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Increasing support for the prevention of adverse childhood experiences and substance use: Implementation of narrative change strategies in local health departments

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Abstract

Adverse childhood experiences (ACEs) are potentially traumatic but preventable experiences that occur before the ages of 18, including child abuse, witnessing violence, and parental substance use. ACEs have been linked with increased risk for substance use, along with a variety of other negative health outcomes. However, there is limited evidence of community-level strategies that link ACEs and substance to increase awareness of prevention efforts. This article reports on a $2.9 million program to promote health equity and inform narratives for the prevention of ACEs and substance use within three Midwestern communities. Program partners sought to create new transformational narratives that linked ACEs and substance use, while underscoring the importance of addressing social determinants of health (SDOH) that lead to disparities in ACEs and substance use. A mixed-methods evaluation design included document review, in-depth interviews with program staff ($N = 8$) and community liaisons ($N = 2$), and site reports from program staff ($N = 8$) and their community partners ($N = 17$). Analyses showed that successful implementation efforts had early leadership buy-in and support, set clear and manageable expectations at the outset of implementation, and developed strong relationships with organizations that engage in health equity work. Training and technical assistance were critical to helping community partners build trust, recognize each other's perspectives, broaden and reframe their world view, and better understand narrative efforts for the primary prevention of ACEs and substance use.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

Keywords

adverse childhood experiences; health equity; narrative; organizational change; prevention; substance use

INTRODUCTION

Local health departments (LHD) play a critical role in the nation's health infrastructure, leading surveillance of, providing direct services for, and working to prevent disease (National Association of City and County Health Officials NACCHO, 2019). According to NACCHO, there were approximately 2800 local health departments in 2019 with responsibility or concern for health at a jurisdictional unit smaller than a state. In addition to individual services and population-based programming, LHDs have increasingly shifted attention to addressing historical health inequities. The ongoing Novel Coronavirus pandemic, current events of racial injustice, and rising drug overdose rates have illuminated the need for LHDs, along with other health agencies, to reconsider their role in addressing historical health and racial inequities (Dobson et al., 2021). Both the American Public Health Association and Centers for Disease Control and Prevention (CDC) have moved to recognize racism as a public health concern (American Public Health Association, 2021; Centers for Disease Control and Prevention [CDC], 2021c). However, documented efforts of LHDs to increase attention on improving conditions toward achieving health and racial equity are limited.

This article summarizes efforts in three midwestern communities to promote the primary prevention of substance use by partnering with LHDs to address racial and health inequities in adverse childhood experiences (ACEs). Efforts included changing organizational norms, strengthening partnerships with grassroots organizations, and framing health inequities in terms of the primary prevention of ACEs and addressing SDOH. We use the CDC's definitions of ACEs and SDOH, with ACEs being defined as preventable, potentially traumatic events that occur before the age of 18 years, including child abuse/neglect, parental substance use, and youth violence involvement (CDC, 2019, 2021a); and SDOH involving factors such as housing, transportation, economic, employment or other conditions in the places where people live, work, and play that can directly or indirectly influence health and quality of life (CDC, 2021b).

Addressing disparities in ACEs and SDOH is a critical step towards achieving racial and health equity and promoting the primary prevention of substance use (Harper et al., 2023; Klevens & Metzler, 2019). This is because of the role of SDOH in increasing the risk for ACEs, as well as the historical influence of factors (e.g., housing and educational inequities) that have exacerbated and entrenched ACEs within communities (Harper et al., 2023; Klevens & Metzler, 2019). Moreover, ACEs substantially increase risk for substance use, substance use disorders, and exacerbate the effects of neighborhood disadvantage on substance use (Handley et al., 2015; Leza et al., 2021; Merrick et al., 2020), with racial/ethnic minority communities and individuals living in poverty at disproportionate risk for experiencing ACEs (Merrick et al., 2020). The interconnections between ACES, substance

use, and SDOH highlight the need for community-level strategies and approaches that can simultaneously impact ACEs and SDOH to prevent substance use.

Community-level strategies for the primary prevention of ACEs and substance use

Past research on community-level strategies (i.e., characteristics of settings, such as neighborhood poverty, residential segregation and instability, high density of alcohol outlets; Dahlberg & Krug, 2002) to increase health equity and address SDOH has tended to emphasize two approaches for improving conditions. One approach has been to strengthen partnerships between community agencies to increase the delivery of evidence-based programs and interventions. For example, *Communities That Care* is an evidence-based prevention implementation model shown to decrease ACEs (i.e., youth violence involvement) through community prevention boards including community leaders and members working collectively to implement programs that directly address risk and protective factors for a variety of youth behavioral health issues (Brown et al., 2011, 2014; Hawkins, Brown, et al., 2008, Hawkins, Catalano, et al., 2008; Quinby et al., 2008). Rigorous evaluations of the *Communities That Care* model demonstrated that community-level emphasis on creating systems that better meet the needs of children and families, including collaboration can enhance population-level improvements in violence and substance use outcomes (Hawkins, Brown, et al., 2008; Hawkins et al., 2009). Moreover, strong, sustainable partnerships aided implementation of evidence-based practices.

Building healthy communities can also be a critical element of implementing effective prevention strategies for ACEs and substance use. Community or relational organizers have historically focused on strategies for community empowerment, particularly for neighborhoods or communities socially and economically marginalized, to directly impact SDOH (Christens, 2010; Christens & Speer, 2015; Christens et al., 2021). Relational organizing focuses on strengthening social networks to build social capital through leadership development and bottom-up decision making to affect community-level outcomes (Chambers & Cowan, 2003; Wood, 2002). For example, Christens and Dolan (2011) found that organizing efforts in California were linked with shifting youth violence prevention interventions from a focus on crime prevention to an emphasis on education and creating safer communities. Similarly, Cooper and Christens (2019) found that organizing efforts were associated with an increased emphasis on restorative justice principles and policies in education systems and a shift away from punitive measures in Chicago.

Organizing efforts may be an important compliment to public health interventions and strategies. Engaging with community organizers has been shown to strengthen data collection efforts for public health needs assessments and planning (Santilli et al., 2016). Obesity prevention effort that linked public health and community organizing, showed an increased attention to cultural assets for health promotion (Hilgendorf et al., 2016). Furthermore, community organizing strategies were associated with increased community capacity in efforts to better address childhood asthma (Parker et al., 2010). These three examples are not intended to be comprehensive; they help highlight some of the ways that linking organizing and public health have strengthened programs and strategies to improve health.

The impact of relational organizing strategies on public health, social, and educational systems suggests that these strategies may bolster primary prevention efforts for ACEs and substance use. Community organizing may help highlight the concerns of communities most impacted by health inequities and increase attention on strategies, resources, or the need to directly address ACEs, substance use, and SDOH.

The current project

Relational organizing and public health efforts highlight two distinct, yet complementary approaches for promoting the primary prevention of ACEs and substance use by addressing racial and health equity. This project bridged community partnership building and organizing approaches to better address ACEs, substance use, and SDOH. Despite the evidence of strategies and approaches for addressing the health and racial inequities that underpin ACEs and substance use (CPSTF Findings for Health Equity, 2021; Harper et al., 2023; Klevens & Metzler, 2019), many LHDs encounter barriers to becoming directly involved in health equity efforts or report limited opportunities for LHDs to engage in health equity efforts. For example, in a survey of LHDs regarding their role in addressing the impacts of foreclosure, less than 30% reported being involved, with evidence that many reported being uninvolved because their role (e.g., educating partners and community members on the detrimental impacts of foreclosures on children and families) was unclear (Schaff & Dorfman, 2019). Thus, increased emphasis is needed on documenting and demonstrating the roles LHDs can play in addressing racial and health inequity with an emphasis on lessons learned for future efforts and building the evidence base for community-level approaches. Previous efforts to document or examine community-level racial and health equity efforts have tended to focus on multisectoral coalitions, community-based organizations, or community organizers with less attention on the unique role and challenges faced by LHDs in addressing racial and health inequity.

This project builds from previous efforts to understand community-level approaches to creating equitable communities, addressing racial disparities in ACEs and substance use, and promoting the primary prevention of ACEs and substance use. Beginning in the Fall of 2018, the National Center for Injury Prevention and Control at CDC funded the National Network of Public Health Institutes (NNPHI) to support the promotion of primary prevention efforts in three midwestern communities. Additional resources for technical assistance and evaluation were provided by the Michigan Public Health Institute (MPHI) through a subaward with NNPHI.

During the 3-year, *Comprehensive Community Strategies for the Primary Prevention of ACEs and Substance Use Project*, there was an emphasis on four frameworks and/or resources for supporting community implementation of activities for the primary prevention of ACEs and substance use: (1) The four baskets framework from the Narrative Initiative (Weidinger, 2020), (2) World Health Organization's SDOH Framework (Solar & Irwin, 2010), (3) CDC's ACEs Prevention Resource (CDC, 2019), and (4) CDC's Child Abuse/Neglect Prevention Technical Package (Fortson et al., 2016). CDC's ACEs Prevention Resource and Child Abuse/Neglect Prevention Technical Packages are compendiums of evidence-based strategies and approaches for the primary prevention of ACEs.

Changing dominant narratives around why people use substances was a critical underpinning of the project (Wainwright, 2019). Narratives are the stories that help us understand why a phenomenon occurs and how to address it. Dominant narratives often focus on individual success or failure, without acknowledging the influence of power hierarchies, to the detriment of groups that have been historically and/or currently marginalized. Narrative change strategies explicitly focus on shifting narratives to include historical, social, economic and/or political contexts, and policy-level responses. The four baskets framework is an approach to informing narrative change work that includes creating, translating, deploying, and observing the impact of narratives to bolster understanding community needs and conditions (Weidinger, 2020; Figure 1). The process shifts accepted negative perceptions about issues to a deeper understanding of values and opportunities for intervention and was used for this project to help identify and implement strategies to strengthen racial and health equity approaches for the primary prevention of ACEs and substance use. The four baskets framework achieves changes in narrative by helping users identify and address gaps in implementation of narratives for the prevention of substance use and ACEs, while iterating through a process to develop and implement more impactful narratives. Finally, ad hoc training sessions were provided and/or facilitated by local agencies (e.g., training sessions on trauma-informed care) and the technical assistance providers (e.g., the role of policies and SDOH in ACEs and substance use).

The World Health Organization's SDOH Framework was embedded throughout the project, with a recognition that many of the connections between ACEs, substance use, and SDOH are the result of shared health inequities (e.g., socioeconomic and educational disparities) that drive disparities in ACEs and many forms of substance use (Solar & Irwin, 2010). CDC's ACEs Prevention Resource and Child Abuse/Neglect Technical Package were also used to shape the overall direction of the project, specifically through the identification of evidence-based strategies for the primary prevention of ACEs, including strengthening economic supports for families (CDC, 2019; Fortson et al., 2016). The WHO SDOH Framework, CDC resources, and four baskets framework from the narrative initiative were integrated into the project with the goal of increasing LHDs' integration of health equity into their primary prevention efforts. These resources were provided to partners during a combination of planning meetings, on-going phone calls and meetings, and trainings.

The primary theory of change for this project was that increased attention to SDOH and ACEs via transformational narrative change would lead to increased support for the primary prevention of ACEs and substance use among LHDs, their partners, and, in the long-term, their broader communities. A mixed-methods evaluation of these efforts was informed by two primary process evaluation questions: (1) what are the strategies that LHDs use to shift the narrative around substance use and ACEs, and (2) what are the training and assistance needs for implementing a transformational narrative intervention? Lessons learned from these evaluation findings could lead to a better understanding of community and organizational processes for LHD racial and health equity efforts; facilitators and barriers to the implementation of racial and health equity efforts; as well as informing future racial and health equity efforts for the primary prevention of ACEs and substance use.

METHODS

Sample

Sites were selected based on previous work with MPHI and NNPI. All three sites in the Midwest experienced high rates of hospitalization and mortality related to opioids or other substance use. The three sites were in urban areas with populations above 300,000. They were also racially diverse with non-White populations greater than 40%. However, the three sites differed in terms of their LHD representation: (1) one site had sole representation from a city health department; (2) one site included representation from the city and county health departments, and (3) one site had sole representation from the county health department. Staff involved in the project from the LHDs had a range of professional backgrounds, experiences, and roles, including health educators, community outreach coordinators, and program managers. The average tenure for associated staff ranged from 1.5 years to 22 years (mean = 7.9 years). All evaluation protocols were reviewed and approved by the Institutional Review Board at MPHI.

Implementation efforts

During the initial year of implementation, project staff from LHDs and their partners were separately engaged in a series of in-person training sessions held by MPHI on SDOH as root causes and the intersection with ACEs and substance use. These trainings were intended to ensure project staff from LHDs and their partners had the same grounding in research on ACEs, SDOH, and substances use; build relationships between the LHDs, their partners, and the agencies providing technical assistance; and supplemented one-on-one technical assistance provided by MPHI. These trainings included the staff from the LHDs and 15–25 of their key partners (e.g., other nonprofits or organizations addressing ACEs and substance use).

During Year 2, LHD project staff were asked to place more emphasis in their work plans on informing narrative as a strategy for addressing SDOH as shared risk/protective factors for ACEs and substance use (Metzler et al., 2021, 2017; National Association of County and City Health Officials NAACHO, 2018; National Network of Public Health Institutes NNPHI, 2022; Tanner et al., n.d). CDC, MPHI, and NNPHI facilitated a series of virtual training sessions on evidence-based policies that impact SDOH from CDC technical packages (CDC, 2019; Fortson et al., 2016) and an in-person training for LHD project staff on strategies to deepen relationships and inform narrative. These trainings included state and municipality specific data, evaluation tools, and resources for improving racial justice and health equity. During these trainings the sites engaged with their partners in a series of activities to identify dominant narratives and alternative narratives that could be disseminated through LHD efforts, including the four baskets framework. Table 1 outlines a synthesis of the new narratives created across sites. Figure 1 contains a high-level overview of how the four baskets framework was adapted for this project.

In March 2020, activities had to be modified to address social distancing procedures and public health recommendations associated with the Novel Coronavirus Pandemic, primarily shifting in-person events (e.g., trainings, community meetings) to being conducted virtually,

changing or canceling activities that could not be conducted virtually, and increasing flexibility for LHD staff assistance in response to the pandemic. Year 3 primarily consisted of direct assistance via virtual team check-ins between project staff from the LHD sites and the technical assistance providers with evaluation efforts led by MPHI.

LHDs were each awarded approximately $100,000 annually to implement strategies (Table 2) for the primary prevention of ACEs and substance use, including the integration of strategies for addressing racial and health inequity that highlighted the importance of achieving equitable outcomes and investing in communities for the primary prevention of ACEs and SDOH (see Table 2). LHDs were encouraged and provided technical assistance (e.g., facilitated conversations) to increase partnerships with relational organizers and community-based organizations. The purpose of these connections was to identify innovative ways that LHDs could inform community efforts (e.g., sharing data and message framing), and vice versa (e.g., building connections with the community and holding joint events).

Starting in Year 2, the project team hired two community liaisons with experience working in the communities and training in facilitation (e.g., meeting planning, dealing with difficult conversations, creating safe spaces), as well as being residents of the communities where the work was being conducted. These two facilitators served as a bridge between the partners' local communities, the funding agencies, and the evaluation team at MPHI beginning in Year 2. They assisted with planning, communication, building consensus for achieving project outcomes, and strengthening relationships between LHDs and community organizations.

Data sources

Process data—MPHI maintained process data documenting project implementation throughout the course of the intervention and evaluation. Documentation included site work plans; quarterly and annual reports; and detailed minutes from regular planning and technical assistance meetings with local health department grantees and community liaisons. Table 1 outlines the activities implemented by site and by narrative change strategy. Project staff from LHDs also used Research Electronic Data Capture or *REDCap*, a web-based software specifically designed to collect data for research studies, to request additional technical assistance and capture tailored implementation approaches (Harris et al., 2009).

Local evaluation plans—MPHI worked with LHD staff to develop specific local evaluation plans (Supporting Information). The MPHI team, with the support of community liaisons, facilitated conversations with each site to help the LHDs think about (1) how their activities were related to the goals of the project, (2) how these activities would be evaluated to inform narrative, and (3) how feasible these activities (including data collection and documentation procedures) would be within the project timeline. Evaluation plans reflected the four baskets framework from the narrative initiative. LHD work plan strategies and activities were categorized by the four baskets framework, and subdivide strategies and activities by audience (e.g., within one's organization, with their partnerships and collaborations, the local community, and general population) to identify areas of expected

change. Evaluation plans also captured LHD efforts to develop new and deeper partnerships with community members, groups, and organizations most impacted by the issues.

Qualitative interviews—The 10 interviews across all three sites focused on learning from the LHD staff engaged in the project ($N = 8$) and community liaisons ($N = 2$) who played a role in supporting the project. Interviewees were asked to (1) reflect as an individual public health professional on their role supporting the project and the extent to which their participation impacted them, (2) discuss how community partnerships shaped the work and their perceptions of what limits or supports public health departments in creating meaningful community partnerships, and (3) share their thoughts related to informing narrative as a strategy for public health departments to employ—its utility, potential challenges to implementing, and perceived impacts of the work.

Individual end-of-award site reporting tool—An individual end-of-award site reporting tool was created to gather information needed for site-specific reports. Respondents were asked to describe, reflect, and expand on their progress toward the stated goal of the project as well as to provide any insights related to best practices, challenges, and lessons learned from their work. Respondents were requested to respond to targeted, strategic closed-ended and open-ended questions across five sections (*Overview of the Grantee Organization [Local Health Department], Partner Organizations, Narrative Change Process, Building Capacity and Technical Assistance, and Overall Perspective on the Projec*t) for the LHD staff and four sections (*Overview of the Partner Organization, Involvement in the CDC-ACEs/Substance Misuse Narrative Change Project, Capacity Building, and Overall Perspective on the Project*) for their community partners. These sections included questions on their organizations, partner information, the narrative process, capacity building and technical assistance, and overall perspectives on the project. A total of 25 responses were collected: 8 from LHD project staff and 17 from their community partners.

Data analysis

The analytic team used a mixed-methods approach to triangulate results across the multiple data sources described above (Rutherford et al., 2010). Quantitative data was reported descriptively, both combined and by site. Qualitative data, including interviews and open-ended survey questions, were double coded. Codes were both deductive and emergent. Interviewers also debriefed at the end of interviews and documented thoughts and insights from the interviews. Three coders were involved in the analysis of interview transcripts, and two coders were involved in the analyses of open-ended survey responses. Analytic memos, or reports, were created for each code, based on coding output and review of interview notes. Qualitative and quantitative results were cross-checked with each other, as well as process documents (e.g. meeting notes, quarterly reports, etc.). Finally, the analytic team conducted "member-checking" with local partners, giving them the opportunity to provide feedback on the evaluation plans and results. Member checking ensures that the evaluation results are consistent with the experiences of implementing and that findings appropriately reflect local experiences. Results described (1) dominant narratives LHDs identified, new narratives

created, and implemented narrative change strategies; and (2) the training and assistance needs of LHDs for implementing a transformational narrative intervention.

RESULTS

Identifying dominant narratives, creating new narratives, and implementing narrative change strategies

Dominant narratives—During narrative workshops, project partners reported that in the context of the current opioid crisis, dominant narratives within and about primarily White people, centered around prescription abuse and what frequently has been referred to as "diseases of despair" (Friedman & Hansen, 2022). However, partners felt a different narrative existed for Black and brown communities. While dominant narratives suggest that "White people accidentally get addicted" to opioids, it also suggests that Black people become addicted to drugs because they "made bad choices." Following that logic, addiction should be "treated" for White communities but "criminalized" in Black communities. Project participants, especially residents of racially segregated communities, expressly addressed how this narrative contributed to structural racism and the lived experiences of historical and ongoing trauma, including the multiple impacts of the 50-year war on drugs such as economic disinvestment, poorly funded schools, intergenerational poverty, lack of access to opportunity, and mass incarceration (Friedman & Hansen, 2022). Because of the racialized dynamic of narratives on opioids compared to "drugs," project partners explicitly chose to focus on preventing *substance use*, as opposed to focusing only on opioid use. Furthermore, while there was general agreement that primary prevention and addressing social determinants of health and ACEs was critical, so were secondary prevention models, such as harm reduction, access to treatment and care, and trauma-informed services, given that many communities faced ongoing exposure to trauma and significant barriers to care and healing.

Transformational narratives—In the workshop sessions, participants worked together to identify and create transformational narratives around substance use, childhood adversity and social determinants of health. Table 2 documents the cross-site narrative created after the workshop. Individual sites then created their own narratives specific to their community. Across all three sites, new narratives focused on collective responsibility for preventing and addressing substance use, the role of trauma, and racism. Instead of focusing on individual blame, narratives highlighted the importance of community-level support for both healing journeys and structural change.

Narrative change strategies—Table 2 outlines the narrative change strategies implemented by LHD by number of sites and by the four baskets framework. For example, health departments used narratives to prioritize the prevention of ACEs within Community Health Improvement Plans to encompass strategies related to training, school partnerships, and early interventions. Other examples of strategies included communication campaigns highlighting health and racial equity in the context of ACEs and substance use, trainings for partner agencies, youth-led summits to address substance use, and awareness campaigns. LHDs also used a variety of digital platforms to engage with residents in their communities.

Examples included recording videos of personal stories, updating webpage content with new narratives, and engaging community members and partners through virtual town halls that increased understanding for improving access to housing, education, and employment opportunities.

Perceived impact—Through collaborative work between LHDs and their partners, three of the four LHDs arrived at a similar reframing of the cause of substance use: from a focus on the individual-level, with associated stereotypes and stigma, to substance use as a systemic problem in need of systemic solutions. LHDs deployed new strategies, most prominently communication efforts, that have and will continue to impact surrounding communities. One LHD not only updated their organizational website to include information on ACEs and substance use, and together with their partners also created six educational video episodes to highlight the interconnections of ACEs, trauma, healing, and systemic adversity with the larger community. Another site conducted virtual and in-person community engagement events to advance equitable, trauma-informed care, and practices to interrupt cycles of addiction and violence, support survivors, and heal roots of trauma. Additional evidence of progress included new pilot projects to provide mentorship, increase youth engagement and promote resilience, and encourage more trauma-informed responses from schools and public safety organizations. Finally, one site was able to partner with relational organizers to share data on the impact of the opioid epidemic on the local community. These types of successes may help mitigate the harms created by health inequities and provide partner organizations new insights and strategies for the primary prevention of ACEs, substance use, and SDOH. Thematic analyses identified several facilitators and barriers to implementation of narrative strategies.

Barriers and facilitators to implementing narrative change strategies

The importance of partnerships for narrative.—The sites had varying degrees of prior relationships with community-based organizations including community organizers and other nonprofits, and organizations from other sectors. Engagement with community partners provided greater grounding in the needs and issues experienced by community members, as by dominant narratives and articulation of new narratives. The LHDs varied in terms of the actual number of partners who were involved in the project from six to eight, for a total of 27 partners across the sites. The type of organizations the partners came from varied with the most cited being human and social services providers/organizations, closely followed by community-based organizations and neighborhood groups including community organizing organizations. The least common type of partners was in the categories of public safety, law, and justice organization and foundation/funding organization.

While the sites might have other partners in their projects, only partners who had some involvement in this project were included in the analysis. Most partners were also partners for other past or ongoing projects. Almost all the partners attended meetings and/or participated in education and training sessions. While all the sites engaged in the traditional public health community engagement activity of educating and informing, the sites also indicated some extent of higher-level collaborative work with their partners, including aspects of joint decision making. More than half were also actively involved in helping

design and implement project tasks and providing feedback and inputs to the LHD. Over 40% of partners even collaborated in the creation and/or translation of new narratives. Additionally, two of the sites specifically reported new collaborations (i.e., data sharing and partnering for events) with community organizers because of this project. Once invested in partnerships, LHDs wanted to continue these partnerships for future efforts.

Having the right people at the table: LHDs considered their community partners great assets to the work. They recognized the community partners as being relatively nimble and quick to respond to and engage community members. They leveraged their partnerships to identify gate keepers in the community to help spread the message about their work, as well as the champions in the community that could move the project farther. The community partners, in turn, appreciated their partnership with the LHDs and what can be accomplished by working together.

Many of the LHD project staff acknowledged that senior leadership at their respective departments were supportive of the project; however, direct involvement waned after a few months of project implementation when the emergence of the COVID-19 pandemic demanded precedence. Most of the LHD staff engaged with this project felt that having leadership engaged more consistently throughout the entirety of the project would have facilitated further accomplishments. While leadership buy-in was important, the LHD staff that did the groundwork were also critical.

Shared language matters: LHDs and community partners described the impact that speaking differently about aspects of the efforts had on the project. Training sessions, partner meetings, community meetings, and other partner and LHD staff engagements provided the opportunities for LHD project staff and their partners to develop a shared language and understanding of the project, including ACEs and health and racial equity. These were opportunities to shift practice and focus by intentionally choosing words to convey the same meaning to different audiences, and to develop a shared language, rather than agency, academic, or industry-specific jargon. Community partners, for example, identified that what they had been working on for some time was related to the “ACEs” construct.

Training events: LHD project staff started this project with varying degrees of community engagement experience, understanding of ACEs and SDOH and their relationship to substance use, and familiarity with narratives related to ACEs and substance use. Throughout the project, LHD project staff asked for support and guidance for project work and on other related concepts (e.g., evaluation planning). While the four baskets framework from the narrative initiative helped LHDs understand narrative, most of them acknowledged the difficulty of informing narrative in their own work. The majority, 78%–86%, of respondents (n = 14) across the three sites, agreed or strongly agreed that the initial narrative workshop helped them gain new insight, enhanced skills, and was applicable to the work with which they were engaged. Additional topics where LHD staff requested technical assistance included ACEs, SDOH/root causes, health equity, racial justice, substance use, COVID-19 assistance, virtual tools or resources, data collection and analysis/other

evaluation activities, and community engagement/collaboration. All three sites requested assistance on narrative and data collection, analysis, and other evaluation activities.

Partner agencies in attendance at training events included community members, representatives of faith-based organizations, public safety, health department staff, recovery support service and treatment stakeholders, teachers and school personnel, social service agencies, and businesses. Participation in the training sessions on narrative and the elements of the narratives (e.g., ACEs, SDOH, health equity, racial justice, etc.) also extended to the larger local health department staff, such as frontline professionals, persons with lived experiences, and organizers, suggesting at least partial diffusion across the public health system. Additionally, the training events and structured learning sessions were generally rated positively by the participants in qualitative feedback.

Community liaisons: Community liaisons met with LHDs one-on-one; facilitated meetings between LHDs, community organizers, and the project management team; attended evaluation meetings with MPHI and the LHDs; assisted LHDs in planning and implementing their activities including designing and conducting data collection activities; bridged relationships between LHDs and their partners and other members of the community; and provided overall support to the LHDs. The project staff from LHDs were asked to rate their experience with their respective community liaisons. All three sites agreed or strongly agreed that the community liaisons provided necessary support, three sites strongly agreed that the liaisons were responsive, and two sites agreed that the facilitators contributed to project accomplishments. Specifically, sites mentioned the importance of the liaisons' facilitation skills: "amazing facilitation skills and is able to hear everyone's thoughts and opinions without judgment and helped us move our activities along…she honestly has done a lot of the guiding work for us."

The LHD staff described the community liaisons as having the following qualities and strengths that made them effective in their roles in this project: (1) knowledgeable about health equity and narrative, (2) extensive community knowledge; (3) acted as "bureaucracy translator" and mediate communication/liaise between the LHDs and the different kinds of partners; (4) served as thought partners in identifying possibilities, and (5) helped LHDs tackle unanticipated issues. Their combination of lived and professional experiences was a pivotal nexus point between community members and LHDs for developing activities and messages.

DISCUSSION

LHDs have an important role in promoting health and racial equity as part of comprehensive strategies to address the interconnections between ACEs, trauma, and substance use and to promote primary prevention of these health outcomes. The *Comprehensive Community Strategies for the Primary Prevention of ACEs and Substance Use Project* helped to support LHD innovation in the development and implementation of new strategies to highlight system and community-level solutions (CDC, 2019; Dahlberg & Krug, 2002; Fortson et al., 2016) to address historical racial and health inequities. Research suggests that narratives around opioids (and substances in general) are often different based on

race (most profoundly), economic class, gender, geography, and other demographics of the person/people who are using substances (Netherland & Hansen, 2017; Santoro & Santoro, 2018). In narrative workshop sessions, comprised largely of community members marginalized by race and economics, participants identified the same pattern. These strategies included creating new media content, implementing new community engagement events, informing new narratives with ongoing projects, as well as strengthening existing and new partnerships.

Findings highlight promising strategies and approaches that LHDs can use to engage in transformational narrative efforts, primarily the four baskets framework. The four baskets framework may help LHDs create, translate, deploy, and observe narratives within their local communities (Weidinger, 2020). However, resources that highlight evidence-based interventions and social determinates of health may also be important for ensuring the implementation of strategies that address historical inequities using interventions that have evidence of impact. Their remains limited evidence of community-level interventions that can increase support for the prevention of ACEs and substance use. Narrative is a promising approach that may help fill this research gap. Future research could consider other models for narrative change implementation, as well as the impact of narrative change on other health outcomes. Transformational narrative interventions should consider the importance of local and historical context, both for implementation and evaluation.

Furthermore, narrative change efforts may be an important component of implementing comprehensive strategies for the prevent ACEs and substance misuse. The community ACEs project explicitly identified and examined current dominant narratives and how they could harm communities at disproportionate risk for ACEs and substance use (Klevens & Metzler, 2019; Metzler et al., 2021). By unpacking the dominant narrative, communities can better develop and implement ACEs and substance use prevention strategies without reinforcing stigma or discriminatory attitudes toward communities that have been historically marginalized. Strategies that unpack the dominant narrative can be useful for strategic planning, program implementation, health messaging, and even considered throughout the evaluation process.

Partnerships and LHD leadership support emerged as important facilitators during a challenging project period. An impetus for this project was a growing recognition of the interconnections between the overdose epidemic and ACEs (Merrick et al., 2020). Approximately 1 year into the project implementation, the COVID-19 pandemic emerged as a major public health concern that impacted how public health resources were used. The pandemic also directly or indirectly changed the way LHDs engaged with the project (e.g., limiting or stopping in-person meetings; Hall et al., 2022). Approximately 18 months into the project period, national protests for racial justice brought increased attention to the need for addressing racism in public health (Bassett, 2020). Thus, the implementation context of this project occurred during a unique period of time in the United States. Some of the impacts of these events were readily observable and managed within the project (e.g., shifting to virtual meetings); however, the impacts from other events may be more nuanced, such as changes in how the public or agencies perceived and addressed issues of racial

justice or health equity. Thus, findings from this project may not be applicable to future LHD efforts.

However, these findings help to highlight important facilitators to shared efforts for implementing transformational narrative change efforts. Transformational narrative change is a relatively new framework for helping communities to create, translate, deploy, and observe narratives that can help increase support for the primary prevention of ACEs and substance use. Many of these facilitators, such as strong partnerships and shared language, have been identified in previous evaluations of community-level strategies, with findings from this project suggesting that they may be important for transformational narrative efforts as well. While this project considered transformational narrative efforts in the context of ACEs and substance use, evaluation results may help inform future efforts around other health topics or other areas related to SDOH.

This is not the first project to consider narrative as a potential tool in addressing systematic health issues. Similar efforts have been considered for both child abuse and neglect (Klevens & Metzler, 2019) and youth violence (CDC, n.d). More efforts are needed for evaluating these types of narrative based intervention and comparing findings across studies with the goal of building a science of narrative change and developing practical guidance for communities interested in narrative change efforts. While many components of a narrative-based intervention are likely to be idiosyncratic, reflecting the needs of the local communities and specific outcomes of interest, it is likely that there are comparable implementation strategies or lessons learned that could be informative across projects and communities.

In addressing the science of narrative change strategies, it is important to consider other similar frameworks that center the voices of communities that have been historically marginalized, such as community engagement and community-based participatory research (Wallerstein et al., 2018). Narrative efforts are unique in that they explicitly consider the importance of addressing community voiced with the goal of addressing structural barriers to the implementation of strategies and interventions that are likely to mitigate health inequities. Thus, narrative change is complementary with community engagement and community-based participatory research, but the focus on SDOH is unique.

Limitations

While this project highlights some important lessons learned for implementation of health equity efforts in LHDs, we were not able to observe the impact of the new narratives on community partners beyond those agencies directly involved in this project likely due to the relatively short project period. Therefore, we cannot make inferences about the effects of the project on community-level changes. More rigorous, long-term evaluation is needed on strategies for promoting health equity at the community-level, particularly protective factors that are likely to build community resilience, promote the primary prevention of ACEs and substance use, and address many drivers of health inequities (e.g., housing, transportation, disparities in healthcare access; CDC, 2021a). Relational organizing strategies implemented in this project (e.g., leadership development, virtual and in-person community events) may complement traditional public health approaches that emphasize partnerships because of the

approach relational organizers take to achieving systems change by building social capital and power for communities that have been economically or socially marginalized. Social capital and empowerment have been described with systemic change across a variety of domains and health outcomes (Christens et al., 2021).

Evaluations attempting to better understand narrative efforts should consider that partnership, implementation strategies, and cyclical nature of narrative efforts. The four baskets framework explicitly lays out the way the creation, translation, deployment, and observation are a process in which the narrative is adapted for different purpose (Weidinger, 2020). Therefore, evaluations that seek to understand and model the narrative translation and deployment process should be attentive to this translation process. The attention to translation is particularly important as the narrative process will likely be influenced by the broader organizational goals and community context in which the narrative is deployed. Qualitative, mixed-method, and multi-informant evaluation strategies maybe most apt to capture the nuance of narrative change process.

CONCLUSIONS

Supporting narrative change efforts at the local level is not a static process (Tanner et al., n.d). The culture, organizational norms, values, and priorities of LHDs reflect the communities they serve. Narrative-based efforts to promote and inform racial and health equity strategies in LHDs may consider the unique local context and characteristics of a community and provide flexibility to help promote a range of public health strategies, while also informing efforts to address historical inequities (Tanner et al., n.d). Findings from this project demonstrate key lessons including the importance of partnerships, developing a shared language, and supportive training for advancing collaborative approaches between LHDs and community members in advancing narrative change efforts. Collaborative approaches to narrative change could increase opportunities for all people to sustain and attain higher levels of health.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Highlights

- Local health departments strategies to promote health equity and inform narrative are important.
- Training and technical assistance are important for helping community partners understand narrative.
- Successful implementation of narrative efforts included leadership support and strong partnerships.

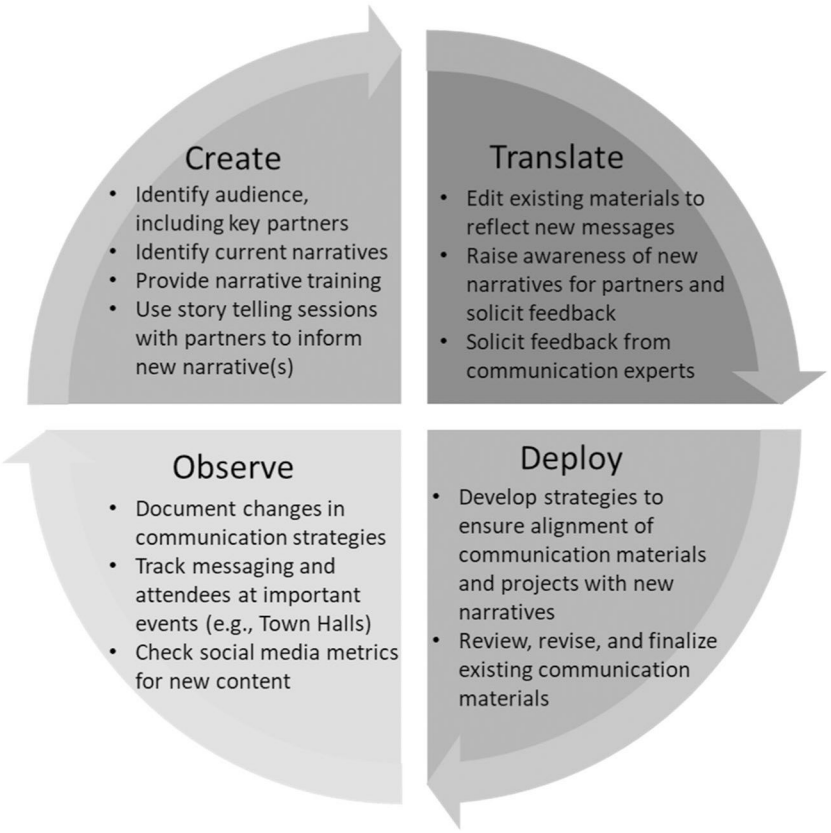

FIGURE 1.
Adapted four baskets framework for narrative implementation from narrative initiative (Weidinger, 2020).

TABLE 1

Cross-community narrative synthesis.

All children, families, and communities deserve the chance to live full, meaningful lives. People deserve unconditional basic supports, opportunities and conditions to thrive, no matter where they live, who their parents are, or the color of their skin.
Substance use is a response to pain: Physical, emotional, and/or mental. Individuals struggling due to the impacts of trauma and/or disability are more likely to turn to substances. Reducing pain and trauma will reduce substance use.
If we prevent oppression, abuse, and trauma, we prevent substance use. Preventing adverse childhood events can break the generational cycle of substance use. We can create the conditions where all children can thrive.
Substance use is a symptom of a much bigger problem. The real problem is political and structural. People who misuse substances often face poverty, institutional oppression such as racism and mass incarceration, trauma and other forms of abuse.
People with substance use disorder (SUD) deserve dignity, care, treatment, and the ability to use safely. People and families dealing with SUD deserve to be treated with love, kindness, and, respect. People who use substances are able to love and be loved. They can be successful community members and parents.
We are all in this together. Everyone has a part to play in reducing the stigma attached to SUD. Families, friends, and communities can support people in recovery. We can all play a role in preventing substance abuse.
Economic prosperity should be attainable for all people, no exceptions. Each individual should have access to a good paying job, adequate housing, food, education, medical care, and occasional vacations.
The community has a collective responsibility to ensure that all children and families can thrive. We can create systems so that all can benefit. We can use our government to create the conditions for all to thrive. We can and will do better for, by and with each other.

TABLE 2

Narrative strategies implemented organized by four baskets framework with number of implementing sites.

	# of sites
Articulating dominant narrative(s)	
• Reviewed existing policies and what the narrative is indicated in the policies	1
• Conducted structured data collection activities with partners and other community members to get baseline knowledge of partners regarding ACEs, opioids use and addiction; identify what the dominant narrative is, unpack what this narrative means to them (i.e., surveys and focus group discussions).	3
• Engaged coalition and community members via discussions, and presentations	4
• Conducted listening sessions and testimonials	1
• Conducted presentations aimed at educating on how to identify dominant narratives, how framing issues can impact narrative, health equity, on ACEs	1
Creating new narrative(s)	
• Identified key stakeholders for participation in creation and dissemination of new narrative from within their own organizations and among their community partners and coalitions	4
• Invited LHD leaderships and other key stakeholders to attend CDC narrative workshops	4
• Met internally with program managers and leadership who were working on other ACES related initiative to discuss their respective programs	1
• Hosted the CDC presenting SDOH/ACES through a webinar that was open to staff and the community at large	1
Shared project activities with leadership, internal and external task forces and workgroups Served/participated on various internal and external task forces, workgroups, coalitions and initiatives	3
• Conducted collaborative workshops with partners, worked with partners on creating new narrative (through zoom meetings, story- telling sessions facilitated by the community liaison, and various phone calls)	2
• Crafted a letter that was presented to the Health Commissioner expressing their desire to continue working closely with their partners at another health department on creating a narrative to be uplifted in the collective region as opposed to developing competing narratives	1
• Partnered with another health department to create a new narrative; determined shared messaging	2
Translating new narrative(s)	
• Reviewed and edited current ACEs materials to reflect new narrative and incorporate into new materials	1
• Connected the leads of each program with the health commissioner and medical director to bring awareness to each of their respective projects; also, to have the leadership team to help deploy new narrative to staff	1
Provided training specifically to LHD staff on racial and health equity and SDOH, on ACEs and trauma and on substance misuse. Held agency meetings to discuss current narrative and what narrative means.	3
• Conducted listening sessions, focus groups, photovoice projects, testimonials, infographics	2
Brainstormed with community organizing team and conducted sessions with community liaison to review questions around narrative. Provided specific training to key partners in the community including other partner agencies on racial and health equity and SDOH, on ACEs and trauma, substance use—and other concepts relevant to the new narrative.	2
• Partnered with messaging and communication experts, and worked with the local agencies on communication strategies	1

	# of sites
• Worked with current members in coalition to identify additional partners and community gatekeepers to work with, engaged with them and provided training to help build trust and excitement around the narrative change—with the goal being that when the new narrative was ready for dissemination there is already buy in to spread the new narrative throughout the communities	1
• Identified audiences and community agencies to work with, reviewed education session materials, thinking about what messaging their agencies offer when discussing substance use disorder and ACES	1
Deploying the new narrative(s)	
• Updated a webpage to include SDOH emphasis around ACEs and substance use disorder	1
• Created educational video series to move new narrative forward with their partners, including through storytelling by community members who have overcome traumas and found healing. Mental health, substance use disorders and domestic violence are a few of the topics that are explored throughout the series.	
• Conducted training on ACEs, substance use, harm reduction, drug endangerment, intimate partner violence; town halls on COVID including racial disparities and vulnerability of persons with substance use disorder(s); digital storytelling, public education campaign, capturing opinions of community members regarding movements, local and national issues	1
• Provided trainings to LHD staff and community partners on racial and health equity, SDOH, on ACEs and trauma, on substance misuse—and other concepts relevant to the new narrative	2
• Implemented a pilot project to increase childhood resiliency through arts enrichment and parent knowledge around ACEs and trauma	1

Abbreviations: ACEs, adverse childhood experiences; SDOH, social determinants of health.