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Trauma-Informed Screening for Structural Drivers of Health

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Abstract

Screening for structural drivers or determinants of health (SDoH), as mandated by recent federal regulations, raises ethical questions about screening processes and tools. Early childhood adversity and trauma, which can influence a person's health throughout their lifespan and contribute to chronic disease and early death, can be identified through standardized screening for SDoH. However, screening without awareness of the potential interface between SDoH and trauma can retraumatize those administering or completing the screening process. This article suggests that implementation of a trauma-informed approach to SDoH screening is consistent with biomedical and public health ethics and contributes to efforts to keep clinical environments emotionally safe.

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Adverse Childhood Experiences

Structural drivers or determinants of health (SDoH) are upstream contributors to health that have social, cultural, economic, or political origins and that can contribute to premature morbidity and mortality.[1] The US Department of Health and Human Services (HHS) describes SDoH as "conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[2] HHS offers illustrative examples of SDoH, including "safe housing, transportation, and neighborhoods" and "education, job opportunities, and income," in addition to access to healthy food, water, and air. In its SDoH screening requirements for patients 18 years of age or older admitted to hospitals participating in the Hospital Inpatient Quality Reporting Program, the Centers for Medicare and Medicaid Services (CMS) includes "food insecurity, housing instability, transportation needs, utility difficulties and interpersonal safety" as relevant screening domains.[3]

Adversity, including early childhood adversity, is its own driver of health. Childhood experiences of poverty, community violence, and loss of a parent are examples of early childhood adversity; adverse childhood experience (ACEs) are associated with negative health outcomes, including lifelong biopsychosocial maladaptation, chronic adult illness,

and other risk factors for shortened life.[4] Classic intrafamilial ACEs, such as parental separation,[5] substance use,[6] incarceration,[7] or death,[8] can create economic strain on individuals and families. Adults who report experiencing more ACE types are more likely to face socioeconomic challenges than those who report no ACEs,[9] which might contribute to their reproducing adverse SDoH, such as unemployment, food insecurity, or housing insecurity, for children growing up in their households. Racism, discrimination, and community violence are all significant SDoH that can also contribute to early childhood trauma, community trauma, and retraumatization during health care encounters. Nearly two-thirds of US adults have experienced at least one ACE,[10] and studies in the United States[11] and globally[12] suggest that 70% or more of adults experience at least one traumatic event in their lifetime. Individual trauma "results from an event, series of events, or set of circumstances that is … physically or emotionally harmful or life threatening and that has lasting adverse effects on … mental, physical, social, emotional, or spiritual well-being."[13] Because early trauma impacts adult health[14]—and given the connections between SDoH, adversity, and trauma—ethically acceptable screening strategies require trauma-informed approaches.

Screening Retraumatization Risk

Trauma-informed care (TIC) is a framework that realizes the prevalence and impact of trauma, recognizes its "signs and symptoms," responds with trauma-informed principles, and seeks to resist retraumatization.[13] Trauma-informed principles promote emotional and physical safety, trust and transparency, peer support, inclusion, empowerment, voice, and choice. The TIC framework also includes the influence of history and culture on achieving these aims.[13] Policy statements on adoption of TIC in health care systems, such as that of the American Academy of Pediatrics,[15] require translating TIC frameworks into actionable practice,[16] including screening practices.

In addition to the implicit, often mutually amplifying relationship between SDoH, adversity, and trauma, there is an explicit connection among these factors in many tools currently used for SDoH screening. SDoH screeners often include questions directly related to trauma and adversity. One review of SDoH screeners deployed in pediatrics identified 11 distinct screeners.[17] Each included questions regarding the domains of adversity and potential trauma, such as intimate partner, household, or community violence; substance use and mental health concerns; physical, emotional, and sexual abuse; and parental separation or incarceration.[17]

CMS does not require or recommend a specific screening tool, recognizing that local and population context may influence how best to screen for its identified screening domains (ie, food, housing, transportation, utilities, safety).[3] Screening for interpersonal safety is particularly open to variable implementation and could include safety within living, working, relational, or community environments. Thus, interpersonal safety screening may identify or reflect sources of adversity and trauma. Considering the absence of specific screener guidance, facilities may seek to adopt or adapt existing screeners to meet CMS requirements. As noted, many of these include questions about adversity or trauma.

For example, the Safe Environment for Every Kid Parent Questionnaire (SEEK-PQ) is one tool that inpatient facilities may adopt to meet CMS screening requirements. Questions include experiences with worrying about or running out of food; needing support with transportation, housing, or utilities; and household safety features like gun locks and smoke detectors in the home.[18] In the pediatric context, screening tools are completed

by parents or other caregivers in the service of the pediatric patient. The SEEK-PQ screens the patient's parent or caregiver for drug and alcohol use, fighting with their partner, and depression.[18] These behaviors may constitute ACEs for pediatric patients, impacting their health and well-being. But they may also impact the screened parent or caregiver's health and well-being.

Screening a parent or other caregiver to address the patient's SDoH introduces additional considerations about how to best mitigate stress and retraumatization for the parent or other caregiver when completing the screener. It also introduces concerns about how to address identified psychosocial needs of the screened parent or other caregiver when screening is not occurring within a trusted relationship between the caregiver and their own health care clinician. The different, and sometimes competing, obligations pediatricians have to their patients and to their patients' caregivers create challenges for providing adequately informed—and trauma-informed—consent to screening for SDoH and addressing identified needs. For example, screening may introduce different risks and benefits for the screened caregiver than it does for the patient. Moreover, empowering the voice and choice of a parent or other caregiver to opt-out of screening may be a trauma-informed practice that is attentive to their needs, but opting out of screening may not support the health and trauma-informed needs of the pediatric patient.

Screening Ethics

Like screening for SDoH, screening for adversity and trauma on a population-health level can make connections between these experiences and health outcomes. Given that SDoH screening is now a CMS requirement for some hospitalized patients—and considering the interconnection among SDoH, trauma, and adversity—the benefits and risks of screening for trauma and adversity are relevant to SDoH screening. Potential benefits of screening for adversity, like screening for SDoH, include identifying unmet needs and connecting people to resources, although screening individuals for classic ACEs is more ethically controversial.[19] When resources are unavailable, screening may not be ethically justifiable unless understood by the patient or caretaker as a needs assessment.[20] Surveillance regarding patient safety may be a clinically indicated and ethically supportable alternative to screening that may also help identify and address unmet needs. Informal surveillance is typically a conversational approach that elicits patients' questions and concerns on a topic (as distinct from formal screening that poses structured questions via a validated tool to collect data on the topic[21]). Safety surveillance is commonly adopted in adult[22] and pediatric[23,24] practice and can be more relational when done through attentive, face-to-face discussion rather than through a screening tool alone, paired with private opportunities for disclosure.[25]

Even in the absence of resource referrals, there may be other benefits of SDoH and adversity screening, such as enabling clinicians to promote known protective factors. Protective factors can be personal, familial, or communal sources of strength that buffer the impact of trauma and adversity. The most effective protective factor that mitigates lifelong effects of early childhood adversity is a safe, stable relationship with a nurturing adult.[26] Clinicians can recommend interventions to foster relational health, which is the capacity to develop and sustain these safe and stable relationships. Recommendations may include shared book reading between children and caregivers, encouraging developmentally appropriate play, and connecting families to quality early childhood education.[26] The promotion of protective factors and relational health can also be a universal intervention for all patients, regardless of screening, given the overall benefits

of relational health, just as implementing universal SDoH screening rather than only screening Medicaid patients could mitigate potential screening bias.[20] Similarly, universally screening for and promoting protective factors would be a trauma-informed approach that recognizes and responds to the known prevalence of trauma.[10,11,12]

Risks of screening for trauma and adversity include lacking appropriate resources to address identified needs, as well as the potential for retraumatization during the screening process. Weighing potential benefits of screening against harms of retraumatization can be especially complex when parents are screened for their own adversity and early childhood trauma in the context of their child's health outside of a patient-clinician relationship that is oriented to address the parent's needs. Screening may also trigger strong emotional reactions in health care workers who recognize in their patients and families their own similar adverse or traumatic experiences.

Given the intersection among SDoH, adversity, and trauma, SDoH screening needs to be trauma informed to reduce harms and maximize benefits. If SDoH screening cannot be trauma informed, then it might not be ethically supportable to proceed. However, not complying with CMS requirements may burden already vulnerable patient populations enrolled in Medicare or Medicaid if hospitals caring for them face penalties for noncompliance that impact their ability to care for their patients. Inpatient facilities unable to provide trauma-informed SDoH screening may consider a minimal approach to screening by asking narrow questions about housing, transportation, food, and utilities, with safety questions limited in scope and content. Even if care facilities do not use one of the validated screening tools that include questions about adversity or trauma, questions pertaining to CMS' 5 domains may trigger a traumatic response from or retraumatize the parent or other caregiver (ie, questions about personal safety or questions whose answers involve upstream or historical adversity). This possibility should be factored into the screening tool a facility adopts or develops.

Trauma-Informed Strategies

Personal or historical trauma impacts patients, families, caregivers, and health care workers. Because many health care experiences, including being screened for SDoH, can reveal unresolved trauma or retraumatize, TIC should be a universal precaution applied to all health care encounters. As a basic intervention, health systems should provide TIC education for all staff, whether patient facing or not. Implementing ethical SDoH screening means promoting trauma-informed principles in the design, implementation, and outcomes of SDoH screening. These trauma-informed principles are compatible with and can support clinical ethics and public health ethics principles, such as solidarity. Trauma-informed SDoH screening practices and the principles they embody include the following:

- Screening for and promoting relational health and protective factors,[20,26,27] consistent with harm avoidance, prevention, and beneficence.

- Screening for needs for which there are available resources, consistent with distributive justice, family empowerment, and the professional duty to care.

- Involving families and community leaders in the development of screening tools and decisions about which SDoH to prioritize and how they can be addressed in the community, supporting the principle of solidarity and meaningful engagement.

- Offering sincere choices about participation in SDoH screening and, if agreed to, when and how SDoH screening will be conducted, such as face-to-face, on paper, or electronically, to maximize personal choice and enhance the principles of autonomy, proportionality, and cultural awareness.

- Sharing information about why SDoH screening is occurring and what the results of the screening may be, including outcomes at the individual and population levels in terms of how data will or will not be used, analyzed, documented, or retained, supporting the principle of transparency and increasing trust.

- Ensuring that all personnel involved in preparing, performing, and reviewing screening tools are trained in trauma-informed principles and have supportive resources available to mitigate secondary trauma, reflecting the principles of beneficence, justice, and prevention.

A trauma-informed approach to SDoH screening will likely expand the resources that could— and should—be offered in response to positive screening and shape how clinicians approach ethically responsible SDoH screening in their practices and health systems. Specifically, such an approach involves adopting the practices described above and providing resources for health care workers experiencing retraumatization or secondary trauma when screening patients for SDoH and caring for patients experiencing adversity. Finally, extending CMS-required screening from inpatient settings to outpatient settings with trusted clinicians may foster trauma-informed environments for patients and staff and promote relational health.

Conclusion

Screening for SDoH is an important strategy to identify economic and social risk factors that interfere with family and child well-being. However, the screening process may surface previous traumatic experiences and can trigger retraumatization. Application of the principles of trauma-informed care to the screening process, including meaningful involvement with families and identification of relational protective factors, can mitigate the risk of retraumatization. This paper suggests that the principles of trauma-informed care are consistent with public health and biomedical ethics and, if applied, can help create an emotionally safe clinical environment.

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