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Re-Visioning Public Health Approaches for Protecting Children

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Chapter 28
New Directions for Public Health Approaches: Key Themes and Issues

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28.1 Introduction

Authors in this volume call for reform of child protection (CP) systems that refocuses services on prevention and early intervention grounded in a public health framework. The goal is to reach families in need of support well before problems worsen and potentially become intractable and resistant to change. The public health model stresses the importance of universal, 'whole-of population' level efforts (Higgins et al. Chap. 1 in this volume) that seek to lessen risk factors for child maltreatment and to promote protective factors that enhance the well-being of all children, including those who are more vulnerable to child maltreatment and associated outcomes because of the effects of poverty (see Klevens and Metzler Chap. 13 and Bywaters Chap. 17 in this volume).

The public health model calls for comprehensive reform of an outdated CP system that increasingly stigmatizes and punishes families who require assistance from public agencies. Authors argue that reform across a broad scale can reduce

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disproportionality and systemic marginalization and racism, which has been well-documented in CP internationally. There are significant issues with regard to the ethics of current risk-saturated and avoidant policy and practice frameworks that drive CP and fall disproportionally upon particular groups who have long been overrepresented in contact with these systems and who show the intergenerational impacts of this (see Duthie and colleagues Chap. 20 in this volume).

Arguably, public health approaches provide a critical way to reform and re-calibrate CP approaches, particularly regarding the humane treatment of families who are marginalized and struggling, and with respect to children in out-of-home care whose issues are highlighted in Chaps. 2 and 3 in this volume. Featherstone et al. (2014), and Lonne et al. (2016) have highlighted how the (mis)use of power with vulnerable groups and families reflects on many levels the individual focus of child protection that allocates almost total responsibility to parents and downplays or ignores the structural factors at play, and the neoliberal underpinnings of many contemporary social welfare policies. Families who often have significant issues with alcohol and drug abuse, family and domestic violence, disability and poverty can find that the interventions they receive do not readily provide tangible assistance and support to address these. Rather, they can find themselves immobilized by forceful directions to provide a level of care that appears out of reach in the short time frames demanded by the interveners. Removal of children in these situations, while providing immediate safety, can result in their permanent separation and many years in out-of-home care which sometimes entails numerous placements and poor life outcomes. Unfortunately this can end up as a state intervention that leaves no one better off.

28.2 The Limitations of Child Protection

The history of CP shows that many groups who are overrepresented have high support needs and require longer intervention periods to address the significant life issues they encounter in their daily lives. Yet, regrettably, much of CP uses case management approaches that embrace very short-term intervention timeframes, with removal seen as the option when families are hostile toward ongoing involvement with state authorities.

Current policies and practices within CP disadvantage Indigenous children and children of color, who are both overrepresented and underserved. Responding to child maltreatment within a public health paradigm requires actions to address how economic, social and environmental factors influence not only the incidence of maltreatment but also the inequitable distribution of maltreatment (see for example Chaps. 13 and 17 in this volume). Because proportionally more Indigenous children and children of color involved with CP also live in poverty, their needs are complex and systems that include CP are poorly equipped to respond in turn (see Chaps. 2 and 12 in this volume). Further, authors (e.g., Duthie et al. Chap. 20) note that Indigenous and First-Nations families are disproportionately impacted by a CP

system that is "founded in European or Western worldviews," which they and others believe perpetuate racist and discriminatory practices and policies that add to the burden of risk encountered by Indigenous peoples. It is important to recognize that inter-generational trauma is present for many of these groups, and that continual removal of their children by the state perpetuates this trauma cycle. Different approaches are therefore needed. Unsurprisingly, there is evidence that CP approaches have led to distrust within Aboriginalcommunities and fear of statutory protective interventions (Newton 2017).

As noted by Higgins et al. (Chap. 1), CP has become narrow in its mission and limited in its approach, primarily managing the highest risk families to avoid serious harm befalling vulnerable children. CP involvement comes too late to address the factors that impinge on the functioning of families. Instead, services are, as Higgins et al. suggest, forensically oriented – meaning that the focus is mainly on investigating and prosecuting crimes of mistreatment. Recent noteworthy incidents of children who are harmed while under the watchful eye of CP workers have highlighted notable gaps and oversights in case planning that have degraded trust in the system and have led to outcries by the public to hold CP workers accountable. It is an understandable reaction to a tragic series of events. However, CP workers are also victims of a system in decline and disarray (see for example Chaps. 2 and 15 in this volume). According to Higgins et al., "Statutory child protection services are overwhelmed, and have over-grown their intended purpose, and many would argue are at risk of failing to deliver well enough on the aims they have espoused."

In Part I, the authors address in detail the significant shortcomings that befall contemporary child protection systems, with many service users not experiencing satisfactory outcomes. Buckley and colleagues (Chap. 2) have drawn on numerous studies to highlight that many service users including parents and children, as well as staff, can find that the relationships they experience with others in the system are not facilitative toward change, and their experiences are stigmatizing and blaming. Conley Wright and Kaltner (Chap. 3) closely examine out-of-home care and conclude that public health approaches offer much potential in evaluating the outcomes for children in more systematic ways whereas at present this is haphazard. Parton and Williams (Chap. 4) use their recent research to understand how community members conceptualise neglect. They critically examine the implications for public education strategies and community mobilization approaches to enlist the support and assistance of citizens to assist vulnerable families and children in need.

A 2015 Springer publication *Mandatory reporting laws and the identification of severe child abuse and neglect* evidenced how mandatory reporting is a contested policy and one which has some intended consequences (identification, quantification and protection of children at risk of harm) as well as some unintended and unwelcome ones (fear of seeking help by some families and net widening, along with mistrust in system responses by mandated reporters) (see also Sedlack and Ellis 2014). Importantly, in regard to the development of public health approaches, the institutional success of mandatory reporting can place hindrances upon the propensity of key stakeholders within health, education, and other systems, to embrace active referral processes for community-based supports for struggling families. Yet,

a public health system for protecting children from maltreatment relies upon an ability of various professionals and organizations being able to refer and pass on information so that families and children can receive the help they need when they need it, and in ways that encourage them to access assistance free from stigmatization. Hence, the policy framework of public health needs to resolve the practice and legal tensions that currently exist in CP particularly with respect to human rights of various parties (see Bross and Mathews Chap. 18 in this volume). Differential responses appear to have a particular relevance with regard to these vexed issues and may well provide a set of institutional and organizational arrangements that can provide targeted assistance (See Merkel-Holguin et al. Chap. 12) in combination with universal services that underpin a public health approach (see Daro and Karter Chap. 8).

Costs of maintaining CP services, as they are, are unsustainable. Because children who enter the CP system stay in care longer, fewer children are served but costs are problematically high – and they are climbing higher. At the same time, it is unknown whether children who enter CP actually benefit beyond being extracted from an unsafe home environment. CP lacks a robust infrastructure for evaluation and it has been slow to embrace the use of evidence-based programs and practices (Jonson-Reid and Chiang Chap. 21), leading to accusations that the system is wasteful and ineffective. This seems to be a critical issue with respect to moving toward a public health approach, which embraces as foundational the embedding of robust data systems and evaluations of intervention efficacy (see Runyan and Runyan Chap. 6, and Scott and Faulkner Chap. 16). Trocmé and colleagues (see Chap. 25) have highlighted the complexities and difficulties inherent when trying to implant research and evaluation methodologies within existing child protection administrative data systems. Yet, it seems inexplicable that, given the huge social investments, there is little by way of robust program or system evaluation of CP systems that have been around for decades, and seem to continually introduce new programs of intervention and services for ameliorating risk of harm, but without much evidence of effectiveness or success. Within this context for CP systems, Merkel-Holguin et al. (Chap. 12) highlight that hostile debates around extending differential responses have been unhelpful to overall system development, and may indeed hinder the development of innovation for public health approaches.

28.3 Promoting Systems Change/Reforming the System

With concerns as heightened as they are, it is surprising that changes within CP have not come about more rapidly. Authors touch on several reasons why. One reason is financial; there is simply too little money made available by government agencies to bring about reform that will change the system as we know it. Added to that are the politics around government ‘intrusion’ on the privacy of families (see Higgins et al. Chap. 9). Efforts at reform have been slowed or blocked altogether by strong and prevailing beliefs about the privacy of families and hard resistance to the

idea of having government agencies become even more involved in the care of children. The use of evermore sophisticated ICT to expand social surveillance, particularly for 'troublesome' groups and communities has fostered broader concerns about the role of the state and its data collection systems in combatting child maltreatment (see Parton Chap. 5 and Gray and Schubert Chap. 14). Further, some believe that the current system preserves a deeply rooted model of Colonization and domination that has historically advantaged the needs of some over others (Duthie et al. Chap. 20).

Gray and Schubert (Chap. 14) outline that there are a number of limitations and challenges with public health approaches to preventing child maltreatment. For example, they highlight that public health approaches utilise conceptualizations of risk in order to target interventions at various levels, yet for impoverished communities this may well entail or be perceived as increased social surveillance of people who are highly vulnerable and in desperate need of assistance. They question the extent to which public health approaches that utilize whole of population strategies can be truly effective in providing necessary social and emotional supports to groups who perceive themselves to be 'targeted' by risk-saturated and punitive CP systems that must be a part of a system-wide reform and re-calibration. In Chap. 5 Parton notes the criticality of having the social determinants of health as central to public health approaches but notes how conceptions of risk have altered over time to become dominant within the context of increasingly neoliberal policy frameworks that emphasize individual rather than collective responsibilities.

In Chap. 28 Parton argues that where public health approaches have been introduced they have often not addressed the key social and structural dimensions to the problem of child maltreatment and its associations with poverty and inequality (see also Klevens and Metzler Chap. 13 and Bywaters Chap. 17). He posits that children's well-being and overall social capital will be improved in public health approaches by integrating a children's rights perspective within them that attends to the "wide-spread *social harms* to children." Hence, public health approaches should not be seen as a panacea but, rather, an important development in the quest to eradicate child maltreatment and do so with ethical measures and practice.

28.4 Public Health Model

The public health model positions services along a continuum, with universal programs as the first level of engagement. The model supports an 'upstream' approach that locates evidence-based prevention programs and practices centrally. Primary prevention focuses on eradicating risk factors for child maltreatment before they enter the child welfare system and relies on "universal" strategies that reach all segments of a population. These are foundational to a public health model, yet they often remain under resourced by governments despite their established benefits (See Daro and Karter Chap. 8). Secondary prevention focuses on reducing risk levels in segments of a population that are more vulnerable and at higher risk for child

maltreatment. And, tertiary prevention involves strategies to lessen the recurrence of abuse and neglect among child victims. The current structure of CP is more aligned to tertiary approaches than to primary or secondary prevention, but a public health model is reliant for its success upon the integration of all three levels of response.

Adopting a public health model helps to address the limitations of the current system because it fundamentally changes how services are conceptualized and delivered. Embracing Bronfenbrenner's (1979) ecological systems theory, public health approaches conceptualise societies and communities, and the citizens within them, as being deeply relational and interconnected. Different system levels function using rules, norms and roles to enable people to meet their various needs from a variety of sources, with support being fashioned in accessible and timely ways. Whereas the goal of a reactive system is to protect children at the last possible point before removal is imminent, a primary prevention focus turns attention to upstream approaches that engage families far earlier, before children are in danger. The model supports proactive strategies over reactive measures and places an emphasis on universal programs, followed by those geared to subgroups of the population in need of more intensive intervention (Herrenkohl et al. 2015). Because universal programs apply to all families, there is less stigma attached to services that are received, and there are more ways to help families rebound and return to a higher level of functioning (see Daro and Karter Chap. 8), but nonetheless there are major issues faced in trying to build cohesive systems where universal services are well integrated with secondary and tertiary ones – this remains as a critical obstacle to the introduction of effective public health approaches (see Harries and O'Donnell Chap. 15).

Authors draw on different aspects of the public health model in Chaps. 5–22. They discuss how a public health model can better serve the needs of children and families – and also the obstacles that stand in the way of reforming CP to align with the model. The key elements are a population perspective, a focus on primary prevention, and interventions that rely on evidence and attempt to solve the root causes of problems through large-scale social change, all underpinned by a embedding evaluation of approaches so that service responses are evidence-based. Runyan and Runyan (Chap. 6) propose the use of an injury prevention model, Haddon's Matrix, to clearly articulate primary, secondary and tertiary responses, and which enables well conceptualized and clearly targeted programmatic responses to be delivered and integrated within the whole system. Herrenkohl and Klika posit that the study of risk and protective factors are central to increasing capability of services to adequately response to the polyvictimization that many maltreated children experience (see Chap. 7).

Moreover, because of its multi-pronged capabilities, a public health model provides opportunities for a variety of innovative intervention approaches. For example, Quadara (Chap. 10), Walsh (Chap. 22), and Kaufman and colleagues (Chap. 11) outline population-level strategies for preventing child sexual abuse as well as organizational and situation prevention programs to protect children from egregious sexual assaults and other maltreatment that impacts their well-being. Taussig and Weigler (Chaps. 19) extend these sorts of innovative approaches further and focus upon mentoring for youth in foster care, arguing that, done well, these evidence-based

programs have much to offer regarding prevention of the sometimes poor outcomes for alumni of the care system.

Merkel-Holguin et al. (Chap. 12) introduce the idea of 'differential response' (DR), an approach that allows discretion in the provision of services when allegations of child abuse and neglect are made. The authors argue that DR can serve the goal of advancing public health prevention by placing resources in services focused on low and moderate risk families, while also attending to the needs of those at higher levels of risks. DR grew out of a concern about the growing number of cases reported to CPS and the awareness that many reports do not require the resources of a full investigation. DR is thought to increase transparency in CPS decisions, prioritizing support of families over punishment. The authors suggest that DR "embodies" principles of early intervention that align with a public health model, including an emphasis on social support and providing non-stigmatizing services to help parents succeed in their caregiving responsibilities. Importantly they argue that DR provides an evidence-based approach that can be foundational to rolling out a broader preventive and early intervention system, and that this can provide an institutional basis for service delivery that enables CP organizations to operate as a residual program for high-risk cases rather than diverting its focus on investigating matters that do not require a statutory forensically-oriented intervention.

Daro and Karter (Chap. 8) argue for a strategy that strongly emphasizes universal services, noting that targeted interventions for families at high risk have not always worked well, and have generally failed to establish conclusive efficacy. This strategy of universalism should, according to the authors, focus on "raising awareness around a common need or shared concern and providing a mechanism to ensure families are provided access to the level of support they require." This theme is also built upon by Bross and Mathews (Chap. 18) who detail the success of historical public health approaches and detail its application in the area of child maltreatment, and how legal foundations are necessary for ongoing system reform.

Moving to a universal model will improve outcomes for families, contain costs, and reduce stigma for those who are served. Indeed, universal service systems are the bedrock upon which public health approaches are founded. This approach assumes that all children can benefit from a stronger and more deliberate engagement of the community in their care and well-being. As we have noted elsewhere, this appears to be a largely undeveloped aspect of public health approaches, yet there is growing empirical evidence of how informal helping networks can provide robust, timely and non-stigmatizing support to families and children in need (Holland 2014; Molnar and Beardslee 2015; Scott et al. 2016).

Harries and O'Donnell (Chap. 15) emphasize the need for coordination across service sectors to align with a vision for public health prevention. This, according to these authors, will require a "culture shift" in service planning that engages families differently. Here, government agencies and community organization work collaboratively to design and implement services that meet the needs of families locally. They explain that an overhaul of the child welfare system requires organizational changes that re-orient services to this new model and also a restructuring of roles that allow for a more integrated system oriented to universal approaches. Klevens

and Metzler (Chap. 13) propose a more radical approach that targets the "conditions and contexts" that increase child maltreatment. The authors encourage a dual emphasis on increasing prevention efforts while also working to make systems more responsive and dedicated to the needs of vulnerable children and families. They view community organizing and partnerships between public health and grassroots organizations as helping to further this cause.

Drawing on data from the UK, Bywaters (Chap. 17) focuses on a similar set of issues. He attends to neighbourhood structural and social factors that drive disparities and undermine the functioning of poor families. He calls for a focus on primary, secondary and tertiary prevention, while also underscoring the need for more research that differentiates cause from correlation so that programs can target the most salient risks. His work here attests to the history of CP and its non-use of available data to identify the salient and underpinning associations of maltreatment within impoverished communities in England. However, this point also applies to many other jurisdictions where the social determinants of health data and analysis is typically given scant attention when developing programs and services aimed at reducing maltreatment prevalence and incidence.

Within the latter chapters in Part III, a number of countries' initiatives are outlined, including Australia, Canada and Ireland (see Chaps. 15, 24 and 23). Norway's situation is also outlined, (see Chap. 26) albeit from the perspective of a country that has a very well-developed early intervention and prevention approach. Norway is trying to attend to the limitations of this by putting increased emphasis upon statutory capacity to ensure that family environments that pose significant risk for children are addressed within a framework that provides necessary protective measures, particularly for adolescent children. Canavan and colleagues (Chap. 23 in this volume) provide a detailed outline of Ireland's major reforms towards an early intervention and prevention system, but also describe the challenges in addressing system and community complexity and how developing an overarching data collection and evaluation framework is fraught within a dynamic and evolving policy environment.

From a different cultural and social perspective Barraclough et al. (Chap. 24) describe the reform of Alberta's CP system to incorporate a range of different approaches that promote community-based programs to deliver support and assistance, including practice models that enable CP staff to work collaboratively within Indigenous communities. Their account illustrates a central principle of this book: That each jurisdiction has its own unique history, cultural, social, institutional and political environment and that public health systems, and for that matter CP systems, must be congruent with the local context. But still, there are some common elements as Trocmé and colleagues show (Chap. 25) with their sharing of how embedding a culture of data collection, evaluation and utilisation of the available evidence is quite difficult, and takes time to develop. Although their chapter concerns their longstanding work in Canada including the Canadian Incidence Study, the issues they highlight could also be found in many other jurisdictions. Their chapter portends to the very real and practical challenges to be faced in operationalizing public health approaches to improve protective system outcomes for children and families.

28.5 Challenges to Overcome

Gray and Schubert (Chap. 14) highlight "tensions" and barriers to change, as they relate to the public health model, both theoretically and operationally. These include competing priorities related to "control" and "care" in systems that are difficult to align, as well as the difficulties that come with trying to implement a model that current systems are not prepared to support. In many jurisdictions there is very little system integration or organizational communication, collaboration or conflict resolution that are necessary for inter-professional and inter-organizational practice to be reliable and effective. For decades CP has been hamstrung by a lack of buy-in to calls for children's protection to be "everybody's business," and this has particularly been evidenced by adult services' and programs' reluctance to recognize or operationalize a remit to embrace policies and practices that meet children's needs for protection. Rather, many organizations have used narrow foci upon their own clients' interests and privacy as their priority. Indeed, there currently is no infrastructure for the rollout of a large scale universal strategy that supports primary prevention, nor are there agreed upon models for promoting cross-institutional coordination, communication, and collaboration that will enable the implementation of integrated system responses characteristic of a public health approach.

Recent efforts at reform have focused on professional sources of help and there does not yet seem to be a clear set of strategies for community participation in prevention and early intervention. Relatedly, there is a need for workforce development to accompany public health initiatives so that staff have the requisite skills, understandings, and knowledge to work in prevention and early intervention.

Another significant challenge has to do with evidence and the use of evidence-based programs. As noted above, there currently is little information about which interventions are best suited to a public health approach and limited evidence for their effectiveness—in part because programs have often gone untested (see for example Chaps. 21 and 25 in this volume). Relatedly, there is no systemic culture of evidence-based practice underpinning CP systems. This will need to change for reform efforts to move forward. As they do, there attention will also need to focus on developing robust evaluative data systems that can measure multi-dimensional change in processes, outcomes and program/service efficacy. Linkages between system stakeholders and universities/research institutes need to be strengthened and funded to ensure that there is increased capacity for robust foundational research and program evaluation.

Foundational research is required with respect to the associations between indicators of social and economic disadvantage and prevalence of maltreatment, community and family needs, contact with CP, and development of service responses that foster community social capital and social care capacity (see Scott and Faulkner Chap. and 16 Bywaters Chap. 17). There is as yet an under focus on the development of models for service user and community involvement in the ongoing system reform processes (see Chap. 15), but there is clear evidence of the centrality of local, bottom-up community-led engagement in building community social capital and

collective approaches that nurture and protect children and foster their socialisation (Jack and Gill 2010; Melton 2014; Melton and Anderson 2008; Molnar et al. 2016). But all too often present reforms tend to supplant grass roots involvement and leadership with a professionalised model of intervention. Is this because CP system reform processes that accompany public health initiatives seem to be fraught and unable/unwilling to let go power unless there is strong leadership?

Perhaps the most daunting challenge is overcoming political resistance to having public agencies engage with families, particularly at a time when some are calling for scaling back services organized centrally in favor of more localized control and oversight of child welfare programs. Public health approaches offer encouraging approaches to address the over-representation of Indigenous children (see Chap. 20), but the bigger issues that remain largely ignored are the over-representation of dominant CP rescue discourses that are not culturally safe and bypass recognition of the intergenerational impacts of Colonisation, trauma and inequity/inequality. To succeed in reforming the CP system, there will need to be political and institutional/administrative support that is steadfast and has a vision for the new system, as well as community willingness to institute reforms. Scandals and tragedies that have undermined trust in CP will have to be addressed and repaired.

Despite the many real and significant challenges, a number of jurisdictions are demonstrating success in smaller scale reform efforts. In fact, there is growing evidence internationally of the promise of public health approaches in Ireland, Australia, Canada and some parts of Europe and USA, many of which are captured in chapters in this volume (see for example Chaps. 23 and 24). Each is being done in within particular ideological, political and institutional, and organisational contexts and it is impossible to portray this as a single 'model' of intervention – a lot of diversity is evident. Much can be learned from these examples and translated into goals to be scaled.

But judicious appraisal is required rather than slavish adherence to a notion that even evidence-based programs can easily or successfully be transplanted into environments that are quite different from the contexts in which their program or service efficacy was established. Unfortunately, in some jurisdictions the imperatives of system reform have oft translated into what *Yes Minister's* Sir Humphrey Appleby once described as the 'politician's syllogism'; "something needs to happen", "this is something", therefore "we should do this". Political exigency should not supplant the requirement for careful consideration of the context and how the evidence-based interventions might best be applied in light of the local circumstances.

As Barraclough and colleagues illustrate (Chap. 24), plans for reform do not have to be all laid out at the front, but the principles and broad architecture, including the portals and processes for the community accessing help when they need it, do need to be articulated. However, shifting beliefs and norms to normalize outside engagement with families; strengthening data systems; and building capacity for more progressive models by linking and reforming systems are all required to realize this vision for more universal care.

28.6 Conclusions

This volume has involved researchers and authors from many countries and, despite the jurisdictional diversity and variations in the social, political and institutional environments, there are nonetheless some key points and principles made that are applicable across the board. First, CP approaches are critical to addressing the needs of children at risk of significant harm and need to be a core part of every protective system, and a public health model includes these as part of the tertiary level responses. CP is, however, subject to a variety of significant limitations that have been outlined here, particularly in Part I of this volume. For example, many families and children find the forensically- and risk-oriented interventions deeply stigmatizing. Further, the life course outcomes of many children in out-of-home care are unacceptable – there is far more required for these children and their families than mere 'child rescue'. The disproportionality that is found amongst those in contact with these systems is also unacceptable. As Parton notes, (in Chap. 27), CP does not really address the underlying social and structural inequities that are associated with much child maltreatment. But nor was CP designed to do so.

A public health model, on the other hand, is designed to do so, with multiple strategies and formal interventions across the primary, secondary and tertiary levels, and a focus upon addressing the social determinants of health and, thereby, reducing the prevalence of child maltreatment. This is necessary if we are to address the inequities and resulting inequalities that are found associated with all forms of child maltreatment, but particularly neglect which is the 'big kid on the block'. Using data to provide the information to target interventions to where they are most needed and likely to have the greatest preventive effects is essential. But this is not value free, and community concern about intrusive state interventions is an important consideration when designing and implementing system responses. Gray and Schubert (Chap. 14) point out that the use of data mining and predictive risk modelling remains contentious and must be done within an ethical framework, and that public health models entail a risk of ever-expanding social surveillance by the state.

Trocmé and colleagues (Chap. 25) and Scott and Faulkner (Chap. 16) highlight how developing robust data collection systems and analytical frameworks is fraught, takes many years of hard work to accomplish, and yet is ongoing with the job never quite coming to completion. Using data to establish program and service efficacy is not a 'magic wand' for resolving these system issues which hinder the operationalization of public health approaches (see Chap. 21). The reality is that establishing the 'right' models for specific jurisdictions and then implementing change processes to bring about improved system processes and outcomes is very difficult indeed, and requires inter-organizational collaborations and system integration which hitherto have proved to be major obstacles to successful reform and improved system outcomes for children, families and communities (see Chaps. 8, 12, 15, 23 and 24).

But despite these impediments there is a groundswell trend across many nations toward the implementation of public health models for preventing child maltreatment. This is a new direction in many jurisdictions, but has also been a 'slow train

coming'. These new directions entail the key themes outlined in this volume, such as employing epidemiological approaches, and building in system capability for the expanded use of a diverse information systems as a foundation to determining program and system efficacy beyond the often narrow outcomes measured within current CP approaches.

An important aspect of reform noted by many authors here has been the importance of community-based and -led responses that utilise informal neighbourhood and community relationships and connections to build webs of care for vulnerable children and families, who are often struggling to get by within impoverished communities that involve significant hardships and inequality. Public health initiatives need to supplement these informal caring networks, not supplant them. We endorse these approaches as important alternatives to 'power over' professional interventions that do not yet properly utilise the strengths and resilience of these communities and their citizens. Future responses to the plight of many Indigenous peoples and their child rearing needs must embrace approaches that no longer utilize discourses that over-represent western world viewpoints and attitudes steeped in colonising perspectives. Public health approaches offer much to combat such negative and unjust belief systems and interventions, and instead promote community led and controlled services that entail embedded culturally-safe practices and attitudes.

Parton's emphasis upon system reforms steeped in a child rights framework and the concept of the social harm caused by maltreatment (see Chap. 27) are noted as being congruent with a public health model, not least because they provide an overarching understanding that children's well-being entails far more than just the prevention of maltreatment. Public health approaches and strategies provide us with the conceptual and operational wherewithal to tackle the pernicious effects of deeply imbedded social inequities that result in the profound inequalities associated with higher likelihoods of children being abused and neglected. This volume provides much of value to enable us to re-vision public health approaches for protecting children and supporting their families and communities, and thereby to reduce the prevalence of maltreatment. In doing so it provides a mind map and practical guidance for the sorts of system reforms and innovations that can help make the world a better place for all children, their parents, families, friends and communities.

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