

Research Article

A Qualitative Study Identifying a Rural Community's Barriers and Facilitators to Addressing Adverse Childhood Experiences in Families with Young Children

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Adverse childhood experiences (ACEs) are traumatic events experienced before the age of 18 and include experiences of abuse, neglect, and household dysfunction. Exposure to ACEs early in life is a risk factor for adverse physical and mental health outcomes in adulthood, which may lead to subsequent child abuse, neglect, and household dysfunction. This study examined a rural community's barriers and facilitators to addressing ACEs in families with young children from the perspective of organizations serving children and families. The Innovation Corps (I-Corps) methodology was used to develop an ecosystem map of 64 community stakeholders, including 12 government, 13 healthcare, 27 early childhood education (ECE), and 12 community-based organizations, involved in the community's system of care for families with young children. Representatives from the stakeholder organizations identified in the ecosystem map were then recruited via purposeful and snowball sampling, and semistructured interviews were conducted with 37 participants. Transcribed notes and direct quotes were analyzed using a constant comparison analysis approach, and five themes emerged from the analysis. Barriers to addressing ACEs included limited mental health resources in ECE settings for both children and teachers, stigma, and limited access to local healthcare, while facilitators included establishing trusted relationships between organizations and families and using strengths-based approaches with families. This study characterized facilitators and barriers to addressing ACEs in families with young children residing in a rural community and provides guidance to inform future community-level ACEs interventions and policies.

1. Introduction

Adverse childhood experiences (ACEs) are traumatic events experienced before the age of 18 and include experiences of abuse, neglect, and household dysfunction. Abuse can be classified as physical, sexual, and emotional abuse; neglect can include physical and emotional neglect; and household dysfunction can include substance misuse, mental illness, and divorce or separation, among other experiences[1]. A nationally representative survey of adults in 23 states in the United States indicated that 62% of the population had experienced at least one ACE and 16% of the population had

experienced four or more ACEs [2], and a seminal article by Felitti et al. [3] demonstrated a significant dose-response relationship between ACE exposure and poor health outcomes later in life. Specifically, the degree of exposure to childhood trauma correlated with a graded risk of chronic disease in adulthood, such as ischemic heart disease, cancer, liver disease, and chronic lung disease. Since this study, there has been a surge of research on ACEs linking the accumulation of ACEs to risk for poor physical and mental health outcomes later in life [4–6].

While many factors contribute to ACEs, certain risk factors exist that increase risk of ACE exposure, including

identifying as Black, Hispanic, multiracial, gay, or lesbian; having less than a high school education or an income of less than \$15,000 annually; and being unemployed [2]. Protective factors that reduce the likelihood of ACEs include safe, stable, and nurturing family relationships; caring adults outside of the family; access to medical care and mental health services; high-quality preschools; and safe and stable housing [7]. These risk and protective factors, often examined at the individual, interpersonal/family, organizational, and community levels, can inform prevention (e.g., preventing ACEs, such as abuse, neglect, and household dysfunction, from occurring) and treatment (e.g., reducing the negative effects of ACEs, such as mental health conditions and substance use) strategies.

A recent national study reported that 55% of U.S. adults living in rural areas have experienced at least one ACE and 15% have experienced four or more ACEs [8]. While the prevalence of ACEs in rural areas may be similar to national rates, rural areas also account for over 80% of all counties experiencing low employment, child poverty, and low educational attainment [9]. Rural Americans also face barriers to receiving healthcare services, including fewer providers residing locally, unaffordable costs of care and limited access [10], and mental health services, including stigma and practical barriers (e.g., cost, availability, and transportation) [11].

ACEs can lead to significant economic and social tolls on families, and as a result, ACEs prevention and treatment efforts have largely focused on children and families [1]. For parents, the association between ACE exposure and poor physical and psychological outcomes may lead to the intergenerational transmission of ACEs to their children through resultant abuse, neglect, and familial dysfunction [12]. Such intergenerational transmission of ACEs can result in excess health and economic hardship, and the poor health of parents and social challenges stemming from ACEs have been identified as catalysts for children to experience ACEs themselves [13, 14]. Ultimately, trauma can constrain a family's collective resources, such as time, money, and energy, and subsequently, the prevention and treatment of trauma in children may not be successful if a parent's trauma goes untreated [15]. Given the high prevalence of ACEs and associated multigenerational deleterious health outcomes, there is a need for more prevention and treatment efforts, especially in rural communities that experience barriers to care.

Organizations serving children and families, including government, healthcare, early child education (ECE), and community-based organizations, are well-positioned to work alongside families with young children to address ACEs. Recent evidence has identified gaps and barriers to addressing the root causes of ACEs through child health systems and community partners in urban settings [16] as well as ACEs prevention and treatment efforts targeting families with young children (ages 0–5) in urban settings [17]; however, similar studies in rural communities have not been conducted to the authors' knowledge. Therefore, the purpose of this study was to understand the barriers and facilitators to addressing ACEs in families with young

children of ages 0–5 years in a rural community in Colorado from the perspective of organizations serving children and families to inform a local research project aiming to decrease the intergenerational transmissions of ACEs. The findings from this study will be valuable to inform other community-level ACEs prevention and treatment efforts in rural communities.

2. Methods

2.1. Setting. The San Luis Valley (SLV) of southern Colorado is a rural, intermountain valley located on the upper Rio Grande River, surrounded by the Rocky Mountains and adjacent to the New Mexico border. The region encompasses six counties, and half (50%) of residents are of Hispanic origin. Additionally, approximately 26% of residents have household incomes below the poverty level; 13% of residents are uninsured; and 45% of residents rely on Medicaid for access to healthcare [18]. The SLV is also identified as a health professional shortage area and a medically underserved area, two key federal designations that identify areas with severe healthcare provider access issues and areas in need of assistance with healthcare delivery [19].

The research team has a strong academic-community partnership with the SLV where they meet monthly with a 12-member Community Advisory Board (CAB). The CAB has provided guidance to the research team on intervention development, study methodology, and dissemination and translation of findings and products for the last 25 years. Five years ago, the CAB went through what was called a “year of learning” process, where local and state experts were invited to CAB meetings to share the latest research and practice evidence about a public health topic every month for one year. After the “year of learning,” a criteria-based decision-making process to select a public health topic area to be focused on for the next 5-year research grant was conducted, and the CAB selected addressing ACEs in early childhood. The grant was funded, and the research study and project were entitled STANCE (linking Systems To Address ACEs in Childhood Early on), which aimed to decrease the intergenerational transmissions of ACEs in the SLV.

ACEs prevalence data for the SLV are similar to state and national estimates of ACEs for rural areas. Of the 96 adults residing in the SLV who completed a recent Behavioral Risk Factor Surveillance System (BRFSS) module, 60% (CI: 46–74%) reported one or more ACEs; 45% (CI: 29–60%) reported being emotionally/verbally abused by a household member before the age of 18; and 23% (CI: 10–36%) reported living with a substance-abusing household member before the age of 18 [20].

2.2. Methodology. To conduct this study, the research team participated in the National Science Foundation's (NSF) Innovation Corps (I-Corps) program through the University of Colorado's Clinical and Translational Sciences Institute [21]. I-Corps is a federally funded program to help prepare scientists and engineers to extend their focus beyond the university to accelerate the economic and societal benefits of

basic research projects that are ready to move toward commercialization. The I-Corps program integrates scientific inquiry, value propositions, and industrial discovery to maximize the relevancy and benefits of products, services, interventions, and policies, and the methodology involves two key activities: ecosystem mapping and stakeholder interviews. First, in ecosystem mapping, all stakeholders related to a specific issue are identified and their relative relationships are described visually in a map. These stakeholders include the decision-makers, payers, end users or participants, influencers, recommenders, and even saboteurs who might interact with an issue. Second, using the ecosystem map, semistructured interviews are conducted with stakeholders to characterize and understand the issue. The real-world learnings gathered through the ecosystem map and stakeholder interviews are then used to characterize an issue and inform or adapt products, services, interventions, or policies.

Formative evaluations in public health are usually conducted before a program is fully implemented and are a fundamental method for obtaining user feedback in the early stages of a tool, product, or program's design and development [22, 23]. This study utilized the I-Corps methodology to conduct a formative evaluation as part of the larger STANCE study. The I-Corps program's key strength as a formative evaluation methodology is the stakeholder interview process (also called customer discovery interviews). Through semistructured interviews, the process collects qualitative data about stakeholders' "pains and gains," which are critical for aligning products or services with stakeholder needs and community realities. Additionally, the stakeholder interview process requires the researcher to conduct "experiential learning," positing that the best way for researchers to design and refine an intervention is to "get out of the building and learn by doing" [24]. In fact, a recent publication on the I-Corps program noted that a key strength of the stakeholder interview methodology was that it challenged social science and behavioral health researchers to design with dissemination and implementation in mind [25], and the integration of the stakeholder interviews and ecosystem map in the I-Corps methodology facilitates practical applications of findings into a real-world setting or market.

2.3. Procedures. The qualitative approach was a case study approach where the case was the rural SLV community. All organizations serving children and families in the SLV, including stakeholders from government, healthcare, ECE, and community-based organizations, were identified with guidance from our SLV CAB. Across the six counties in the SLV, the CAB and research team identified 64 stakeholder organizations involved in the community's system of care for children and families, including 12 government, 13 healthcare, 27 ECE, and 12 community-based organizations. These organizations and their relative relationships were illustrated through the development of an ecosystem map. Using the ecosystem map and a combination of purposeful and snowball sampling [26], key representatives from each

organization were identified by either the CAB members or by other community members within or between agencies/organizations and were contacted via email or phone and recruited for stakeholder interviews. Interview participants included directors and teachers from ECE centers; government officials, such as county commissioners and social services directors; healthcare workers and administrators; and representatives from community-based organizations.

The interview protocol and guide were codeveloped with the SLV CAB. The interview guide featured 14 discussion prompts and focused on understanding facilitators and barriers to addressing ACEs in families with young children. Items assessing barriers included prompts such as "What do parents/caregivers of young children in the SLV struggle with the most?" and "What are the main challenges to supporting parents/caregivers of young children in the SLV?" Items assessing facilitators, on the other hand, included prompts such as "What is working well for parents/caregivers of young children?" and "If you had a magic wand, what would you do to best support parents/caregivers of young children in the SLV?"

Semi-structured interviews of approximately 30 minutes in length were conducted by the research team (DL, JP, BR, MM, and JL), all of whom were trained in qualitative research methodologies. Two members of the research team participated in each interview; one member facilitated the interview while the other member transcribed descriptive notes and direct quotes from participants. All researchers had high levels of education and recognized their positionality was shaped by their privilege and access to resources but were cautious to not make assumptions in the interview process based on their own experiences and opinions. Interviews were conducted under the Clinical and Translational Sciences Institute's educational course institutional review board approval and were also approved by the Colorado Multiple Institutional Review Board (COM-IRB) under protocol #19-1969. Consent was obtained from each interview participant prior to conducting the interview, and interview transcripts were deidentified before analysis.

2.4. Data Analysis. Interview notes and quotes were read multiple times by a member of the research team (TR) to develop familiarity with the data. Constant comparison analysis was employed to analyze the interview data [27], and this analysis technique was chosen to allow for points of comparison between interviews and exploration of emerging themes [28]. In following best practices for constant comparison analysis, data were divided into small segments, and codes were attached (open coding). Next, codes were grouped into similar categories (axial coding), and then themes were generated from the categories (selective coding).

Codes developed as part of the constant comparison analysis approach were also reviewed and revised in the context of the social-ecological model (SEM) [29]. This model, an adaptation of ecological systems theory [30], depicts multiple levels of influence that impact human development across individual, interpersonal, community,

and societal contexts. Disease prevention and health promotion strategies are commonly designed to target specific levels of the SEM, and past work has used the SEM to examine ACEs prevention and treatment programs [31, 32].

A comprehensive audit trail of coding decisions and theme development was maintained throughout the data analysis process. To improve the reliability of the findings [33], the research team (TR and RL) double-coded 15% of the transcripts to ensure concordant coding. If discordance on the meaning of the codes was present, a discussion occurred between the coders (TR and RL) to reach consensus on the coding structure. The other 85% of the transcripts were coded by one member of the research team (TR).

3. Results

Figure 1 is the ecosystem map that was developed to facilitate an understanding of the distribution of organizations across the six counties of the SLV. County and organization names were removed from the ecosystem map to maintain confidentiality, and analysis of the ecosystem map demonstrated that organizations serving multiple counties were key stakeholders and connectors in the network. Additionally, the ecosystem map revealed county-specific gaps in particular services, such as a single ECE center serving County 1 and one healthcare organization in County 1, County 3, and County 4.

As the ecosystem map was being developed, it informed the recruitment of key informant interview participants, which were representatives from each stakeholder in the ecosystem map who could elucidate some of the gaps in services that were being identified. In total, 37 interviews were conducted with representatives from government ($n=9$), healthcare ($n=6$), ECE ($n=15$), and community-based organizations ($n=7$) (organizational response rate = 44%), which included representation from each of the six SLV counties. The primary themes that emerged included limited mental health resources in ECE settings for children and teachers, stigma, limited access to local healthcare, trust, and strengths-based approaches. These themes are categorized as barriers or facilitators, described in greater detail, and supported by direct quotes from participants in the following sections.

3.1. Barriers. Using the SEM framework, barriers were identified at the community, organizational, and interpersonal levels. These included limited mental health resources in ECE settings for both children and teachers, stigma, and limited access to local healthcare.

3.1.1. Limited Mental Health Resources in ECE Settings for Both Children and Teachers. According to stakeholders, there has been an increase in problem behaviors in children, and there are limited mental health resources for both children and teachers to address this in ECE settings, which is an organizational-level barrier to promoting positive social-emotional development early in life. Social-emotional

development is an important protective factor that can mitigate the deleterious effects of ACEs on one's mental health. Stakeholders reported that challenging behaviors in ECE classrooms have increased in recent years, which has contributed to poor mental health for teachers (burnout and emotional exhaustion). A stakeholder working as a school psychologist throughout the SLV stated, "I've also seen more of the physicality, crossing the lines. It's really increased aggressiveness. It correlates with increased [teacher] frustration." Another stakeholder working in a leadership role at an ECE center explained that teachers are limited in their ability to manage children who have poor mental health and exhibit challenging behaviors because of a lack of needed resources, noting, "Their challenge is not being able to help students and being at a loss for what to do next and not knowing what to do next. Coaching for teachers on those behaviors would be helpful." Multiple stakeholders recommended that ECE centers (as well as primary and secondary schools) employ more mental health staff and offer training to address these behavior and social-emotional development concerns. For example, one stakeholder suggested, "[Teachers] need more education on the impact of trauma on the brain and how children respond, what a response looks like in a child." Another stakeholder with extensive experience in social, behavioral, and educational programming and who currently works at a diversion program stated,

In preschools and schools, making sure that the teachers are equipped to work with the kids when they are acting out. The interventions and how they respond and react to the kids is so important. Knowing how to manage their behaviors in the classroom is so important. Just putting fires out, not enough staff to actually do the core work they are supposed to do. Not enough counselors and therapists.

3.1.2. Stigma. Stakeholders described community stigma as an interpersonal-level barrier to family engagement with community services. In this context, they were referring to a set of negative or unfair beliefs that members of this small, rural community had related to seeking and receiving mental health services. One stakeholder who directs a community-based organization stated,

Some families think that if you get behavioral health services, you're crazy. Getting families to understand them, feel comfortable about the services, and reduce the stigma is essential to overcoming these barriers. Also, families think that if they go and get services, then they're in trouble and they might have their kids taken away.

Another stakeholder who works as a community health worker reported, "Parents often don't utilize services based on judgement. For example, if I wanted to go to a parenting class, people would think I did something wrong." Stakeholders also noted the importance of healthcare providers in addressing stigma. One stakeholder leading a community-

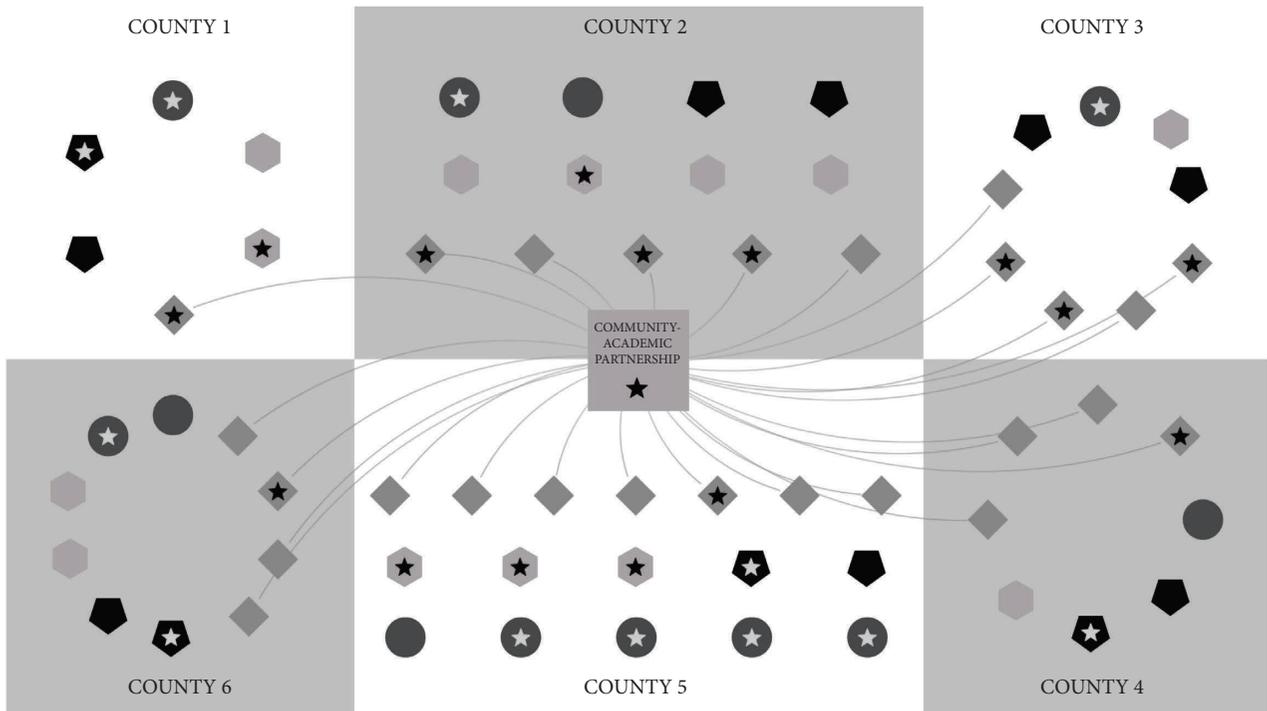


FIGURE 1: An ecosystem map of organizations serving children and families in a rural community spanning six counties. ★ = stakeholder interview; ● = community-based organization; ◆ = early childhood education center; ⬠ = state/government agency; ⬡ = hospital/clinic; arrows = flow of resources from community-academic partnership to early childhood education centers.

based, nonprofit offering afterschool youth services remarked that, “Providers need to get to know kids and their families because services are stigmatized. They [providers] need to create relationships prior to emergency situations.”

3.1.3. Limited Access to Local Healthcare. Stakeholders shared that parents of young children in the SLV often forgo preventative services due to individual-level access issues, including inadequate transportation, travel distance, insurance coverage, and legal status. For example, one stakeholder reported,

A lot of people don’t have transportation so it’s hard to get in for different services. . . .so for someone who is having a bad mental health day who would seek out behavioral health care, they can’t get transportation to get to an appointment, so they are less likely to make it.

Stakeholders also stated that residents may fall out of care as a result of poor networking and failed referral processes among agencies. An ECE center leader reflected, “Primary care, social services, and behavioral health in the SLV are pretty significant silos.” Stakeholders also cited challenges related to delays in the referral process for behavioral health care and a lack of follow-up for client retention. Behavioral health systems were also reported to be inaccessible for certain populations. A stakeholder working for a county public health department shared “[The] behavioral health referral process is also a nightmare, especially for individuals with low literacy levels.”

3.2. Facilitators. The facilitators identified in this study were associated with only the interpersonal level of the SEM framework. These included trust and strengths-based approaches in supporting families.

3.2.1. Trust. Trusted relationships with families emerged as a key facilitator to addressing ACEs in families with young children. Stakeholders agreed that activities such as sharing meals together, being visible and connected in the community, and spending time getting to know families are essential to creating trusted relationships between families and organizations. For example, when asked how best to work with families, one stakeholder from the education sector shared, “It takes time, it takes relationship building. Getting everyone to trust each other is key.” Another stakeholder described how, conversely, mistrust can be a barrier, stating “A big challenge is building trust with clients; some people have been let down time and time again and say, I’ve already heard this, you’re no different from the last person I spoke to.” The stakeholder expanded on this point and stated, “Follow through is how you establish trust and what works well. You need to do what you say you’ll do and be honest.”

3.2.2. Strengths-Based Approaches to Supporting Families. Stakeholders described the development of positive relationships with families through focusing on families’ strengths and how they are important and vital members to the community. One stakeholder stated, “Not everybody wants help. They need help, but it’s hard for them to get help

because they haven't always had a good experience. [They] need positivity." Similarly, when asked what change would positively impact families in the SLV struggling with ACEs, a director of a community-based organization passionately said, "Changing the attitude in which families are approached; change that [approach] as a whole, and we would see more success. We need to view families as assets and less as an entity needing a resource." Ultimately, stakeholders emphasized the importance of working with a family and developing plans that use a family's strengths to address their needs.

4. Discussion

This qualitative study used the I-Corps methodology to visually map organizations serving children and families and characterize barriers and facilitators to addressing ACEs in families with young children living in a rural community. This methodology allowed for the engagement of community members in identifying all organizations and agencies serving young children and their families in a rural setting. It also highlighted gaps in services in the "ecosystem" and pointed the researchers to the organizations/agencies where stakeholders could be recruited to participate in interviews. These interviews ultimately facilitated a better understanding of barriers and facilitators to engaging families in ACEs prevention and treatment work.

Themes that emerged from the interviews reinforced well-established barriers to addressing health issues in rural communities, including stigma and poor access to health services [10, 11] and the lack of mental health resources [34, 35]. During interviews, the stakeholders specifically focused on the lack of mental health resources in ECE settings for both children and providers. For children, lack of mental health resources can manifest as poor social-emotional skills, such as problem behaviors, and for providers, the issue can contribute to emotional exhaustion and burnout. These identified barriers can inform ACEs prevention and treatment because they highlight the need to focus on approaches that destigmatize mental health conditions and the use of mental health services in rural communities. Mental health conditions for parents/caregivers are considered an ACE, and destigmatizing such conditions and normalizing the use of mental health services could mitigate the harms of ACEs. Because having trusted relationships with children and families was identified as a facilitator, using trusted messengers in the community, such as doctors, teachers, or pastors, to deliver messages that destigmatize mental health conditions and the use of services may be a successful approach. Having better integrated health systems and leveraging the primary care setting to screen for and address ACEs in rural settings could also address the identified barrier to health services [36].

Nearly two-thirds of preschool-aged children (3–5 years old) attend early education programs [37]. Many of the children and parents that interface with ECE settings will have experienced ACEs. As such, it is an important setting to conduct screening and ACEs intervention programming early in a child's life. Teachers in ECE settings play an

instrumental role in promoting young children's social-emotional skills development, which can be a protective factor against childhood trauma. Working in ECE settings is stressful, however, and ECE teachers often face excessive demands and low-resourced workplaces [38, 39]. Teachers who have poor mental health are challenged to have high-quality interactions with the children in their care, which can inhibit their social-emotional skill development. Therefore, it is important that ACEs prevention and treatment programs provide the needed resources to support the mental health of teachers, as well as children, in an ECE setting. Because of the unique challenges rural communities face, interventions such as telehealth and mobile teams can support the mental health of teachers. Mental health professionals in the ECE settings, such as early childhood mental health consultants, can partner with teachers, children, and their families to support children's social-emotional development, strengthen relationships between children and parents, reduce parental stress, and provide referrals to community resources [40, 41]. The structural barriers related to the lack of access to trainings and professional development opportunities for teachers in rural ECE settings can be addressed by making virtual professional development opportunities, like the Pyramid Model for Supporting Social-Emotional Competence in Infants and Young Children, accessible to rural ECE teachers. Such training can give teachers the skills needed to emotionally regulate themselves and improve children's social skills and reduce their challenging behaviors [42].

The facilitators to addressing ACEs in families with young children that stakeholders identified, including developing trusted relationships and leveraging strengths-based approaches to working with families, align with key recommendations for preventing ACEs from the Centers for Disease Control and Prevention. These recommendations include promoting safe, stable, and nurturing relationships and environments for children and reducing stigma around seeking help for parenting challenges and behavioral health [43]. In building trust and leveraging strengths-based approaches, organizations supporting children and families can provide families with resources and support that emphasize their strengths while also identifying areas of need. The Children's Bureau, part of the United States Department of Health and Human Services, offers a six-factor framework that can help community-based organizations identify family strengths, including nurturing and attachment, knowledge of parenting for child and youth development, parental resilience, social connections, concrete supports for parents, and social and emotional competence of children [44].

Burke et al. [45] noted the need for effective early identification of ACEs because it could lead to identifying children who are at risk for chronic diseases and/or psychological problems later in adolescence and adulthood and allow for the implementation of early prevention and treatment programs. While evidence demonstrates the importance of screenings for ACEs in order to develop effective prevention and treatment models [45], screening for protective factors such as benevolent childhood

experiences, the positive counterpart to ACEs, may be equally as important when working with families in rural communities [46, 47]. Finally, taking strengths-based approaches with families can shift the focus from individual responsibility to community solutions that can prevent and treat ACEs [7, 48]. This finding helped inform the larger STANCE intervention and should be considered in the development and implementation of future ACEs programs and policies.

This study was conducted as part of a longstanding community-academic partnership in the SLV, which adheres to the principles of community-based participatory research (CBPR) [49]. As such, this study demonstrated that the I-Corps methodology may be a novel and beneficial approach to CBPR because it involves community members in identifying an ecosystem map, which can illuminate gaps in services. Per Israel et al., CBPR “focuses on social, structural, and physical environmental inequities through active involvement of community members, organizational representatives, and researchers in all aspects of the research process” [50]. Additionally, a key principle in CBPR focuses on understanding a community’s needs and problems while building on strengths and resources, and in this study, the I-Corps methodology provided a comprehensive approach to identifying “pain points,” or the most pressing needs, of community members and the wider ecosystem of stakeholders. For other researchers utilizing CBPR, the I-Corps methodology may be a useful, complimentary approach for understanding issues and designing interventions, policies, and implementation strategies.

This study has several limitations. First, the study achieved a 44% organizational response rate for the stakeholder interviews. While stakeholders from each sector and county were well-represented, these themes may not represent all stakeholders’ perspectives. Additionally, these findings for the SLV case study may not be transferable to other rural communities, as each rural community will likely have a distinct ecosystem of stakeholders. Finally, the descriptive notes and direct quotes transcribed by members of the research team may be subject to individual biases.

5. Conclusion

Recent evidence indicates that rural children have higher rates of exposure to the majority of ACEs, including economic hardship, household substance use, mental illness, and violence [51, 52]; however, evidence for community-level ACEs interventions in rural communities is limited. The findings from this qualitative study identify barriers and facilitators to addressing ACEs in families with young children and can, therefore, provide guidance to organizations and practitioners serving children and families, including public health professionals, policymakers, community planners, and program directors, on future ACEs intervention and policy design in rural communities. Additionally, this study emphasizes the importance of trust and strengths-based approaches in working alongside rural families with young children. While understanding the prevalence of ACEs through screening efforts is important,

screening for protective factors and using family strengths to inform support and resources is also necessary.

Data Availability

Data used in this study are available on request from the corresponding author.

Additional Points

What Is Known about This topic. (i) Adverse childhood experiences (ACEs) can have profound impacts on long-term health. (ii) Community approaches to addressing ACEs should be multilevel, focusing on children, their caregivers, and the communities in which they live. (iii) Rural communities face barriers to healthcare services, including fewer providers residing locally, unaffordable costs of care, and limited access. *What This Paper Adds.* (i) In rural communities, organizations serving children and families face barriers to addressing ACEs, including limited mental health resources in early childhood education (ECE) settings for both children and teachers, stigma, and limited access to local healthcare. These organizations also report important facilitators to addressing ACEs, including establishing trusted relationships and leveraging strengths-based approaches. (ii) The Innovation Corps (I-Corps) methodologies of ecosystem mapping and stakeholder interviews are a novel and beneficial approach to community-based participatory research (CBPR) in rural settings.

Disclosure

Centers for Disease Control and Prevention sponsors had no role in determining study design; data collection, analysis, or interpretation; writing the report; or the decision to submit the report for publication.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

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