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Public Health Approaches to Child and Parent Screening: Implications for Child Protection

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PUBLIC HEALTH APPROACHES TO CHILD AND PARENT SCREENING: IMPLICATIONS FOR CHILD PROTECTION

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In recent years, there has been an expansion of wide-scale screening of young children and parents for mental health problems, although screening efforts that target children have outpaced those focused on parents. This article examines the potential benefit of child and parent screening to state and community child protection efforts. Gaining a deeper understanding of current trends in screening may help individuals involved in child welfare across multiple disciplines promote approaches to screening that could maximize its value for child protection.

This article begins with a discussion of a public health approach to screening and the research supporting this approach. Next, examples of state screening policies and initiatives are described, along with evidence of their capacity to identify vulnerable children and parents. A final section discusses the multiple ways in which child and parent mental health screening can advance child protection and the most promising approaches to screening.

I. A PUBLIC HEALTH APPROACH TO CHILD AND PARENT SCREENING

Screening for mental health conditions involves the use of a standardized tool to identify individuals at high risk of a condition who should be further evaluated to determine the need for intervention.[1] A public health approach entails efforts to

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[1] *E.g.*, Council on Children With Disabilities et al., *Identifying Infants*

screen *all* individuals within a defined population that may be circumscribed by certain characteristics, such as age (e.g., all preschoolers) or geography (e.g., within a community).[2] The goal of a public health approach to screening children and parents for mental health problems is to identify problems as early as possible in order to offer interventions designed to help reverse or prevent the worsening of difficulties that can have broadly negative effects on children's well-being and functioning. Often, public health screening uses public awareness messaging about the benefits of screening. Both positive public messaging and the way in which broad screening efforts do not predetermine or label those most at risk may help reduce any stigma associated with participation. While noting the merits of public health screening, it is also important to appreciate more targeted screening efforts that can help ensure identification of mental health and developmental problems in very high-risk populations. A notable example is the child screening that is required under the Child Abuse Prevention and Treatment Act ("CAPTA").[3] Under CAPTA, child protective agencies are required to refer a child involved in a substantiated case of child abuse or neglect to the Part C Early Intervention Program or to conduct developmental screening to determine

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and Young Children with Developmental Disorders in the Medical Home: An Algorithm for Developmental Surveillance and Screening, 118 AM. ACAD. PEDIATRICS 405, 414 (2006), *available at* http://pediatrics.aappublications.org/content/118/1/405.full.html. For a study that demonstrates the "effectiveness . . . of screening and follow-up care," see Barbara P. Yawn et al., *TRIPPD: A Practice-Based Network Effectiveness Study of Postpartum Depression Screening and Management*, 10 ANNALS FAM. MED. 320 (2012). *See also* Cheryl B. Brauner & Cheryll B. Stephens, *Estimating the Prevalence of Early Childhood Serious Emotional/Behavioral Disorders: Challenges and Recommendations*, 121 PUB. HEALTH REP. 303, 303–09 (2006) (discussing the increase and prevalence of emotional/behavioral problems in young children).

[2] *See* JON MILES ET AL., A PUBLIC HEALTH APPROACH TO CHILDREN'S MENTAL HEALTH: A CONCEPTUAL FRAMEWORK 29 (2010), *available at* http://gucchdtacenter.georgetown.edu/publications/PublicHealthApproach.pdf (defining "population" and "community" in the public health context).

[3] 42 U.S.C. §§ 5101–07, 5116–16i (2011).

whether such a referral is needed.[4] Each state's Part C program provides developmental screening and evaluation as well as early intervention services for children birth to age three who are found to have developmental delays or a physical or mental condition likely to result in a delay;[5] states also have the option of serving children at risk of developmental delay.[6]

There is strong research support for a public health approach to screening. Rates of behavioral difficulties in young children are high, ranging from nine to fourteen percent in the general population[7] and approaching thirty percent among poor children.[8] Behavioral problems have been found to be more prevalent among poor children compared to more affluent children as early as nine to twenty-four months.[9] Mental health problems identified in early childhood tend to persist in the absence of interventions and have negative effects on children's learning and school success.[10] Evidence linking behavior problems in

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[4] CHILDREN'S BUREAU, U.S. DEP'T OF HEALTH & HUMAN SERVS., CHILD WELFARE POLICY MANUAL 65 (2012) *available at* http://www.acf.hhs.gov/cwpm/programs/cb/laws_policies/laws/cwpm/pdf/cwpmall.pdf.

[5] TANIESHA A. WOODS ET AL., PROMOTING THE SOCIAL-EMOTIONAL WELLBEING OF INFANTS AND TODDLERS IN EARLY INTERVENTION PROGRAMS: PROMISING STRATEGIES IN FOUR COMMUNITIES 5 (2010), *available at* http://nccp.org/publications/pdf/text_946.pdf.

[6] *Id*. at 11.

[7] Cathy Huaqing Qi & Ann P. Kaiser, *Behavior Problems of Preschool Children From Low-Income Families: Review of the Literature*, 23 TOPICS EARLY CHILDHOOD SPECIAL EDUC. 188, 198 (2003). One study found the "prevalence of emotional/behavioral disturbance in children 0–5 years" old to be even higher: between 9.5% and 14.2%. Brauner & Stephens, *supra* note 1, at 307.

[8] Huaging Qi & Kaiser, *supra* note 7, at 198; *see also* Adriana Feder et al., *Children of Low-Income Depressed Mothers: Psychiatric Disorders and Social Adjustment*, 26 DEPRESSION & ANXIETY 513, 514 (2009) ("34% of the assessed children of depressed mothers had a current psychiatric disorder.").

[9] TAMARA HALLE, ET AL., CHILD TRENDS, DISPARITIES IN EARLY LEARNING AND DEVELOPMENT: LESSONS FROM THE EARLY CHILDHOOD LONGITUDINAL STUDY – BIRTH COHORT (ECLS-B) 7 (2009), *available at* http://www.childtrends.org/Files/Child_Trends-2009_07_10_FR_DisparitiesEL.pdf.

[10] *See* Alysia Y. Blandon et al., *Testing a Developmental Cascade Model of Emotional and Social Competence and Early Peer Acceptance*, 22 DEVELOPMENTAL PSYCHOPATHOLOGY 737, 746 (2010) ("[C]hildren's ability

children to child maltreatment suggests that children with challenging behaviors, which may include oppositional or aggressive styles, may elicit abusive treatment from adults.[11]

Rates of maternal depression are also high during pregnancy and in the first year after birth, ranging from ten to twenty percent, but are even higher for women in poverty—over twenty-five percent.[12] Among low-income mothers of young children, research shows rates of depression as high as forty to sixty percent.[13] There is substantial evidence that maternal depression has negative effects on children's cognitive and behavioral outcomes.[14] Chronic depression in children's early years may be especially harmful. Dr. S.B. Ashman and colleagues examined associations between mothers' experience of different patterns of depression from a child's birth through

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to comply with adult directives and mange impulsive responses are key aspects of children's behavioral regulation, which are thought to be important for their transition into the school environment." (internal citation omitted)); Rebecca J. Bulotsky-Shearer & John W. Fantuzzo, *Preschool Behavior Problems in Classroom Learning Situations and Literacy Outcomes in Kindergarten and First Grade*, 26 EARLY CHILDHOOD RES. Q. 61, 68 (2011) (discussing the correlation between children that have exhibited behavioral issues within structured learning environments and low literacy rates).

[11] *See* Angela Moreland Begle et al., *Predicting Child Abuse Potential: An Empirical Investigation of Two Theoretical Frameworks,* 39 J. CLINICAL CHILD & ADOLESCENT PSYCHOL. 208, 213–16 (2010); Ginny Sprang et al., *Factors that Contribute to Child Maltreatment Severity: A Multi-Method and Multidimensional Investigation*, 29 CHILD ABUSE & NEGLECT 335, 344 & tbl.3 (2005) (evidencing the correlation between a child's externalized delinquent behavior (i.e., "CBCL eternalizing") and the "[s]everity of child maltreatment").

[12] Marian F. Earls, Committee on Psychosocial Aspects of Child and Family Health, *Clinical Report – Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice*, 126 PEDIATRICS 1032, 1032 (2010).

[13] *Id.*

[14] *E.g.*, Nat'l Scientific Council on the Developing Child, *Maternal Depression Can Undermine the Development of Young Children* 5–6 (Harvard Univ. Ctr. on the Developing Child, Working Paper No. 8, 2009), *available at* http://developingchild.harvard.edu/index.php?cID=341 (internal citation omitted).

age seven.[15] Compared to mothers with decreasing or mild, stable depression, children of mothers with chronic, severe depression had the highest levels of externalizing problems and lower social competence. These children also showed decreased generalized brain activation, a possible indicator of reduced attentiveness. Elevated, but less severe, behavioral problems were also found in children of parents with decreasing or mild depression.

II. STATE CHILD SCREENING POLICIES AND INITIATIVES

In various forms, child screening is prevalent across the states. All states conduct some level of developmental screening of infants and toddlers as part of the Part C Early Intervention Program.[16] In addition, developmental screening is part of well-child pediatric care under Medicaid and the Child Health Insurance Program, which, combined, serve over half of low-income children. [17] Several states are also expanding screening for children under age six with standardized tools that can identify children at risk for social-emotional difficulties.

Minnesota is notable for its comprehensive system of child screening that uses different, but coordinated, approaches for children under age three and for preschoolers ages three to five. At all ages, children are screened for both broader developmental and social-emotional problems.[18] The *Follow-*

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[15] Sharon B. Ashman et al., *Trajectories of Maternal Depression Over 7 Years: Relations With Child Psychophysiology and Behavior and Role of Contextual Risks*, 20 DEV. & PSYCHOPATHOLOGY 55, 72 (2008).

[16] Pascal L. Trohanis, *Progress in Providing Services to Young Children With Special Needs and Their Families: An Overview to and Update on the Implementation of the Individuals with Disabilities Education Act (IDEA)*, 30 J. EARLY INTERVENTION 140, 146 (2008).

[17] Genevieve M. Kennedy & Jennifer E. Pelletier, *The Role of Developmental Screenings in Medicaid and CHIP*, *in* IMPROVING THE LIVES OF YOUNG CHILDREN, at 1 (Urban Inst., Brief No. 1, 2010), *available at* http://www.urban.org/uploadedpdf/412275-improving-lives-young-children-1.pdf.

[18] SHEILA SMITH ET AL., NAT'L CTR. FOR CHILDREN IN POVERTY, BUILDING STRONG SYSTEMS OF SUPPORT FOR YOUNG CHILDREN'S MENTAL HEALTH: KEY STRATEGIES FOR STATES AND A PLANNING TOOL 18 (2011), *available at* http://nccp.org/publications/pdf/text_1016.pdf.

Along Program targets infants and toddlers through local public health agencies.[19] The agencies mail parents of all children under age three the Ages and Stages ("ASQ") and Ages and Stages-Social-Emotional ("ASQ-SE") to complete and return for scoring. ASQ is a broad developmental screening tool, while ASQ-SE focuses on behavioral and social-emotional concerns.[20] Three-quarters of Minnesota counties automatically enroll children from birth records; children are also enrolled by public health nurses making home visits, Women, Infants and Children (WIC) food and nutrition programs, and other social service agencies. Parents participate at a high rate, with ninety percent reported to return completed assessments. Preschool-age children are screened through the states' school districts under the Early Childhood Screening Program ("ECS"). Each year, approximately eighty percent of the state's preschoolers are screened before kindergarten entry; about five percent are found to have possible social-emotional difficulties and are referred for further evaluation. The ECS program reaches out to parents using a brochure that is available in five languages. This brochure provides a positive message about the free screening opportunity, inviting parents to come to the screening prepared to discuss questions they have about their child's development.

Arkansas has implemented a large-scale pilot that is screening children in child care settings.[21] In this pilot, directors and teachers in over 100 child care centers were trained to support parents' completion of the ASQ and ASQ-SE instruments. Screenings are followed up with reports to parents who are encouraged to discuss screenings with the child's pediatrician. In addition, teachers provide social-emotional supports in the classroom and report positive screens to children's pediatricians. Child care staff visited physicians' offices to describe the project and provide a letter from the

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[19] *Id.*

[20] Kelly A. Feeny-Kettler et. al., *Screening Young Children's Risk for Mental Health Problems*: *A Review of Four Measures*, 35 ASSESSMENT FOR EFFECTIVE INTERVENTION 218, 225 (2010).

[21] SMITH ET AL., *supra* note 18, at 17.

Arkansas chapter of the American Academy of Pediatrics that strongly encouraged health care providers to participate.

In addition to these examples, several states are expanding child screening through their Race to the Top Early Learning Challenge ("RTT-ELC") grants. For example, Massachusetts will provide ASQ and ASQ-SE tool kits to organizations involved in family support services and home visiting with the expectation that these organizations will screen fifty percent of children from birth to five years of age in the state.[22] In Maryland, expanded training on early childhood mental health screening and intervention will be provided to pediatricians.[23] States that applied for but did not receive RTT-ELC grants are also using their Early Learning Advisory Councils ("ELACs") to plan for expansions in child screening focused on young children's social-emotional well-being. New York's ELAC, for example, recently disseminated information about prototype communities in the state where wide scale screening is already taking place; the Council's workgroups are designing strategies for statewide expansion of child screening and response systems.[24]

III. STATE MATERNAL DEPRESSION SCREENING POLICIES AND INITIATIVES

Maternal depression screening, while less prevalent than child screening, is gaining momentum in a number of states.

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[22] COMMONWEALTH OF MASS., FROM BIRTH TO SCHOOL READINESS: THE MASSACHUSETTS EARLY LEARNING PLAN 2012–2015, at 57 (2011), *available at* http://www.ed.gov/programs/racetothetop-earlylearningchallenge/applications/massachusetts.pdf.

[23] STATE OF MD., RACE TO THE TOP: EARLY LEARNING CHALLENGE APPLICATION FOR INITIAL FUNDING 63 (2011), *available at* http://www.marylandpublicschools.org/NR/rdonlyres/E6A935DD-6D5B-4C71-8BF3-2CBB0ED437D9/31626/MDapplication.pdf.

[24] *See generally* N.Y. STATE EARLY CHILDHOOD ADVISORY COUNCIL, PROTOTYPE COMMUNITIES ACROSS NEW YORK STATE WITH INNOVATIVE DEVELOPMENTAL SCREENING SYSTEMS (2012), *available at* http://ccf.ny.gov/ECAC/ECACResources/ECAC_PrototypeChart.pdf (describing "some of the innovative early childhood developmental screening systems that exist throughout" New York State).

Ohio recently began implementing wide scale maternal depression screening through its statewide home-visiting program, which also provides child screening. During a pilot leading up to this expansion, fifteen percent of women screened positive for depression. Research on maternal depression screening has identified many obstacles to successful referrals and engagement in treatment, including attitudinal barriers, such as concern about stigma associated with psychological conditions and limitations in health care providers' ability to help women connect to needed services.[25] In order to help ensure that Ohio women who screen positive for depression obtain further evaluation and treatment, home visitors provide on-the-spot referrals to community mental health providers.[26] Ohio is also screening young children for social-emotional problems through its Alternative Response System.[27]

A small number of states have passed maternal depression screening legislation. Illinois passed the Perinatal Mental Health Disorders Prevention and Treatment Act in 2007,[28] and New Jersey passed the Post-Partum Depression Law in 2006.[29] Both states' legislation requires health care providers to screen women for depression during prenatal and postpartum visits, and to also provide women and their families with information about depression and treatment. Full-scale implementation is still awaiting the development of regulations in Illinois. A study of

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[25] Dwenda K. Gjerdingen & Barbara P. Yawn, *Postpartum Depression Screening: Importance, Methods, Barriers, and Recommendations for Practice*, 20 J. AM. BOARD FAM. MED. 280, 285 (2007), *available at* http://www.jabfm.org/content/20/3/280.full.pdf+html.

[26] SMITH ET AL., *supra* note 18, at 15–16.

[27] *Id.* at 26; *see also* OHIO DEP'T. OF HEALTH, HELP ME GROW POLICY AND PROCEDURE: HOME VISITATION SCREENING, ASSESSMENT AND PROGRAM EVALUATION (2010), *available at* http://www.ohiohelpmegrow.org/professional/laws/policies.aspx (follow "Home Visitation Screening, Assessment and Program Evaluation" hyperlink).

[28] SMITH ET AL., *supra* note 18, at 14.

[29] S. 213, 212th Leg., 1st Ann. Sess. (N.J. 2006) (codified at N.J. STAT. ANN. § 26:2-176 (West 2007)). For up-to-date information about state legislation, see *Legislation*, POSTPARTUM SUPPORT INT'L, http://www.postpartum.net/Professionals-and-Community/Legislation-.aspx (last visited Sept. 30, 2012).

women receiving Medicaid in New Jersey showed no improvement in the receipt of postpartum depression treatment following enactment of the legislation.[30] In 2010 Massachusetts passed a maternal depression law creating a commission to strengthen postpartum screening and treatment.[31] Partly in response to the findings in New Jersey, Massachusetts developed standards for implementing effective maternal depression screening.[32] These standards emphasize screening in multiple settings, special outreach to vulnerable populations including families experiencing financial insecurity, and efforts to address barriers to effective follow-up treatment, including the development of mechanisms to monitor patients' successful engagement in evaluation and treatment.[33]

A few other states are coming closer to passage of maternal depression legislation. Oregon's mental health commission has recommended the passage of legislation requiring the offer of screening to all women in prenatal and pediatric settings by 2015. Recently, maternal depression legislation was introduced into New York's Senate.[34] These and other state efforts are expected to receive support from the Federal Affordable Care Act ("ACA").[35] When fully implemented, the ACA will make grants to states to support maternal depression education, screening, and treatment.[36]

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[30] Katy Backes Kozhimannil et al., *New Jersey's Efforts To Improve Postpartum Depression Care Did Not Change Treatment Patterns for Women on Medicaid*, 30 HEALTH AFF. 293, 297 (2011).

[31] MASS. DEP'T OF PUB. HEALTH, STANDARDS FOR EFFECTIVE POSTPARTUM DEPRESSION SCREENING IN MASSACHUSETTS AND RECOMMENDATIONS FOR HEALTH PLANS AND HEALTH CARE PROVIDERS POSTPARTUM DEPRESSION SCREENING DATA REPORTING 5–6 (2012), *available at* http://www.mass.gov/eohhs/docs/dph/com-health/postpartum-depression/standards-recommendations.pdf.

[32] *Id.*

[33] *Id.* at 8–13.

[34] S. 383, 231st Legis. Sess., Reg. Sess. (N.Y. 2009).

[35] Patient Protection and Affordable Care Act (PPAC), Pub. L. No. 111-148, § 2952, 124 Stat. 119, 226–28 (2010) (codified at 42 U.S.C. § 712 (2011)).

[36] *Id.*

IV. HOW CHILD AND PARENT SCREENING CAN STRENGTHEN CHILD PROTECTION

There are several ways in which wide-scale screening for children's mental health problems can enhance child protection, although in each case, screening is just one important component of a broader strategy that would help vulnerable children. First, universal screening can increase young children's access to evidence-based interventions for social-emotional and mental health difficulties. Interventions are called "evidence-based" when they have shown evidence of effectiveness in one or more rigorous evaluations, most often randomized control trials in which participants are randomly assigned to treatment and control (non-intervention) groups. An increasing number of evidence-based interventions are available for young children from infancy through the early grades who are experiencing behavioral and mental health problems.[37] These interventions include dyadic therapy, such as Parent-Child Interaction Therapy, in which a clinician helps a parent learn more positive styles of interacting with her child,[38] as well as parent training delivered in group sessions, such as that offered in the Incredible Years Parent Training programs.[39]

Scaling up evidence-based interventions is challenging since practitioners need considerable expertise to deliver programs that show fidelity to a model. North Carolina has adopted a long-term plan for scaling up the Incredible Years parenting program

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[37] *See generally* Sheila M. Eyberg, Melanie M. Nelson, & Stephen R. Boggs, *Evidence-Based Psychosocial Treatments for Children and Adolescents with Disruptive Behavior*, 37 J. CLINICAL CHILD & ADOLESCENT PSYCHOL. 215, 215–37 (2008) (analyzing sixteen evidence-based psychological interventions).

[38] Rae Thomas & Melanie J. Zimmer-Gembeck, *Behavioral Outcomes of Parent-Child Interaction Therapy and Triple P—Positive Parenting Program: A Review and Meta-Analysis*, 35 J. ABNORMAL CHILD PSYCHOL. 475, 493 (2007).

[39] Francis Gardner et al., *Randomised Controlled Trial of a Parenting Intervention in the Voluntary Sector for Reducing Child Conduct Problems: Outcomes and Mechanisms of Change*, 47 J. CHILD PSYCHOL. & PSYCHIATRY 1123, 1129 (2006).

that could be used for other evidence-based interventions.[40] Through ongoing training activities, the state will work over several years to increase the number of professionals who are trained and certified to support other practitioners in delivering Incredible Years parent training with high fidelity to the model.[41]

Some advocates of child screening may be concerned that scaling up screening in advance of building an adequate supply of providers who can deliver effective interventions will lead to identified children being left unserved. While this is a reasonable concern, it can also be argued that the level of need for interventions can be documented in screening initiatives and this evidence can be used to advocate for building treatment capacity. Moreover, some children who screen positive for mental health problems, and who are confirmed by further evaluation to have difficulties, may still benefit from available community-based programs, especially high-quality early care and education. High-quality early care and education settings can provide children with strong supports for social-emotional competence, and in some cases, help reduce behavior problems.[42] An increasing number of states are using early childhood mental health consultants to work with teachers to create strong supports for children's social-emotional growth and individualized help for children with challenging behavior.[43] One response to a positive screen (in addition to further evaluation) would be placement in a high-quality early care and education setting, ideally one served by a mental health consultant.

While improving children's social-emotional functioning is certainly relevant to a broad definition of child protection, it is also possible that a reduction in child behavior problems can help reduce the chance that challenging child behavior will

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[40] SMITH ET AL., *supra* note 18, at 7.

[41] *Id.*

[42] Ellen S. Peisner-Feinberg et al., *The Relation of Preschool Child-Care Quality to Children's Cognitive and Social Developmental Trajectories through Second Grade*, 72 CHILD DEV. 1534, 1547 (2001).

[43] DEBORAH F. PERRY & ROXANE K. KAUFMANN, INTEGRATING EARLY CHILDHOOD MENTAL HEALTH CONSULTATION WITH THE PYRAMID MODEL 1 (2009), *available at* http://www.challengingbehavior.org/do/resources/documents/brief_integrating.pdf.

trigger maltreatment. Several models targeting children with behavior problems have shown reductions in children's challenging behavior and parent stress, including Parent-Child Interaction Therapy (described earlier) and Triple P Positive Parenting Program, a system of parenting interventions with varied levels of intensity.[44] In addition, evidence-based interventions focus on strengthening the parent-child relationship and parents' capacity for positive nurturing and guidance. To the extent that screening leads parents to interventions that strengthen their relationship with their child and their parenting skills, it strongly serves the goal of child protection.

Wide-scale screening for maternal depression also has the potential to increase the number of parents who receive effective treatment, although, as shown by research cited earlier, highly vulnerable women may need considerable support to engage in follow-up evaluations and treatment. A recent research synthesis suggests that treating depressed mothers without involving their children can help reduce depressive symptoms but does not improve child development outcomes.[45] However, parent-child treatments, such as Parent-Toddler Psychotherapy, have been shown to improve parenting behaviors and child outcomes among mother-child dyads in which the parent is depressed. More adaptive parenting and child behavior are likely to reduce the risk of abuse and neglect. Together, both child and parent mental health screening have the potential to lead to interventions that can reduce parental stress and children's challenging behaviors, both contributors to child maltreatment.

A final issue regarding maternal depression screening is a concern among legal advocates that positive results could be used as evidence that a parent is likely to neglect or abuse her child, leading, in some cases, to the inappropriate removal of the child.[46]

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[44] Thomas & Zimmer-Gembeck, *supra* note 38, at 491.

[45] Nat'l Scientific Council on the Developing Child, *Maternal Depression Can Undermine the Development of Young Children* 5–6 (Harvard Univ. Ctr. on the Developing Child, Working Paper No. 8, 2009), *available at* http://developingchild.harvard.edu/index.php?cID=341 (internal citation omitted).

[46] This concern was raised by a participant in the symposium who represents mothers in child welfare adjudications.

Clearly, considerable harm to a child would occur if the child were separated from a depressed mother, who, with treatment and adequate support, could safely care for and nurture the child. Given the long-term potential benefits of mental health screening and intervention for both mothers and children, legal advocates for mothers with depression and other mental illness should consider promoting both policies that protect mothers from inappropriate use of mental health diagnoses and policies that lead to increased identification and treatment of mothers experiencing depression.

CONCLUSION

In order for expanded mental health screening of young children and parents to enhance child protection efforts, screening must become an effective pathway to evaluation and to evidence-based interventions and other promising supports such as high-quality early care and education that can address challenging child behavior and other risk factors for maltreatment. It is clear from screening efforts that have shown poor referral outcomes that both children and parents need facilitated referrals in which a professional provides direct assistance, such as helping the parent see the value of a referral and taking the immediate step with the parent to set up an evaluation or intervention appointment. Also, there is a great need for building the workforce of professionals who can deliver evidence-based interventions that target children and parents with mental health problems. Last, many exceptionally vulnerable families may need support to stay engaged in interventions, including practical supports such as transportation and child care. With all of these supports in mind, professionals involved in child protection across a variety of disciplines should consider promoting not only an understanding of the role of mental health screening in child protection, but also the larger systems requirements (e.g., facilitated referrals and expansion of evidence-based interventions) that would make screening a key component of child protection.