# School Practitioner Community of Practice

**(A network for sharing & exchange)**

**January 22, 2020**

## Topics for discussion –

**>Controversy about screening students for toxic stress**

## Links to a few other relevant resources & other topics of concern

**Note: Go to** http://smhp.psych.ucla **for links to other Center resources including**

>Upcoming initiatives, conferences & workshops

>Calls for grant proposals, presentations, and papers

>Training and job opportunities

>Upcoming webcasts & other professional development opportunities

**This resource is from the**
**Center for MH in Schools & Student/Learning Supports, UCLA**

**Given education budgets, we have been asked to increase our outreach to make our free resources more available (e.g., for planning, professional development, etc.).**

*So please feel free to share with anyone you think might benefit (e.g., forward our resources to individuals and share on listservs and websites).*

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**For those who have been forwarded this and want to receive resources directly, send an email to Ltaylor@ucla.edu**

**For previous postings of community of practice discussions, see**
http://smhp.psych.ucla.edu/practitioner.htm

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## Topic for Discussion –

### >Controversy about screening students for toxic stress

As you can read below, California will be screening children for toxic stress. Other states are likely to follow.

Because first level screening of young people raises serious issues, it is time for a renewed, widespread discussion of the matter. While the potential benefits of first level screening are commonly highlighted, the negatives consequences are not. Any discussion of such a public health intervention should focus on the question: ***Do the potential benefits outweigh the negatives for children, adolescents, families. schools?***

Here's a recent article that can be used as a stimulus for discussion:

From: *5 Things To Know As California Starts Screening Children For Toxic Stress*
https://www.usnews.com/news/best-states/articles/2020-01-08/5-things-to-know-as-california-starts-screening-children-for-toxic-stress

> Starting this year, routine pediatric visits for millions of California children could involve questions about touchy family topics, such as divorce, unstable housing or a parent who struggles with alcoholism. California now will pay doctors to screen patients for traumatic events known as adverse childhood experiences, or ACEs, if the patient is covered by Medi-Cal — the state's version of Medicaid for low-income families....

The public health impact could be significant as Medi-Cal covers 5.3 million kids — roughly 40% of all California children. ...

At a typical well-child visit, parents or caregivers will be asked to fill out a state-approved questionnaire about potentially stressful experiences in their children's lives. For children under age 12, caregivers fill out the survey. Young people ages 12-19 will complete their own questionnaire in addition to their caregivers' questionnaire.

The questions will touch on 10 categories of adversity spanning the first 18 years of life: physical, emotional or sexual abuse; physical or emotional neglect; and experiences that could indicate household dysfunction, such as a parent who has a serious mental illness or addiction, having parents who are incarcerated or living in a home with domestic violence.

The screening will measure for experiences that could regularly trigger fear and anxiety, including homelessness, not having enough food or the right kinds of food, and growing up in a neighborhood marred by drugs and violence.

Some caregivers and children might be reluctant or unwilling to disclose sensitive information, particularly if they fear shame or repercussions....

Physicians will review the responses and discuss them with caregivers during the visit. Doctors will have access to free online training on how to communicate with families and connect them to community resources. Physicians will be eligible for a $29 reimbursement for each Medi-Cal patient screened.

The responses are considered confidential patient information and won't be shared with state officials....

***What happens after the screening is less clear.***

Community clinics often have social workers or 'navigators' available to connect families to aid like food stamps or counseling. Doctors in private practice, however, are less likely to have those resources...".

The hope is that the screenings, accompanied with early intervention, will help families build resilience and reduce stress.

### *But there is a downside.*

Sociologist David Finkelhor, director of the Crimes against Children Research Center at the University of New Hampshire, is among those who caution that universal screening for ACEs is premature, given there is little consensus about the potential negative effects of screening or the best interventions. He states:

"The good news is that we are focusing on these adversities that are clearly the source of so many downstream health and mental health problems," Finkelhor said. "But the bad news is we're moving way too fast, before we know how to best conduct this kind of screening and intervention, and we could get it wrong with pretty disastrous consequences."

"Mostly, we don't know what to do with somebody who has a high ACE score," he said. "There are already long waits to get into family counseling or child mental health programs."

For example, a doctor might be legally required to report previous abuse to authorities, upending a family even if the child no longer is exposed to the abuser..."

In a recent journal article, Finkelhor further stresses:

"...it is still premature to start widespread screening for adverse childhood experiences (ACE) in health care settings until we have answers to several important questions: 1) what are the effective interventions and responses we need to have in place to offer to those with positive ACE screening, 2) what are the potential negative outcomes and costs to screening that need to be buffered in any effective screening regime, and 3) what exactly should we be screening for? ...

...it is not at all clear that we have evidence based interventions for high ACE scores, and certainly the protocols for packaging such information into a rigorous intervention are still in the early stages of development. The typical intervention in discussions and examples of ACE informed practice is referral to a behavioral health practitioner or social worker with knowledge about a variety of treatments or referral options. But the range of specific needs in high ACE referrals may run from domestic violence intervention to grief counseling, childhood aggression and substance abuse. Success of the intervention will be very dependent on the quality of available treatments in the community or the skill and training of the behavioral health practitioner getting the referral. The training and funding requirements to achieve an adequate resource level in all these areas may be prohibitive for many communities. This raises the question: is it ethical or justified to screen for conditions when proper treatment cannot be assured? Moreover, until the intervention package is fairly well specified, it will be hard to disseminate any successful model with any fidelity....

In the pediatric setting, the problem of mandatory child abuse reporting adds considerably to the cost benefit equation in countries with such laws. Even when settings try to get aggregate ACE scores without the disclosure of specific reportable behaviors, the inquiries into this domain could well provoke suspicions of abuse that will lead to increased reporting, especially given the low threshold that is supposed to trigger a report in many places such as most states in the US. It is also hard to imagine how the referral services can treat the child or family without doing a more specific assessment that would then trigger reports.

If this results in child welfare actions that protect some vulnerable children, it could be a major benefit to screening. But the state of current research on child abuse reporting does not foster confidence that it has net benefits, given that most reports in the US are not substantiated...

Finally, one of the most important hypotheses prompted by the ACE research is that the prevention of childhood adversities may have substantial population level health benefits. There is a temptation to pursue this hypothesis with more studies about which items best predict health problems. But the most useful confirmation of this hypothesis is not through the refinement of better ACE screening tools. Rather it is through the development and evaluation of programs that prevent the occurrence of childhood adversities in the first place and then the experimental demonstration of the population health effects from their dissemination..."

Finkelhor, D. (2018). Screening for adverse childhood experiences (ACEs): Cautions and suggestions. *Child Abuse & Neglect, 85*, 174-179. doi:10.1016/j.chiabu.2017.07.016

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**Please let us hear from you**

What are your views/experiences related to first level screening?

How does universal screening relate to building a comprehensive system that promotes healthy development, prevents problems, responds early after the onset of problems, and addresses serious and chronic problems?

**Share your perspective about this topic!**

**And send it and any other comments to** Ltaylor@ucla.edu

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## Links to a few other relevant resources & other topics of concern

*Addressing trauma and other barriers to learning and teaching: Developing a comprehensive system of intervention*
http://smhp.psych.ucla.edu/publications/adressingtraumaandotherbarrierstolearning.pdf

*Mapping a school's resources to improve their use in preventing and ameliorating problems*
http://smhp.psych.ucla.edu/publications/53 mapping a schools resources to improve1.pdf

*Prevention and schools* http://smhp.psych.ucla.edu/pdfdocs/prevention.pdf

*Supports for students deemed at risk* http://smhp.psych.ucla.edu/pdfdocs/risk.pdf

*Addressing neighborhood problems that affect the school*
http://smhp.psych.ucla.edu/pdfdocs/neighpn.pdf

*About addressing poverty: What's a school's role?* http://smhp.psych.ucla.edu/pdfdocs/poverty.pdf

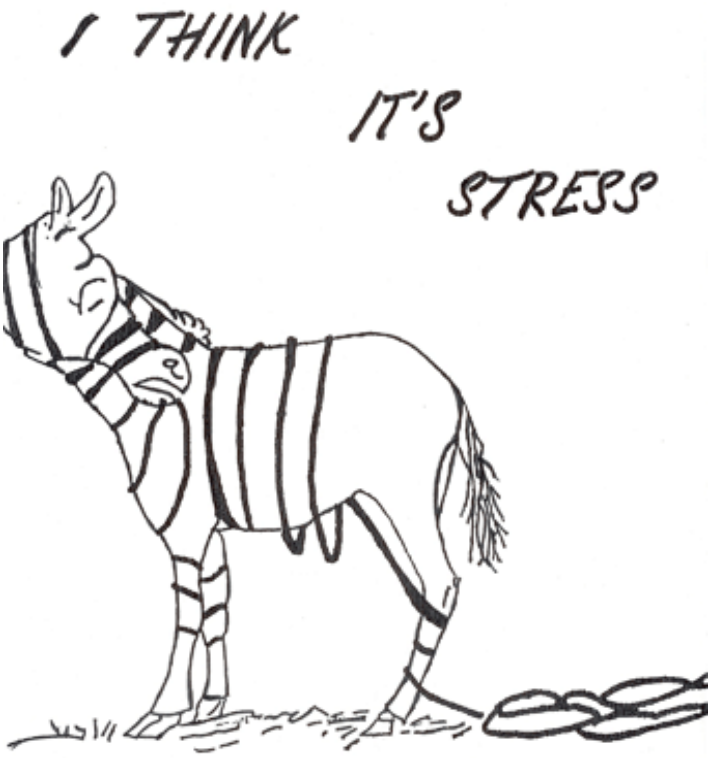
*Preventing adverse childhood experiences*
https://www.cdc.gov/violenceprevention/pdf/preventingACES-508.pdf

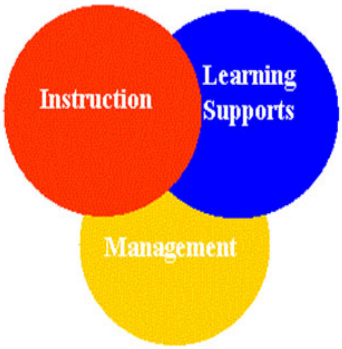
*Preventing and mitigating the effects of adverse childhood experiences*
https://www.ncsl.org/research/health/preventing-and-mitigating-the-effects-of-adverse-childhood-experiences.aspx

*Ways to Create community resilience and help prevent adverse childhood experiences*
https://nationalresilienceinstitute.org/2017/08/create-community-resilience-help-prevent-adverse-childhood-experiences-aces/

*Recommendations for addressing racial bias in risk and needs assessment in the juvenile justice system*
https://www.childtrends.org/publications/recommendations-for-addressing-racial-bias-in-risk-and-needs-assessment-in-the-juvenile-justice-system

*Equity of opportunity is fundamental to enabling civil rights;*
*transforming student and learning supports is fundamental to*
*enabling equity of opportunity, promoting whole child development,*
*and enhancing school climate.*



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For information about the

**National Initiative for Transforming Student and Learning Supports**

go to http://smhp.psych.ucla.edu/newinitiative.html

Also online are two related free books

***Improving School Improvement***

http://smhp.psych.ucla.edu/improving_school_improvement.html

***Addressing Barriers to Learning: In the Classroom and Schoolwide***

http://smhp.psych.ucla.edu/improving_school_improvement.html

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**THE MORE FOLKS SHARE, THE MORE USEFUL AND INTERESTING THIS RESOURCE BECOMES!**

**For new sign-ups – email Ltaylor@ucla.edu**

**Also send resources ideas, requests, comments, and experiences for sharing.**

**We post a broad range of issues and responses to the Net Exchange on our website at http://smhp.psych.ucla.edu/newnetexchange.htm and on Facebook (access from the Center's home page http://smhp.psych.ucla.edu/ )**