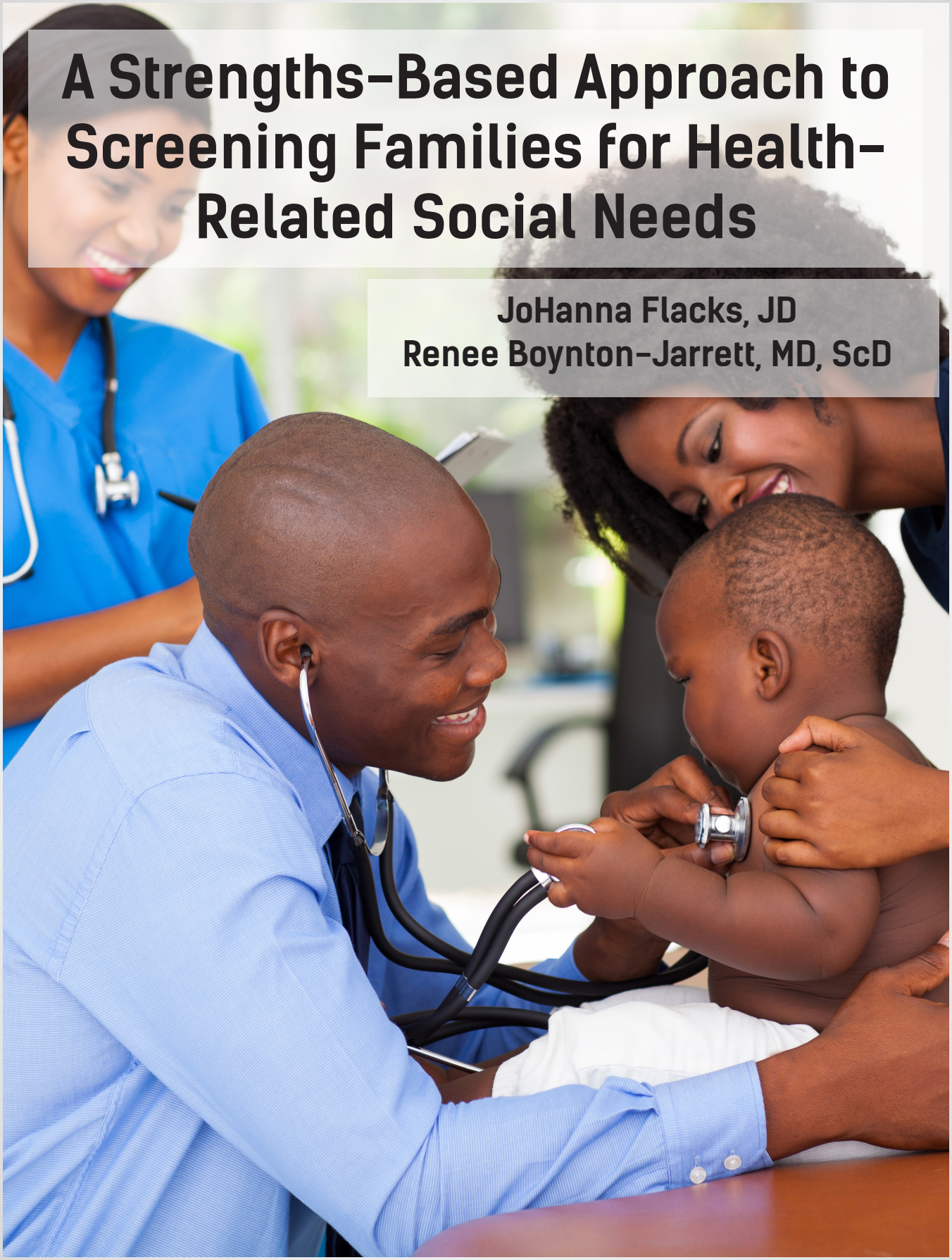
A Strengths-Based Approach to Screening Families for Health-Related Social Needs

JoHanna Flacks, JD
Renee Boynton-Jarrett, MD, ScD



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A. Introduction

In the healthcare field – especially in pediatrics – significant work is being done to refine screening approaches to detect health-related social needs (HRSN)[i,1] and to develop effective strategies to help meet families' needs when they are identified.[2] Whenever screening is undertaken, it is critical that families are respected and not diminished in the process.

This brief builds on recent scholarship on how to avoid unintended consequences when screening for health-related social needs[ii,3] and presents six recommendations for operationalizing a strengths-based approach to such screening. These recommendations are informed by the *Strengthening Families* framework[4] and the five Protective Factors that serve as its foundation.

When the Centers for Medicare Services and Medicaid Services (CMS) unveiled its *Accountable Health Communities* program in 2015, it coined the term "health-related social needs" and prioritized the following five domains, representing a core subset of social determinants of health:[5]

- Housing instability;
- Food insecurity;
- Transportation needs;
- Utility needs; and
- Interpersonal safety.

Strengthening Families

Strengthening Families™ is a research-informed approach to increase family strengths, enhance child development and reduce the likelihood of child abuse and neglect. It is based on engaging families, programs and communities in building five protective factors:

- *Parental resilience:* Managing stress and functioning well when faced with challenges, adversity and trauma including historical family and community trauma.
- *Social connections:* Positive relationships that provide emotional, informational, instrumental and spiritual support.
- *Knowledge of parenting and child development:* Understanding child development and parenting strategies that support physical, cognitive, language, social and emotional development.
- *Concrete support in times of need:* Access to concrete support and services that address a family's needs and help minimize stress caused by challenges.
- *Social and emotional competence of children:* Family and child interactions that help children develop the ability to communicate clearly, recognize and regulate their emotions and establish and maintain relationships.

Using the Strengthening Families framework, more than 35 states are shifting policy and practice to help programs working with children and families focus on protective factors. States apply the Strengthening Families approach in early childhood, child welfare, child abuse prevention and other child and family serving systems. For more information, visit www.strengtheningfamilies.net.

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[i] The term Health-Related Social Needs (HRSNs) refers to non-medical factors that drive health care utilization and impact health outcomes. The Centers for Medicare & Medicaid Services (CMS) *Accountable Health Communities* Model supports promising service delivery approaches aimed at linking beneficiaries with community services that may address health-related social needs in five domains (i.e., housing instability, food insecurity, transportation difficulties, utility assistance needs and interpersonal safety).

[ii] These principles include: 1) Ensuring that HRSN screening is person-centered; 2) Integrating HRSN screening with referral and linkage to community-based resources; 3) Screening within the context of a comprehensive systems approach; 4) Not limiting screening practices based on documented or assumed membership in particular social groups; 5) Acknowledging and building upon family strengths.

These areas – especially as they relate to food, energy, and housing security – coincide with the "concrete supports" protective factor prioritized in promoting family strength and stability.

The six recommendations are as follows:

1. *Involve families and communities in the development of screening tools and protocols.*
2. *Screen for both risk factors and protective factors.*
3. *Set person-centered screening priorities within the universe of health-related social needs.*
4. *Ensure that screening is conducted by care team[iii] members trained and supervised in strengths-based approaches.*
5. *Recognize that screening for health-related social needs is not risk-free for families, and proceed accordingly.*
6. *Acknowledge family-level risks and strengths in a broader historical context.*

The association between poor health and a person's social context – including socioeconomic status[6] (specifically, poverty) and racism[7,8,9] -- is well-established. When social determinants of good health are optimized, a family has consistent access to:

- Safe and stable housing;
- Adequate, nutritious food;
- Economic and job opportunities;
- Health care services;
- Quality education and job training;
- Transportation options;
- Communication and information technology;
- Recreation activities and culture; and
- Public safety.[10,iv]

Poverty limits access to many of these resources, and can have a substantial harmful impact on child health and well-being. In the U.S. in 2015:

- Twenty-one percent (one in five) of all children under 18 years of age lived in a family with income below the poverty level – which in 2015 was $24,036 for a family of four with two children;
- Forty-three percent of all children under 18 years of age lived in low-income families (defined as households with incomes at or below 200 percent of the federal poverty level);
- Over 60 percent of Native American, Black and children lived in low income families, compared with thirty percent of White children; and
- Over 30 percent of Native American, Black and Latino children lived in families with income below the federal poverty level, compared with 12 percent of White children.[11]

The disproportionate prevalence of poverty among children of color compounds racial and ethnic health disparities. This intersection is especially profound in the context of residential racial segregation.[12]

Screening for health-related social needs presents unique opportunities but also challenges, both for care teams and families. Pediatric practices now are equipped with a range of social needs screening tools to choose from,[13] but often lack a framework for how to assure that each screening encounter is effective, high-quality and family-centered. The stakes are high. Questions about social needs may cause families to feel that they are being blamed for having these needs or that they should be ashamed of their social circumstances. They may fear that acknowledging their needs could trigger serious consequences, such as having their child removed from their care. Yet effective screening is essential to identifying a need for specific concrete supports, potential barriers to those supports and connecting families to resources and services.

At the family level, resolution of these needs can prevent individual and family crises and promote optimal health and family stability. At the system level, successful social screening encounters – above and beyond traditional clinical and behavioral health screening interactions – can improve care quality and contain costs by detecting drivers of unnecessary healthcare utilization, such as harmful housing conditions. It is critical that screening families for health-related social needs be done in a way that builds rather than undermines trust with families and honors the agency of caregivers in problem-solving.

The adverse consequences of child poverty extend into adulthood and negatively impact population health and the vitality of our society.

[iii] We use the term "care team" to encapsulate all members of the healthcare and allied health workforces charged with collaborating to meet patients' needs – both in general, and with regard to HRSN in particular. Screening responsibility may vary within and across teams, and depending on circumstances may reside with a pediatrician, a nurse, a social worker, a patient navigator, a *promotora de salud*, or any number of other job titles under the emerging "Community Health Worker" umbrella.

[iv] This is in addition to freedom from health-harming factors including concentrated poverty, discrimination, language barriers, racial segregation and social isolation.

B. Screening Families for Health-Related Social Needs in Ways that Acknowledge Their Strengths: Six Recommendations

The field of pediatrics is in the vanguard in terms of adopting and implementing formal social needs screening protocols.[14,15] This leadership reflects recognition of the long-term consequences that adversities early in life can have on health and social mobility over the life course.[16] Both screening for social needs and connecting families with appropriate resources can be enhanced by using a strengths-based approach that can inform a variety of child health and well-being interventions. These six recommendations can guide strengths-based screening:

1. Involve families and communities in the development of screening tools and protocols

Caregivers[v] are the subject-matter experts on their own lives and their children's lives. A strengths-based approach to composing screening questions and determining protocols for how such questions are posed requires that the intended beneficiaries inform both the content and the process. Caregivers should be consulted as experts on how screening questions could be perceived by families, as opposed to relying on the assumptions of care teams. This should happen before any social screening administration protocols are finalized.

Incorporating insights from community members can strengthen health-related screening and interventions.

Recommendation in Action

Practitioners in the field of Community Based Participatory Research (CBPR) incorporate insights from community members to improve the quality of screening tools, better align interventions and increase caregiver comfort with the screening process. The experience of CBPR practitioners has found that engaging community stakeholders in designing the social needs screening process can help to reduce health disparities; efforts with youth indicated improved mental health outcomes, increased self-efficacy and collective efficacy, and were associated with better school achievement.[17]

2. Screen for both risk factors and protective factors

An effective screening process designed to identify health-related social needs must go beyond screening solely for risks.[18] It must include features capable of revealing buffering strengths, or protective factors, that can identify existing family assets, strengths and social supports that can help prevent risks from becoming real needs and can help practitioners arrive at a more accurate assessment of a family's problem-solving capacities. Elevating families' strengths also can empower caregivers to take an active role in developing and prioritizing solutions.[19] For example, it is important not to assume that families need help or want help addressing every need.

Screening for strengths also helps address a common concern raised by providers when considering screening for social needs: "fear of the empty toolbox." Providers may find it problematic to imagine identifying needs, without having the ability to connect families to appropriate assistance or resources. This can result in no screening at all, or referring families outside the practice for such screening. As an illustration, rather than screening only for risk of social isolation with a question that asks about isolation on an agree/disagree scale, strengths-based screening by pediatric clinicians and staff can provide an opportunity to engage caregivers in the process of mapping their social network. This invites them to consider, for example, who might help them if they needed a babysitter on short notice in order to make it to work on time. While this approach can reveal true isolation

[v] Families are diverse. For clarity we use the term "caregivers" throughout the remainder of this paper acknowledging that a parenting role may be played by caregivers of different formal or informal kinship statuses – including parents, grandparents, aunts, uncles, or friends of the family. The recommendations in this paper are equally relevant regardless of the relationship giving rise to the caregiver's parenting role.

requiring intensive assistance, it also can identify assets that are a source of strength for families – assets that may not have been top of mind in response to a simple social isolation question. Screening across the full strength/risk continuum increases the likelihood that the "toolbox" will not be completely empty.

Recommendation in Action

The *Child and Adolescent Needs and Strengths (CANS) Assessment Tool* screens youth over age 5 based on research findings that "optimally effective treatment of children and youth should include both efforts to reduce symptomatology and efforts to use and build strengths".[20] In its family screening *User Guide*, the CANS tool emphasizes, "Remember, this is not a 'form' to be completed, but the reflection of a story that needs to be heard." Effective screening should draw out the richness of a family's story so that a caregiver can see beyond the one dimension of yes/no questions that screen for risk, and identify sources of strength that may not have been readily apparent.

Incorporating an assessment of family protective factors into screening organically spotlights strategies that may be available to address HRSN within a network of existing familial assets, strengths and social supports.

We Care™ is an example of an SDOH screening tool that embeds this consideration in its screening framework.[21,22]

3. Set realistic, family-driven screening priorities within the universe of health-related social needs

The universe of health-related social needs is large and daunting. Given the overwhelming needs that many families face, homing in on achievable goals and next steps is critical. Pediatrics-based social screening – often conducted within the confines of a 20-minute visit – should focus on priority domains, should be realistic in scope and follow the family's lead on whether they wish to dive deeper.

In a strengths-based context, care teams that commit to a set of priority screening domains will be more able to respond meaningfully when families screen positive for those needs – especially if the prioritized domains have remedies under current law and public policy. In this way, embracing screening priorities is family-centered, realistic and efficient. Priority-setting of this kind also presents an opportunity to normalize need, empower families to contribute their own problem-solving skills and offer support.

Priority-setting has the added benefit of preserving time so that the practitioner can embrace a universal screening approach. This approach does not target particular "at-risk" families for screening and instead communicates to caregivers that all families are screened. This reduces the risk of stigmatizing or alienating families and increases the likelihood that the screening process will be successful. This means fewer missed opportunities to help, which results in more equitable help.

Recommendation in Action

Preventing "Check-list check-out":

A member of the care team says to a caregiver: "OK, sorry for rushing, I know you're busy too. I'm going to ask you a bunch of questions. Just respond yes or no:

- Any problems at school?
- Do you and your kids feel safe at home?
- Do you ever feel down in the dumps?
- Are you all set with housing and food?"

Caregivers may respond to these questions with what could be termed a "check-list check-out" reaction. Simply reframing one of these "yes/no" questions in an open-ended strengths-based way can help the caregiver check back "in" to the interaction and leave them feeling more empowered and less stressed. For example, consider this alternative script on the subject of housing stability:

"I spend a moment more on housing with all the caregivers I talk to, because many families find that the rent bill is too big and pay and benefit checks are too little. We want to help with this if we can, especially given that heating bills will start coming in, too. What strategies did you use to get by last year during heating season? Would you like to brainstorm together about what could help this year?"

4. Ensure that screening is administered by care team members who are trained and supervised in strengths-based approaches

Those who conduct social needs screening encounters with families must be strengths-based practitioners, with training and experience in the core competencies of trauma-informed and culturally effective care. Because members of the screening workforce inevitably bring varied experience – lived, academic, and professional – programs must assure that all members receive baseline (and ongoing) training on how to apply the full spectrum of Strengthening Families™ Principles. Among other strengths-based skills, trauma-informed communication with caregivers needs to be a core competency in order for screening on health-related social needs to maximize effectiveness and prevent harm.

Engaging with caregivers on subjects tied to high levels of toxic stress[23] is a high-stakes activity, both for the care

team member charged with asking the questions and the parent invited to answer those questions. While many patients may be accustomed to sharing information about their physical health, questions that delve into non-clinical areas may be disorienting or threatening. This is especially so for individuals who are members of marginalized populations that may more frequently experience these kinds of inquiries as judgmental.

Moreover, screening for health-related social needs is an important opportunity to activate the Concrete Supports protective factor with families – a specific action-oriented strategy in which caregivers can participate – as opposed to leaning unsustainably on parental resilience as a primary buffer of toxic stress. Providers need to avoid screening approaches that could seem to hold families individually accountable for adversities that have structural roots with no short-term solutions, and which therefore require families to draw upon their resilience alone.

All members of the healthcare workforce will benefit from training on culturally competent care and how to recognize and mitigate implicit bias. Appropriate training will equip providers to identify and eliminate potentially alienating lines or styles of questioning, and institute productive strategies for patient-centered engagement in the screening process. Doing so can lead to more meaningful screening results and consistent patient engagement by building a foundation of trust with families.[24,25]

One way to reduce the risk of stigmatizing or alienating families is to embrace a universal screening approach – one that does not target particular "at-risk" families for a unique screening encounter.

Cultural appropriateness is part of trauma-informed care. It requires attention to language differences between patients and providers, as well as health literacy and avoiding practices that may unintentionally undermine the dignity of families with health-related social needs. Training on trauma-informed practices addresses the impact not only of personal traumas on individuals but also of historical traumas on individuals, families and communities. This is discussed further below under Recommendations 5 and 6.

Recommendation in Action

Pediatric practices have been supported by sound best practice guidelines for some time. The Institute of Medicine has prioritized, as one of several core competencies for healthcare professionals, the recognition of culture and values as factors that influence victims' perspectives on intimate partner violence (IPV).[26] Therefore, providers should be sensitive to socio-cultural differences that influence one's willingness to disclose IPV. For example, a victim who has had traumatizing encounters with law enforcement in the past may be concerned that disclosing abuse will trigger dangerous interactions with law enforcement, for her and/or her abusive partner. Similarly, past experiences may lead to negative parent perceptions of mental and behavioral health services that might be recommended in an IPV context and difficulty with the logistics of participating in services for their children.[27] Having a history of trauma or maltreatment and belonging to a cultural or ethnic minority group are both predictors of premature disengagement from treatment.[28]

A qualitative study of 59 mothers who brought their child to the pediatrics emergency department, published in *JAMA Pediatrics* in 2002, found that with respect to screening for IPV, caregivers rated the following qualities as critical for providers: demonstrating empathy, addressing first the child's medical needs, having an organized approach, and providing services.[29] In the case of family violence, the American Academy of Pediatrics recommends providers use a sensitive and skillful manner to intervene with primary attention to the safety of the caretaker and the child.[30] However, a strengths-based framework can substantially enhance these recommended practices with support for parental resilience in the context of any intervention to mitigate social adversities. This requires patience without judgment because resilience comes from the inside. Providers can help cultivate caregivers' resilience by asking questions that (a) validate a right to safety, and (b) build a relationship of respect and trust in which an IPV victim, if she is or becomes a victim, will feel comfortable disclosing her need when she is ready.[31] Training providers and staff in these principles is critical to this kind of strengths-based screening.

5. Recognize that social needs screening is not risk-free for families

Health and human services professionals are duty-bound to protect families from collateral harm when they are taking steps to identify needs and address them. Thus, screening design must acknowledge several barriers to open dialogue between caregivers and those charged with screening them for health-related social needs:

- Caregivers may worry that by acknowledging unmet basic needs, they may be opening the door to charges of child neglect or abuse, as to which pediatricians and their clinical colleagues are mandated reporters to child protective services (CPS).[32,vi]

- Caregivers may be concerned that if they disclose unmet basic needs, they may be be viewed as "to blame" for the problem.

- Caregivers may feel that disclosing a problem with no conceivable near-term solution – such as housing instability tied to the insufficient supply of affordable housing – is simply not worth sharing, or too tied to feelings of despair to discuss in this setting, if at all.

Recommendation in Action

An example of this consideration in action draws upon recommendations regarding cultural competence and implicit bias training and acknowledgment of historical traumas.

Accounting for racial and ethnic disparities in Child Protective Services reporting:

Children who belong to racial and ethnic minority groups are more likely to be evaluated and reported for suspected child abuse in clinical settings.[33,34] Since this presents an obvious barrier to full forthrightness about serious material hardship, caregivers may forego an opportunity for concrete support in a time of need. One disparity then leads to another.

That healthcare providers are widely considered among the most trusted professionals[35] presents an opportunity – and also vests in providers a responsibility – to approach health-related social needs screening with awareness that a family's past history with CPS (whether personal or vicarious) may inhibit disclosure of social needs. Having had negative experiences with healthcare or social services, including child protective services, can be traumatizing for families, thus caregivers can be triggered by a screening intervention that may have the potential to lead to similar outcomes. Achieving this awareness through training is an important first step in preparing providers and staff for screening encounters that build trust with families, rather than undermine it.

6. Acknowledge family-level risks and strengths in broader historical context

Screening should not be limited to familial and personal behaviors, but also involve an assessment of the neighborhood environment, with attention to structural racism and other drivers of health inequities. Strengths-based social needs screening is conducted at the family level. While large-scale policy drivers of health-related social needs – such as nationwide gaps in affordable housing – will not be solved at the family level, intentional acknowledgment of factors that families likely cannot change on their own can help prevent these screening interactions from alienating families by implicitly assigning them responsibility.

Acknowledging the experiences of families, particularly contextualizing how structural violence[vii,36] and societal systems of oppression contribute to risk for chronic housing insecurity, exposure to community violence or underemployment, is validating and therefore may improve engagement in the screening and referral process. It can communicate honesty and mitigates the risk of implicitly "overpromising" by asking questions as to which there may be no easy answers. Only with a foundation of candor about root causes that reside outside the family, can trust and resilient responses be cultivated in a social screening encounter.

Strengths-based and trauma-informed advocacy calls upon care providers to consider the historical context of oppression reflected in the health-related social needs as to which screening is conducted. Adverse social settings and structural racism both are associated with family adversities and negatively impact child health, development, and social mobility.[7,37,38,39] There is indisputable medical and public health research establishing the association between social factors, neighborhood environments and morbidity and mortality. Yet, there is reluctance among many physicians to address the role of racism and consider how medical practices reinforce stereotypes.[7,36,40] Providers often contextualize health risks in relation to family systems, family history, and lifestyles. Extending this

[vi] Having outlined some perils to avoid and opportunities to seize in the effort to advance HRSN screening practice, an unacknowledged peril is letting the perfect be the enemy of the good: while refining screening tools, another generation easily could advance out of early childhood without the benefit of any HRSN screening at all, thereby missing the opportunity to benefit from useful screening tools as a preventive intervention. One bright spot to reduce that risk is the apparent higher credibility enjoyed by qualitative evidence in the HRSN domain compared with other areas of clinical research. This may afford screening tool developers purchase against the dominant research culture that holds up RCTs as the gold-standard for building an evidence base. Given that HRSN are inherently intersectional, the RCT method is too inflexible to account for the many variables affecting people's real lives.

[vii] The term 'structural violence' is one way of describing social arrangements that put individuals and populations in harm's way.

process to include the broader social context responsibly protects patients from feeling at fault, ineffective, and thus depressed, and is also an accurate representation of what is known from research.

Providers have a moral and professional obligation to avoid screening approaches and associated intervention models that may create a sense of shame, or that blame families for structural socio-economic conditions.

Poverty and trauma are disproportionately prevalent among populations in the United States that have been systematically oppressed.[41,42,43,44] The inequitable *status quo* arises from long chapters in history, law and public policy, including:

- The colonization of land populated by indigenous peoples for millennia before a border was imposed dividing today's Mexico from the southwestern US;[45]
- Enslavement of African peoples for centuries, subsequent government-sanctioned segregation of African-Americans from economic opportunity and continuing racial oppression of Descendants of Africans Enslaved in the United States (DAEUS)[36,viii] that directly drives today's widening racial wealth gap and related health inequities;[7,46,47,48,49,50]
- Invisibility and neglect of stark socioeconomic and health disparities among Asian American and Pacific Islander populations because data collection and analysis systems treat distinct populations with vastly different heritages and needs as a single group;[51]
- Disenfranchisement and reproductive control of women and increasing threats to reproductive freedom today;[52] and
- Denial of basic civil rights to LGBTQI[ix] people that persists in many states.[53]

Bearing this background in mind, failure to acknowledge the contributions of systemic inequities to health while encouraging caregivers to do more to improve their child's health can be undermining and disempowering. For a variety of reasons ranging from degree of education to seriousness of responsibility, medical professionals' opinions tend to be respected by caregivers. Thus, their affirmative acknowledgement of historical context for adversity can be a powerful way to engage caregivers around those individual actions that can be impactful.

There are a variety of ways to approach this complex task, ranging from symbolic statements to formal statements of purpose in the design of interventions.

Recommendation in Action

Creating a "safe space" for screening encounters:

In essence, calling upon providers to acknowledge a context of societal inequity serves a purpose akin to the "safe space" movement. Sometimes a visual display like a rainbow flag or pink triangle sticker communicates awareness of and rejection of bias against LGBTQI people.[54] While there is no one-size-fits-all visual that effectively communicates informed empathy across all cultures, providers can and should make an effort to do so in other ways. This can

[viii] The term DAEUS acknowledges the historical origins of anti-black racism, white supremacy, and economic and health inequities that uniquely burden Americans of African descent whose ancestors were enslaved in the United States. The DAEUS experience is distinct from that of non-DAEUS persons of African descent, including recent immigrants, whose ancestors were not survivors of the trans-Atlantic slave trade. Refer to endnote 36.

[ix] Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, and Intersex

include references supporting public health research on disparities, systemic inequities, and the broader social context during the screening process. This in turn requires professional development and training of providers and staff in awareness of systemic inequities and how they drive health-related social needs across populations, including specific training on the impact of implicit bias on access to quality health care.[55]

Taking the first step to support caregivers in reflection about the social ecology of their need:

Interactions of this kind inherently require customization to individual families and provider relationships, but a few sample case studies are instructive.

- African American mother of premature newborn, lost her job due to extended leave caring for premature child and then recently evicted due to loss of income from work to pay rent. Family presents to the ER because the newborn has congestion and mother reports homelessness and that they are living in their car. ER department reports the family to CPS. A hospital may have a policy of reporting any parent of an infant who is living in their car to CPS. A provider can support a family in this crises by acknowledging (a) the specificity of the mandated reporting role; (b) the lack of affordable housing; (c) the disproportionate need for affordable housing due to race discrimination in the housing market (d) insufficient parental leave policies that led to job loss; and (e) the public health research indicating that the experience of racism contributes to preterm births regardless of income level. If this mother's trust can be earned, she may be able to engage in health-related social needs screening that will enable her to engage productively with CPS, receive supports to provide for her baby and demonstrate resilience in the face of many layers of trauma.

- Family resides in neighborhood with concentrated disadvantage, lack of thriving businesses, no banks or supermarkets, predatory pay-day lending and few quality childcare options. Mother reports child is noted to be behind at the beginning of early Head Start preschool. Acknowledge strength of family for enrolling child in early Head Start and acknowledge the broader social context with low teacher-to-child ratios, concentrated disadvantage and lack of child enrichment. Orient this in a larger historical context (e.g. residential racial segregation, tax-revenue based economic development). This non-judgmental candor may foster engagement with strengths-based screening including social network mapping that identifies (a) the child and family's gifts and (b) their social network's resources, around which feasible therapeutic interventions can be tailored.

The changes to United States immigration policy in 2017 provides a useful context for illustrating this recommendation in concert with the preceding recommendations.

C. Screening for Health-Related Social Needs with Immigrant Families

Immigrants entering the healthcare system share with U.S.-born patients the same predictable stresses about health problems, navigation of large bureaucracies, and power imbalance in the patient-clinician relationship. Immigrants, however, bring unique strengths and risks both of which should be accounted for in development of screening processes that will benefit immigrant patients. While fear of detection by immigration enforcement officials long has impeded many undocumented immigrant families' engagement with preventive and even emergency healthcare, in 2017, providers and advocates have observed increasing disengagement among immigrant patients, with and without documentation.[56] Understandably, screenings of virtually any kind may feel risky, especially those that seem remote from traditional healthcare subject matter, and even more so, those that address immigration issues head-on.

Historical trauma impacting screening engagement:

For many immigrants, trauma in the home country related to maltreatment by government officials can provoke rational suspicion of any screening questions that refer to government processes – including processes that may address health-related social needs. For these reasons, engaging in trust-building before screening is especially crucial and has to be specially tailored if we are to reach diverse immigrant populations supportively. A strength of many immigrant communities can be brought to bear in meeting this challenge, as described in the next paragraph.

Community engagement can increase screening engagement:

For centuries, people have arrived in a particular area of the U.S. (or neighborhood within a U.S. city) because immigrants from their homeland have already built community there. These immigrant enclaves are home to many in the existing and growing community health worker workforce who can inform screening protocols that will serve (rather than further stress) immigrant populations.

Best practices to earn trust include:

- Affirmative transparency that any questions about immigration status are for benefit eligibility evaluation purposes only and will not be recorded without permission;
- Vigilance around avoiding references to immigration status in health records;[57]
- Gestures as simple as closing a notebook and setting aside a pen, or turning away from a keyboard can communicate utmost respect for the family's privacy;
- Linguistic appropriateness of all oral and written information;
- Accessibility regardless of literacy level by ensuring that relevant legal information is shared both orally and in writing;
- Legal advocacy resource curation so providers can point immigrant patients/clients toward qualified and sometimes free or affordable assistance, and;
- Acknowledgement of the historical context in which restrictive immigration policy is situated and candor that there may not be immediate pathways to citizenship if that is desired, but that there are many strong allies within and outside their community to whom they can be connected should that be of interest.[58]

IV: Conclusion

The long-term consequences of social adversities on population health are increasingly acknowledged. This contributes to the growing interest in screening for health-related social needs and screening in the pediatric setting holds particular promise for its primary prevention power.[15,59] Effective screening is indispensable if pediatric health care providers are to identify and address health-related social needs. When pediatric screening leads to health-related social needs alleviation, pediatricians and their colleagues may help prevent and mitigate the health effects of social adversity for families, for children and for the adults that children will become.

Grounded in the *Strengthening Families* protective factors framework, we recommend that efforts to implement and innovate health-related screening in pediatrics settings should:

- Involve families and communities in the development of screening tools and protocols.
- Screen for both risk factors and protective factors.
- Set person-centered screening priorities within the universe of health-related social needs.
- Ensure that screening is conducted by care team members trained and supervised in strengths-based approaches.
- Recognize that screening for health-related social needs is not risk-free for families.
- Acknowledge family-level risks and strengths in a broader historical context.

We currently have a window of opportunity to link the known benefits of promoting family resilience using the Protective Factors framework with evidence-informed screening tools to detect health-related social needs. If systematic social screening efforts are to be useful to families and feasible for pediatric clinics, family-centered design principles and administration protocols – including the six referenced here – must be the foundation.

V. Endnotes

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