**Children Australia**
Volume 40 | Number 1 | pp. 69–77 | © The Author(s) 2014 | doi:10.1017/cha.2014.37

# A Public Health Approach to Child Protection: Why Data Matter

Karen Broadley and Chris Goddard
*Child Abuse Prevention Research Australia, Monash Injury Research Institute, Monash University, Clayton, Victoria, Australia*

In Australia, many researchers and policy makers believe that statutory child protection systems are overburdened and ineffective. The way forward, they suggest, is a public health model of child protection. A public health approach comprises four steps: (1) collecting surveillance data; (2) establishing causes and correlations; (3) developing and evaluating interventions; and (4) disseminating information about the effectiveness of intervention activities to the public health community. However, in Australia there are no reliable surveillance data. There is no information about 'person'. Information is not collected about the characteristics of children (e.g., ethnicity) and parents (e.g., mental illness) reported to child protection services. Data are not comparable across place. This is because the states and territories have their own child protection legislation, definitions and data recording methods. Data are not comparable over time. This is because many jurisdictions have introduced new data recording systems over recent years. This paper concludes that it is essential to develop an effective child protection surveillance data system. This will ensure that services are located in areas and targeted towards populations in greatest need. It will enable large-scale evaluation of the effectiveness of prevention and intervention activities.

■ **Keywords:** public health, surveillance, data, child protection, child abuse and neglect

## Introduction

In Australia, many researchers and policy makers are concerned that statutory child protection systems have become 'overloaded' (O'Donnell, Scott, & Stanley, 2008, p. 325; Scott, 2006, p. 11), 'unsustainable' (Allen Consulting Group, 2008, p. vi; O'Donnell et al., 2008, p. 325; Scott, 2006, p. 9) and, most importantly, are failing to protect children (Allen Consulting Group, 2008; Scott, 2006). The way forward, they suggest, is to adopt a public health approach to child protection (Allen Consulting Group, 2008; Council of Australian Governments, 2009; O'Donnell et al., 2008; Scott, 2006). For example, Scott (2006) argues:

> So what can be done to reform [child protection] systems which are unsustainable and which can inflict such harm? While a legal model of child protection is necessary to protect a small number of abused and neglected children, a public health model has much greater potential to reduce the level of child abuse in the community. (p. 11)

Similarly, a report released by the Australian Research Alliance for Children and Youth (ARACY) claims 'current systems for protecting children in Australia are failing in their primary objective: to protect children' (Allen Consulting Group, 2008, p. vi). The report calls for a 'system which uses a public health model of primary, secondary and tertiary prevention to ultimately assist in reducing the prevalence of child abuse and neglect in Australia' (Allen Consulting Group, 2008, p. ix). Obviously, this call has been heard, as there is clear evidence that it is shaping the policy paradigm of child protection in Victoria and other jurisdictions (Hunter, 2011).

The *Report of the Protecting Victoria's Vulnerable Children Inquiry* used a public health perspective to inform recommendations (Cummins, Scott, & Scales, 2012). The *Queensland Child Protection Commission of Inquiry* noted that 'submissions to the commission . . . reflect strong support for the public health model for child protection' (State of Queensland, 2013, p. 10). The Council of Australian Governments in their *National Framework for Protecting Australia's Children 2009–2020* used a public health model to develop what has become a key reform driver in the integration of statutory child protection systems within a broader

ADDRESS FOR CORRESPONDENCE: Karen Broadly, Child Abuse Prevention Research Australia, Monash Injury Research Institute, Monash University, Building 70, Clayton Campus, Wellington Road, Clayton, Vic, 3800, Australia.
E-mail: karen.broadley@monash.edu

framework underpinned by child and family support services (Babbington, 2011; Council of Australian Governments, 2009).

This is not only an Australian phenomenon. Many international researchers and organizations also recommend a public health approach to child protection. For example, the 2002 *World report on violence and health*, and the 2003 World Health Assembly resolution on implementing the report's recommendations, both emphasise the role of public health in preventing and responding to child maltreatment (World Health Organization, 2006). The World Health Organization (WHO) in *Preventing child maltreatment: A guide to taking action and generating evidence* (2006) advocates a public health model of child protection, one that focuses on prevention and early intervention, and reduces the necessity for tertiary services. The Center for Disease Control and Prevention (CDC) in Georgia, USA, also recommends a public health model of child safety, to prevent maltreatment before it occurs (Leeb, Paulozzi, Melanson, Simon, & Arias, 2008).

While international researchers have a very similar vision to researchers and policy makers in Australia, and agree that a public health model of child protection consists of three service platforms – primary, secondary and tertiary – many of them also argue that a high-quality data surveillance system is the first step toward such an approach (Jack, 2010; Leeb et al., 2008; World Health Organization, 2006; Wulczyn, 2009). Similarly, interdisciplinary public health experts suggest that surveillance is 'the eyes and ears of public health' (Webb & Bain, 2011, p. 308), the 'cornerstone' and the 'foundation' of public health practice (Lee, Teutsch, Thacker, & St. Louis, 2010, p. 17). Sound epidemiological principles must then be used to design a data system, and accurately interpret the data. According to Lee and colleagues (2010, p. 17), the role of a high-quality surveillance system is to guide 'epidemiologic research and influence other aspects of the overall mission of public health'.

This paper argues specifically that high-quality surveillance data would improve the effectiveness of early intervention, prevention and statutory intervention services for children who have been, or who are, at risk of child abuse and neglect. The paper is in four sections. First, we define surveillance and explain why it is an essential component of public health practice. In the second section, we describe what a high-quality child protection data surveillance system should collect. In the third section, we consider Australia's 'child protection data surveillance system' and demonstrate that in Australia there is a 'complete lack of reliable national data' (Goddard & Tucci, 2008a, p. 9). In the final section, we consider the impact of these data deficiencies on members of the public health community as they attempt to respond to the problem of child abuse and neglect; and on children themselves. Ultimately, we contend that unreliable data are no better than no data at all; and that the lack of data is yet another of the forces that silence children and minimise their abuse (Broadley, Goddard, & Tucci, 2014; Goddard & Hunt, 2011; Mudaly & Goddard, 2006).

## What is 'Surveillance' and Why is it Important?

What is surveillance? According to Webb and Bain (2011):

> The word surveillance, meaning 'the constant watching of subversives', came into use during the time of the Napoleonic wars. The modern epidemiological meaning is consistent with the idea of constant watching, but usually of diseases rather than suspects. (p. 308)

The word surveillance, as it is used within the public health context, is quite different from the way it is most commonly used within the child protection literature, in which vulnerable children and families are seen to be the victims of a surveillance approach that is seen as preventing the giving of help and care (Lonne, Parton, Thomson, & Harries, 2008; Scott, 2006). Within this literature it is clear that the surveillance, which means 'constant watching' (Webb & Bain, 2011, p. 307), is over individual children and families who are considered to be particularly 'vulnerable' or 'at risk'. For example, Fluke, Shusterman, Hollinshead and Yuan (2008, p. 78) examined whether 'families are subject to greater surveillance in the community when they receive services'. Scott (2006, p. 11) also uses the word surveillance in this context when she suggests that the 'scale on which child protection surveillance is now occurring in Australia' could be causing parents to become anxious and withdrawn, and contributing to the child abuse and neglect problem.

In the context of public health, however, surveillance means something quite different. While it still refers to 'constant watching' (Webb & Bain, 2011, p. 308), it is watching over populations rather than individuals. It refers to the collection of data (de-identified data) so that a problem, for example child abuse and neglect, can be understood, monitored and responded to effectively.

### Surveillance, the first step toward a public health model of child protection

Many experts explain that a public health approach to child protection is made up of four vital steps, all of which call for good evidence, and which ultimately inform one another.

The first step is surveillance – to know the magnitude of the child abuse and neglect problem. While we know that many incidents of child abuse and neglect are not notified to child protection authorities, and that child protection data significantly underestimate the real magnitude of the problem, it is still important to have accurate information about child protection activity, to inform the setting of priorities and allocation of resources (Leeb et al., 2008; Peden et al., 2008; Whitaker, Lutzker, & Shelley, 2005; World Health Organization, 2006, 2007).

The second step is to identify risk and protective factors, and 'at-risk' populations. This involves making associations between measures of child abuse and neglect and a range of

other factors. These 'other factors' may relate to the family (for example, the family structure, income or ethnicity), the parent (parental substance misuse, mental illness, domestic violence or disability), the child (the age or sex of the child) and/or the community (whether it is rural or disadvantaged). While many risk factors that are associated with child abuse and neglect are already known (such as parental substance misuse), a high-quality surveillance system may uncover others, and may reveal the degree to which risk factors are inter-related (Leeb et al., 2008; Whitaker et al., 2005; World Health Organization, 2006, 2007).

The third step is to develop and evaluate prevention and intervention strategies. It is important to identify which communities are most affected and the associated risk factors, in order to target interventions accordingly. The efficacy of these interventions must also be evaluated. The WHO (2006) suggests that one way of evaluating prevention and intervention strategies is to compare incidence rates pre- and post-intervention. They describe an effective intervention strategy as being one that:

> . . . reduces the incidence of child maltreatment in the intervention population, or at least lowers the rate at which incidence is increasing. (World Health Organization, 2006, p. 32)

The WHO suggests that another way of evaluating the effectiveness of an intervention, policy or law is to compare populations cross-sectionally. Comparison populations can be constructed 'at the beginning of the program, through some type of matching process . . . (or) . . . after the fact' (World Health Organization, 2006, p. 48). Then, if there is a reduction in the incidence of child abuse and neglect, it may be attributed to the intervention, policy or law.

The fourth and final step is to disseminate information about the effectiveness of intervention activities to the public health community, to enable widespread adoption of evidence-based programmes and policies (Leeb et al., 2008; Peden et al., 2008; Whitaker et al., 2005; World Health Organization, 2006, 2007).

The ideas contained in these four activities are not new. Over a decade ago, Professor David Finkelhor (1999) said:

> First we need good epidemiological data to see the location and source of the child abuse problem, and also to be able to track and monitor its response to our efforts. This is something we currently do not have, at least at the level that would satisfy any even generous public health epidemiologist. (p. 969)

More recently, Leeb et al. (2008) said:

> . . . [the] lack of consistent information about the number of children affected by maltreatment . . . limits ability to gauge the magnitude of child maltreatment . . . limits ability to identify those groups at highest risk . . . [and] . . . limits ability to monitor changes in the incidence and prevalence of child maltreatment over time. In turn, this limits the ability to monitor the effectiveness of child maltreatment prevention and intervention activities. (p. 3)

## A High-quality Child Protection Surveillance Data System – What Information do We Need to Know?

If surveillance is the first step, and enables and informs the following three steps, what exactly must this surveillance data look like (Lee et al., 2010; Webb & Bain, 2011)?

To start with, it is important to have accurate data on basic child protection activity, such as reports about alleged child abuse and neglect that are made nationally each year. It is also important to know the number and details of notifications that are substantiated.

Before proceeding, it is important to make some brief comments about definitions. Very generally, any person within Australia who has concerns about the safety of a child can make a 'notification' to the statutory child protection authority in their State or Territory. However, in some jurisdictions this is referred to as a 'report'. In this paper, we have chosen to use the term 'notification' so as not to confuse the term with a written 'report'.

In relation to the term 'substantiation', Bromfield and Higgins (2005) say that it:

> . . . refers to notifications (or 'reports' or 'allegations') of maltreatment or harm that are found on investigation by a statutory child protection service to have 'substance' (that is are true). (p. 3)

Again, this is a very loose definition. In reality, each of the Australian States and Territories define and understand the terms 'notification' and 'substantiation' very differently. We will explore this in further detail in the following section.

The important point to be made at this stage is that information about the number of notifications and substantiations is important so that, as a first step, we can know the scale and the magnitude of the child abuse problem. Other detailed information must also be gathered to inform the subsequent three steps.

In order to gather information that is relevant and that will inform each of these steps, it is useful to turn to the field of epidemiology. According to Valanis (1999), the epidemiologist is like a 'medical detective concerned with the *who, what, where, when* and *how* of disease causation' (p. 3), the ultimate goal being to prevent or control the occurrence of the disease. According to Grimes and Schulz (2002):

> Good descriptive research, like good newspaper reporting, should answer five basic 'W' questions – who, what, why, when and where . . . (p. 145)

We will now use the five 'W' questions to guide us as we suggest the types of surveillance data that are required as a first step toward a public health model of child protection. For illustration purposes we will focus on notifications.

The 'who' question refers to the children who are the subject of the notification – for example, their sex, age and ethnicity. 'Who' refers also to the parents – whether they are single parents, same sex parents, or blended family/parents, whether there are parental drug or alcohol problems or parental mental illness. 'Who' also refers to type of notifier – for example the police, school employee or parent/guardian. These details are important because they can help answer the final 'why' question. That is, if the final analysis does reveal an increase in notifications over time, then it can be very useful to know the characteristics of the children being notified (are some ethnic groups over-represented?), the characteristics of the parents (is there a growing problem of parental drug and alcohol use?), and the characteristics of the notifiers (is there a rise or change in the number of notifications from one or more professional or community groups?).

The 'what' question refers to what the notification is about – physical abuse, sexual abuse, family violence, emotional abuse or neglect. 'What' also refers to the number of re-notifications. Again, these details are important because they can help answer the final 'why' question.

The 'when' question refers to time. Information that is gathered regularly, over a period of years, can reveal trends (whether numbers of notifications are stable, increasing or decreasing). Clearly, this information can only be generated by a surveillance system that continuously uses the same operational definitions of child abuse and neglect, and the same data-reporting methods, year in and year out.

The 'where' question refers to place. This information tells us whether there are more notifications made to child protection about alleged abuse or neglect in some geographical areas than in others. Again, this information can only be generated by a surveillance system where every part of the system uses the same operational definitions of child abuse and neglect, and the same data-reporting methods. The WHO agrees that 'for good surveillance, operational case definitions should be clearly set out and agreed upon by the different sectors involved in the data collection' (World Health Organization, 2006, p. 28).

Finally, the ability to answer the 'why' question is largely dependent upon the quality of what has gone before. Indeed, a high-quality surveillance system that gathers a wealth of 'who' and 'what' data and uses common operational definitions over time (when) and place (where), can provide valuable information about the problem of child abuse and neglect, to assist governments and community organizations as they plan and prioritize prevention and response programmes.

## Child Protection Surveillance Data in Australia

Unfortunately, in Australia we do not have a high-quality surveillance data system (Broadley et al., 2014). This means that we do not, as a first step, know the magnitude of the child abuse and neglect problem. We cannot, as the second step, accurately and promptly identify the groups who are at the highest risk. We cannot as the third step, rigorously evaluate our intervention activities. And we cannot, as the final step, disseminate information to the public health community about 'what works'.

For almost 20 years Goddard and his colleagues have laboured this point (Broadley et al., 2014; Goddard, 1995; Goddard & Hunt, 2011; Goddard & Mudaly, 2006; Goddard & Tucci, 2008a, 2008b; Liddell, Donegan, Goddard, & Tucci, 2006). For example, in 2008 Goddard and Tucci complained that 'official figures are unreliable . . . even basic measures are not available . . . and to spend so much and to know so little defies belief' (Goddard & Tucci, 2008a, p. 12).

Cummins, Scott and Scales (2012), in the *Report of the Protecting Victoria's Vulnerable Children Inquiry*, concur that:

> . . . comprehensive and robust data over time to provide the basis for . . . overarching assessments for the statutory child protection system in reducing the incidence and impact of child abuse and neglect are not available for Victoria or indeed most other jurisdictions. (p. 77)

### There is a Lack of Reliable 'Where' Data

There is a complete lack of reliable 'where' data. For more than 10 years, the Australian Institute of Health and Welfare (AIHW) has released an annual *Child Protection Australia* report. This report is the main source of publicly available data relating to state and territory child protection systems. For more than 10 years the report has warned that the data from the different jurisdictions are not comparable. As the reports explain every year, this is because there are major differences between jurisdictions in definitions and data-recording practices, these differences affect the data provided, and data from different jurisdictions should not be used to measure the performance of one jurisdiction relative to another (AIHW, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013).

In practice, this means that there is no way of knowing whether there are more incidents of child abuse and neglect in some geographical areas than there are in others. A brief look at the number of child protection substantiations that occurred across Australia in 2011–2012 illustrates this point: substantiations in relation to physical abuse ranged from 13% in the Australian Capital Territory to 29% in Victoria; substantiations in relation to emotional abuse ranged from 27% in South Australia to 54% in Victoria; and substantiations in relation to neglect ranged from 7% in Victoria to 53% in the Northern Territory (AIHW, 2013, p. 59). Possibly the most startling variation in substantiations is in relation to sexual abuse, where it ranged from 3% in the Northern Territory to 22% in Western Australia (AIHW, 2013, p. 59). Indeed, if these figures had any meaning, it would be very concerning that, three years after the commencement of the Federal Government's

Northern Territory 'Intervention', targeted at the 'significant problem in Northern Territory Communities in relation to sexual abuse of children' (Northern Territory Board of Inquiry, 2007, p. 6), there still appear to be significantly fewer substantiated cases of childhood sexual abuse in the Northern Territory than other parts of the country. However, because each of the States and Territories define and understand the term 'substantiation' very differently, there is no way of knowing unequivocally whether there is a greater problem of child sexual abuse in the Northern Territory remote Aboriginal communities than other parts of the country. It is possible that John Pilger (2013) is correct in asserting that the claims that have been made in relation to the particular problem of child sexual abuse in the Northern Territory, are false and defamatory. As Liddell et al. (2006) have noted, 'it is not obvious that such differences can be explained simply on the basis of procedural differences between the jurisdictions' (p. 15). The fact that we cannot know whether these differences are a result of differing definitions or differing realities of child sexual abuse is a very serious problem.

### There is a Lack of Reliable 'When' Data

There is a complete lack of reliable 'when' data. For many years the AIHW *Child Protection Australia* report has warned that comparisons even within many of the states and territories should be treated with caution (AIHW, 2010, 2011, 2012). This is because many of the states and territories have introduced new data-recording systems over recent years and this means that much of the data in later years cannot be compared to data in earlier years (AIHW, 2012). For example, changes were introduced to the Australian Capital Territory child protection systems in 2003, to the Victorian system in 2007, to the South Australian system in 2009, to the Queensland system in 2005 and again in 2007, to the Western Australian system in 2006 and again in 2010, and to the New South Wales system in 2003 and again in 2010 (AIHW, 2005, 2010, 2012). This makes it impossible to identify trends over time, and it also makes it impossible to know if the child abuse problem is growing or abating.

A brief study of substantiations illustrates the point. For example, the AIHW *Child Protection Australia* reports reveal that in New South Wales there were 16,765 substantiations in 2002–2003, then as a result of the 2003 system change there was a significant upward trend, which peaked at 37,094 substantiations in 2006–2007 (AIHW, 2008). Then there was another system change in New South Wales, which caused the number of substantiations to drop to a low of 18,596 in 2010–2011 (AIHW, 2012). In relation to the upward trend, the AIHW 2002–2003 report explains:

> The number of child protection notifications, investigations and substantiations in New South Wales in 2002–03 differs significantly from the numbers in previous years. This difference is a direct result of changes to the Department of Community Services client information system . . . For this reason, New South Wales Child Protection data for this year is not comparable with the data for previous years published in this report (AIHW, 2004, p. 12).

In relation to the downward trend, the AIHW 2009–2010 reports states 'the data reported for part of 2009–2010 reflect legislative changes . . . data are not comparable to previous years' (AIHW, 2011, p. 120).

### There is a Lack of 'Who' and 'What' Data

There is a complete lack of detailed and reliable 'who' and 'what' data. For example, in Australia there is no information about the number of children and young people from culturally and linguistically diverse families notified to, or involved with, child protection (Kaur, 2009). There is no information about the percentage of notifications where there is parental drug and alcohol use, mental illness, family violence or disability:

> . . . there are no systematic monitoring processes in the public domain that allow for an analysis of parental characteristics of children entering the child protection system. (Dawe et al., 2007, p. 7)

There is also no information about the number of notifications that are re-notifications (for the first time, second time, third time, or even 20 or more times). Even the data in relation to Indigenous children is unreliable. This is confirmed by the AIHW 2011–12 report. which states that:

> Over the last few years, several jurisdictions have introduced measures to improve the identification of Indigenous clients. However, in some jurisdictions, the high proportion of children whose Indigenous status is unknown still affects the quality of data on Aboriginal and Torres Strait Islander children. (AIHW, 2013, p.7)

Finally, the complete lack of reliable 'where', 'when', 'who' and 'what' data makes it impossible to answer the important 'why' question – about the nature and causes of child abuse and neglect.

## The Lack of Surveillance Data Limits the Ability of Government and the Public Health Community to Respond to the Problem of Child Abuse and Neglect

The lack of reliable surveillance data makes it impossible move through the four steps that are integral to a public health approach to child protection.

In Australia we are unable to identify risk factors and risk populations, and this limits our ability to target interventions to those who are most in need. For example, research suggests that families who make up the primary client group of child protection services have high levels of parental substance abuse, parental mental health problems and domestic violence (Bromfield, Lamont, Parker, & Horsfall, 2010). It is further suggested that these types of problems are 'often inter-related, chronic in nature and

rarely occur in isolation' (Bromfield et al., 2010, p. 1). The lack of child protection surveillance data, however, means that there is not sufficient detail or certainty within any of these statements to inform action – for 'if you don't know you can't act' (Krieger, 1992, cited in Goddard & Hunt, 2011, p. 414). Indeed, if the government and public health community knew the degree to which these families make up the primary client group of child protection, the degree to which their problems are inter-related, and whether these families are concentrated within particular geographical areas or demographic groups, then they would be in a stronger position to know how to act. In fact, such knowledge could provide the impetus needed to end a service system 'comprised of single input services, based on categorical funding, each service typically defining one family member, or one aspect of their needs, as their specific domain' (Scott, 2005, p. 133); and the beginning of a new type of service delivery that meets people's needs holistically, that is family-focused and child-centred. Not only would this knowledge ensure that prevention interventions are targeted towards specific risk factors, it would also ensure that services are located in 'communities where maltreatment is most common, relatively speaking' (Wulczyn, 2009, p. 42).

In Victoria, the *Report of the Protecting Victoria's Vulnerable Children Inquiry* found that families involved with statutory child protection services are concentrated in specific geographical areas. The report stated that notification rates in the Gippsland and Loddon Mallee regions were approximately two times higher than the average across the state. The lack of timely dissemination of this data, however, has resulted in long-term under-resourcing of regional, rural and remote areas (Hodgkin, 2002; Ombudsman Victoria, 2011). Moreover, the public health community has not been able to use this information to inform their early intervention and prevention activities, to ensure that they target their services to those who are most in need.

### Evaluation

The lack of reliable and comparable data over time hinders the ability to rigorously evaluate prevention and intervention strategies. In 2009, for example, the state and territory governments endorsed the *National Framework for Protecting Australia's Children 2009–2020*, which aims to achieve 'a substantial and sustained reduction in child abuse and neglect in Australia over time' (Council of Australian Governments, 2009, p. 11). But how can this be measured when 'the base data are clearly deficient'? (Goddard & Hunt, 2011, p. 414). Even the first *Annual Report to the Council of Australian Governments 2009–2010* on implementing the *National Framework* acknowledges that specifying 'relevant and feasible indicators of change . . . [is an] . . . ongoing and significant challenge' (Council of Australian Governments, 2010, p. 2). The second *Annual Report to the Council of Australian Governments 2010–2011* does not make this same acknowledgement. Ironically, it points to the *Child Protection Australia* report as being one of the 'measures to track progress' (Council of Australian Governments, 2012, p. 6)!

### The Public Health Community do not have Information to Inform the Development of their Early Intervention Efforts

Within the four-step model of public health practice, the focus of the fourth and final step is to disseminate information about the effectiveness of intervention activities to the public health community, to enable widespread adoption of programmes and policies that work (Leeb et al., 2008; Peden et al., 2008; Whitaker et al., 2005; World Health Organization 2006, 2007). In Australia, however, this is impossible. Despite this reality, the Council of Australian Governments in their *National Framework for Protecting Australia's Children 2009–2020* has given the public health community the impossible task of responding to the problem of child abuse and neglect, and many of the Australian States and Territories have done likewise.

For example the *National Framework for Protecting Australia's Children 2009–2020:*

> . . . seeks to involve other professionals, families and the wider community – enhancing the variety of systems that can be used to protect children and recognizing that protecting children is everyone's responsibility. (Council of Australian Governments, 2009, p. 8)

Similarly, the Victorian Government paper – *Victoria's Vulnerable Children Our Shared Responsibility* –says:

> The Victorian Government has a key role to play in protecting vulnerable children. However, protecting children is a community wide responsibility . . . [and] . . . in line with this shared responsibility, organizations should strive to provide connected services and get those services to those who most need them. (Victorian Government, 2012, p. 3)

The Northern Territory's *Safe Children, Bright Futures Strategic Framework 2011–2015* names child protection, 'other government agencies, the non-government sector and the community' as being 'partners in change' (Department of Children and Families, 2011, p. 5).

The Australian Capital Territory's *Sharing Responsibility: A Framework for Service Collaboration for the Care, Protection and Well-being of Children and Young People in the ACT* promotes:

> . . . the care, protection and wellbeing of children and young people as a shared responsibility . . . [and] . . . the development of services will aim to be supported by evidence based policy and practice, effective data collection and evaluation processes. (Vardon and Murray Reports Steering Committee, 2005, p. 3)

The Western Australia's *Supporting Individuals and Families at Risk or in Crisis Strategic Framework and State Plan 2009–2012* also states that 'responding effectively to issues requires a shared responsibility between government

agencies' (Department for Child Protection, 2009, p. 6). 'All agencies have a responsibility to be aware of the evidence that exists in the areas of specialisation, and to ensure that this informs the development of their services and interventions' (Department for Child Protection, 2009, p. 19).

To claim to have a public health approach to child protection, to announce that child protection is a 'shared responsibility' between government and the public health community, to insist that agencies should use evidence, and 'get those services to those who most need them' (Victorian Government, 2012, p. 3) and yet consistently ignore the vital role of surveillance produces a contradiction, a nonsense (Goddard & Hunt, 2011).

## Conclusion

In Australia, the current rhetoric is that a public health approach to child protection is the answer to claims that child protection systems are overburdened and ineffective. This rhetoric, however, ignores the vital role of surveillance, and ignores the fact that the public health community is hindered from taking on a 'shared' responsibility for protecting children when it is not equipped with detailed, relevant and reliable surveillance data (Broadley et al., 2014).

If a public health model of child protection really is the answer, then it cannot be simply imposed on a structure which is already flawed (Stanley & Goddard, 2002). Clearly, there must be a new structure, a new system that involves all the states and territories having the same operational definitions of child abuse and neglect over time, and the same data-recording methods. There must be a shared agreement about the types of information that are needed (for example, information about parental substance misuse, mental illness, disability, family violence, family ethnicity) and unified definitions of each type. It will be difficult to find agreement about how to define these and many other terms. However, for the sake of children's safety it is essential that this occur. Indeed, if government and the public health community are to respond effectively to the problem of child abuse and neglect, they must work together to develop an effective child protection surveillance data system – one that yields high-quality, reliable and useful data that can inform policy and practice. This is the essential first step toward the safety of Australia's children.

## Acknowledgement

The authors would like to thank the late Kirsty Hamilton for her financial and moral support.

## References

AIHW (Australian Institute of Health and Welfare). (2001). *Child Protection Australia 1999–2000* (Vol. Cat. No. CWS 13). Canberra: AIHW.

AIHW (Australian Institute of Health and Welfare). (2002). *Child Protection Australia 2000–01* (Vol. Cat. No. CWS 16). Canberra: AIHW.

AIHW (Australian Institute of Health and Welfare). (2003). *Child Protection Australia 2001–02* (Vol. Cat. No. CWS 20). Canberra: AIHW.

AIHW (Australian Institute of Health and Welfare). (2004). *Child Protection Australia 2002–03* (Vol. Cat. No. CWS 22). Canberra: AIHW.

AIHW (Australian Institute of Health and Welfare). (2005). *Child Protection Australia 2003–04* (Vol. Cat. No. CWS 24). Canberra: AIHW.

AIHW (Australian Institute of Health and Welfare). (2006). *Child Protection Australia 2004–05* (Vol. Cat. No. CWS 26). Canberra: AIHW.

AIHW (Australian Institute of Health and Welfare). (2007). *Child Protection Australia 2005–06* (Vol. Cat. No. CWS 28). Canberra: AIHW.

AIHW (Australian Institute of Health and Welfare). (2008). *Child Protection Australia 2006–07* (Vol. Cat. No. CWS 31). Canberra: AIHW.

AIHW (Australian Institute of Health and Welfare). (2009). *Child Protection Australia 2007–08* (Vol. Cat. No. CWS 33). Canberra: AIHW.

AIHW (Australian Institute of Health and Welfare). (2010). *Child Protection Australia 2008–09* (Vol. Cat. No. CWS 35). Canberra: AIHW.

AIHW (Australian Institute of Health and Welfare). (2011). *Child Protection Australia 2009–10* (Vol. Cat. No. CWS 39). Canberra: AIHW.

AIHW (Australian Institute of Health and Welfare). (2012). *Child Protection Australia 2010–11* (Vol. Cat. No. CWS 41). Canberra: AIHW.

AIHW (Australian Institute of Health and Welfare). (2013). *Child Protection Australia 2011–12* (Vol. Cat. No. CWS 43). Canberra: AIHW.

Allen Consulting Group. (2008). *Inverting the pyramid: Enhancing systems for protecting children*. Melbourne: The Allen Consulting Group.

Babbington, B. (2011). National framework for protecting Australia's children: Perspectives on progress and challenges. *Family Matters*, *89*, 11–20.

Broadley, K., Goddard, C., & Tucci, J. (2014). *They count for nothing: Poor child protection statistics are a barrier to a child-centred national framework*. Melbourne: Australian Childhood Foundation and Child Abuse and Prevention Australia, Monash University.

Bromfield, L., & Higgins, D. (2005). National comparison of child protection systems. *Child Abuse Prevention Issues*, *22*.

Bromfield, L., Lamont, A., Parker, R., & Horsfall, B. (2010). Issues for the safety and wellbeing of children in families with multiple and complex problems. *Family Matters*, *88*, 76.

Council of Australian Governments. (2009). *Protecting Children is Everyone's Business. National Framework for Protecting Australia's Children 2009–2020*. Canberra: Commonwealth of Australia.

Council of Australian Governments. (2010). *Annual Report to the Council of Australian Governments 2009–2010, Protecting Children is Everyone's Business; National Framework for Protecting Australia's children 2009–2020.* Canberra: Commonwealth of Australia.

Council of Australian Governments. (2012). *Annual Report to the Council of Australian Governments 2010–2011, Protecting Children is Everyone's Business; National Framework for Protecting Australia's children 2009–2020.* Canberra: Commonwealth of Australia.

Cummins, P., Scott, D., & Scales, B. (2012). *Report of the Protecting Victoria's Vulnerable Children Inquiry*. Melbourne: Department of Premier and Cabinet.

Dawe, S., Frye, S., David, B., Moss, D., Atkinson, J., Evans, C., . . . Harnett, P. (2007). *Drug use in the family, impacts and implications for children.* Canberra: Australian National Council on Drugs.

Department for Child Protection. (2009). *Supporting Individuals and Families at Risk or in Crisis – Strategic Framework and State Plan 2009–2012.* Perth: Western Australian Government.

Department of Children and Families. (2011). *Safe Children Bright Futures Strategic Framework 2011–2015.* Darwin: Northern Territory Government.

Finkelhor, D. (1999). The science. *Child Abuse & Neglect*, *23*(10), 969–974.

Fluke, J. D., Shusterman, G. R., Hollinshead, D. M., & Yuan, Y. T. (2008). Longitudinal analysis of repeated child abuse reporting and victimization: Multistate analysis of associated factors. *Child Maltreatment*, *13*(1), 76–88.

Goddard, C. (1995, 9 May). Kids deserve better. *Herald Sun,* p. 13.

Goddard, C., & Hunt, S. (2011). The complexities of caring for child protection workers: the contexts of practice and supervision. *Journal of Social Work Practice*, *25*(4), 413–432.

Goddard, C., & Mudaly, N. (2006, 25 July). Deaf ears to the suffering of our children. *The Australian.*

Goddard, C., & Tucci, J. (2008a). *Policy analysis: Responding to child abuse and neglect in Australia.* Melbourne: Australian Childhood Foundation Protecting Children, Child Abuse Prevention Research Australia.

Goddard, C., & Tucci, J. (2008b, 18 November). Secretive system doesn't bear scrutiny. *The Australian,* p. 12.

Grimes, D. A., & Schulz, K. F. (2002). Descriptive studies: What they can and cannot do. *Lancet*, *359*(9301), 145–149.

Hodgkin, S. (2002). Competing demands, competing solutions, differing constructions of the problem of recruitment and retention of frontline rural child protection staff. *Australian Social Work*, *55*(3), 193–203.

Hunter, C. (2011) *Defining the public health model for the child welfare services context.* National Child Protection Clearinghouse Resource Sheet. Melbourne: Australian Institute of Family Studies.

Jack, S. M. (2010). The role of public health in addressing child maltreatment in Canada. *Chronic diseases in Canada*, *31*(1), 39–44.

Kaur, J. (2009). Developing 'Culturally Sensitive' practice when working with CALD communities in child protection: An Australian exploratory study. *Developing Practice: The Child, Youth and Family Work Journal*, *23*, 22–34.

Lee, L. M., Teutsch, S. M., Thacker, S. B., & St. Louis, M. E. (2010). *Principles and practice of public health surveillance.* New York: Oxford University Press.

Leeb, R., Paulozzi, L., Melanson, C., Simon, T., & Arias, I. (2008). *Child maltreatment surveillance: Uniform definitions for public health and recommended data elements.* Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Liddell, M., Donegan, T., Goddard, C., & Tucci, J. (2006). *The state of child protection: Australian child welfare and child protection developments 2005.* Melbourne: Australian Childhood Foundation Protecting Children, Child Abuse Prevention Research Australia

Lonne, R., Parton, N., Thomson, J., & Harries, M. (2008). *Reforming child protection.* London: Routledge.

Mudaly, N., & Goddard, C. (2006). *The truth is longer than a lie: Children's experiences of abuse and professional interventions.* London: Jessica Kingsley.

Northern Territory Board of Inquiry. (2007). *Little children are sacred.* Darwin: Northern Territory Board of Inquiry into the Protecton of Aboriginal Children.

O'Donnell, M., Scott, D., & Stanley, F. (2008). Child abuse and neglect – is it time for a public health approach? *Australian and New Zealand Journal of Public Health*, *32*(4), 325–330.

Ombudsman Victoria. (2011). *Investigation regarding the Department of Human Services Child Protection Program (Loddon Mallee Region).* Melbourne: Ombudsman Victoria.

Peden, M., Oyegbite, K., Ozanne-Smith, J., Hyder, A. A., Branche, C., Rahman, A. F., . . . Bartolomeos, K. (2008). *World Report on Child Injury Prevention.* Geneva, Switzerland: World Health Organization.

Pilger, J. (2013). *Utopia.* Subiaco, Western Australia: Kanopy.

Scott, D. (2005). Inter-organisational collaboration in family-centred practice: A framework for analysis and action. *Australian Social Work*, *58*(2), 132–141.

Scott, D. (2006). Research Article 1: Towards a public health model of child protection in Australia. *Communities, Children and Families Australia*, *1*(1), 9–16.

Stanley, J., & Goddard, C. (2002). *In the firing line: Violence and power in child protection work.* Chichester: Wiley.

State of Queensland. (2013). *Queensland Child Protection Commission of Inquiry: Discussion Paper.* Queensland: Queensland Child Protection Commission of Inquiry.

Valanis, B. (1999). *Epidemiology in health care* (3rd ed.). Connecticut: Appleton & Lange.

Vardon and Murray Reports Steering Committee. (2005). *Sharing responsibility: A framework for service collaboration for the care, protection and wellbeing of children and young people in the ACT.* Australian Capital Territory: Department of Disability, Housing and Community Services.

Victorian Government. (2012). *Victoria's Vulnerable Children Our Shared Responsibility, Directions Paper May 2012.* Melbourne: Victorian Government.

Webb, P., & Bain, C. (2011). *Essential epidemiology: An introduction for students and health professionals* (2nd ed.). Cambridge: Cambridge University Press.

Whitaker, D. J., Lutzker, J. R., & Shelley, G. A. (2005). Child maltreatment prevention priorities at the Centers for Disease Control and Prevention. *Child Maltreatment*, *10*(3), 245–259.

World Health Organization. (2006). *Preventing child maltreatment: A guide to taking action and generating evidence.* Geneva: WHO Press.

World Health Organization. (2007). *Preventing child maltreatment in Europe: A public health approach.* Rome: WHO Press.

Wulczyn, F. (2009). Epidemiological perspectives on maltreatment prevention. *The Future of Children*, *19*(2), 39.

■