45.2</td>
<td>40.7</td>
<td>41.3</td>
</tr>
<tr>
<td>≥4</td>
<td>10.7</td>
<td>6.8</td>
<td>7.3</td>
</tr>
</tbody>
</table>
Figure 2: Positive Childhood Experiences by Type
Among children ages 6-17, National Survey of Children’s Health

- Resilient family
- Supportive neighborhood
- Safe neighborhood
- Connected Caregiver
- Guiding mentor
- Community volunteer
- After school activities

*Statistically significant
RACIAL/ETHNIC DIFFERENCES IN ACES AND PCES
ACE EXPOSURE, BY RACE/ETHNICITY

Proportion (%) of Adverse Childhood Experiences, by count, among rural children ages 6-17, National Survey of Children's Health
### Adverse Childhood Experiences among rural children ages 6-17, National Survey of Children's Health, in Total and stratified by race/ethnicity

<table>
<thead>
<tr>
<th>ACE Types</th>
<th>Total</th>
<th>Hispanic</th>
<th>White</th>
<th>Black</th>
<th>AI/AN</th>
<th>API</th>
<th>Other</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td></td>
</tr>
<tr>
<td>Parental separation/divorce</td>
<td>35.2</td>
<td>37.5</td>
<td>34.6</td>
<td>36.6</td>
<td>11.0</td>
<td>45.6</td>
<td>38.2</td>
<td>0.0690</td>
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<td>Parental death</td>
<td>5.1</td>
<td>7.2</td>
<td>4.3</td>
<td>7.3</td>
<td>4.4</td>
<td>9.8</td>
<td>7.3</td>
<td>0.0393</td>
</tr>
<tr>
<td>Household incarceration</td>
<td>12.9</td>
<td>17.2</td>
<td>11.6</td>
<td>13.9</td>
<td>D</td>
<td>D</td>
<td>22.9</td>
<td>&lt;.0001</td>
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<tr>
<td>Witness household violence</td>
<td>9.3</td>
<td>10.9</td>
<td>8.7</td>
<td>10.3</td>
<td>1.1</td>
<td>19.2</td>
<td>11.9</td>
<td>0.0740</td>
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<tr>
<td>Witness neighborhood violence</td>
<td>6.2</td>
<td>7.7</td>
<td>5.5</td>
<td>8.6</td>
<td>0.5</td>
<td>13.0</td>
<td>10.0</td>
<td>0.0098</td>
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<tr>
<td>Household mental illness</td>
<td>11.7</td>
<td>12.5</td>
<td>11.5</td>
<td>9.2</td>
<td>8.8</td>
<td>12.7</td>
<td>17.2</td>
<td>0.3433</td>
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<td>Household substance misuse</td>
<td>14.3</td>
<td>12.6</td>
<td>14.3</td>
<td>9.6</td>
<td>7.2</td>
<td>20.3</td>
<td>26.1</td>
<td>0.0004</td>
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<tr>
<td>Racial/ethnic mistreatment</td>
<td>3.6</td>
<td>7.8</td>
<td>1.0</td>
<td>14.2</td>
<td>12.3</td>
<td>10.2</td>
<td>15.8</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Economic hardship</td>
<td>26.2</td>
<td>20.9</td>
<td>24.8</td>
<td>40.1</td>
<td>17.7</td>
<td>42.7</td>
<td>36.8</td>
<td>&lt;.0001</td>
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</tbody>
</table>
### Positive Childhood Experiences among rural children ages 6-17, National Survey of Children’s Health, overall and stratified by race/ethnicity

<table>
<thead>
<tr>
<th>PCE Types</th>
<th>Total</th>
<th>Hispanic</th>
<th>White</th>
<th>Black</th>
<th>AI/AN</th>
<th>API</th>
<th>Other</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>After school activities</td>
<td>76.6</td>
<td>68.5</td>
<td>78.3</td>
<td>72.5</td>
<td>77.9</td>
<td>60.5</td>
<td>78.3</td>
<td><strong>0.0004</strong></td>
</tr>
<tr>
<td>Community volunteer</td>
<td>48.0</td>
<td>38.2</td>
<td>49.7</td>
<td>44.0</td>
<td>41.8</td>
<td>33.4</td>
<td>45.4</td>
<td><strong>0.0003</strong></td>
</tr>
<tr>
<td>Guiding mentor</td>
<td>94.6</td>
<td>87.8</td>
<td>96.1</td>
<td>91.0</td>
<td>90.3</td>
<td>85.7</td>
<td>94.6</td>
<td>&lt;<strong>.0001</strong></td>
</tr>
<tr>
<td>Connected caregiver</td>
<td>95.6</td>
<td>92.6</td>
<td>96.9</td>
<td>92.1</td>
<td>D</td>
<td>D</td>
<td>89.4</td>
<td>&lt;<strong>.0001</strong></td>
</tr>
<tr>
<td>Safe neighborhood</td>
<td>97.2</td>
<td>95.5</td>
<td>97.9</td>
<td>93.0</td>
<td>D</td>
<td>D</td>
<td>97.5</td>
<td>&lt;<strong>.0001</strong></td>
</tr>
<tr>
<td>Supportive neighborhood</td>
<td>59.8</td>
<td>50.6</td>
<td>63.3</td>
<td>47.8</td>
<td>49.4</td>
<td>34.8</td>
<td>52.3</td>
<td>&lt;<strong>.0001</strong></td>
</tr>
<tr>
<td>Resilient family</td>
<td>92.1</td>
<td>91.3</td>
<td>92.9</td>
<td>90.0</td>
<td>91.6</td>
<td>80.4</td>
<td>88.0</td>
<td><strong>0.0176</strong></td>
</tr>
</tbody>
</table>
RURAL CHILDREN WITH 4+ ACES OFTEN LACK PCES
RESULTS

- Nearly all rural children are reported to have a guiding mentor (94.6%), with no difference between children with a high level of ACEs exposure and other children.
- Unfortunately, however, children with high ACE exposure were less likely to be reported to have each of the six categories of positive experience shown below.
CONCLUSIONS
FILLING THE GAP IN THE LITERATURE

• Examining the prevalence of ACEs and PCEs in rural communities can provide insight on areas for possible improvement to help mitigate the long-term health and wellness impacts of ACEs.

• This study examined whether ACE and PCE exposure differs between rural and urban children, finding a mix of advantages and disadvantages facing rural families.

• Focusing first on threats to children’s health and growth, our results confirm previous findings that rural children consistently have higher rates of exposure to nearly all the ACEs that were assessed, with the exceptions of parental death and racial/ethnic mistreatment, which were not statistically significant different from urban rates.
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthen economic supports to families</td>
<td>• Strengthening household financial security • Family-friendly work policies</td>
</tr>
<tr>
<td>Promote social norms that protect against</td>
<td>• Public education campaigns • Legislative approaches to reduce corporal punishment</td>
</tr>
<tr>
<td>violence and adversity</td>
<td>• Bystander approaches • Men and boys as allies in prevention</td>
</tr>
<tr>
<td>Ensure a strong start for children</td>
<td>• Early childhood home visitation • High-quality child care</td>
</tr>
<tr>
<td></td>
<td>• Preschool enrichment with family engagement</td>
</tr>
<tr>
<td>Teach skills</td>
<td>• Social-emotional learning • Safe dating and healthy relationship skill programs</td>
</tr>
<tr>
<td></td>
<td>• Parenting skills and family relationship approaches</td>
</tr>
<tr>
<td>Connect youth to caring adults and activities</td>
<td>• Mentoring programs • After-school programs</td>
</tr>
<tr>
<td>Intervene to lessen immediate and long-term</td>
<td>• Enhanced primary care • Victim-centered services • Treatment to lessen the harms of ACEs</td>
</tr>
<tr>
<td>harms</td>
<td>Treatment to prevent problem behavior and future involvement in violence • Family-centered treatment for substance use disorders</td>
</tr>
</tbody>
</table>
HEALTH SECTOR SOLUTIONS

• Rural children disproportionately live in homes affected by current substance misuse or mental illness.

• Rural communities, however, are more likely than urban areas to lack effective treatment programs for alcohol and opioid misuse and nearly all rural counties are health professions shortage areas for mental health care.

• Development of programs that can extend treatment capability through modalities such as telehealth may help address local service shortfalls.
BUILDING OPPORTUNITIES WITHIN THE FAMILY: PARENT AND HOME-BASED INTERVENTIONS

• Home visiting programs
  • Particularly important as ACEs can repeat across generations
  • Early childhood interventions

• Parent education and support
  • Address secure attachment in parent child relationship; help parents and caregivers tune in to their children
  • Referral to parenting programs such as Strengthening Families and Empowering Families

• Parent mental health and substance misuse care
BUILDING OPPORTUNITIES OUTSIDE THE FAMILY: COMMUNITY INITIATIVES

• Community level initiatives can help link families with services. One such example is the SEEK program (Safe Environment for Every Kid), which connects families, through their primary health care providers, to community supports.

• Family-based resource centers may help community programs connect directly with neighborhoods and families.
CONTINUED PUBLIC HEALTH SURVEILLANCE IS NEEDED

• Continued monitoring of rural children’s ACEs exposure will be needed, both to monitor the effectiveness of community interventions and, unfortunately, to assess the effect of the current public health emergency.

• Estimates of family disruption due to COVID-19 vary, and no studies specifically examining rural children’s experience of family disruption have yet been published. At the national level, researchers have estimated that for every 100 COVID deaths, 7.8 children experience parental death, with an estimated 43,000 parental deaths through February 2021.

• A different research group, studying loss of a primary caregiver, whether parent or grandparent, estimated that 120,630 children faced this loss across the 15-month period from April 2020 through June 2021, with the burden falling more heavily on non-white children, due to the racial/ethnic disparities seen with COVID morbidity and mortality.

• Given the trajectory of the epidemic over time, the COVID-19 pandemic may have placed rural children at increased risk for parental loss, as rural vaccination rates have been lower, and rural death rates higher, for this disease.
NATIONAL RESOURCES

KIDS COUNT data center
A PROJECT OF THE ANNIE E. CASEY FOUNDATION

HRSA
Maternal & Child Health

NCTSN
The National Child Traumatic Stress Network

Prevent Child Abuse America®

National Children’s Advocacy Center

ACES Connection

South Carolina
The Rural and Minority Health Research Center receives funding from a variety of federal, state, and local grants and contracts including a cooperative agreement with the Federal Office of Rural Health Policy.
REFERENCES + USEFUL RESOURCES

• Examining exposure to adverse childhood experiences and later outcomes of poor physical and mental health among South Carolina adults. *Children and Youth Services Review*, 84:193-197.
• Crouch, E., Strompolis, M., Morse, M., Bennett, K., and Radcliff, E. (2017). Assessing the Interrelatedness of Multiple Types of Adverse Childhood Experiences and Odds for Poor Health in South Carolina Adults. *Child Abuse and Neglect*, 65, 204-211.
REFERENCES + USEFUL RESOURCES


Rural Health Research Gateway

The Rural Health Research Alert email provides periodic updates when new publications become available. Alerts are available by email and posted on our Facebook and Twitter accounts.

Recent Updates

- **January 5, 2022**
  An Enhanced Method for Identifying Hospital-Based Obstetric Unit Status
  New Research Product

- **January 3, 2022**
  Upcoming Webinar: Aging in Place in Rural America - Challenges, Opportunities, and Policy Initiatives
  Upcoming Webinar

- **December 3, 2021**
  Rural Urban Variation in Travel Burdens for Care: Findings from the 2017 National Household Travel Survey (executive summary)
  New Research Product

- **November 30, 2021**
  New Articles Published on Telehealth, Tobacco, Suicide, and Cancer Screening and Treatment
  Published Journal Articles

- **November 17, 2021**
  Using CPT Charges as an Economic Proxy for Telehealth and Non-telehealth Emergency Department Utilization
  New Research Product

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For more than 30 years, the Rural Health Research Centers have been conducting research on healthcare in rural areas.

The Rural Health Research Gateway ensures this research lands in the hands of our rural leaders.

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