Adverse Childhood Experiences Prevention Policy Toolkit

July 2023

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Reducing and Preventing Adverse Childhood Experiences Promotes Public Health

Adverse childhood experiences (ACEs)—as defined in the original ACE study, published in 1998—include abuse (emotional, physical, and sexual), household challenges (violence in the home, substance use, mental illness, parental separation or divorce, and incarcerated household member), and neglect (emotional and physical) experienced before age 18. Since the initial publication of the 1998 ACE study, research about ACEs has grown rapidly, and the concept has received increasing attention in news media and among policymakers.
A substantive body of evidence demonstrates that ACEs are risk factors for negative physical health, mental and behavioral health, biological health, substance use, and social outcomes in adulthood. ACEs have cumulative effects, in which a higher number of ACEs leads to a higher risk for negative outcomes. However, ACEs and their consequences can be prevented through policies that support children and families. Research also shows that many people who experience ACEs can build resiliency through individual, family, and community protective factors.

Recent research has expanded the definition of ACEs to include community violence, lack of neighborhood safety, racism, living in foster care, food insecurity, and adverse community environments such as poverty, discrimination, community disruption, lack of opportunity, lack of economic mobility and social capital, poor housing quality and affordability, and community violence. These chronic stressors impact health outcomes similarly to the stressors listed in the original definition of ACEs.

The ACEs that occur yearly in the United States have enormous costs for healthcare, criminal justice, social welfare, and special education systems. Specifically, the number of incidents of child maltreatment (e.g., physical abuse, sexual abuse, and neglect) that occur in the U.S. annually contributes to $100 billion in costs for these systems. Moreover, when accounting for the lost productivity related to ACEs, the figure increases to over $400 billion.

Adverse Childhood Experiences Have Inequitable Impacts

ACEs disproportionately affect racial and ethnic minorities in the United States, with Black children experiencing about 11% more ACEs than White children, most often due to social circumstances that result from racism. For example, the poverty rate is more than twice as high among Black people than White people because of factors such as inequalities in educational opportunities and discriminatory housing and employer policies. Exposure to racism includes discrimination, stigma, minority stress, and historical trauma, and children who experience individual/interpersonal racism (treating someone unfavorably because they are of a certain race or because of personal characteristics associated with race) are at higher risk for exposure to structural/systemic racism (forms of racism that are embedded in systems laws, policies, practices, and beliefs).

Low-income families experience more ACEs, with research showing that 35% of children living below the poverty level have two or more ACEs compared to only 10% of children in households with income four times the poverty level. Furthermore, because of factors such as inequalities in employment opportunities and discriminatory criminal justice policies, Black youth are more likely to have an incarcerated parent. Black youth are exposed to substantially more community violence than non-Hispanic White youth, even when they live in the same neighborhood, and Hispanic youth are 56% more likely to be victims of assault than White youth.

ACEs also disproportionally burden people who identify as lesbian, gay, bisexual, transgender, and/or queer (LGBTQ+). The percentage of adults reporting childhood emotional, physical, and sexual abuse is higher among bisexual, gay, and lesbian adults than straight adults. For example, the estimated average ACE score is 3.14 among bisexual adults, 2.19 among gay/lesbian adults, and only 1.60 among straight adults. In addition, in one study, transgender participants were more likely than cisgender LGB respondents to report an ACE score of at least 4. Transgender adults are also more likely than cisgender adults to report experiencing childhood emotional abuse, emotional neglect, and physical neglect.

ACEs Have Intergenerational and Cyclical Effects

At the population level, ACEs contribute to the estimated annual 47,646 deaths by suicide, 107,622 deaths from drug overdoses, and 2.7 million people with opioid use disorder in the United States. The public health significance of these outcomes is magnified when one considers that many occur among parents and primary caregivers—which, in turn, are ACEs for their children and increase the children's risk of developing these outcomes in adulthood. More recent longitudinal data show that—after adjusting for a range of risk factors—a child having a family member attempt suicide increases the odds of that child attempting suicide by 94%. This is consistent with prior research showing that a parent's death by suicide increases the risk that their child may one day die by suicide. (See Suicide Prevention Resource for Action for more information about suicide prevention.)

Strategies for Preventing ACES

Implementing policies that reduce risk factors and/or promote protective factors will likely decrease the overall prevalence of ACEs in a community. Public health expertise is important for informing ACEs-reducing policies that are based on the best available evidence. CDC's 2019 Preventing Adverse Childhood Experiences (ACEs): Leveraging the Best Available Evidence guide highlights the following six broad strategies that can prevent ACEs:

1. **Strengthening economic supports for families.** Caregiver stress is a major risk factor for ACEs, especially for child abuse and neglect. Thus, policies that strengthen caregiver financial security (e.g., increasing minimum wage and paid family and medical leave) can prevent ACEs.

2. **Promoting social norms that protect against violence and adversity.** Media campaigns have demonstrated some promise in shifting parenting norms and improving caregiver skills and knowledge to prevent ACEs. These campaigns use both mass media (e.g., television, radio, posters) and social media channels.

3. **Ensuring a strong start for children.** Strengthening a child's relationship with others and improving the connections between home and school (e.g., through early childhood home visitation, high-quality childcare, and preschool enrichment programs with family engagement) help support a child's development and ability to thrive.

4. **Teaching skills.** Parent education programs are typically delivered in group settings and can prevent ACEs by improving caregivers' skills, knowledge about child development, and capacity to use positive child-rearing strategies. The Triple P-Positive Parenting Program is one widely studied program that has demonstrated effectiveness at preventing ACEs and can be readily scaled up by public policy.

5. **Connecting youth to caring adults and activities.** Mentoring and after-school programs are two approaches to promoting youth connectedness and preventing ACEs. Youth who feel more connected to their school and community are at lower risk for self-harm, bullying, violence, and suicide.

6. **Intervening to lessen immediate and long-term harms:** Timely access to primary care, victim-centered services, and treatment services can help reduce children's chances of experiencing prolonged effects from ACEs.

Public Health's Role in Policy Development: Direct and Indirect Authority

State and territorial health agencies directly and indirectly shape public health policy in their jurisdictions. As leaders of their agency, state and territorial health officials (S/THOs) have specific powers to protect public health as well as direct authority over many agency operations. Specific S/THO powers are often delineated in state law, establishing the scope of a S/THO's **direct authority**. In some instances, the S/THO is provided direct authority to act on an issue or establish a program under state law, with discretion on how best to implement the law. For example, under Minnesota law, the commissioner of health is required to establish family home visiting programs for families at or below 200% of the federal poverty level in order to reduce the risk of ACEs. While the S/THO is required to establish this program, they are also granted the discretion to determine how the program is developed by establishing training requirements and minimum supervision requirements for home visitors.

In addition to direct authority, S/THOs can have **indirect authority** established under state law where the official or agency is required to be consulted by the official or agency that does have direct authority to take an action. For example, under Oklahoma law, the Department of Environmental Quality is required to consult with public health agencies, water utilities, and other groups when developing and implementing groundwater protection education programs.

Lastly, S/THOs and public health leaders can have **influence** over policy development that would support public health goals like reducing and preventing ACEs. Public health influence in policy development, implementation, and outcome can take many forms, including educating policymakers on the public health benefits of addressing an issue and building a coalition of policymakers, nongovernmental organizations, and community members to support a policy change. For example, in 2019, Minnesota Health Commissioner Jan Malcom testified in support of a paid family leave proposal before the Minnesota House Health and Human Services Finance Division committee hearing, focusing on the public health benefits of providing paid family leave.

In 2021, a coalition of community leaders, researchers, and Minnesota state officials worked together to create and implement The Healthy Start Act to reform the state's criminal legal system. This action, which allows the commissioner of corrections to release pregnant or immediately postpartum people to a community-based supervision program instead of requiring them to remain incarcerated, was supported by the Minnesota Department of Health, which served as a "bridge and champion" during the policy development process. In this case, the public health department did not have an official role in the development or adoption of the policy proposal but was able to provide data in support of the efforts that may reduce ACEs.

To best navigate the policy development process to reduce ACEs, public health leaders should assess how the health official and health department relate to the core issue being discussed. When approaching a new policy issue, public health leaders should determine the following:

Who has the authority to act on this policy issue?

- *Does public health have direct authority, indirect authority, or influence on this topic?*
- *What other policymakers or decision-makers have direct authority, indirect authority, or influence on this topic?*

Assessing the Policy Landscape

Public health leaders working to adopt policies that prevent or reduce ACEs should periodically assess the policy landscape—including policymakers' and public support for policy change—to determine whether there is a political will to adopt a policy change. Political will is when decision-makers share a common understanding of a problem and support a policy solution to address it. There are many factors that contribute to political will, including current events, public discourse, and advocacy efforts by people seeking a policy change. To determine the **political will**, a policy team can monitor public discourse (e.g., news coverage, op-eds, and social media discussion) related to the topic and assess how prevalent the issue is among the public.

In assessing the appropriate time to adopt a policy and whether public health leaders should play a leading role or supporting role, consider the following:

- ***Is there a political will to act?***
- ***Are preventing ACEs a fundamental part of policy action or a benefit of broader policy goals?***

Identifying Policy Solutions to Reduce ACES

Preventing ACEs is a broad public health policy goal that intersects with many other aspects of public policy, making it difficult to identify discrete policies to change. Therefore, identifying specific policy goals that will reduce ACEs within a jurisdiction over a period of time (e.g., 3-5 years) can lead to an effective strategy for policy change. To determine which policies to pursue, state teams should clearly define the issue (e.g., "recent Youth Risk Behavior Survey data reveals an increase in reported interpersonal violence among high school students") and then identify several potential policy solutions that can address the problem.

Public health agencies can identify policy options to pursue by searching through reports, articles, white papers, and reviews, requesting technical assistance, and asking professional colleagues. Several policies that support evidence-based ACEs prevention strategies are detailed in the previously-mentioned guide CDC's Preventing Adverse Childhood Experiences: Leveraging the Best Available Evidence, which discusses a range of areas where public health leaders have influence but often do not have the authority to implement change.

Policy Levers

Policies to prevent ACEs can be found across all levels of government. **Policy levers** are the tools and mechanisms available to policymakers to effectuate change. They can range from legal instruments (e.g., constitutions, statutes, and regulations) to organizational documents (e.g., agency handbooks and guidance). Below are several policy levers that help shape the landscape for ACEs prevention, along with considerations for using these levers to reduce ACEs. Find more information on these policy levers in ASTHO's Health Equity Policy Toolkit.

Federal Policy Levers

Federal Legislation

When Congress considers legislation that impacts ACEs, state public health leaders can educate lawmakers about how the proposed policy can improve or worsen public health outcomes. To do this, public health leaders can meet with legislators, correspond with their representatives, or even provide written or oral testimony.

> *When advocating for a policy change, state health agency staff should consult their internal policies and procedures to determine which actions they can take. Many states place limitations on advocacy efforts conducted by state employees in their official capacity (e.g., some jurisdictions only allow agencies to submit informational testimony on a bill, and some restrict partisan activities).*

Congress can pass legislation that supports all six of the CDC's evidence-based strategies to reduce or prevent ACEs. For example, in 1990, Congress established the Child Care and Development Block Grant, which provides financial assistance to low-income families for childcare, thereby increasing economic support for families. In subsequent years, Congress has reauthorized the grant several times, along the way strengthening safety requirements, improving the quality of childcare, and allocating additional funds.

The 118th Congress is considering bills that could reduce or prevent ACEs by strengthening family economic supports and supporting family-friendly work policies. For example, in January 2023, the Senate introduced the New Parents Act, which would allow new parents early access to social security benefits to support a three-month period of paid family leave during the first year after a child is born or adopted. Also, the Child Care for Every Community Act, introduced in the House of Representatives in February 2023, aims to establish universal access to high-quality, affordable childcare options nationwide.

> *On March 23, 2023, ASTHO President and Alaska Department of Health Chief Medical Officer Dr. Anne Zink **testified** before the House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies on behalf of ASTHO members. In her testimony, Dr. Zink urged Congress to consider sustainable and flexible funding to support a range of public health priorities, including funding to grow jurisdictional capacity to address social determinants of health like housing, food security, and education—policies that likely will reduce ACEs.*

Federal Executive Actions

A common policy lever used by the executive branch is agency **rulemaking**. Federal agencies are tasked with implementing laws enacted by Congress, exercising their expertise to establish how a federal program will be implemented. The rulemaking process is governed by the federal Administrative Procedure Act and generally requires an agency to provide the public notice of the agency's plan to create a rule, propose a draft rule and collect feedback in the form of formal comments, and then finalize the rule after considering the formal comments.

Congress grants federal agencies the authority to create regulations or rules. State public health leaders can participate in the rulemaking process by providing comments to the federal agency. Additionally, federal agencies can issue guidance on how their rules are interpreted, sometimes in response to specific requests from state officials. For example, in 2012, officials from the Georgia Department of Health sought clarification on a 2003 U.S. Department of Transportation rule defining multifunction school bus activity. Responding to Georgia's inquiry, the federal agency issued a letter explaining that the agency regulations applied to the sale of busses used to transport students from school to a childcare center.

The federal courts are empowered to review federal agency regulations to determine whether an agency is acting within the bounds established by statute. Often, the court will defer to the agency based on the agency's expertise and the regulation's sufficient alignment with the law authorizing the agency's rulemaking. Sometimes the courts review agency rulemaking that is related to preventing ACEs. For example, in the 2012 case ***Astrue v. Capato****, the Supreme Court unanimously ruled that the Social Security Administration's interpretation of a federal law providing surviving children benefits until they reach adulthood was reasonable and valid.*

State Policy Levers

Because **states retain significant authority to protect public health and safety**, state policy levers are valuable tools to promote public health goals.

State Legislation

Similar to the division of power found in the federal government, state legislatures propose, consider, and enact laws within their jurisdictions. Most state governments provide the legislature with the power to levy taxes and appropriate funds to support government programs and operations. Unlike the federal government, which can operate with a deficit budget, the majority of states require a balanced budget, which can limit the size and scale of some state programs.

State legislatures have significant power to enact laws that can prevent and reduce ACEs and child maltreatment. A recent report from the National Conference of State Legislatures highlights several types of state legislation aimed at reducing childhood violence, including supporting economic benefits for families, providing access to safe and supportive housing, and supporting parents' physical and mental health. In 2022, ASTHO released findings from a nationwide legislative scan that identified over 700 legislative proposals across 48 states and Washington, D.C., related to policy issues that could prevent or reduce ACEs.

State Executive Actions

As head of the state executive branch, a governor can encourage or direct executive branch agencies to advance policies aligned with their policy priorities. For example, in 2020, Tennessee Governor Bill Lee exercised his direct authority and issued an executive order to provide paid family leave for all state employees.

Beyond the governor's direct actions, executive branch agencies like the health department are often conferred power to adopt rules or regulations to fill in the details of legislation; implement, interpret, or set policy; or establish practice or procedural requirements of the agency. Legislation may also authorize state health agencies to adopt rules or explicitly direct health agencies to do so. Each state establishes its own procedures for creating regulations, and jurisdictions looking to implement policy change through rules should consult their jurisdiction's attorney to ensure they follow the appropriate **rulemaking** process.

In cases where the public health agency is granted direct authority to act—including for legislation empowering the agency to create rules supporting an ACEs prevention program or allocating additional resources to enhance department activities that would prevent ACEs—public health leaders can have a significant impact. For example, in 2019, the Oregon legislature established a voluntary universal newborn nurse home visiting program to be administered by the Oregon Health Authority. To implement the law, Oregon Health Authority issued rules establishing the certification requirements for providers and standards for home visits and required follow-ups and determining how providers may be reimbursed for their services.

Local Policy Levers

Many state constitutions specify that local governments are only provided the powers designated to them by the state. In some states, local governments have limited powers to make laws and can only exercise the powers the state specifically grants them. In other states, local governments are expressly allowed to self-govern.

Depending on the local government structure, state public health leaders can have an influence on local policies that prevent or reduce ACEs. Building partnerships with local governments can help state policymakers develop state-level policies that support local government efforts. For example, the Colorado Department of Public Health and Environment collaborated with business leaders to develop the Family Friendly Workplace Toolkit. This toolkit provides business leaders with resources to assess their internal policies and links leaders to advocacy efforts to support family-friendly policies at the state and local levels. Additionally, the Colorado organization Executives Partnering to Invest in Children published several case studies of local policies that could prevent or reduce ACEs.

Considerations for Tribes and Territories

The relationship between federal and state governments and tribes is unique to each tribe. To help public health professionals navigate this relationship, the Network for Public Health Law has created the guide Tribal Public Health Law Resource.

Many policies aim to help tribal governments reduce or prevent ACEs, with a number of these policies further clarifying the intergovernmental relationship between tribes and the state/federal government. For example, the federal Indian Child Welfare Act—a 1978 law regulating the adoption of Native children—guides states on how child abuse and neglect and adoption cases ought to be considered to protect the best interest of the child and promote stability and security of tribes. In some states, such as New Mexico, the state law mirrors the Indian Child Welfare Act's requirements and the existing process.

Developing Your ACEs Policy Strategy

Determine Your Strategic Priorities

Establishing strategic priorities for reducing or preventing ACEs can help public health officials and staff efficiently navigate the policy development process. These priorities can be driven by identified problems or issues that increase risk factors or reduce protective factors for ACEs framed within the jurisdiction's current policy landscape and context. It can also be valuable to establish priorities for a multiyear period (e.g., 3-5 years). Policymaking can be a slow, incremental process, so having additional goals within the timeframe can help move the priorities forward.

Strategic priorities for reducing or preventing ACEs should consider a variety of perspectives (e.g., community members and partner organizations) as well as the current policy landscape. Based on that assessment, the policy team can work with public health leaders to identify specific issue areas where the agency would like to focus its ACEs prevention policy work in the medium term (e.g., 3-5 years). This could include issues where there is already strong support within the jurisdiction but no fully adopted legislation yet. For example, in a jurisdiction where the legislature has considered paid family leave legislation, public health leaders may include paid leave as one of the priority issue areas to support.

Additionally, public health leaders can strategically prioritize elevating a policy issue not currently considered by policymakers. For example, public health leaders can educate policymakers on the risks associated with housing insecurity and work together with other interested parties to identify appropriate economic supports to decrease housing insecurity in the jurisdiction.

Mapping Positions of Key Policymakers

After developing the health agency's strategic priorities and selecting specific policy actions, it is helpful to identify key policymakers' positions regarding the policy goals. One tool that state health agencies can use to assess policymakers' positions and the feasibility of policy actions is **power mapping**. Power mapping helps visualize the authority and influence different policymakers have over a policy action. It is a best practice to map the positions of key decision-makers for each policy selected.

Legislature

Public health agencies can educate legislators on public health issues as apolitical experts and often have staff members who serve as agency liaisons to the legislature. Legislators come from different professional backgrounds, and many assume office with little public health expertise. Organizations like the National Conference of State Legislators provide resources for legislators and their staff on a variety of topics. Public health agency leaders can work with their legislative liaison to determine how legislators view proposed policy solutions.

Mapping key legislators—the majority and minority leaders of each body and committee chairs—can help identify the path legislative action will likely take. From there, state public health agencies can determine whether these legislators are aware of the policy proposal, what their stance is, and if there is an opportunity to educate the legislators on the importance and impact of the policy change. Beyond legislative leaders, other influential legislative members, such as long-serving members or members with expertise on the policy issue, may support the policy change or champion a proposal, increasing the likelihood of legislation passing.

Governor

The governor can hold direct authority over a policy change (e.g., issuing an executive order or signing a bill into law) as well as influence policy change (e.g., encouraging legislators to introduce a bill). The governor's office can also advance strategic priorities identified by public health leaders. Building relationships with the governor's support staff and advisors can strengthen the support the governor provides to public health policy priorities.

Advancing policy through the governor's office (whether by executive order or adding program funding to a budget request) requires help from the governor's staff. A resource from the National Governors Association details the roles and responsibilities of the governor's office. Including the governor and key members of the governor's staff in a power mapping exercise for each policy priority can inform a team's policy strategy.

Other State Agencies

Often policy considerations to reduce ACEs fall within the realm and authority of other state agencies. For example, CDC's 2019 report stated that access to high-quality childcare reduces caregiver stress and rates of child abuse, which are risk factors for ACEs. However, regulations regarding childcare centers and preschool programs may fall under a jurisdiction's department of education. State health agencies can look for opportunities to build relationships with staff from other state agencies, offering public health expertise and insight into proposed regulations or new programs and finding paths for future agency collaboration.

Local Governments and Community-Based Organizations

Understanding the structure and authority of local governments allows you to know how individuals at each level of government can act and resolve public health issues. Working with local governments and officials can also give insight into what policies currently exist in the jurisdiction and what types of policies a local jurisdiction is able to develop. In addition, implementing policies at the local level may require local buy-in or assistance.

Developing partnerships with community-based organizations can help state agencies connect with people with lived experiences and build trust within the community. The expertise these organizations provide can also help agencies identify where alterations to state laws or policies may help or hinder local efforts to advance a policy issue.

> *After identifying relevant policymakers, it is important to find out where they stand on your issue, the amount of influence they have, and how best to communicate with them. Ask yourself:*
>
> - *Does this person have direct authority over the proposed policy action?*
> - *Is this issue a priority for them?*
> - *Have they led policy change in this area before? If not, are they willing to?*
> - *If this person does not have direct authority over the action, are they influential in the process?*
> - *Is this issue a priority for them?*
> - *Have they led policy change in this area before? If not, are they willing to?*
> - *Do they have a relationship with the health department? If so, how strong is the relationship?*
> - *How do they relate to other key decision-makers?*

Identifying Trusted Messengers

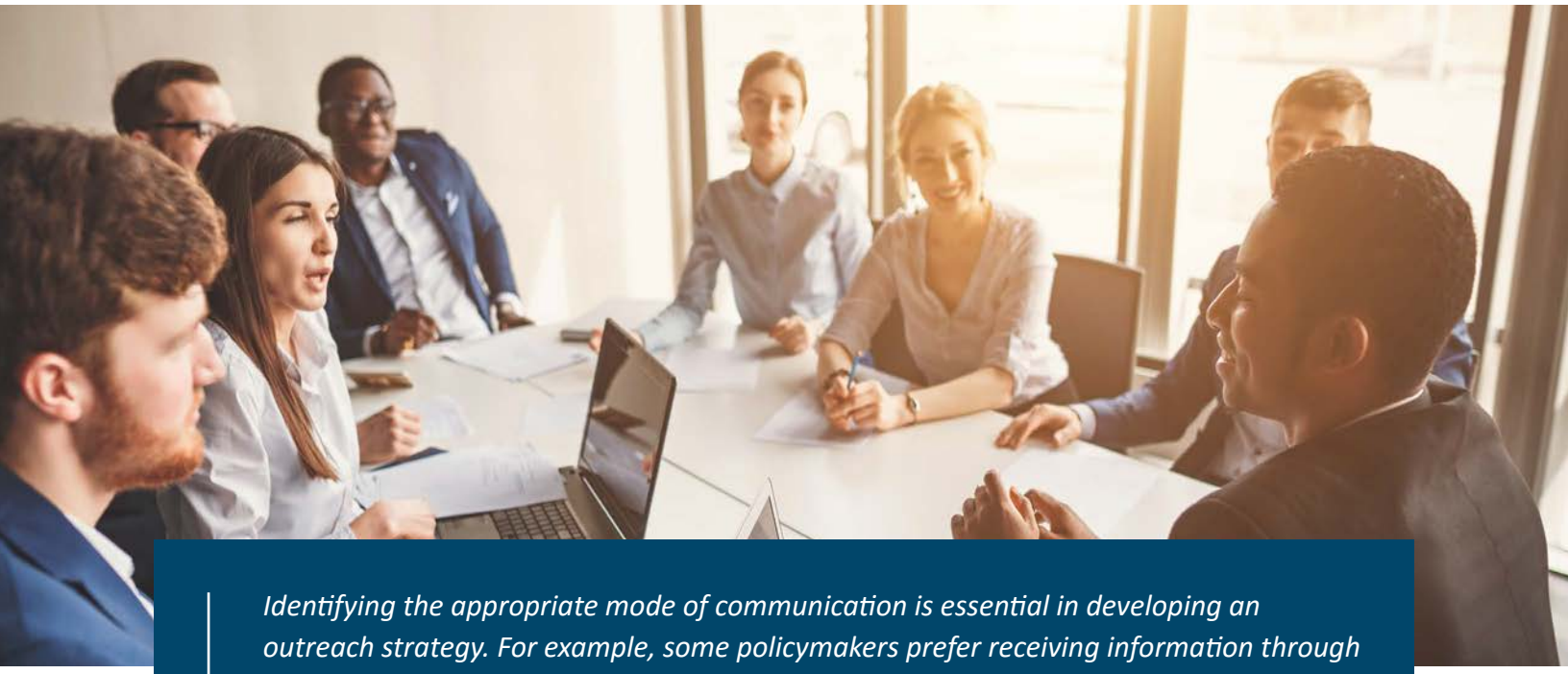
In addition to mapping key policymakers, public health leaders can identify trusted messengers to educate the public and others on policies to prevent ACEs and advocate for policy action. **Trusted messengers** are people deemed honest and credible by a person receiving the message or information. Who is considered a trusted messenger can vary depending on the issue, the message receiver's experience and perspectives, and the broader social context. In 2022, the Ad Council released the Trusted Messenger Study to identify whom Americans turn to for information on social and societal issues (e.g., mental health, climate change, the COVID-19 pandemic). The study found that most people place high levels of trust in their partners, immediate family members, and friends, and varying levels of trust in subject matter experts, religious leaders, and community leaders. For example, respondents from rural areas reported lower levels of trust for scientists and academic experts than urban and suburban respondents did.

Developing an Outreach Strategy

After mapping policymakers' and interested parties' key positions and identifying trusted messengers, the state public health policy team can develop an outreach strategy to engage these individuals. This strategy should be specific to each policy action and, ideally, defined in SMART terms:

- **S**pecific: Clearly define the policy action (e.g., passing a bill, issuing an executive order, creating a rule) and the entity with authority to take the action (e.g., the legislature, governor, or agency).
- **M**easurable: Establish what a "win" looks like (e.g., passing a bill out of committee, getting additional funding in the agency budget to support a program).
- **A**chievable: Determine whether there is a path to your "win" and assess whether you have the tools needed to get there.
- **R**elevant: How does this policy action fit into the policy landscape?
- **T**ime-based: What is the timeframe in which you would like to achieve your policy goal (e.g., within one year)?

With the broader SMART policy goal in mind, the policy team should identify clear roles and responsibilities for a policy team member, coalition member, and others engaged in developing the policy. These roles could include providing data to coalition partners to inform their advocacy efforts, holding briefings for policymakers on an issue, and leveraging trusted messengers to engage directly with policymakers or the public.



Identifying the appropriate mode of communication is essential in developing an outreach strategy. For example, some policymakers prefer receiving information through in-person briefings where they are able to ask subject matter experts questions about the material, while others prefer written reports.

Anticipating Roadblocks

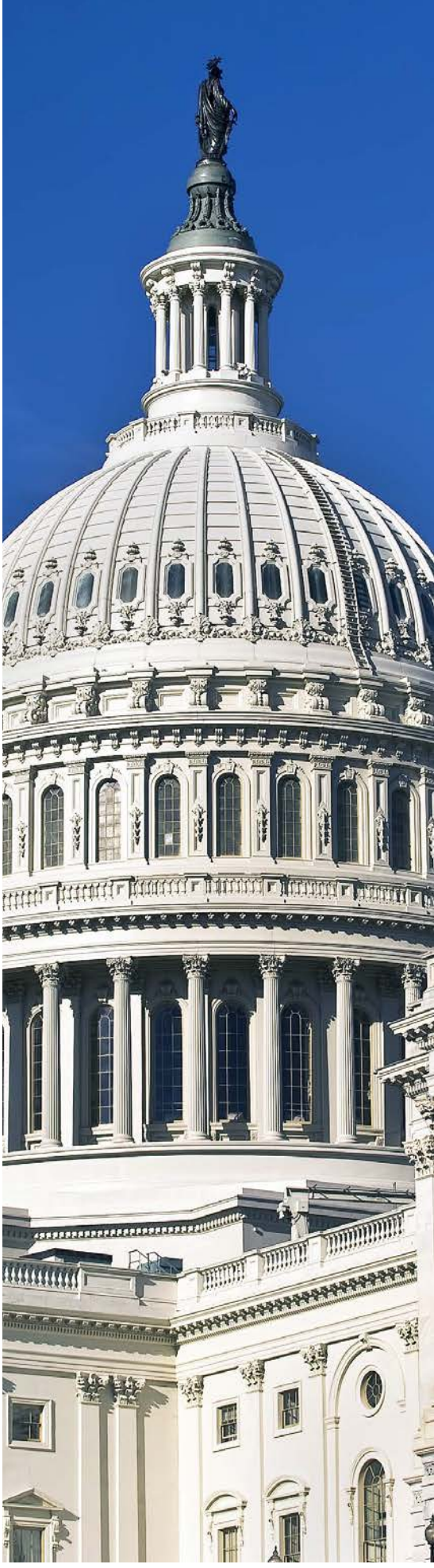
The path to a policy goal is often not smooth, so it is important to anticipate roadblocks and strategize how to avoid or overcome them. A policy's opponents may advocate against the policy or, after its adoption, bring legal challenges against the policy. To prepare for these actions, the policy team should include a diverse group of professionals who can assess what potential roadblocks will arise and be prepared to respond to any opposition.

Time is another potential challenge to adopting policy. The time between selecting a policy solution to enacting and implementing the policy can be long. The policy strategy team should discuss whether incremental steps toward a policy goal are preferable to an immediate, all-encompassing policy change.

Finally, state health agencies and coalitions may want to discuss possible concessions that they can make to opponents while still adopting the policy. During these discussions, consider the impact these concessions could have on public health, particularly the population the policy would support, and if this is a temporary concession (i.e., tabling the issue and revisiting it later) or a permanent one.

Coalition Building

A coalition can help lead to a policy change by providing advocacy at various levels of government, generating greater public awareness, providing personal perspectives from those directly affected by the issue, offering subject matter expertise, and mobilizing collective resources. Coalition members may also be able to engage in activities that state health agency staff legally cannot. Coalition members can include individuals from communities the policy intends to benefit, individuals from communities burdened by policy action, representatives from nongovernmental organizations, and advocates interested in the topic.



Considerations When Building a Coalition

When starting to establish a coalition to move a policy forward, it's important to take the following steps:

- **Identify and focus on an issue.** There are many policy strategies for preventing ACEs. By focusing on a specific issue, the policy team can identify and collaborate with the appropriate coalition partners interested in the policy change.
- **Center the people most impacted by the policy issue.** Originating in the disability rights movement, the mantra "nothing about us without us" applies across policy efforts. Engaging people most impacted by an issue and helping them shape the appropriate policy action to address the issue can lead to more successful policy outcomes.
- **Identify who is operating in the policy space and if there is an existing coalition.** For many issues, there may already be a coalition of partners working in the policy space. Engaging with an existing coalition with interest in the topic, such as working with an existing healthy babies coalition to support policy changes to an early childhood home visiting program, can make for a stronger policy team.
- **Find a backbone organization for the coalition.** If there is not an existing coalition, consider which group may be best positioned to serve as the backbone organization to coordinate and facilitate the coalition. Candidates for the backbone organization will depend on the policy goal. For example, if the policy goal is access to affordable housing, the backbone organization would likely be an entity with expertise in housing policy rather than the health department.
- **Identify coalition membership, roles, and responsibilities.** Coalition members can bring various resources and influence to the table, such as human capital, finances, and connections with policymakers. Be thoughtful when considering where the health department can fit into the strategy, and if you are not the backbone organization, recognize that you may not be in the final decision-making role. Consider ways to ensure that community partners have shared ownership of the coalition goals.
- **Clarify anticipated outcomes.** Being transparent about elements of the process, such as timeframes, the level of resources available, and cost-sharing implications, will minimize unrealistic expectations for the coalition. In addition, consider any important decision points and whether there is a need for buy-in from the group.

> *Building a coalition often requires organizers to navigate boundaries within their agency as well as with external partners. ASTHO offers the **Boundary Spanning Leadership** training to help groups work together and identify ways to better collaborate across organizations.*

Communication Strategies

Messaging and communicating your policy action to policymakers and the public is a mixture of art and science. While data sway some people, a growing body of research shows that messages built on shared values are highly effective in engaging your audience and motivating them to support the policy action. Communication resources for public health agencies include the Network for Public Health Law's Becoming Better Messengers guide, which helps public health leaders frame communication for policymakers, and the Berkely Media Studies Group report Championing public health amid legal and legislative threats: Framing and language recommendations, which includes resources for developing and delivering messages.

Berkeley Media Studies Group Tips for Framing Your Message

- **Frame your policy as indispensable and repeat it.** *The more people hear your message, the easier it will be for them to understand and support it.*
- **Avoid shaming and scolding.** *Emphasize the positives of your policy to create a social norm people want to be a part of.*
- **Avoid using myth vs. fact.** *Instead, explain what your policy is about, what you hope to achieve, and what we know is true.*
- **Use a "truth sandwich."** *Start with the truth, indicate the misinformation (but don't repeat it), then repeat the truth.*

Policy Evaluation

Evaluating policy can involve evaluating the implementation of an adopted policy as well as evaluating the ultimate effectiveness of the policy. Evaluating policy implementation focuses on whether policy implementation was planned, whether that plan was followed, and whether there were barriers or facilitators to implementing the intended policy. When evaluating policy implementation, public health leaders and policymakers should also consider how the policy is intended to be enforced and whether that enforcement mechanism is equitable.

Evaluating a policy's effectiveness after implementation allows policymakers to identify the policy's intended and unintended outcomes and provide information for other policy solutions about possible impacts, barriers, and opportunities in order to increase knowledge and awareness. One way to evaluate policy is a concept called legal epidemiology. This method uses the study of law as a factor in the cause, distribution, and prevention of disease and injury and applies scientific methods to translate complex legal language into data that policymakers can use to make decisions on issues that affect population health.

Conclusion

From building and participating in community coalitions to educating policymakers and refining messages to better resonate with the public, public health leaders play a crucial role in developing policies to prevent ACEs. The resources provided in this toolkit are designed to help support public health agencies in these efforts. For additional support, state public health agency leaders can contact ASTHO for technical assistance at ask@astho.org.

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