



# Screening Adolescents for Adverse Childhood Experiences (ACEs):

## ADDRESSING THE UNIQUE NEEDS OF IMMIGRANT YOUTH

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# INTRODUCTION

**A**pproximately half of all adolescents ages 12-17 in the United States have experienced at least one Adverse Childhood Experience (ACE)<sup>1</sup>—a potentially traumatic event that can have profound detrimental effects, including increased risk for poorer physical health and learning and behavioral issues during childhood and adolescence, and depression, substance abuse, chronic illness and shorter lifespan in adulthood.<sup>2</sup> Adolescence is a critical time to address the impacts of trauma and toxic stress to support the health and well-being of young people. Youth who immigrate to the United States may experience ACEs that are unique to their experiences of immigration and acculturation and that require culturally sensitive supports.<sup>3</sup>



This practice paper examines the current literature on ACEs and ACE screening with immigrant youth and summarizes findings from qualitative research conducted with adolescent health providers and adolescents to understand their perspectives on this topic. Based on this examination, the paper provides recommendations for adolescent health providers to effectively implement ACE screening with immigrant youth in primary care settings. This paper is a companion document to the authors' practice paper entitled *Screening Adolescents for Adverse Childhood Experiences (ACEs): Incorporating Resilience and Youth Development*.

# BACKGROUND

## What Are ACEs?

Adverse Childhood Experiences (ACEs) are adversities experienced in childhood and adolescence that have been linked to serious health and social challenges in adulthood, including decreased productivity, mental health disorders, substance use, chronic illnesses, and decreased life expectancy. A landmark 1998 study by the Centers for Disease Control and Prevention (CDC) and Kaiser Permanente defined ACEs as exposure to any of several categories of exposure related to abuse, neglect, and household challenges.<sup>4</sup> Research has found a dose-response relationship between ACEs and increased risk of negative outcomes in childhood, adolescence, and adulthood.<sup>2,4</sup>

## Immigrant Youth and ACEs

Nearly 11 million immigrants<sup>a</sup>—about one-quarter of the foreign-born population in the U.S.—reside in California; most were born in Latin America (50%) or Asia (39%).<sup>5</sup> Half of California children have at least one parent who is an immigrant to the U.S.,<sup>5</sup> and one in five children enrolled in California public schools is an English language learner.<sup>6</sup>

Nationwide, one in four youth ages 12-17 has experienced two or more ACEs.<sup>1</sup> Compared with non-Hispanic white children, Latinx<sup>b</sup> children in the U.S. experience ACEs at higher rates: 42%

of Latinx children experienced at least one ACE, as compared to 36% of their non-Hispanic white peers.<sup>7</sup> Among Latinx youth, first generation immigrants report fewer ACEs than their second and third generation peers.<sup>8</sup> These data may reflect the U.S. immigrant paradox, finding that children of immigrants generally demonstrate better outcomes than their native-born peers, despite often having more disadvantaged backgrounds, with the phenomenon fading in subsequent generations.<sup>8-10</sup> However, some researchers suggest that traditional ACES screening may fail to capture the particular stresses of undocumented immigrants or children in mixed status families,<sup>11</sup> and that deprivation of resources and threats or experiences of deportation should be integrated more fully into assessments of childhood adversity.<sup>12</sup>

It is important to recognize that not all immigrants share the same life experiences regarding what motivated them or their families to leave their countries of origin, how they entered this country, the timing and political context of rejection or acceptance of immigrants and refugees, or their legal status ([see page 3](#)). As a result, many experience circumstances that place them at greater risk for ACEs, either before their arrival to this country, as part of their adjustments to their new country, or both. For example, many immigrants experience community and family

a The term “immigrant youth” is used throughout this practice paper to refer to all youth who enter the U.S. from other countries, regardless of their reason for immigrating (first generation), and youth born in the US to immigrant parents (second generation).

b Latinx is a gender-inclusive term, in place of Latino/a. These terms are also considered more inclusive of peoples from Mexico, Central and South America than Hispanic, which is still used in many Federal forms and reports.

## DEFINITIONS OF TERMS PERTAINING TO ADOLESCENTS' AND THEIR FAMILIES' IMMIGRANT STATUS

<b>IMMIGRANT YOUTH</b>	An immigrant is someone who consciously decides to leave their home country and move to a foreign country to settle there. Immigrants can decide to return home at any time.  <i>Note: The term “immigrant youth” is used throughout this practice paper to refer to all youth who enter the U.S. from other countries, regardless of their reason for immigrating (first generation), and youth born in the U.S. to immigrant parents (second generation).</i>
<b>NEWCOMER</b>	Newcomers are foreign-born youth who have recently arrived in the U.S. (usually within the past three years). Newcomer students may include asylees, refugees, unaccompanied youth, undocumented youth, migratory students, and other immigrant children.
<b>UNACCOMPANIED IMMIGRANT YOUTH</b>	Minors who have no lawful U.S. immigration status and crossed U.S. borders without a legal parent/guardian and do not have a legal parent/guardian in the U.S.
<b>UNDOCUMENTED YOUTH</b>	Minors who entered the U.S. without legal immigrant status.
<b>CHILDREN OF MIGRANT FAMILIES</b>	Migrant families move within and outside of their countries or across borders, usually to seek better opportunities, such as for seasonal work.
<b>REFUGEE/ASYLEE</b>	An individual who is forced to flee their home country because of past persecution or fear of persecution. Refugees apply for refugee status before entering the U.S. and are given protections. Asylees apply for asylum after entry and must be able to prove that they meet the criteria to be covered by refugee protections.

Adapted from: California Department of Education. (2021). *Newcomer Students*.  
Available from: <https://www.cde.ca.gov/sp/el/er/newcomerstudents.asp>. Accessed on November 14, 2021.

violence in their home countries as well as trauma throughout their immigration journey.<sup>13</sup>

Once they arrive, many experience additional fears and stress related to the politicization and stigmatization of immigration<sup>14-16</sup> in this country. Furthermore, literature is emerging related to the trauma experienced due to family separation resulting from segmented immigration and deportation, with parents leaving their children behind either in their country of origin or in the U.S., and sometimes not reuniting for years, although research thus far has not specifically explored this in relation to ACEs.<sup>17</sup> Research has also documented how fear of deportation in undocumented and mixed status families—in

which some members were born in the U.S. or have legal papers while others do not—impacts the health and well-being of children and adults.<sup>15,16</sup>

Furthermore, many experience additional trauma related to structural racism<sup>18</sup> and inequities in distribution of community resources, such as unequal funding of schools, lack of access to transportation, and safe environments, all of which can contribute to ongoing stress. Given the large number of immigrant youth and families in California, it is important to ensure that there are culturally supportive services that address their unique needs, particularly related to identifying and addressing the impacts of trauma and ACEs. Immigrant youth who experience racism,





## Screening for ACEs Among Immigrant Youth

The purpose of ACE screening in all populations is to open up a conversation about and assess for risk of toxic stress (changes to the individual's neurologic, endocrine, immune, metabolic and epigenetic regulatory systems). If risk is identified, providers can encourage the use of seven evidence-based strategies for mitigating toxic stress, including promoting supportive relationships, quality sleep, balanced nutrition, physical activity, experiencing nature, mindfulness

practices, and mental health care as needed.<sup>2</sup> Previous research has found that ACEs screening is associated with high patient satisfaction for some populations,<sup>21-23</sup> though this research has not focused on adolescents or immigrant youth in particular.

There is scant literature on the acceptability or best practices for screening immigrant adolescents for ACEs in the U.S. or globally. Within this limited research, there has been a greater focus on ACEs among Latinx children and youth than on any other group of immigrant youth. However, immigration status is often omitted from the research. Findings in one study document that third-generation Latinx youth reported higher levels of household dysfunction, while first generation Latinx youth reported higher levels of sexual abuse.<sup>24</sup> Another study using chart review of early childhood screening for ACEs in a large managed care organization found that higher prevalence of ACEs was associated with Black or Latinx families, lower income, and some chronic health conditions. White, Asian and Pacific Islander families had lower prevalence of ACEs.<sup>25</sup>

While some results have been reported related

bullying, fear of deportation for themselves or family members, and generational trauma are particularly vulnerable to the impacts of ACEs. Immigrant populations in the U.S. have been found to be at greater risk of mental health concerns due to stressors such as discrimination, poverty, and poor working conditions.<sup>19</sup> Strict immigration policies and enforcement strategies, such as family separation, raids, detention, and deportation, can be particularly traumatizing for immigrant youth.<sup>20</sup>

Youth who are forced to flee their native countries, either alone or with caregivers, due to violence or discrimination are at elevated risk for ACEs before and during migration. Once they arrive in the U.S., unaccompanied youth are especially vulnerable due to their personal circumstances, such as lacking a legal guardian to advocate for them. Despite their significant health and social needs, research with undocumented immigrant youth shows that many forego health care, even when offered through safety net providers, due to fear of amassing potential debts that could trigger deportation.<sup>14</sup> Understanding the perspective of this group of youth is critical to ensuring that services are sensitive and responsive to their needs.

to screening outcomes, there have not been any studies on the acceptability of screening for ACEs in immigrant adolescents across different countries of origin or generation. There is a need to develop a global literature on screening for ACEs and how best to frame screening in culturally appropriate ways, with specific sensitivity to the immigrant experience.<sup>3,26</sup> Additionally, as health care programs increasingly incorporate screening for social determinants of health (SDOH), there is also a need to recognize that many immigrants may be reluctant to disclose social and economic needs due to their perceptions regarding the risk of public charge regulations.<sup>27</sup> Providers may find that such needs emerge as part of their interactions with their clients, although at different points in their visit.

One clear advantage for immigrants living in California is our state's policies regarding their access to Medi-Cal, California's Medicaid program. Currently, Medi-Cal covers 40% of all children in California, and one in three individuals overall.<sup>28</sup> Half (50%) of all individuals covered by Medi-Cal are Latinx, 19% are white, 10% are Asian, and 9% are Black. Among beneficiaries, 62% speak English and 32% speak Spanish. Children ages 0 to 20 comprise 42% of Medi-Cal enrollees.<sup>28</sup> In California, all children and adolescents who qualify for state Medi-Cal benefits by income (up to 226% of Federal Poverty Level) are eligible, regardless of citizenship or immigration status.<sup>28</sup> Health care providers who seek Medi-Cal reimbursement for screening immigrant adolescents for ACEs will need to respond to the rich cultural and linguistic diversity of young Californians, but at least will not encounter problems for reimbursement that might occur in states with eligibility restrictions.

There are several tools designed to screen youth for ACEs. In California, clinicians must use the Pediatric ACEs and Related Life-events Screener (PEARLS) with children and adolescents ages 0-19 to receive Medi-Cal payment for conducting



ACE screenings. Both the adult and pediatric versions of the screener contain the 10 questions about ACEs from the original Kaiser Permanente and CDC study.<sup>4</sup> The PEARLS screener has an additional section with nine questions about community violence, discrimination, and other social determinants of health, with one reference to separation from a parent due to immigration.<sup>29</sup> The PEARLS is available in 17 languages. Studies on the validity and acceptability of this tool in primary care settings are emerging;<sup>30,31</sup> however, as noted above, additional research is needed to understand whether the PEARLS is acceptable and effective with immigrant youth—in other words, how comfortable youth feel in disclosing sensitive information. One aspect that may help to make the tools more acceptable is the use of a de-identified screener, reporting on a composite ACEs score as compared to reporting on a specific ACE they have experienced.

# QUALITATIVE STUDY

## METHODOLOGY

The aim of our study was to obtain feedback from health care providers and adolescents on how to implement developmentally and culturally appropriate ACE screenings and follow-up for immigrant adolescents, as well as adolescents in general. We conducted individual interviews with providers and focus groups with adolescents. Our study was approved by the Institutional Review Board of the University of California, San Francisco.

### Health Care Provider/ Administrator Interviews

We conducted Zoom interviews with 14 adolescent health care providers/administrators (10 in California and four from other states) who had considered or were implementing ACE screening efforts. Participants were recruited through postings on listservs of adolescent health care providers, referrals by providers to other potential study participants, and other word-of-mouth strategies. The recruitment letter specified that we were interested in speaking with providers working with low-income and immigrant adolescents. Each interview participant received a \$25 gift card for their time. All interviews were recorded through Zoom, with permission of the participant, and transcribed.



Reflecting California's diverse population and the high number of immigrant families in the state, all the clinicians we interviewed worked with at least some immigrant families, and many with a primarily immigrant patient population. Two participants worked in designated refugee clinics. Nine had been screening for ACEs between three months and 10 years, and five (including two outside of California) had not yet begun screening adolescents for ACEs, including the two providers who worked in refugee clinics. Four participants were designated champions for implementing ACE screening in their respective institutions. Most health care practices that screened for ACEs used the PEARLS. The others used the original ACE screen,<sup>1</sup> with their own additional questions about social determinants of health (SDOH). SDOH questions included such factors as exposure to violence, discrimination, and housing and food insecurity. The providers who participated in the



study cared for Latinx, Middle Eastern, Asian, and African immigrants, refugees, and asylees. Any quotes about a particular group of immigrants reflect that participant's own experience and are not meant to be definitive generalizations.

To provide a multi-dimensional picture of the range of ACEs-related experiences, we sought to capture a continuum of experiences, given that adolescents have traditionally not been screened for ACEs. We included providers who were not yet screening for ACEs in order to increase the usefulness of this study for those just beginning their ACEs screening implementation efforts, and we incorporated insights from sites and providers with ACE screening experience, including those—referred to as “champions”—who have provided trainings. We also developed a set of recommendations that respond to perceived barriers identified by those who previously have hesitated to engage in screening.

## Adolescent Focus Groups

Two focus groups were conducted with adolescents and young adults in English via Zoom with four youth in each group. At least one youth in each group was from an immigrant background. Participants ranged in age from 13 to 21 and were recruited through referrals from individuals working in adolescent health care and social service settings. As with other studies being conducted in immigrant communities, the COVID-19 pandemic impacted all focus group recruiting.<sup>32</sup> All recruiting was done via phone or electronically, and many immigrant families had limited access to Wi-Fi or computers. These populations, like others, were more comfortable with the face-to-face outreach and providing permission that they experienced prior to COVID.<sup>32</sup>

We obtained verbal permission from all adolescents and, for those under age 18, their parents or guardians. We recorded the focus

groups with permission of all participants. All youth participants received \$30 gift cards for their time.

## Data Analyses and Reporting

We analyzed the interview and focus group data using Atlas ti version 9 software. Coding was conducted using grounded theory methods<sup>33</sup> and emerging themes identified.<sup>34</sup> Preliminary analysis informed continuing data collection, and individual interviews were discontinued when data saturation was reached—that is, when no new themes or codes emerged. Codes and emerging themes were compared and discussed among investigators and research associates.

We have not identified individual providers or adolescents in the quotes below in order to preserve their confidentiality. In sections where there are multiple quotes, each quote is from a different participant unless noted. We did not identify health care providers by role (such as nurse practitioner or physician), as we found that opinions and insights about screening for ACEs did not differ across these disciplines. We occasionally report the kind of setting a participant works in to help with context.

Because a minority of youths in the focus groups came from or spoke specifically about their experiences in immigrant families, relevant quotes from the focus group participants are noted and interspersed with provider views to capture both perspectives.

# QUALITATIVE STUDY

## FINDINGS

### Benefits of Screening Immigrant Families for ACEs

Interview participants shared that a key benefit of screening immigrant adolescents and their families for ACEs was opening up the conversation about trauma and its impact on the family, as noted by one provider:

“I think I have seen that to be true across cultures. I have noticed for sure that the way people of different cultural backgrounds respond to our concern about trauma, or the way they contextualize what to do about it may be very different. But the asking about it in the conversations about trauma are actually not as variable as I thought they might have been.”

They also saw positive changes in the clinic atmosphere as it pertained to prioritizing ACEs:

“I think it was very eye-opening for the staff. Over time, we’re seeing that they’re integrating that language around ACEs, around trauma into their day-to-day, into our work day-to-day, that it’s just as how we talk about blood pressure and height and weight, we talk about ACEs cause and ACEs exposure. That it’s just integrated into our workflows.”

### Immigrant Families and ACEs Screening During COVID

The COVID-19 pandemic has impacted California’s immigrant families even more than other low-income families, as they often do not have access to any government assistance, are working jobs with minimal health and safety protections, and often live in crowded, substandard housing.<sup>32</sup> Additionally, interview participants reported that, at the height of the pandemic, many clinics prioritized in-person visits for younger children who needed vaccines and surveillance of rapid developmental changes, rather than in-person adolescent visits. Although this allowed more time for planning how to institute ACE screening with adolescents, it also meant that adolescent health needs were not being adequately addressed.

Before COVID-19, adolescents and parents in several health care organizations would both fill out confidential screeners in the waiting room, which raised concerns that parents had viewed or even filled out the screener. However, because of social distancing protocols during COVID-19, teens were roomed immediately without their parents, and filled out PEARLS and other screeners by themselves.

Some clinics with high immigrant populations screened for ACEs only at in-person visits, while others assigned a medical assistant to call the adolescent for all psychosocial screenings, including the PEARLS, and enter them into the electronic record. Then the provider would

would call for a follow-up telehealth visit within 30-60 minutes. De-identified ACE screening was preferred, but stakeholders acknowledged that it was difficult to do via telehealth. This was particularly true for immigrant families, who often did not have access to computers or stable internet connections.

## Language and Literacy Concerns

Language and literacy barriers were a common concern expressed by providers, whether or not they were currently screening for ACEs. Providers shared their worries about the extra time that would be needed to assist immigrant families in filling out the PEARLS, due to low literacy levels and language barriers, given the time needed to fill out existing required screening questionnaires. Several providers working with Latinx immigrants stated that Spanish was often their second language while their first was an indigenous language from Mexico or Central America, and that parents might not be literate in any language. Some newcomer teens might also speak limited Spanish and have low literacy levels in either Spanish or English. One clinician talked about the experiences of new patients before the COVID-19 pandemic:

**“They’d get a stack of papers. They don’t know what goes to the front desk, what are we asking for as far as the clinic side. It’s just so overwhelming.[There are] folks that don’t have good literacy and then the MA [medical assistant] has to come in and literally just translate, read them all the questions, and fill it out with them.”**

This same provider noted that during the pandemic, medical assistants were calling families before their visit to administer the screens, including the PEARLS, by telephone, with the intention that they would be seen in the clinic or by



telehealth by the provider that same day.

Several providers noted that medical assistants were more likely than providers to come from the same communities as immigrant clients, especially Latinx immigrants, and that the burden of reading and translating questions for families fell on them. In combination with other required screens, such as the Staying Healthy Assessment (SHA) and the Ages and Stages Questionnaire for young children, medical assistants in safety-net clinics are often overloaded, even without being called upon to offer extra translation and literacy assistance. In comparison to the SHA and Ages and Stages, the ACE screener is relatively short, “even though it’s emotionally loaded. I don’t think that they are upset about it. It doesn’t take as much of their time.”

When no one in the clinic speaks the language of immigrant families, telephone or video interpreter services are used, which can add even more time to the interview. As a provider noted:

“Then when you actually have to have the interpreter explain the question, and then explain if it’s a scaled response, it can take forever... because in a way the questions are worded, I don’t know if they’re actually being interpreted correctly. Sometimes I’ll have to clarify, but then that takes the back and forth with the interpreter to clarify.”

The quality of interpretation varies, and it is difficult for providers who don’t know the language to assess how sensitive questions and answers are being interpreted. Many clinics in California hire interpreters for indigenous Mexican and Central American languages, which allows for more stability and interpreter-clinician partnership.<sup>30</sup> Some patients who belong to these small linguistic communities express reluctance to use local interpreters, for fear that their confidential information would get back to their community or that the interpreter would look down on them.<sup>35</sup> One provider in a refugee clinic with many Syrian families stressed the importance of having Arabic-speaking clinicians, not just for the language

interpretation, but also to help the clinic staff be more culturally responsive.

## Immigrant Families and the Need for Trust in Health Care Systems

One provider from another state discussed some of the barriers to receiving services from a mobile van, serving the Latinx community and rural areas:

“We are vigilant about not getting a bill coming to the house—there is nothing. This is not in any way connected to the government. Because there’s even concern around immunizations going into the state immunization registry ... There’s lots and lots of discussion around privacy and confidentiality there.”

A mental health clinician working in a California school district talked about screening an adolescent for ACEs in a secondary school with many immigrant teens:

“It could have been my own feeling, or it could have been real or maybe both, but there was a question about immigration there, and they were kind of worried about how tied in we were with the authorities and whatnot, so I don’t think it was ever explicitly said.”

This provider also noted that in one other school students had more trust in the teachers and the principal. “I think having that trust that just exists within the school really helped me facilitate that screening.”

Several other providers stated that their clinic was highly trusted by immigrant families:

“We have a very high Latino population. Our staffing reflects the community as well, so that people do find it to be a safe place and disclose their status and come for care when they need it. I don’t think that people are not being truthful on the screens.”







She specified that this included undocumented families in the practice. Another provider agreed, stating, “I actually would have thought that would be a concern. I think I may have even voiced that during our training initially and it has not come up.” The provider went on to say that even with Spanish-speaking newcomer families, hesitancy, or a reluctance to disclose, did not come up during the ACE screenings he had done.

One immigrant youth described the process by which he felt comfortable seeking confidential services:

“I actually began going there because I had a mentor from one of my mentorship programs who worked there. I think what made me feel comfortable was I knew someone who worked there, not necessarily because they were my physician, but because there was someone ... who I didn’t feel a stranger to.”

While this process of building trust could be important for any adolescent, the personal connection is even more critical for immigrant youth. Providers working with immigrant families also felt that the families needed more explanation about the screening and its purpose to further build their trust.

## Immigrant Families and Unmet Needs: Reluctance to Disclose

Recent immigrants have multiple unmet health needs, which also adds to the complexity of a visit.<sup>36,37</sup> Some providers scheduled a second visit for “close follow up.” One provider at a clinic serving primarily immigrants from Latin America stated, “All of us practice in such a way that we almost always bring them back within a month or two to [ask], ‘Okay, how are things settling in? How are you doing?’”

Providers working with a high proportion of immigrant families noted that they tended to answer “no” to yes/no interview questions, due to unfamiliar formats, and reluctance to disclose problems.<sup>35</sup> This reluctance may change over time, as they build trust in a clinic or with a specific provider.

“I think part of that might just be around the stigma about disclosing things outside of the home... I think also with the ACE screens that I’ve done with the younger kids I have had initially it’s all zeros and then sometimes it’ll come up with one thing as positive over time when you do it.”

One administrator who was a champion of ACE screening in a primarily immigrant community stated:

“For the most part, I would like to think that they were pretty forthcoming, and we did have some scores which were definitely in the high ranges. These came from immigrant families, and most of it I suppose was just related to again, dealing with trauma within their own household and mental health issues within their own household.”

Providers noted that immigrant families were also concerned about the possibility of being reported to Child Protective Services and the impact that

could have on their immigration status, increasing their risk for deportation.

“Anecdotally, and this is a broad observation from a combination of my teens and my younger kids, I found that a lot of families will mark ‘no’ on the PEARLS, and then somewhere else in our history, it will come up and it’ll be clear to me that they did not disclose something on there that they then verbally talked about in some other way. I think families are afraid of what does it mean if I mark ‘yes’ to this, and a lot of the families that we deal with are afraid that it will trigger a child abuse report, and have a lot of anxiety about the child protective system in general.”

An immigrant young adult focus group participant also commented on mandatory reporting:

“We don’t want the spotlight on us because the whole purpose of us just staying in the shadow is to not be noticed. My point is that, as they mentioned, just taking that portion [mandatory reporting] out would help more, at least I can say that it would help more, because it allows that space, to keep on existing, where you can just speak your mind and speak what’s going through you.”

A provider, also concerned about the impact of reporting on immigrant families, said that she consulted with other providers before making a report about an immigrant family:

“We don’t just call on our own. We usually talk with one or two other providers to bounce these things off. It’s something that we’re always worried about. Really, calling DCFS [Department of Child and Family Services] is not an easy thing, even without immigrant status. We still consult each other in those cases.”

## Concerns About Re-traumatization

Many providers working with immigrant families have expressed concerns about re-traumatizing them, especially those who are refugees and asylees, by asking them again about prior traumatic experiences.<sup>38</sup> One clinician in a clinic that served immigrants from Guatemala, El Salvador, Honduras, and Yemen, stated, “All of the teens that come here, especially the unaccompanied ones that we’re talking about, have some kind of trauma. All of them.” One refugee clinic provider who worked primarily with Middle Eastern and African refugees stated that they were often quite reluctant to talk about past traumas, reminding the clinician that they were “here now” and grateful to be in a safer place.

However, most providers who screened for ACEs stated that families seemed to be open to discussing their stresses, either after filling out the PEARLS or after more open-ended psychosocial discussions. Two providers who were experienced in talking with adolescents stated that the PEARLS did not bring up any new topics that they had not already covered in open-ended discussions, particularly reportable topics. One clinician noted, “If you’re treating kids and teens, your role is to constantly assess for safety.” Several providers talked about how they “normalized” screening for past traumas with immigrant teens and offered support with or without disclosure.

“Sometimes I’ve had young people who’ve had some pretty traumatizing things happen before they got here. Or the reasons why they came here, you don’t need to talk to me about that, but this helps us understand if you need more support. Is there stuff that you think might be contributing to where you are and how you’re feeling emotionally or something like that?”

## Screening for Social Determinants of Health

Part 2 of the PEARLS asks more about a history of community conditions and adversities that may represent risk factors for toxic stress, as well as SDOH in general.<sup>2</sup> One provider in a refugee clinic that was not screening specifically for ACEs highly endorsed the SDOH screener they were using, Safe Environment for Every Kid (SEEK),<sup>39</sup> as it helped them understand the extent to which the family's stress reactions came from past traumas or from current stresses, like housing insecurity:

**“Sometimes even if we can't hook them up with a therapist because they don't think of mental health things as things that they address by talking to a therapist, or logistically we can't, sometimes we can hook them up with an organization that can help them address housing insecurity, for example.”**

A health system with a high immigrant population used the traditional ACEs questions and their own SDOH screen, which covered: “A couple of housing questions, food insecurity, electricity, gas, oil, transportation, medication. Do you need legal help? Immigration is one of the examples. It's like child family services, immigration, housing discrimination, domestic issues.”

Another provider in the same system noted that immigrant families, including those who spoke English as a second language, accessed referrals generated out of SDOH screening at greater rates than US-born parents living in the same neighborhood.

A champion of ACE screening in a large health maintenance organization with many immigrant families discussed the issues they were having with the use of the PEARLS questionnaire along with their own pre-existing screeners, although the PEARLS Part 2 did have some additional useful questions:

**“I would say the pros were that it asks some questions that we don't currently ask in our current confidential screeners—for example, about social determinants of health. Our current questions don't ask a lot about what resources they have at home, about poverty-related questions, housing, immigration. Those questions are not really included in our current screeners.”**

This provider also noted that the SDOH screening in PEARLS brought up previously unknown financial issues for teens and families in their practices. She stated that some of these issues could be seen as private for immigrant families.

**“I think that's part of that normalizing it, where they feel a little bit more comfortable in disclosing. Yes, in general, there is this stigma about talking about issues like violence in the home or money issues, financial issues. All of these are considered very personal. Not for fear so much of repercussions, but just that privacy is really considered important.”**

Several providers noted that their clinics had developed important links to organizations serving immigrant families in their neighborhoods.

## Ensuring Confidentiality for Immigrant Teens

The importance of confidential conversations and services for adolescents is well documented in the literature, and research has shown that teens are more willing to disclose sensitive information if screening occurs apart from their parents/guardians.<sup>40</sup> Time alone with a provider is equally important to immigrant adolescents but may be more difficult to achieve. Providers noted the reluctance of immigrant parents to allow adolescents to speak with a provider alone, especially young women. In one refugee clinic, all initial visits were conducted with the entire

family, and teens were seen alone in a subsequent visit, after the family had gained more trust in the setting.

Providers who identified as immigrants themselves noted that their own parents would not leave the room when they were teens, and they discussed several strategies for negotiating confidentiality in their clinics.

“...At least in the past, even prior to ACE screening, one issue that we’ve had with immigrant families is that they are very hesitant to allow the teen to do the visit on their own. Even if they’re 14, 15 years old, they’re like, ‘No, I want to be in the visit the whole time.’”

“Yes, I think there is a big cultural difference in terms of the level of comfort that parents have in allowing the teen to have a confidential visit, or even talking openly about things like your periods—at the age when we start talking about those issues—or how much detail we can talk about it. I’ve definitely had dads leave the room the minute the word period comes up or the minute I say that I want to do an exam, the dad turns around and leaves.”

A provider working primarily with Middle Eastern families stated that families were often reluctant to have young women seen alone or examined due to concerns about the provider doing a genital exam. One of the Arabic-speaking physicians in the clinic encouraged other providers to wait to ask Arabic-speaking adolescent refugees about dating and sexual activity until after they and their parents had gained trust in the clinic and had been in the U.S. a little longer. The provider stated that she did ask “if they’ve ever had any sexual contact in part because of the awareness that someone could be assaulted,”



but otherwise followed the advice of her colleague.

Another provider who self-identified as an immigrant stated that she started “prepping” immigrant families a few years before their children would turn 12, about having time alone with a provider in future visits. She continued, “I do have families where the parent does insist on coming into the room and when that happens, I sort of just allow that and then I do have to politely ask them to step out after a little while.... It does work quite well if you just explain it in a very deferential way.”

An immigrant teen shared their experience:

“Growing up, I moved homes a lot. Depending on the part where I moved, I would have a different care provider. My second most recent care provider... they read it off of paper like, ‘Oh, if you have any questions, you need to see a therapist, just let me know.’ Just basically reading it off of paper while my mom was in the room. I couldn’t really be like, ‘Oh, yes, I want to check out that therapist option,’ because in my culture it’s more of a ‘pull yourself up by the straps and get on with it.’”



# LINKING THE PERSPECTIVES OF PROVIDERS AND ADOLESCENTS

## SUMMARY AND RECOMMENDATIONS

**P**roviders and adolescents shared key insights that can inform more effective ACE screening with immigrant youth. Both providers and adolescents discussed the importance of ensuring confidentiality, allowing time for patients to become accustomed to the provider and clinic before screening, and understanding that some individuals may not want to disclose or discuss past trauma or may have more pressing immediate stressors that need to be addressed. Providers were particularly sensitive to the importance of capacity building across all individuals working in clinics, so that every staff member is attuned to the importance of trauma-informed care.

Based on our review of the current literature on ACE screenings with immigrant youth and findings from our qualitative study, we offer the following recommendations for health care providers to screen immigrant youth for ACEs. Our companion practice paper, *Screening Adolescents for Adverse Childhood Experiences (ACEs): Incorporating Resilience and Youth Development*, offers recommendations for screening adolescents in general. The following recommendations build upon the recommendations from the companion paper, but are focused on the specific needs of immigrant youth and the providers who are



devoted to working with them, as well as the systems in which they work.

### ✔ **Provide culturally appropriate healing-centered training for all clinic staff.**

Immigrant adolescents may experience multiple levels of trauma within their country of origin as well as in adjusting to their new country within the historical and political context shaping immigrants' experiences of being welcomed or rejected. These experiences impact the types of interactions adolescents have with the health care system. For example, under the Donald Trump presidential administration, immigrants entering the U.S. were vilified and threatened with denial of permanent

residence for any use of previously allowable public benefits.<sup>27</sup> This chilling atmosphere affects the willingness of patients to disclose personal experience, and remains a caution in the community, even after a new administration was elected. In turn, a greater sensitivity by the provider is required to sort out where the trauma may have been experienced through an ecological lens—whether these experiences occurred at the family level, the community level, in their home country, during migration, in the U.S., or simultaneously at many levels and times. Refugee adolescents and those seeking asylum have had to tell their stories multiple times, and it may be a more trauma-informed approach to forgo additional screening and focus on providing supports, coping skills, and community and behavioral health referrals.

For many adolescents and their families, SDOH-related issues cause additional stress and impact their abilities to adjust. All of these complexities, as well as the political nature and timing of immigration and asylum seeking, test the compassion and capacity among providers and the settings in which they work. Each of the staff interacting with the adolescent and their family, from the first outreach through clerks and medical assistants to care providers, needs the support, training, and time to deliver trauma-informed, healing-centered care, with the aim of building trust at its core. Clinics should explore local food banks, housing assistance, and legal referrals for immigrant families. For example, some California county health departments and professional organizations have resource pages.

### ✔ **Ensure adequate time for screening, and address screening fatigue.**

Providers caring for immigrant teens recognize that building trusting relationships in which effective screening and conversations about childhood adversity can occur takes time, likely more than one visit. Translating questionnaires (for both the client and the provider), culturally responsive history-taking, addressing stigma, and receiving disclosures later in the visit all add time to the appointment. Safety-net clinics have packed schedules, and clinic staff, providers, and administrators may need to strategize creative solutions to balance the competing needs of immigrant families and clinic functioning. The “screening fatigue” raised by participants comes from multiple lengthy questionnaires on the same day and may also be intensified by the content of the questions. This may also be an issue to address at the level of health departments to see if there is a way to streamline multiple questionnaires or address reimbursement for the extra visit time needed for immigrant families with complex medical and psychosocial needs.

### ✔ **Address potential confidentiality concerns.**

Culturally responsive negotiations with immigrant families to ensure time alone with a provider can be challenging and may not be successful during the first visit. Preparing families by explaining why time alone is acceptable and reassuring them that they will be included appropriately may help. In addition to preparing parents before their children reach adolescence, culturally consonant providers, staff, and youth advisors may be able to develop health education materials for adolescents and parents about confidentiality protections and guidelines, and strategies for working with families to achieve confidential care. This is important not only to provide a safe space in which immigrant youth can disclose private information but also provides an

opportunity for them to start developing the skills necessary to navigate being effective health care consumers in the future.

With the implementation of the 21st Century Cures Act Final Rule, parents have access to their adolescents' medical records until age 18 and may be able to access or control their online portals.<sup>41</sup> Immigrant adolescents may not understand the details or implications of this lengthy and confusing law. It is crucial for health care providers to affirmatively sequester confidential discussions about sexuality, drug and alcohol use, and mental health, including trauma details that the adolescent may not want to reveal.

✔ **Ensure that sensitive information collected during ACE screening is not used to stigmatize immigrant youth and families.**

Provider, family, and adolescent concerns about access to sensitive information, ranging from Child Protective Service reports to immigration status, will remain barriers to effective screening unless all are assured of the rationale for collecting this information, any potential repercussions of this information, and control over its release. As ACEs disproportionately affect communities of color and immigrant communities, it is particularly important that screening is a way to combat rather than add to structural racism<sup>42,43</sup> and immigrants' fears about deportation.

✔ **Consider the value of SDOH screening in differentiating toxic stress due to current SDOH issues versus the impact of past traumas.**

Adolescents and their families may gain additional trust in their provider and system of care when they begin to receive services for their social and economic needs, even if it does not relate directly to healing the trauma they have experienced. Parallel to Maslow's Hierarchy,<sup>44</sup> which holds that basic needs need to be attended to before psychological needs can be dealt with, the adolescent and their family may benefit from the greater acceptability of receiving community support, such as shelter or practical help navigating unfamiliar community institutions. Such stabilizing supports will also contribute to increasing trust with the provider and will enable the adolescent to deal with their traumas, particularly if there is healing-centered care available to deal with their more difficult past and present experiences. Additionally, whatever the stressors, the recommendations for addressing stress from *The Roadmap for Resilience: The California Surgeon General's Report on Adverse Childhood Experiences, Toxic Stress, and Health*<sup>2</sup> can be beneficial for immigrant families. Discussing supportive relationships, quality sleep, balanced nutrition, physical activity, mindfulness practices, experiencing nature, and mental health care as needed in culturally responsive conversations with all immigrant families can strengthen clinic-family partnerships and promote healing.



## RESOURCES FOR SUPPORTING IMMIGRANT YOUTH IN CALIFORNIA

- **American Academy of Pediatrics, Immigrant Child Health Toolkit**  
<https://www.aap.org/en/patient-care/immigrant-child-health/>
- **Caring for former unaccompanied immigrant minors:  
A culturally relevant and trauma responsive toolkit for providers**  
<https://www.bbhouston.org/toolkit>
- **Growing up in a new country:  
A positive youth development toolkit for working with refugees and immigrants**  
<https://brycs.org/toolkit/growing-up-in-a-new-country-a-positive-youth-development-toolkit-for-working-with-refugees-and-immigrants/>
- **Guidance for mental health professionals serving unaccompanied children released from government custody**  
<https://youthlaw.org/publication/guidance-for-mental-health-professionals-serving-unaccompanied-children-released-from-government-custody/>
- **Los Angeles County Immigrant Youth Toolkit**  
<https://aapca2.org/toolkit/>
- **Newcomer Central American Youth: Informing our practice in school-based health centers**  
[https://achealthyschools.org/wp-content/uploads/2021/03/InformingourPracticeLCDLR\\_UIYReport2021.pdf](https://achealthyschools.org/wp-content/uploads/2021/03/InformingourPracticeLCDLR_UIYReport2021.pdf)
- **United We Dream, Resources and Toolkits to protect young immigrants**  
<https://unitedwedream.org/tools/toolkits/>



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