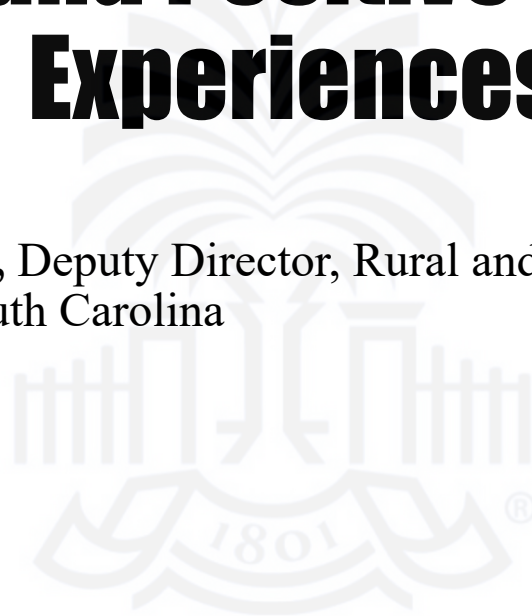


Rural-Urban Differences in Adverse and Positive Childhood Experiences

Elizabeth Crouch, PhD, Deputy Director, Rural and Minority Health Research
Center, University of South Carolina



RURAL AND MINORITY HEALTH RESEARCH CENTER

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





National Advisory Committee on Rural Health and Human Services

Exploring the Rural Context for Adverse Childhood Experiences (ACEs)

August 2018 Recommendations

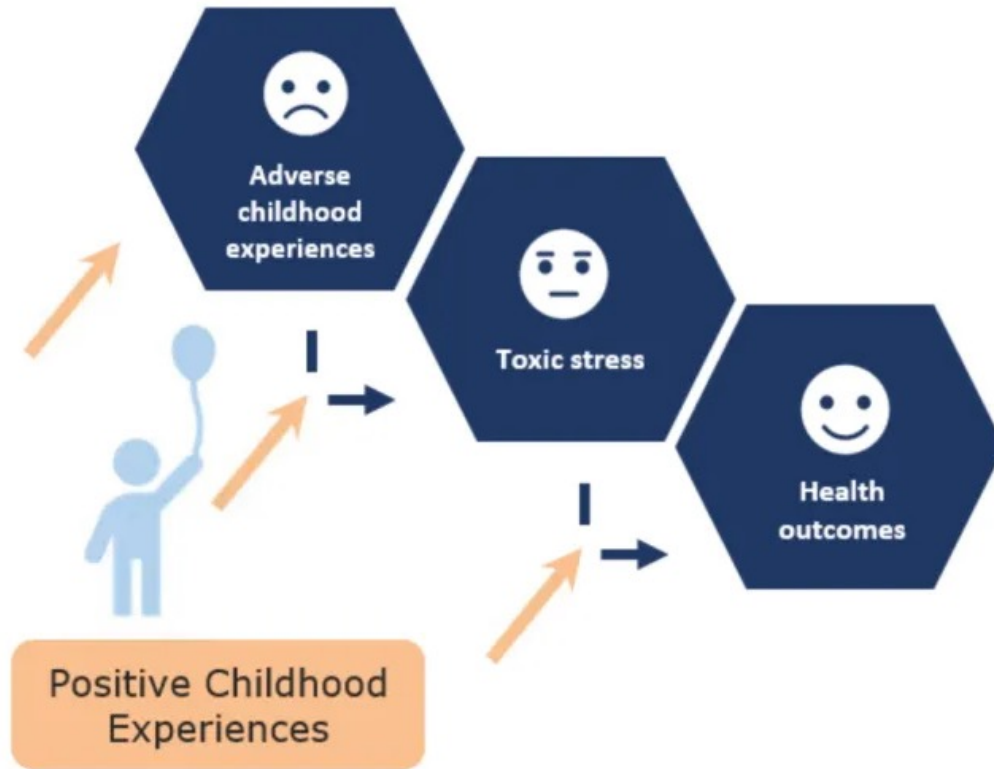
1. “...develop and implement a comprehensive prevention strategy that identifies priority outreach/awareness, programming, research and policy areas to address toxic stress, trauma and the health consequences of ACEs for rural, tribal and other at-risk populations.”
2. “... support research that evaluates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





Positive Childhood Experiences

- Prevent ACEs
- Reduce toxic stress
- Promote Healing

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.

BUILDING BLOCKS OF HOPE

4

Building Blocks of HOPE

1



Relationships

- ...with other children
- ...with other adults
- ...through interactive activities

South Carolina

4

Building Blocks of HOPE

2



Environment

- Safe, equitable, & stable
- Living, playing, & learning
- Positive school & home environments



South Carolina

4

Building Blocks of HOPE

3



Engagement

- Develop a sense of connectedness
- Social/civic activities

4

Building Blocks of HOPE

4



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 ²; & Selina Hunt McKinney, PhD, APRN³

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

³ College of Nursing, 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

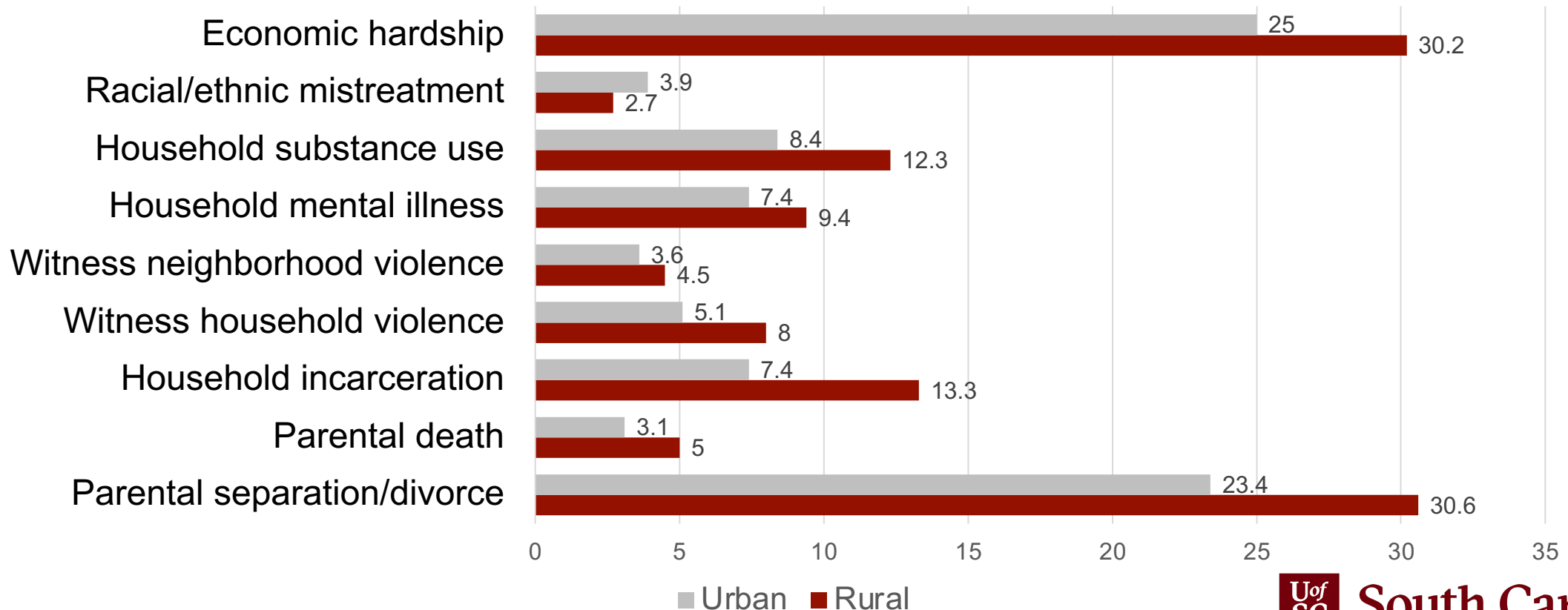
Elizabeth Crouch, PhD ¹; Elizabeth Radcliff, PhD;¹ Melinda A. Merrell, PhD, MPH ¹; & Kevin J. Bennett, PhD ²

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

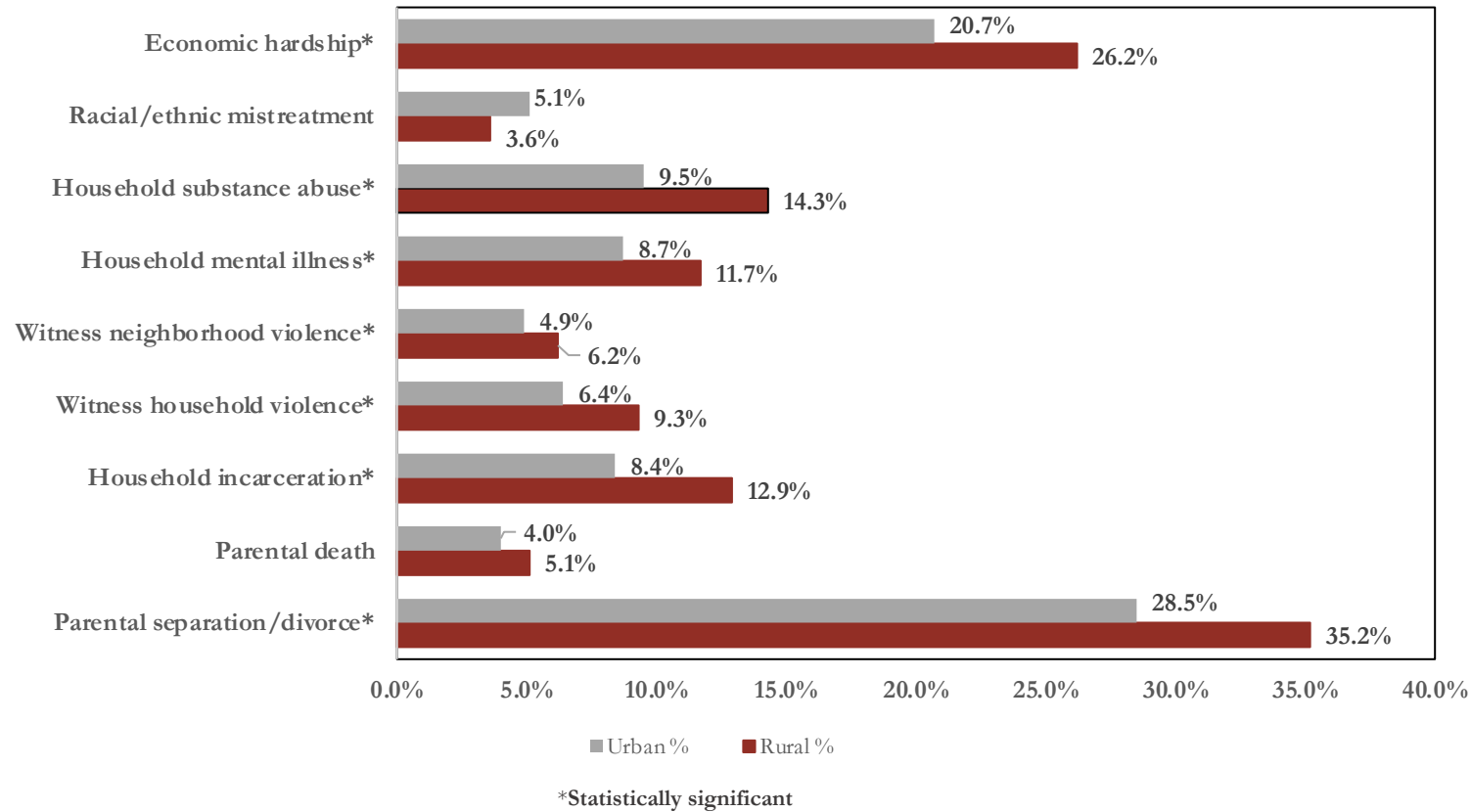
DATA

- 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

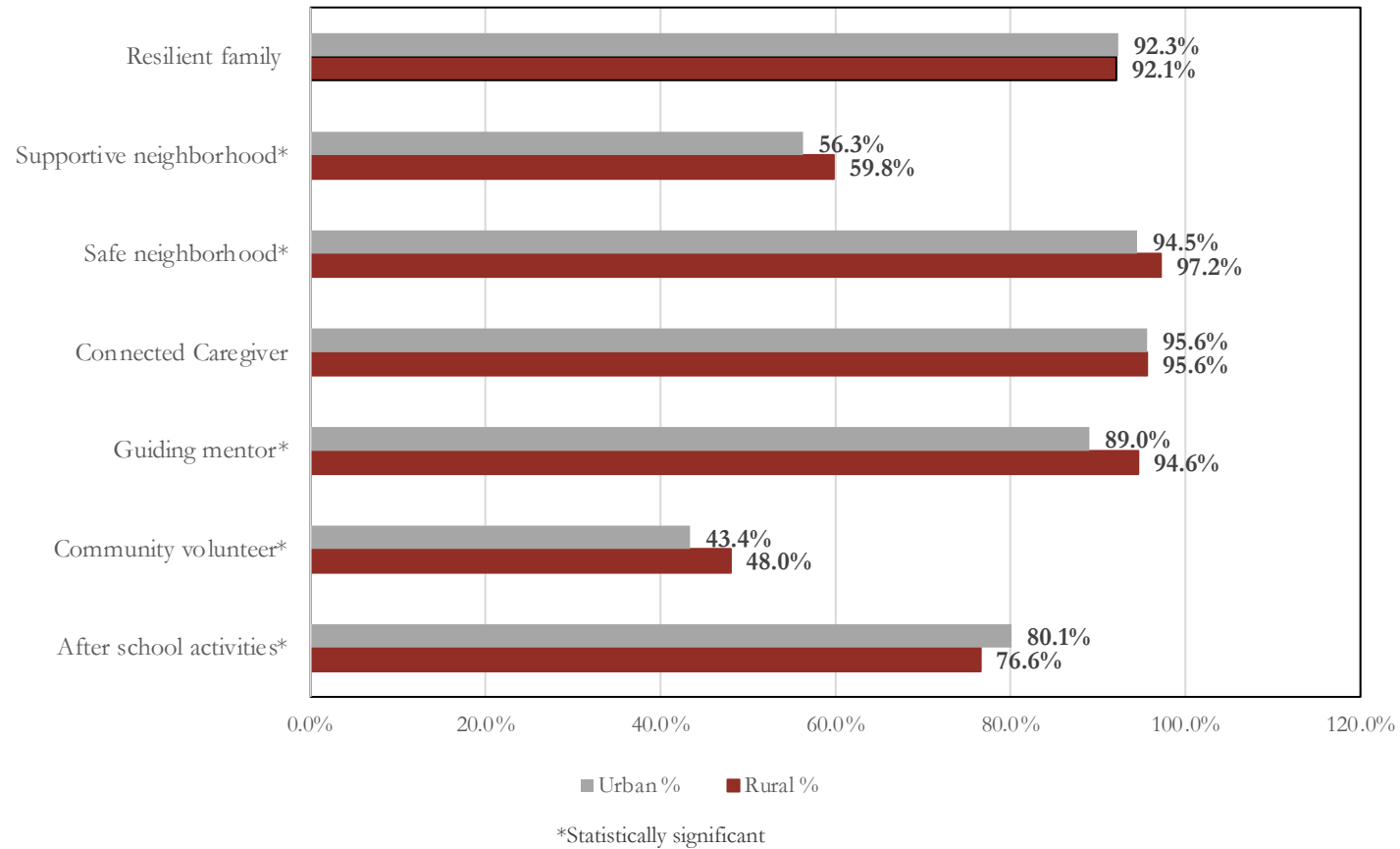


ACES AMONG CHILDREN, BY COUNT

| | Rural (%) | Urban (%) | All (%) |
|-------------------|-----------|-----------|---------|
| ACE Summary Score | | | |
| 0 | 44.1 | 52.5 | 51.5 |
| 1-3 | 45.2 | 40.7 | 41.3 |
| ≥4 | 10.7 | 6.8 | 7.3 |

PCE EXPOSURE

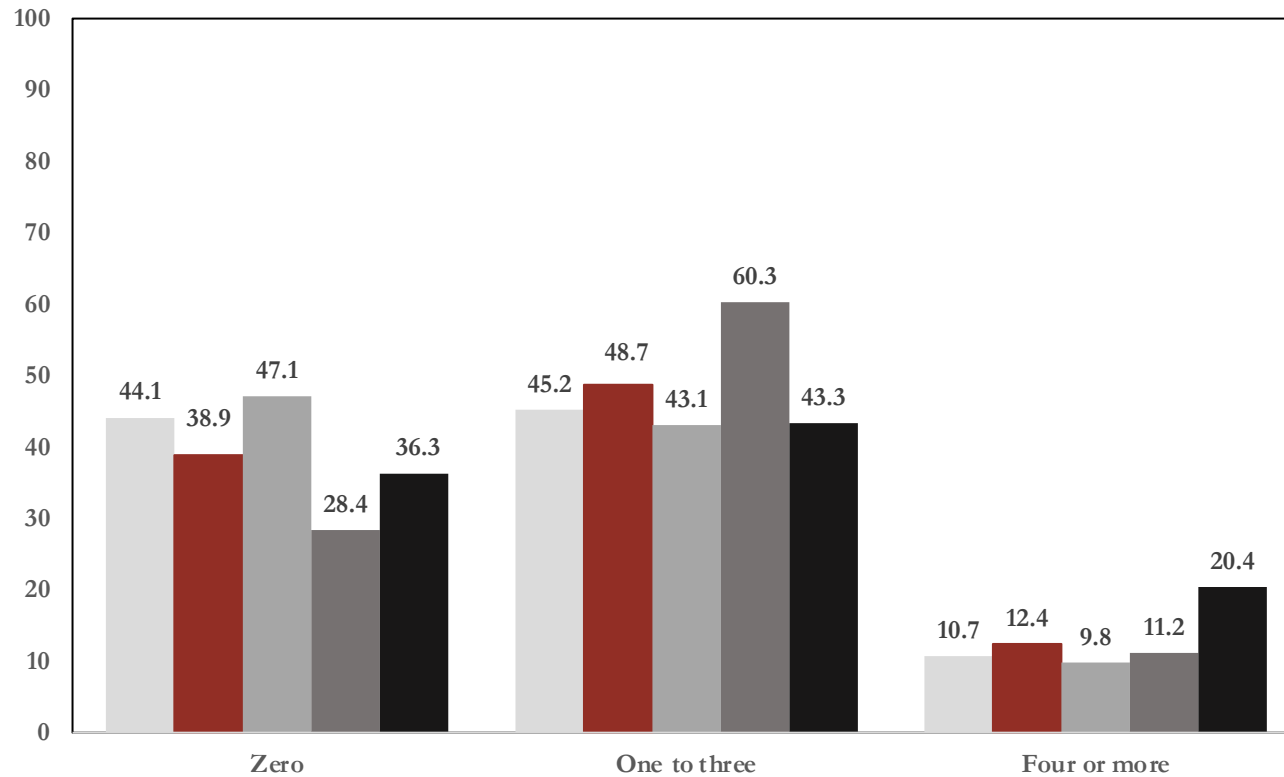
Figure 2: Positive Childhood Experiences by Type
Among children ages 6-17, National Survey of Children's Health



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



■ All Rural Children ■ Hispanic ■ White ■ Black ■ Other, American Indian/Alaska Native, Asian/Pacific Islander



South Carolina

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

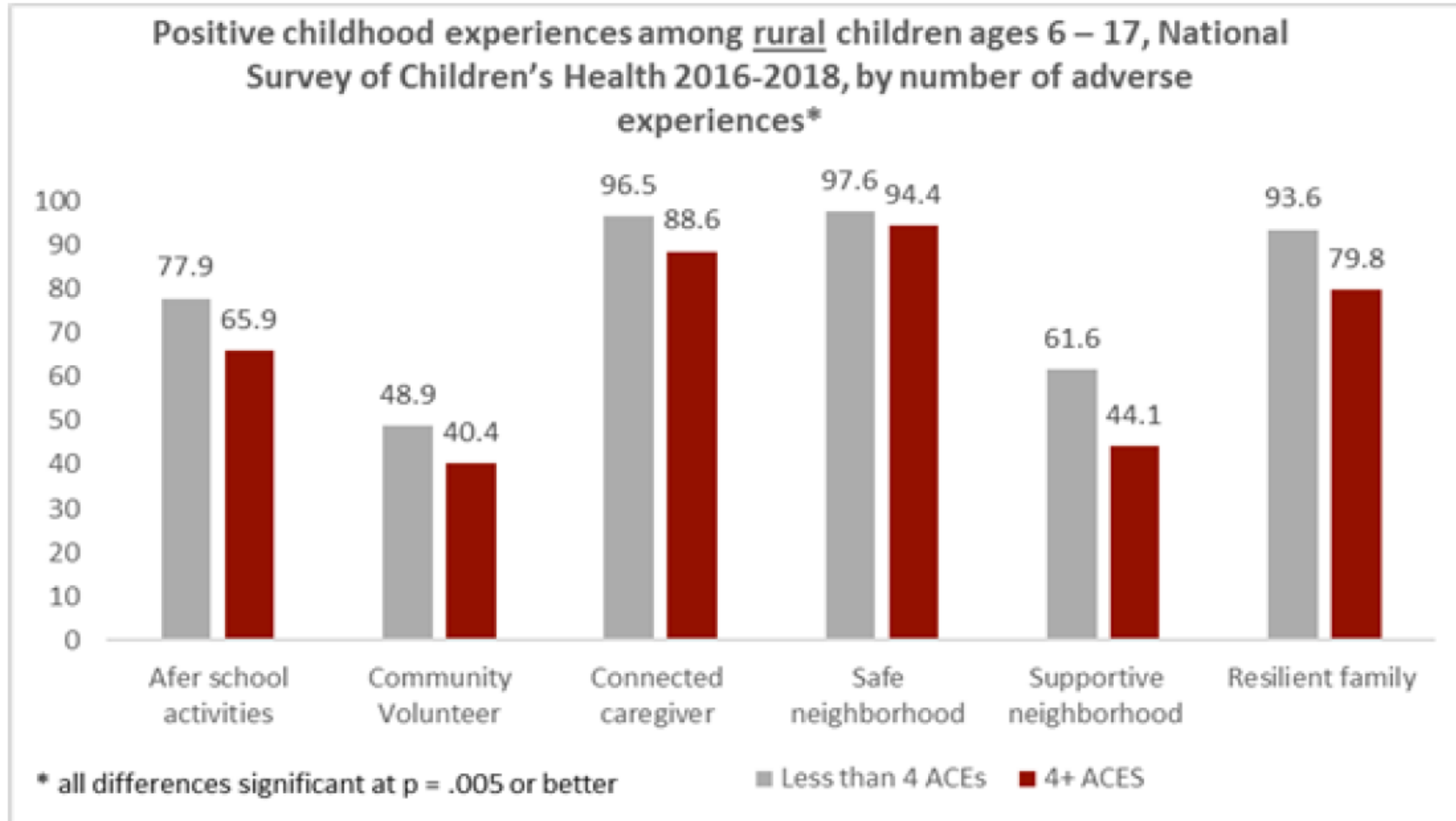
Positive Childhood Experiences among rural children ages 6-17, National Survey of Children's Health, overall and stratified by race/ethnicity

| | Total | Hispanic | White | Black | AI/AN | API | Other | P-value |
|-------------------------|-------|----------|-------|-------|-------|------|-------|------------------|
| | % | % | % | % | % | % | % | |
| PCE Types | | | | | | | | |
| After school activities | 76.6 | 68.5 | 78.3 | 72.5 | 77.9 | 60.5 | 78.3 | 0.0004 |
| Community volunteer | 48.0 | 38.2 | 49.7 | 44.0 | 41.8 | 33.4 | 45.4 | 0.0003 |
| Guiding mentor | 94.6 | 87.8 | 96.1 | 91.0 | 90.3 | 85.7 | 94.6 | <.0001 |
| Connected caregiver | 95.6 | 92.6 | 96.9 | 92.1 | D | D | 89.4 | <.0001 |
| Safe neighborhood | 97.2 | 95.5 | 97.9 | 93.0 | D | D | 97.5 | <.0001 |
| Supportive neighborhood | 59.8 | 50.6 | 63.3 | 47.8 | 49.4 | 34.8 | 52.3 | <.0001 |
| Resilient family | 92.1 | 91.3 | 92.9 | 90.0 | 91.6 | 80.4 | 88.0 | 0.0176 |

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.

RECOMMENDATIONS FROM THE CDC FOR REDUCING ACE TYPES AND BUILDING PCES

| Strategy | Approaches | |
|---|--|--|
| Strengthen economic supports to families | <ul style="list-style-type: none"> • Strengthening household financial security | <ul style="list-style-type: none"> • Family-friendly work policies |
| Promote social norms that protect against violence and adversity | <ul style="list-style-type: none"> • Public education campaigns • Legislative approaches to reduce corporal punishment | <ul style="list-style-type: none"> • Bystander approaches • Men and boys as allies in prevention |
| Ensure a strong start for children | <ul style="list-style-type: none"> • Early childhood home visitation • High-quality child care | <ul style="list-style-type: none"> • Preschool enrichment with family engagement |
| Teach skills | <ul style="list-style-type: none"> • Social-emotional learning • Safe dating and healthy relationship skill programs | <ul style="list-style-type: none"> • Parenting skills and family relationship approaches |
| Connect youth to caring adults and activities | <ul style="list-style-type: none"> • Mentoring programs | <ul style="list-style-type: none"> • After-school programs |
| Intervene to lessen immediate and long-term harms | <ul style="list-style-type: none"> • Enhanced primary care • Victim-centered services • Treatment to lessen the harms of ACEs | Treatment to prevent problem behavior and future involvement in violence • Family-centered treatment for substance use disorders |

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 misuse¹ 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



NCTSN  The National Child
Traumatic Stress Network





thank
you



Elizabeth Crouch, PhD, Rural & Minority Health Research Center
CROUCHEL@mailbox.sc.edu

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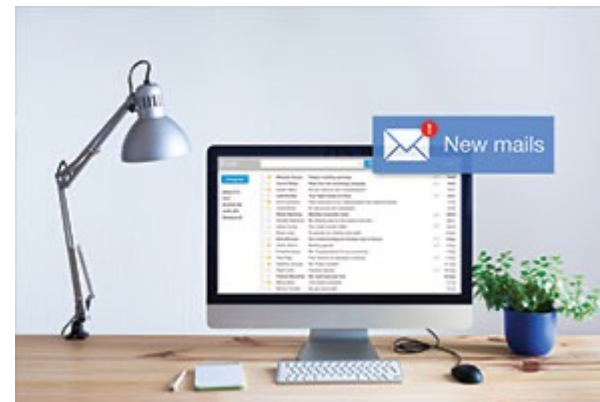
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