

Strengths-based Approaches to Screening Families for Health-Related Social Needs in the Healthcare Setting: Preview of Recommendations

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Screening Families for HRSN in Ways that Acknowledge their Strengths: *Recommendations*

The conceptual commitment to systematic screening of patient-families for HRSN is near universal. A growing number of HRSN policies,¹ scholarship² and products³ have emerged over the last few years. The field of pediatrics is in the vanguard in terms of adopting and implementing formal HRSN screening protocols.⁴

At the same time, the challenges to operationalizing a truly strengths-based screening strategy – as opposed to a conventional risk-driven approach – are significant. Against this backdrop, we offer **six recommendations** to guide strengths-based screening in this context. In short we advocate that both *screening* for HRSN and HRSN *interventions* should be informed by a strengths-based framework.

A. Involve families and communities in the development of screening tools and related administration protocols

Drawing from the field of participatory research, engaging community stakeholders to participate in the HRSN screening process is a strategy to reduce health disparities.⁵ Incorporating insights from community members can strengthen health-related screening and interventions.⁶ The opportunities for engagement range from informing the content and process for screening, to reviewing proposed screening questions, to co-designing the administration protocol – ideally families will engage in all of these steps. This genuine alliance with community members with lived experience will enrich the value of the screening tool and acceptability of the screening process. When HRSN screening innovation is contemplated, it is crucial that representatives of the populations to be screened are consulted as experts about the draft questions and proposed methods of delivering the screen.

B. Screen for risk factors and protective factors

Existing screening tools can be improved by incorporating an assessment of family strengths and protective factors. Sterile screening for risk factors may serve a logical function for healthcare actuaries stratifying risk and seeking appropriate risk-adjusted payments to meet the needs of a disparities population they serve. However, at the individual family level, risk is a necessary but insufficient data point around which to plan person-centered, effective responses to HRSN.⁷

Risk spotlighted in a vacuum identifies problems, but not person-centered solutions. By screening around risk and strengths/protective factors, more individually-tailored solutions can be identified. Likewise, gaps in public policy can be identified as narrowly as possible, which increases the likelihood of advancing a policy solution. In other words, a risk presented outside the context of existing buffering resources presents a bulkier problem that is harder to handle. The real need emerges from a rough formula: *risk factors minus protective factors*. From a policy perspective, this is a more credible, empowering, and efficient version of the problem to solve, and a strengths-based approach to HRSN screening can get us closer to that bottom line. Moreover, it empowers families to engage as active agents in developing solutions.⁸ Indeed, an ideal HRSN screening protocol will not only detect needs, but respect people's agency by directly asking families whether or not they would like help addressing the need.

There also is a practical, provider-centered rationale for this recommendation. A common concern raised by providers when considering screening for HRSN is “**fear of the empty toolbox**” – that they may identify challenges without either (a) the tools necessary to address those challenges or (b) the resources necessary to implement appropriate interventions.⁹ 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.

Importantly, strengths-based, interdisciplinary approaches to screening are underway in related health contexts: For example, the Child and Adolescent Needs and Strengths 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”.¹⁰ This aligns with the logical and person-centered shift toward integrating behavioral healthcare into primary care,¹¹ rather than disciplines that traditionally have been siloed to the detriment of efficiency and effectiveness both for patients and providers.

Fundamentally, a strengths-based approach to HRSN screening can identify and activate readily available buffers, as well as promote health through a screening process that enhances agency and is empowering and health-promoting.

C. Set priorities

Periodic surveillance and screening for HRSN play a critical role in helping care providers identify and address barriers to health and well-being. At the same time, additional screening in the pediatrics context – beyond the current requirements – needs to be culled for redundancy and managed within the confines of limited time.

From a caregiver-centered or community-centered perspective, when questions are asked thoughtfully, they can be empowering. Indeed, they can model unconditional positive regard for the parent in the same way pediatricians coach parents to interact with their children. However, without due care to the curation of questions, haste will make waste: at best, busy parents may tune out and default to negative responses, and at worst, parents may experience the questions as stigmatizing, traumatizing or re-traumatizing. This family-focused reasoning above is bolstered by workforce considerations. Pediatric care teams work under particularly inflexible conditions compared to other health disciplines. In many practices, standard of care well-child screening already includes housing and food insecurity, maternal depression, and school-related needs – which are time-consuming and provocative in their own right. Many pediatric teams also screen routinely for interpersonal violence (IPV) and it is well-recognized that most IPV survivors do not answer in the affirmative the first time they are asked. Healthcare teams delivering care to families cannot realistically add a “laundry list” of HRSN screening questions to the encounter without trade-offs.

D. Ensure that screening is administered by a team member who is accountable for a strengths-based, trauma-informed orientation with families

Current HRSN screening practices take a variety of forms, including asking families to fill out surveys on their own (a/k/a self-administration). Acknowledging this diversity in protocols, for a number of reasons this brief contemplates *active screening of a family by a healthcare team member*. For the workforce members leading this screening work to succeed by person-centered and other quality measures, it is crucial that they be equipped with cultural competency skills¹² and the ability to detect and mitigate the implicit biases inherent among even the most well-intentioned individuals.¹³

When considering ways to strengthen team-based care, trauma-sensitive models suggest a **universal precautions approach**, where all members of the team are knowledgeable and informed about trauma and how it may impact individuals’ wellbeing (including the impact of historical traumas on families and communities), trained in trauma-informed practices, and utilize those practices regardless of actual knowledge of individual patient or family trauma.¹⁴

In addition, accurate screening results and cultivation of consistent patient engagement with ambulatory-sensitive care depend on a **foundation of trust**.¹⁵ The clinician-patient relationship inherently requires unilateral information-sharing of a private nature and vests in the clinician substantial obligations of confidentiality.¹⁶ Yet even within this broad zone of privacy, there are subject matters that the law acknowledges to be more sensitively private: for example, additional layers of privacy protection buffer patients from unauthorized sharing of information related to substance use history, psychiatric care and HIV care. For many patients accustomed to sharing information about their physical health, particularly with the broader generalist brushstrokes of primary care practice, questions that deviate into non-clinical subject matters may be disorienting at best and threatening at worst. This is especially so for marginalized populations that understandably may more frequently perceive inquiries to be judgmental or adversarial. At least one study indicates that patients are substantially less likely to respond to sensitive social screening questions posed in-person versus electronically.¹⁷ This invites consideration of whether the impersonal electronic medium inherently matters, or whether adjustments to the in-person messenger’s approach might foster more responsiveness.¹⁸

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. In order for this approach to have its intended inclusive effect, screening must be described explicitly to the subject as universal. This also reduces the likelihood that HRSN screening will be experienced as a confusing non-sequitur by parents who have been excluded from screening experiences in the past.

Another strategy is to **support all members of the health care workforce to incorporate cultural competency and implicit bias mitigation approaches into care-competencies** that can provide insight about potentially alienating lines or styles of questioning, and productive strategies to engage patients comfortably. As outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA), key principles of trauma-informed approaches include: safety; transparency; peer support; collaboration; empowerment; and acknowledging the breadth of intersectional cultural, historical, and gender issues that undergird experiences of oppression.¹⁹ Trauma-informed programs are aware of the prevalence of trauma, actively try to avoid re-traumatization, incorporate understanding of trauma into policies, and identify signs and symptoms of trauma. Health care workforces that have training in evidence-based screening tools, who are committed to the life-long learning that cultural competency requires, and who incorporate trauma-informed

principles into practice in turn will be better able to administer HRSN screening that empowers and creates alliances with families.

Yet another feature of person-centered HRSN screening is **avoiding stigmatizing patients and parents who have literacy and language barriers**. The authors are aware of multiple HRSN screening pilots that require children or caregivers to affirmatively raise with the person who handed them the screening survey that they are illiterate or low-literate and cannot complete the tool without assistance. This is a recipe for immediate alienation of families. It is far too common the case that health materials are not accessible to patients and the literacy demands of the materials are above the literacy abilities of the readers. Providing culturally effective care requires attention to language barriers as well as health literacy and avoiding practices that undermine the dignity of families.

As described above under recommendation “A,” **including parents and caregivers not only as co-designers in development of HRSN screening processes, but as care team members who can administer, follow-up, or address positive screens**, would align with a strengths-based framework. Notably, in an adaptation of findings from community health worker and home visitor programs, parent coaches and family navigators – who are trusted community members – are being incorporated in pediatric clinical environments more frequently.

E. Recognize that HRSN screening is not risk-free for families

Racial/ethnic minority children are more likely to be evaluated and reported for suspected child abuse in clinical settings, an inequity driven in large part by implicit bias.²⁰ Therefore, screening in the pediatrics context is challenged by the disproportionate disruption of low-income and racial and ethnic minority families by child protective services agencies.²¹ Pediatricians and their clinical colleagues are mandated reporters to child protective services (CPS) agencies which presents an obvious barrier to full forthrightness about serious material hardship: parents confront a Hobson’s Choice between foregoing an opportunity for concrete support in a time of need, in favor of averting the risk that acknowledging the need may trigger a report to CPS based on concerns about child safety or neglect.²² Meanwhile, as observed informally but consistently by pediatric care providers across contexts and over time, a strength many low-income families demonstrate is prioritization of pediatric care above many other demands on their strained resources. This is in large part because people love their children. It is also because healthcare providers poll among the most trusted professionals.²³ Perhaps this is why overall there is high acceptability by parents and caregivers for social screening in the pediatric setting, including for interpersonal violence (IPV).²⁴

Building awareness among clinicians and multidisciplinary teams about existing disparities in screening and reporting is an important first step.²⁵ Next, educating providers on the potential for bias by race/ethnicity and socioeconomic status and the potential for disparities to be reinforced or widened based on discretionary practice is important.²⁶

Providers should be cognizant that past history with CPS may influence caregiver trust and disclosure of social needs. In addition, providers should be sensitive to the role that differences in cultural attitudes around family violence may play in willingness to disclose. Providers should be cognizant of the barriers to engagement facing families who reside in adverse social settings and experience adversity. Past experiences may lead to negative perceptions of mental health services; family stress; lack of social support for receiving behavioral health services; 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 treatment disengagement.²⁸

In using a strengths-based framework to address screening for family violence that might implicate concerns about child abuse or neglect, we draw from one of the most well-researched areas: healthcare-based screening for interpersonal violence. In that context, parents rated the following qualities as critical for providers: demonstrating empathy; first addressing 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 A strengths-based framework considers the need to support parental resilience in the context of an intervention to mitigate social adversities that impact health.

F. Acknowledge family-level risks and strengths in broader context

Family risks and strengths must not be extracted from their broader social context. Adverse social settings (area deprivation, neighborhood disadvantage) and systemic inequities in opportunity structures (institutional racism) are both associated with family adversities and negatively impact child health, development, and social mobility.³¹ For example, there is reluctance among many physicians to address the role of racism and consider how medical practices reinforce stereotypes.³² 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.³³

Counterproductively, sometimes the very systems through which concrete supports in times of need are meant to flow – like government bureaucracies that administer safety-net programs – are shaming to families, which compounds the trauma of material hardship.³⁴ Merely validating this experience is meaningfully supportive in its own right.

In this regard, we endorse two interrelated strategies which can strengthen provider empathy and effectiveness:

- the professional development and training of providers and staff in awareness of systemic inequities and how they drive HRSN across populations including specific training on the impact of implicit bias on access to quality health care;³⁵ and
- the acknowledgment of systemic inequities and the broader social context during the screening process.

Strengths-based HRSN screening is conducted at the family level. While large-scale chronic housing insecurity will not be solved at the family level, intentional acknowledgment of factors that families likely cannot change on their own can help prevent these HRSN screening interactions from reinforcing inequities. Normalizing the experiences of families, particularly those who may feel powerless to change societal symptoms of oppression including chronic housing insecurity, community violence, or underemployment, may improve engagement in the screening and referral process.

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