Adverse Childhood Experiences in States and Territories

A Look at Primary Prevention Priorities

ACEs are potentially traumatic incidents that harm a child's social, cognitive, and emotional functioning and undermine the relationships and environments children need to thrive. State and territorial health agencies (S/THAs) can address ACEs through **primary**, **secondary**, and **tertiary** prevention strategies (hover over underlined text to see expanded term definitions). ACEs prevention strategies have a potential long-term impact on supporting families, and they can sustain family resiliency during times of uncertainty, such as the COVID-19 pandemic.

In 2019, ASTHO conducted the **ACEs Capacity Assessment Tool** (**ACECAT**)[1], an electronic survey of its 59 member agencies, to better understand S/THAs' ability to prevent and mitigate ACEs. The ACECAT included three main components: 1) **background** on the S/THA respondent; 2) **infrastructure** at the health agency to support ACEs prevention; and 3) **topical** prevention strategies health agencies are focused on.

HEALTH AGENCIES ARE PRIORITIZING PRIMARY PREVENTION STRATEGIES TO REDUCE ACES

Health agencies report prioritizing primary prevention strategies above infrastructure and other prevention strategies.

15 S/THAs are prioritizing **primary prevention** strategies that prevent ACEs from occurring in the first place.

10 S/THAs are prioritizing **infrastructure** strategies to operationalize ACEs programs.

9 S/THAs are prioritizing **secondary prevention** strategies that identify high-risk populations.

5 S/THAs are prioritizing **tertiary prevention** strategies that mitigate long-term harm.

HEALTH AGENCIES HAVE VARYING CAPACITY TO PREVENT ACES

Evidence-based primary prevention strategies focus on preventing ACEs before they occur. Health agencies report varying levels of primary prevention capacity[2]:

Highest Capacity Areas:

76% Have efforts to ensure a **strong start** for children.

(e.g., through early childhood home visitation programs, high-quality child care, and preschool enrichment strategies).

76% Have efforts to teach youth **new skills** to manage stress, conflicts, and emotions.

(e.g., by promoting social-emotional learning and healthy family relationship strategies).

56% Have interventions to **lessen immediate and long-term harms** of ACEs exposures.

(e.g., through enhanced primary care services, victim-centered programs, treatment to prevent problematic or violent behavior, and family-centered substance use disorder treatment).

Lowest Capacity Areas:

49% Have efforts to promote **social norms** that protect against violence and adversity.

(e.g., through public education campaigns, legislative approaches to reduce corporal punishment, bystander approaches, and programs that encourage men and boys to serve as allies in prevention).

46% Have efforts to connect **youth to caring** adults who are positive role models.

(e.g., through mentoring and after-school programs).

34% Are working to **strengthen economic supports** to families through financial security and family-friendly work policies.

(e.g., paid family leave, subsidized childcare, assisted housing mobility, and earned income tax credits).

LOOKING FORWARD

Cross-sector partnerships can be used to create programs with a large societal impact. Health agencies should continue to focus on promoting social norms, connecting youth to caring adults and activities, and strengthening economic supports to families.

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[1] For purposes of the ACECAT, capacity is defined as the measurement of an S/THA's efforts, ranging from no capacity, or no efforts currently underway, to full capacity, or the S/THA has targeted initiatives to those in need, and all gaps and challenges related to implementation have been addressed.

[2] Capacity areas sourced from: https://www.cdc.gov/violenceprevention/pdf/preventingACES.pdf

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