# The Analogy of Child Protection as Public Health: An Analysis of Utility, Fit, Awareness, and Need

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**ABSTRACT** Public health approaches to child protection operate by way of analogy. They attempt to import knowledge from the field of public health into the field of child protection by implying equivalences between the fields. This article draws on Kellert's (2008) criteria for evaluating metaphors in scientific reasoning: utility, fit, awareness, and need. It argues that the analogy can be useful but demonstrates poor fit because it relies on false equivalences between maltreatment and health conditions, child protection clients and health consumers, and child protection and health-care systems. Insufficient overt awareness of these false equivalences has resulted in the analogy becoming overstretched and used in support of erroneous conclusions. Knowledge imported from public health is not needed to advance policy and research in child protection. This goal is best served by approaches endemic to child protection that do not rely on the false equivalences that underpin this analogy.

Public health involves attempts to reduce disease and injury within entire populations. The Centers for Disease Control and Prevention (2011) set out four steps that underpin a public health approach: define the problem, identify risk and protective factors, develop and test prevention strategies, and assure widespread adoption. Strategies to deal with health problems can fall into three broad categories (Covington 2013; Scott, Lonne, and Higgins 2016). Primary interventions are those that are aimed at entire populations. These interventions are untargeted and are sometimes referred to as "universal." Secondary interventions are those that are targeted at a subset of the population with a heightened risk of experiencing the identified health problem. These interventions can be targeted at groups (e.g., those living in a geographic region), or they can be targeted at individuals (e.g., those who engage in specified high-risk behaviors). Tertiary interventions are those that aim to ameliorate a health condition once it

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has been acquired. Tertiary interventions are treatments for disease and injury rather than prevention strategies.

This logic has been applied to the field of child protection by way of analogy. Kellert (2008) describes how analogies are used in scientific work to transfer knowledge from one field (the source field) to a different field (the target field) by the drawing of parallels between the two. The analogy implies that the two fields have key features in common, which allows for the importation of knowledge from the source field to the target field. In the analogy of child protection as public health, child maltreatment is equivalent to a health condition that is amenable to prevention with population-wide and targeted interventions. Advocates suggest that such an approach can reduce rates of maltreatment in the population (Covington 2013), reduce pressure on overburdened statutory child protection services (O'Donnell, Scott, and Stanley 2008; Scott et al. 2016; Malvaso et al. 2020), and reduce the long-term costs associated with child maltreatment (Barlow and Calam 2011; Gray 2017). Researchers have suggested that a public health approach is a necessary solution or even the only viable solution to child maltreatment (Prinz et al. 2009; Chahine and Sanders 2013).

Calls to adopt a public health approach are not new. C. Henry Kempe, known as the pediatrician who first articulated the phenomenon of battered child syndrome and as a pioneer in the field of child protection, was a strong advocate of a public health approach to child maltreatment (Krugman 2013). In 1986, Ray E. Helfer, another pioneer of child protection research, who worked alongside Kempe in the early years, gave the keynote address at the Fifteenth Annual Child Abuse and Neglect Symposium. In this speech, entitled "Back to the Future" (a contemporary pop cultural reference), Helfer (1987) asked his audience to draw on the lessons of the past and provide accessible, coordinated, multidisciplinary supports to prevent maltreatment.

Advocacy of a public health approach has been most vigorous in Anglophone countries (Australia, Canada, New Zealand, the United Kingdom, and the United States; Higgins et al. 2019; Malvaso et al. 2020). Child protection systems in these jurisdictions have been criticized as overly forensic, legalistic, concerned with risk rather than need, and reliant on coercive statutory intervention rather than family support (Lonne et al. 2009; Higgins et al. 2019). Public health approaches have been put forward as a solution to these shared problems. Public health has arguably been adopted most

enthusiastically in Australia, where it has dominated policy discourse since the adoption of the National Framework for Protecting Australia's Children 2009–2020, which explicitly takes a public health approach (Council of Australian Governments 2009). Maltreatment has also been taken up as an issue by Australia's national public health agency (Australian Institute of Health and Welfare 2019), the Centers for Disease Control in the United States (Leeb et al. 2008; Centers for Disease Control and Prevention 2011), and the Public Health Agency of Canada (2010). Beyond Anglophone jurisdictions, public health approaches have been advocated in Europe (World Health Organization 2013; Witt et al. 2018; Canavan et al. 2019; Heggem Kojan, Marthinsen, and Clifford 2019), in low- and middle-income countries (Skeen and Tomlinson 2013; Veenema, Thornton, and Corley 2015; Cluver et al. 2016), and globally by the World Health Organization (Butchart and Harvey 2006).

Despite half a century of advocacy, research, and varying degrees of engagement from policy makers around the world, child maltreatment remains widespread (Cyr et al. 2013; Finkelhor et al. 2015) and calls for the adoption of a public health approach to child maltreatment remain common (Herrenkohl et al. 2019; Tonmyr et al. 2019; Bross and Krugman 2020; Malvaso et al. 2020; Runyan et al. 2020). It may be that the discourse of public health has been influential in research and in the language appropriated by policy makers, whereas the practical application of public health principles has been superficial or inadequate. Problems with implementation, fidelity, and insufficient funding for primary and secondary prevention have been put forward as possible explanations for the lack of progress in reducing overall rates of maltreatment (Higgins 2014; Churchill and Fawcett 2016; Bross and Krugman 2020).

Alternatively, it may be that the analogy of child protection as public health does not function as well as is often assumed. The analogy has an intuitive appeal, but the commonsense assumptions that underpin it have rarely been explored or critiqued. Kellert (2008) considers the use of analogies in science as not only potentially valuable but also a potential source of faulty thinking leading to erroneous conclusions. Kellert (2008) sets out four criteria for assessing the value of an analogy in advancing scientific knowledge. He cautions that these should not be applied as strict rules or conditions for reasoning by analogy. Rather, they are considerations about the suitability of an analogy for achieving a particular aim. These criteria are as follows:

- Utility is the extent to which the analogy structures or restructures thinking about the target field. An analogy with utility is one that is more than rhetorical. It does more than highlight known features of the target field; it creates insights about the target field. For an analogy to have utility, there must be some differences between the source field and target field; otherwise the statement is literal, rather than analogous, and the comparison between fields is redundant.
- Fit is the extent to which equivalences in the source and target fields that are implied by the analogy exist in reality. Whether an analogy has fit is an empirical question. Poor fit can lead to erroneous conclusions about the target field.
- Awareness is the extent to which the use of analogy is overt. Awareness makes it possible to be mindful of the utility and fit of the analogy and remain critical of the conclusions that are drawn from what are necessarily imperfect equivalences.
- Need is the extent to which the analogy is necessary to achieve the structuring or restructuring of thinking. Analogies strike a balance between utility and fit and therefore can never be perfect. Analogies can also import conceptual baggage, blind spots, and other problems with the source field into the target field. Given this shortcoming, if the same structuring or restructuring of thinking can be achieved without the use of an analogy, this alternative can be preferable.

The purpose of this article is to evaluate the analogy of child protection as public health using the criteria set out by Kellert (2008). I argue that this analogy demonstrates utility in that it can structure thinking about child protection in useful ways. However, the analogy demonstrates poor fit across several salient dimensions. Specifically, child maltreatment is not equivalent to a health condition, child protection systems are not equivalent to health-care systems, and clients of child protection services are not equivalent to consumers of health services. I set out problematic conclusions that may be derived from these invalid equivalences. I then argue that the field of child protection requires a greater awareness of the analogy that underpins the public health approach to child maltreatment, and I raise questions about how much the field currently needs this analogy to structure thinking.

The article focuses on the analogy of public health as child protection as a conceptual tool. To be clear, the article does not aim to critique the

field of public health more broadly; it focuses only on the knowledge that has been imported into the field of child protection. Nor does it aim to measure the historical impact of this analogy on child protection policy. Although I do discuss the implications of erroneous conclusions that are drawn from the analogy of child protection as public health, this is not to suggest that the analogy is the underlying cause of the current problems in child protection policy. Rather, the purpose is to highlight the limitations of knowledge borrowed from the field of public health for advancing understandings of these problems. The question for this article is not whether knowledge from the field of public health has caused problems in the field of child protection, but whether this analogy is a help or a hindrance in generating solutions.

## UTILITY

As an analogy for child protection, public health has structured thinking in useful ways. The analogy of public health built logically on the medical approach implied by C. Henry Kempe's battered child syndrome. Kempe and his contemporaries were not the first to consider child maltreatment as a serious issue, but by bringing the credibility and weight of the medical profession to bear, they were able to mobilize renewed action (Tomison 2001). Public health, with its focus on prevention at a population level, is an important complement to clinical medicine, which is concerned with treating those who are already sick. Likewise, advocates of a public health approach to child protection argue for a greater emphasis on prevention (O'Donnell et al. 2008; Herrenkohl, Leeb, and Higgins 2016). Insofar as it restructures thinking about child maltreatment to emphasize prevention, public health is a useful analogy.

The analogy of public health also supports understandings of child maltreatment as a problem with causes other than moral failure inherent to individuals or groups of people. Historically, legislation and policy have been framed around the moral corruption of children so that state intervention could be triggered when children were exposed to unfit parents, peers, and places, or when their own behavior demonstrated delinquency or immorality (Forde 1999). This lens of moral danger does not make a clear distinction between children as offenders and victims, or between correction and protection (Ferguson 2007). As a result, where child protection has been framed around moral danger, children have been subject

to the same interventions (which were punitive in their effect although ostensibly intended to be corrective) whether they were offenders, victims of maltreatment, or simply poor. Into the early 1980s in Australia, for example, this resulted in abused and neglected children, among others, being detained in correctional facilities described as "reform schools," "industrial schools," and "training centres" alongside children convicted of offenses (Forde 1999). Perversely, children convicted of offenses were released at the ends of their sentences, whereas children subject to protection from moral danger could be detained for much longer periods, in some cases until they reached adulthood (Forde 1999). Children were sent to industrial and reformatory schools in Ireland under similar circumstances until reformatories were shut down in the 1970s (Ferguson 2007). And in the postwar United Kingdom, welfare policy focused on so-called problem families, a designation that did not make clear distinctions between antisocial behavior, trauma caused by war, poor parenting, and poverty (Lambert 2019).

Moral danger as a feature of cultural groups has also supported immensely damaging paternalistic approaches to indigenous peoples. In Australia, this included forced removals of Aboriginal children in part because "Indigenous families were historically characterized by their Aboriginality as morally deficient" (National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families 1997, 376), and in Canada, Aboriginal children were removed to residential schools, in part to correct what was understood as the moral and spiritual deficiency of indigenous peoples (Truth and Reconciliation Commission of Canada 2015). In the United States, children were also removed into boarding schools forcibly and by coercion (Cooper 2016), and others were adopted into White families, usually living interstate (Thibeault and Spencer 2019). American policies have been framed in more instrumental terms as a response to the perceived threat of Native American cultures to capitalism. However, child removal was also predicated on the moral inferiority of Native Americans, whose refusal to put land to productive (i.e., commercial) use was attributed to indolence (Haag 2007). Whatever economic motivations underpinned policy, children were explicitly taught that their "language, culture, and beliefs were inferior or evil" (Haag 2007, 157). In some locations, these policies and practices remained in full operation through the 1960s and into the 1970s (National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families 1997; Truth

and Reconciliation Commission of Canada 2015; Thibeault and Spencer 2019).

In contrast to this lens of moral danger, the public health perspective construes maltreatment as a distinct problem, like a health condition, to be solved with treatment and prevention. This opens the possibility of nonpunitive interventions to address causes, whether they relate to parents or broader environments. This perspective also makes it possible to disentangle punishment and support for children. Within a public health approach, children can still be removed from their families, but the goal is to move children from harmful environments to supportive environments, rather than to correct purportedly bad children produced by purportedly bad parents or bad cultures. Public health is therefore a useful challenge to the discourse of moral danger and the injustices that it has produced.

A public health lens also views child maltreatment as a social problem and considers populations, rather than focusing only on individuals. As Lonne and Parton (2014) note, media interest, and therefore political interest, tends to center on physical and sexual abuse that is severe or bizarre, and on cases where it is possible to assign personal blame either to a perpetrator or child protection worker. Public health broadens the view of health from individuals to broader systems and entire populations. It measures and tracks problems at aggregate levels (i.e., incidence and prevalence) and highlights the role of universal interventions to enhance health across entire populations (MacMillan et al. 2009; Prinz et al. 2009; Pickering and Sanders 2016). Prevalence studies have demonstrated that maltreatment is a widespread phenomenon (Cyr et al. 2013; Finkelhor et al. 2015). Policy approaches have leveraged existing infrastructure, such as schools and other health and community services, to reach large segments of the population to implement interventions, such as home visitation programs, school-based educational programs, and parent training programs, that are intended to shift overall rates of maltreatment (MacMillan et al. 2009; Prinz et al. 2009). To the limited extent that this public health approach is reflected in popular media, Lonne and Parton (2014) argue that it has had a positive effect on political discourse. The analogy of child protection as public health is one that has some utility. It restructures thinking in useful ways by highlighting the possibility of prevention, challenging the notion of maltreatment as a moral danger, and considering maltreatment at a population level.

## FIT

As noted above, for an analogy to have some utility, the equivalences between the source field and target field cannot be complete. If there were no differences between public health and child protection, the field of child protection would have been subsumed into the field of health, and calls for a public health approach to child protection would be redundant. The analogy requires differences between the source field and target field, but some differences can be problematic. The analogy is built on a series of premises that the field of child protection is like the field of public health in some meaningful ways. These premises must be tested against empirical observation because where these premises are invalid, invalid conclusions may follow. In the following sections, I describe three problematic premises embedded in the analogy of child protection as public health, along with the erroneous conclusions that follow.

### MALTREATMENT IS NOT EQUIVALENT TO A MEDICAL CONDITION

Public health aims to address health problems with discrete definitions, including diseases and injuries, mainly through preventative strategies. In the analogy of child protection as public health, child maltreatment is positioned as equivalent to preventable injuries and diseases. Equivalences are drawn between the prevention of child maltreatment and the prevention of brain injuries through the uptake of helmets for cyclists; prevention of sudden infant death syndrome by putting babies to sleep on their backs (Rivara and Johnston 2013); the use of safety features in cars, including child restraints and seatbelts, to prevent injuries; and smoking cessation to prevent lung cancer (Daro 2016; 0). Maltreatment is also compared with human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS; Gilbert et al. 2009), pool drownings, accidents caused by drunk driving (Chahine, Pecora, and Sanders 2013), and type 2 diabetes (Chahine and Sanders 2013).

### MALTREATMENT IS NOT AN ATTRIBUTE OF THE CHILD

Health conditions, including diseases and injuries, are defined with reference to the attributes of the patient. The circumstances surrounding the

patient may provide some clues about the condition but do not define the condition. For example, if a person was struck in the head after falling from a bicycle without wearing a helmet, a skull fracture might be suspected. However, a fracture would ultimately be either diagnosed or ruled out by examining the patient, perhaps by taking an X-ray. Conversely, it would be possible to diagnose a patient with a fractured bone even if this seemed inconsistent with the patient's surrounding context. It might not even be clear how the patient could have acquired the injury, but if the X-ray showed a fracture, the patient would be diagnosed with a fracture. The same applies to diseases, which are diagnosed by observing the patient's symptoms or by performing diagnostic tests on the patient. There is a conceptual distinction between the health condition, which is defined as an attribute of the patient, and the surrounding circumstances, which may be indicative or explanatory but are not essential to diagnosis. The opposite is true of child maltreatment. When child protection practitioners substantiate maltreatment, the attributes of the child are indicative or explanatory only. A child may have physical, psychological, or developmental symptoms consistent with abuse or neglect, but maltreatment can only be substantiated through investigation of the circumstances surrounding the child to determine the cause of these symptoms. For example, two children may present with identical physical injuries. Maltreatment could be substantiated in one case whereas the other case is assessed to be an accident and therefore unsubstantiated. Correspondingly, it is not necessary for the child to display any particular symptoms for maltreatment to be substantiated. If an infant is left unsupervised for a prolonged period in unsafe conditions, neglect can be substantiated even if, on this occasion, the child suffered minor injury or no injury at all. Similarly, there are no specific symptoms required or diagnostic tests that can be performed on children to substantiate physical, sexual, or emotional abuse.

Maltreatment is therefore sometimes treated as an attribute of parents or a set of discrete behaviors, especially in Anglophone jurisdictions with a child protection orientation (Bromfield and Gillingham 2008; Higgins et al. 2019). However, as is recognized in European family-service-oriented jurisdictions, maltreatment is more complicated (Parton 2019). Certain parental omissions may constitute neglect for one child but be unproblematic for another child who is less vulnerable or surrounded by a more supportive network of extended family. In cases of physical and emotional abuse, maltreatment may be chronic and cumulative rather than acute

(Bromfield, Gillingham, and Higgins 2007), so it may be difficult to identify a particular action or actor responsible. Even in cases of sexual abuse, which may relate to one or more discrete assaults, a nonoffending parent may be substantiated for failing to protect the child from the perpetrator (Coohey 2006). Maltreatment is a failure of the child's ecology and is therefore assessed holistically with reference to the child's environment, capacities, circumstances, and relationships (Hearn 2011). In contrast to the case of health conditions, there is no clear conceptual distinction between maltreatment and the circumstances surrounding the child because maltreatment is in itself a set of circumstances surrounding the child.

Because the acquisition of a health condition involves a change in the attributes of a person, there is generally a corresponding qualitative shift in the approach to addressing the condition. Prevention is replaced with treatment. Once a person has acquired a brain injury, a helmet is of no use. It may prevent subsequent injuries, but it does nothing to treat the current condition, which requires a range of diagnostic techniques, such as X-rays and magnetic resonance imaging, and interventions to support rehabilitation. Similarly, treatments generally make little sense as preventative interventions. Chemotherapy can treat lung cancer but is not useful as a prevention strategy. However, maltreatment is defined by circumstances and behaviors external to the child, so there is no qualitative shift by which a child acquires a new or transformed state and whereby preventative strategies are rendered redundant and must be replaced with a set of treatments. This has some important implications for the application of public health approaches to child protection.

The distinction between primary, secondary, and tertiary interventions is one of the central planks of public health as applied to child protection (Covington 2013; Scott et al. 2016). The distinction between secondary and tertiary interventions hinges on a qualitative shift from prevention (secondary interventions) to treatment (tertiary interventions). If there is no qualitative shift from prevention to treatment of child maltreatment, there is no way to draw a meaningful distinction between secondary and tertiary interventions in child protection. Nevertheless, a great deal of thinking goes into considering whether there is an appropriate funding balance between secondary and tertiary interventions (Fallon, Trocme, and MacLaurin 2011) and whether individual cases meet the threshold for more specialized intervention (Hood 2015). In Australia, this consideration has arguably become the main preoccupation of policy makers (Council of Australian Governments

2009). Discussions such as these that rely on a distinction between secondary and tertiary interventions necessarily stretch the analogy of child protection as public health.

One way of drawing a distinction between secondary and tertiary child protection interventions is to conflate statutory child protection responses with tertiary interventions. For example, O'Donnell and colleagues (2008, 329) describe secondary interventions as those aimed at vulnerable families and describe tertiary intervention as involvement with statutory child protection services for children who "need to be quickly assessed and provided with effective treatment for their abuse and trauma." More often, researchers describe statutory child protection services, particularly out-of-home care, as intended for children who have already experienced maltreatment, whereas nonstatutory services are provided mainly for children who have not (MacMillan et al. 2009; Waldfogel 2009; Scott et al. 2016). Similarly, secondary interventions are positioned as an alternative to statutory child protection services (O'Donnell et al. 2008; Chahine and Sanders 2013; Covington 2013; Higgins 2014; Scott et al. 2016).

Although there is some relationship between statutory child protection involvement and experiences of maltreatment, the overlap is not as neat as is often implied. In the United States in 2017, 60.2 percent of children identified as victims of maltreatment received a postinvestigative service from the child protection service, while 29.6 percent of children who were not assessed as victims received services (Children's Bureau of the US Department of Health and Human Services 2019). Service provision was more likely for children subject to substantiated maltreatment, but this was by no means a determining factor. Furthermore, because only a minority of child protection investigations result in a substantiation, in raw numbers, the bulk of interventions were provided in response to unsubstantiated cases. Almost three-quarters (71.2 percent) of children who received postinvestigative services in 2017 were not assessed as victims of maltreatment (Children's Bureau of the US Department of Health and Human Services 2019). At least according to official data, statutory child protection services are not exclusively or even mainly provided to children who have been maltreated. Of course, official substantiation data do not capture all maltreatment. It has long been argued that most children reported to child protection services, even those who are unsubstantiated, have been subject to some form of maltreatment (Jenkins et al. 2017). It may therefore be argued that statutory services are provided mainly to children who have

experienced maltreatment, even if that maltreatment has not been formally substantiated in a child protection investigation. However, the same logic must then be applied to nonstatutory interventions. Rates of maltreatment in the community are well above rates of child protection involvement (Cyr et al. 2013; Finkelhor et al. 2015); rates of maltreatment in the high-risk groups targeted by nonstatutory interventions would be substantial. These services could not therefore be characterized as secondary prevention. Whether substantiated investigations are used as a proxy for maltreatment or population-based surveys are used, it is clear that statutory services do not constitute tertiary responses as understood in the field of public health.

The conflation of tertiary interventions and statutory responses leads to some problematic conclusions. One conclusion is that statutory child protection services are reactive rather than preventative (Herrenkohl et al. 2016), or they are a last resort and therefore represent a failure of prevention (Council of Australian Governments 2009). However, for some children, statutory services may be timely, preventative, and the most appropriate response. Statutory services may be particularly useful in cases where parents are not willing to engage with support services on a voluntary basis (Valentine and Katz 2015) and to provide a legal framework for the transfer of custody or guardianship to alternative caregivers if such a transfer is required. This is true for children suspected or known to be in danger of experiencing adverse outcomes in the future, whether they have been subject to maltreatment in the past or not.

When tertiary intervention is conflated with statutory service provision, policy makers may also conclude that children receiving nonstatutory services have received intervention earlier or have been subject to less serious forms of maltreatment. However, because there is no qualitative shift from prevention to treatment as there is with health conditions, there is no reason that any particular preventative service would become ineffective once a child has been subject to maltreatment. Nonstatutory services are routinely provided to children who have experienced maltreatment in the past. Indeed, nonstatutory services are routinely provided to children who have been subject to periods of statutory intervention (Valentine and Katz 2015). Where tertiary intervention is conflated with statutory services, policies and expenditure to boost nonstatutory services are assumed to be cost-effective because they are preventative (Barlow and Calam 2011; Gray 2017), which may or may not be the case. When nonstatutory services receive referrals from the statutory child protection service, whether at the end

of an investigation or at the end of a period of intervention, nonstatutory services cannot be characterized as earlier or less reactive than statutory services.

The sense that statutory services are reserved for children who have experienced the worst maltreatment at the hands of the purportedly worst parents after all else has failed has been reinforced by the creation of parallel systems designed to keep families away from statutory services. In Australia, networks of (ostensibly secondary) nonstatutory service providers have been funded to divert children away from statutory services (Harries et al. 2014; Lonne et al. 2014; Valentine and Katz 2015), as if the problem is service provision rather than maltreatment. Elsewhere, differential, dual-track, or multiple-track responses have been implemented. In these cases, two or more processes run in parallel—for example, an investigative process runs parallel to an assessment process (Hughes et al. 2013). There is considerable variation both within and across jurisdictions in the numbers and nature of cases assigned to different tracks because, as Hughes and colleagues (2013) point out, there is no clear or consistent rationale for dividing children into these separate streams. In addition to creating increased complexity for service systems (a process I discuss below), this division of services reinforces the stigma associated with child protection and the perception that statutory interventions are punitive by design. The literature on differential response characterizes child protection responses as punitive, judgmental, adversarial, and as quasi–law enforcement mechanisms (Hughes et al. 2013). A service system characterized in this way becomes the basis for an artificial categorization of children as abused and not abused, and of parents as abusive and nonabusive (Elliott 1998). These separate and parallel networks of services only appear to make sense because of an erroneous assumption that there are two qualitatively different groups of children, maltreated and not (yet) maltreated, who require qualitatively different responses.

## MALTREATMENT DOES NOT HAVE A CLEAR DEFINITION WITH A KNOWN ETIOLOGY

Another difference between child maltreatment and the health conditions addressed by public health approaches is that these diseases and injuries have coherent definitions and known etiologies. It is understood that smoking causes lung cancer, HIV/AIDS is sexually transmissible, obesity

causes type 2 diabetes, and there is a causal connection between sleeping position and sudden infant death syndrome. However, child maltreatment does not have a coherent definition with a set of known causes. Child maltreatment is a broad term that is applied to a wide variety of circumstances and behaviors. It includes acts, omissions, and circumstances as diverse as emotional unavailability, predatory sexual abuse, excessive physical discipline or assaults, provision of inadequate nutrition, exposure to domestic violence, child abandonment, unsafe living environments, and verbal abuse (Australian Institute of Family Studies 2018). Addressing child maltreatment through a public health approach is less like addressing lung cancer, HIV/AIDS, or type 2 diabetes and more like trying to address all three as if they were a single condition. As described above, the first step in addressing a health condition with a public health approach is to define the condition (Centers for Disease Control and Prevention 2011). There is no consensus about how to distinguish between maltreatment and parenting that is good enough (Gibbs et al. 2013; Australian Institute of Family Studies 2018). There is certainly no consensus about how to divide maltreatment into discrete, diagnosable conditions underpinned by shared causal mechanisms.

Even if preventative interventions were to focus on discrete and definable circumstances or behaviors, such as inadequate supervision, harsh physical discipline, and exposure to domestic violence, the causes are so varied and complex that they would not be amenable to focused interventions. By contrast, in the field of health, it has been estimated that each year in United States, 480,000 deaths and $132.5–$175.9 billion in direct health-care costs can be attributed to the relatively straightforward behavior of tobacco consumption (US Department of Health and Human Services 2014). As Rivara and Johnston (2013) point out, broad public health approaches are most effective when there is a simple but sustained intervention that interrupts an empirically validated causal pathway. By contrast, the social and psychological causes that underpin behaviors like domestic violence and drug misuse are varied, contested, and are often considered wicked public policy problems in their own rights (Stockings et al. 2018; Trabold et al. 2018). Producing widespread and sustained change in relation to comparatively simple behaviors like smoking, participating in screening for a type of cancer, or wearing seatbelts is challenging (Wakefield, Loken, and Hornik 2010; Rivara and Johnston 2013). Shifting the rates of social problems that underpin child maltreatment is so much more

challenging as to be incomparable. In the absence of specific definitions and identified modifiable underlying causes, it is not clear how interventions can be targeted or what they should do.

The dilemma of who to target for secondary intervention and how to intervene has been dealt with in two main ways. The first is to assume that the serious problem of maltreatment can be prevented by provision of support to families that are functioning well enough but are experiencing some less serious problems. This assumption is embedded in calls to support families before they reach a point of maltreatment and require statutory services (O'Donnell et al. 2008; Herrenkohl et al. 2019). The logic embedded in these calls is that families who require statutory services begin in a functional state and then deteriorate over time, and that this downward trajectory is signaled and caused by a series of small but growing problems that eventually accumulate to cause maltreatment (Valentine and Katz 2015). Following this logic, advocates of a public health approach to child protection assume that families' decline can be prevented by interventions that address relatively small problems (i.e., where circumstances are suboptimal but are not so bad as to constitute maltreatment). They further assume that, without service support, decline is inevitable for most families experiencing these small problems. These assumptions underpin claims about the cost-effectiveness of secondary interventions (Gilbert et al. 2009; Barlow and Calam 2011; Gray 2017) and are evident in claims that these interventions can take pressure off statutory services (O'Donnell et al. 2008; Scott et al. 2016). Secondary interventions can only operate as reliable and efficient prevention if some substantial proportion of families receiving help with small problems would have continued to deteriorate to maltreatment and would have required statutory intervention.

Within the field of public health, there are some conditions that conform to this pattern. For example, chronic diseases like type 2 diabetes and heart disease may follow this pattern with a range of lifestyle factors, such as poor diet and lack of exercise, leading to obesity and other health problems that accumulate and worsen until more serious illnesses develop. However, diseases do not always unfold along these lines. Conditions can have sudden onset. This is obviously the case for injuries, but it also applies to infectious diseases. Prevention does not necessarily involve addressing smaller problems. It can involve targeting people who are well—for example, by increasing uptake of safety equipment and through vaccination programs. The assumption that serious problems develop from smaller problems

has not been imported from the field of public health. Rather, it appears to have developed within the field of child protection in response to the dilemma of implementation of prevention strategies in the absence of known, linear causal connections between modifiable underlying factors and child maltreatment. The question is whether there is theory or evidence to support the assumption that child maltreatment develops in this fashion.

In the relevant literature, general discussions about public health approaches to child protection tend not to be explicit about theories of causation and change. Understandings of maltreatment as the product of downward trajectories caused by the accumulation and worsening of small problems are usually implied and assumed rather than articulated and supported with evidence (Valentine and Katz 2015). Notwithstanding the prior discussion about the difficulty of making any definitive claims about consistent underlying causes of maltreatment, evidence suggests that maltreatment does not typically develop in a slow, downward trajectory. As described above, maltreatment is not a discrete event or even a set of parental behaviors. It is a failure of the child's ecology to meet the child's needs. The most consistent pattern of change in a child's ecology is the child's own development. When children are first born, they are at their most vulnerable and require the highest level of care. As children grow, the level of care they require declines and the nature of care they require changes. Many parenting practices that are injurious to infants or otherwise concerning are not relevant for older children and adolescents. As a result, as children grow and their vulnerability reduces, maltreatment and child protection involvement become less likely over time, even if parental capacity fails to improve or even deteriorates. This pattern can be observed in official statistics. By far the most common age for children to have maltreatment substantiated by child protection services is before they reach the age of 1 year, the period of time in which they are most vulnerable. In the United States in 2017, 25.3 per 1,000 children under age 1 were subject to substantiated maltreatment. This compares to 11.7 per 1,000 children age 1, which was the next most likely age for children's maltreatment to be substantiated. Rates of substantiated maltreatment were progressively lower in every subsequent age group up to 17 years; the rate for 17-year-olds was 3.6 per 1,000 children (Children's Bureau of the US Department of Health and Human Services 2019). These figures include all children subject to substantiated maltreatment, so age of first substantiated maltreatment would be skewed even

more heavily toward younger children. If parenting capacity does tend to gradually decline over time, the effect on maltreatment and child protection systems appears to be overwhelmed by maturation effects, while children's vulnerability declines over time.

This is not to suggest that parental capacity is entirely irrelevant. However, there is no reason to suggest that it usually deteriorates in a sufficiently predictable fashion for secondary interventions aimed at small problems to have much overall effect on future rates of maltreatment or statutory service provision. For the vast majority of families, life is full of both ups and downs. When families come into contact with services of any kind, whether intended as prevention or otherwise, they are more likely to be at a low point. In the vicissitudes of daily life, for these families, the future is statistically likely to be better than the present, even without any intervention. This phenomenon, referred to as "regression to the mean" in the field of statistics (Linden 2013), suggests that targeting prevention at families when they first begin to manifest small problems will result in systematic targeting of families who would have otherwise improved on their own. If maltreatment were the end point in a predictable downward trajectory signaled and caused by small problems, targeted secondary interventions could be effective and efficient in preventing maltreatment. However, evidence and theory suggest that this is not how maltreatment happens. Support should still be available to families with needs below the threshold for what would be considered child maltreatment. However, these supports should not be funded and evaluated on the basis of improbable claims about maltreatment prevention or cost savings to the statutory child protection system that will eventuate months or years in the future. Supporting families to improve lives is a worthwhile goal in itself, even if this has little effect on aggregate incidence of maltreatment or child protection activity.

The second main approach to this problem is to focus mainly on who to target and pay less attention to the problem of how to intervene. Although it is not possible to identify simple, linear causes of maltreatment and child protection involvement, it is comparatively straightforward to identify factors that are statistically correlated with maltreatment, or at least with child protection involvement. There are factors related to the child (e.g., disability or failure to thrive), factors related to the parent (including maternal depression, young parents, and parental drug use), and factors related to the family (e.g., single parenthood, a large number of children, and poverty; Dubowitz et al. 2011). Once children are subject to involvement

with statutory services, it is equally easy to predict which children will be subject to subsequent involvement. Factors associated with recurrence include initial allegations of neglect, young children, parental substance misuse or mental health problems, and prior child protection involvement (Hélie and Bouchard 2010; White, Hindley, and Jones 2015; Jenkins et al. 2018). These statistical correlations solve half of the problem in that they guide decisions about whom to target, but the question about how to intervene remains open. Many of the factors that are most strongly correlated with maltreatment and child protection involvement are static or historical and therefore not modifiable (Douglas and Skeem 2005; De Bortoli et al. 2017; Jenkins et al. 2018). And even if they were modifiable, there is no reason to believe that these statistical correlations exist because of simple causal relationships (Jenkins et al. 2017). Where families are assessed as having a level of risk that is above average but still relatively low, it is common to revert to the approach described above of addressing small problems that may or may not be causally related. This approach may be ineffective in reducing rates of maltreatment in the population, but it is relatively innocuous in that it does provide services to families who may obtain some benefit, even if children would never have gone on to be maltreated.

Families that display several of the attributes statistically associated with future child protection involvement can be classified as high risk, and for these families, interventions are not always benign. These statistical correlations are used to construct risk assessment tools, which are in turn used to guide decisions about which children to subject to coercive intervention (Coohey et al. 2013; Russell 2015; van der Put, Assink, and Boekhout van Solinge 2017). The relationships among these correlates, child protection involvement, child maltreatment, and interventions designed to prevent maltreatment are not straightforward and are poorly understood (Jenkins et al. 2017). For example, one of the best predictors of future child protection involvement is the provision of prior support services, even after we control for all other known correlates that might predict service provision (Fluke et al. 2008; Fuller and Nieto 2014). As a result, children are first deemed high risk, in part because of their prior receipt of services, and are then provided with yet more services to ameliorate that risk. In these cases, especially where children are classified as high risk because of historical and static factors that cannot reduce over time, within the context of risk-averse and defensive practice (Munro 2010; Sultmann

2014), the likelihood of eventual placement in out-of-home care is high. Once children are known to child protection services with coercive powers, it is especially problematic for service providers to focus on who to target without an understanding of how to intervene.

## CHILD PROTECTION CLIENTS ARE NOT EQUIVALENT TO PATIENTS

The analogy of child protection as public health implies an equivalence between patients and clients of child protection services, but medical patients and child protection clients differ in some important ways. Roles of patient and client are defined by their relationships to service providers in each field. As noted above, in the field of health, patients generally have a direct relationship with a clinician. This is not the case in the field of child protection. Because maltreatment is a failure of the child's ecology, it is possible for interventions to be multipronged and distributed across the child's entire ecology. Within the discipline of social work, which has exerted considerable influence in the development of child protection practice, people are understood as embedded in their environment and social relationships (Chenoweth and McAuliffe 2014). This approach is exemplified by family service–oriented jurisdictions in Europe, but even in the more adversarial and legalistic Anglophone jurisdictions, child protection agencies must prioritize working with families where possible (Parton 2019). Given this approach, interventions can relate to a range of people, including children, caregivers, and often others in the family and broader environment. Rather than working in the context of a one-to-one relationship between clinician and patient, child protection practitioners work through entire families and communities and are required to reconcile collective and individual interests.

It is tempting but problematic to view the relationship between a child protection worker and a child as equivalent to the relationship between a clinician and patient. As Parton (2009) has pointed out, legislation and policy that position children as the primary client in child-centered systems have the effect of artificially disaggregating and fragmenting families into individuals, obscuring the human relationships that underpin child safety. At its most extreme, this approach not only justifies the removal of children from parents but also allows for the separation of siblings (Featherstone, Morris, and White 2014). As Featherstone and colleagues

(2014) have pointed out, it is so intuitively appealing and seems so morally correct to place children at the center of decision-making as the primary client of child protection work that it is easy to overlook how incongruent this approach is with understandings of family functioning and good casework. Although power imbalances exist in relationships between medical clinicians and patients, the nature and level of coercion inherent in child protection sets it apart. Patients are afforded the right to make decisions about their own care, with involuntary treatments restricted to patients with serious mental health conditions and used to a limited extent (Sheridan Rains et al. 2019). However, coercion is at the heart of child protection as currently constituted. Statutory child protection workers have powers to investigate and can invoke legal processes to remove children (Pelton 2016). Families can choose to work cooperatively with practitioners, but even if practitioners do not exercise their powers, these powers still shape the relationship between client and worker (Pelton 2016). Referral pathways between nonstatutory and statutory services mean that there is a subtext of coercion even in services that are ostensibly voluntary. Practitioners and families understand that if people refuse to accept help from a nonstatutory service, a referral to a child protection authority may be made (Valentine and Katz 2015). The nature of the relationships between clients and practitioners changes the way the service system operates. In the field of health, services can screen, identify, and refer individuals who require targeted intervention or treatment, and in most cases, patients want this treatment. In child protection, this type of integration between services is problematic because it may result in families being referred to statutory services against their wishes. Attempts to screen families in voluntary services may erode trust within the community and deter the most vulnerable families from seeking help of any kind for fear of being subject to investigation and coercive intervention (Pelton 2016). It is worth noting that this conflict does not arise in other applications of public health principles, even in other areas that involve illegal behavior and coercion. Illegal drug use is a case in point. There are both voluntary and coercive responses to drug use, as there are in child protection. However, unlike child protection, coercive treatment is usually either part of a criminal sanction or an attempt to divert an offender away from a more punitive criminal response (Hall and Lucke 2010). Public health principles provide a solution to the problem of how to balance punitive and helping responses by prioritizing support over punishment. In child protection, the choice is not between a helping response and a

punitive response. Rather, the choice is between two different helping responses. Attempts to transfer the logic of diversion applied in criminal justice to child protection result in the contradiction of using one set of support services to divert families away from another set of support services (Tilbury 2016). Rather than families remaining in the most helpful service, the result for many families is a more indirect and complicated pathway to the statutory service that they needed all along.

The nature of the relationships between clients and services also has implications for the way stigma plays out in each field. In the field of health, there is considerable stigma associated with particular conditions—for example, with sexually transmitted infections (Geter, Herron, and Sutton 2018) and drug use (Biancarelli et al. 2019). Clinicians can treat these conditions within a clinical relationship that is nonjudgmental, and prevention efforts can be supported by attempts to reduce stigma associated with both the condition and treatment (Geter et al. 2018; Biancarelli et al. 2019). However, child protection practitioners are responsible for not only providing prevention and treatment, but also assessing the capacity of caregivers and determining whether members of their client group have engaged in physically, sexually, or emotionally abusive behaviors. It is understandable that parents experience child protection involvement as an accusation of failure and therefore as stigmatizing (Quick and Scott 2019). Case workers can do a great deal to manage this stigma in their interactions with clients (Quick and Scott 2019), but it is an entirely different proposition in child protection compared with the field of health. Advocates of the public health approach to child protection have often called for more nonstigmatizing voluntary services (Churchill and Fawcett 2016; Scott et al. 2016). However, there is an inherent contradiction in these calls when services, and therefore service users, are classified according to the likelihood that children will be maltreated. Although it is possible for primary interventions to be nonstigmatizing, it is not clear how it is possible to explicitly target services at communities and individuals considered likely to engage in abusive and neglectful parenting without those communities and families experiencing stigma.

## CHILD PROTECTION SYSTEMS ARE NOT EQUIVALENT TO HEALTH-CARE SYSTEMS

The analogy of child protection as public health suggests that the child protection system is equivalent to a health-care system. Most of the

health-care system, as it is usually conceptualized, involves the provision of health and medical services directly to patients. The Australian Institute of Health and Welfare (2018) estimates that 84 percent of health-care expenditure in 2018 (both public and private) related to medical services, including hospitals (39 percent); nonreferred health services, including general practitioners (35 percent); and referred medical services (10 percent). In the United States, 75 percent of health-care expenditure was proportioned as follows: 33 percent for hospital care; 20 percent for physician and clinical services; 10 percent for retail prescription drugs; 5 percent for other health, residential, and personal care services; 4 percent for dental services; and 3 percent for other health practices, including physical therapy, optometry, and podiatry (Centers for Medicare and Medicaid Services 2017). Although there are exceptions (e.g., health promotion activities and research), health-care systems are mainly concerned with service provision that involves a direct interaction between the service and the patient. Child protection systems do not operate in this fashion. As described above, child maltreatment is a failure of the child's ecology, so interventions are distributed across the entire ecology. Interventions necessarily operate on and are mediated by parents, families, and the broader environment. Where health-care systems generally provide services to meet needs directly, child protection services rarely meet children's needs in this way.

The poor fit between health-care systems and child protection systems results in some problematic reasoning. To start, it creates confusion about the conceptual boundaries of the child protection system. Drawing boundaries around complex systems is never straightforward, especially if systems involve human beings. Networks of relationships between people are expansive and open, which means that systems do not have neat, naturally occurring edges (Meadows 2009). Notwithstanding this difficulty, defining the boundaries of systems is an important conceptual task to ensure different understandings of a term like "child protection system" have enough in common for the term to be useful. Understandings of boundaries also underpin understandings of how systems work. System boundaries can be defined in broad strokes according to the function of the system (Meadows 2009). The health-care system therefore includes the things that contribute to the provision of health care to people. This seemingly pedestrian observation suggests that health-care systems operate as a network of service providers staffed by clinicians who act as the interface

between that system and patients. Similarly, the child protection system includes the things that contribute to the protection of children. Conceptualizing the child protection system as a network of service providers and practitioners excludes a large and crucial part of the system—namely, the families and communities that ensure children's needs are met. This is precisely what happens when child protection systems are understood as equivalent to health-care systems.

This observation has implications for the way that governments approach child protection policy. If child protection systems are understood as networks of service providers, this suggests that child protection is under the control of administrators, regulators, and ultimately governments. In fact, the components of the system that have the most direct influence over children's well-being and safety operate beyond the direct control of governments. Compared with health-care systems, child protection systems are more expansive, more organic, and more complex. Calls to reform or implement systems (Scott et al. 2016; Higgins 2017; Bross and Krugman 2020) fail to recognize these fundamental attributes. Child protection systems are therefore less like health-care systems and more like the housing sector. Certainly, government policy plays an important role in the functioning of the system. However, it is understood that governments only have power to move policy levers and influence how the sector operates; they do not have power to direct, plan, or implement it. Understanding child protection as the function of a complex, organic system, rather than the output of a network of service providers, highlights different opportunities for policy makers. For example, housing and poverty are inextricably linked to child neglect (Hearn 2011). Within the analogy of child protection as public health, housing needs are to be met by delivering services to families. However, contemporary housing policy involves much more than this. Promising policy approaches include interventions in markets (both sales and rentals) to increase supply of affordable housing; community-level interventions to support local economies; application of vouchers, tax breaks, and tax credits not just to provide support to individual households but to shape the spatial distribution of poverty; regulation for neighborhood preservation to counter effects of gentrification; regulation of credit; and even management of student debt (Reina and Landis 2019). These approaches do not fit into a system comprising service delivery divided into primary, secondary, and tertiary responses. The analogy of child protection as public health simultaneously suggests that governments have more direct influence over outcomes than they do and

obscures policy options that involve interventions other than service delivery led by child protection practitioners.

## AWARENESS

The lack of fit in the analogy of child protection as public health is not inherently problematic. As described previously, analogies are imperfect by their nature. If there were perfect fit between the source field and target field, the analogy would operate as a literal rather than figurative statement and would therefore not achieve any conceptual restructuring of the target field. What matters is how analogies are used. Ideally, analogies are used to restructure thinking in useful ways and are put aside when the lack of fit between the source field and target field leads to erroneous conclusions. This requires a sustained awareness of the analogy to ensure that it is not overstretched in this way.

An overt awareness of the utility of public health as an analogy for child protection is evident in the literature. Proponents of the public health approach write persuasively about the advantages of taking a broader social and population-level approach to the problem of child maltreatment, the value of prevention, and understanding child maltreatment as a problem with causes and solutions rather than a moral failure to be punished. However, awareness requires a deliberate balancing between utility and fit, and, despite decades of scholarship and policy, the fit of the analogy is rarely questioned. The failure of public health approaches to produce population-wide reductions in maltreatment (Gilbert et al. 2012) is often attributed to limited or poor implementation (Higgins 2014; Churchill and Fawcett 2016). There is also a tendency to ignore previous attempts to import knowledge from the field of public health into the field of child protection and thus ignore the difficulties inherent in this approach. As described at the beginning of this article, a public health approach to maltreatment has been advocated since the beginning of the contemporary field of child protection (Petersson 1977; Krugman 2013). Since then, however, it has been perpetually described as an emerging idea on the cusp of being realized. In 1984, Wolfe and Manion noted that "ten years ago parents had to be identified as abusive before help was offered. . . . Today, many more communities are offering parent support services, innovative primary and secondary prevention campaigns" (47). A decade later, Thyen, Thiessen, and Heinsohn-Krug (1995, 1337) observed that "while intervention after-the-fact (tertiary

prevention) predominated initially, concepts of secondary and primary prevention have gained increasing attention." And at the turn of the millennium, Tomison (2001) contended that "interest in the *prevention* of child abuse and neglect increased substantially in the last 20 years, and even more dramatically in the last decade" (53), in contrast to the "investigation-driven child protection response of the early 1990s" (53). Toward the end of that same decade, O'Donnell and colleagues (2008, 327) contended that "the knowledge base for a public health approach to child abuse and neglect is still in its infancy." And more recently, Covington (2013, 25) stated that "it was not until this century that child maltreatment in and of itself was described within a public health framework." More recently still, Scott and colleagues (2016) observed that "there have been increasing calls for the implementation of the public health model to prevent child maltreatment" (408), which they describe as "a viable alternative solution and means to address the needs of families and children at risk of maltreatment" (415). By ignoring its history, scholars have been able to treat the public health approach as an unproven but promising new idea rather than an old one that has failed to deliver. It has been possible to avoid obvious questions about why jurisdictions that have implemented successful public health strategies to address diseases and injuries have failed to do the same for child maltreatment. As a result, the inherent incompatibilities between public health and child protection that might explain this failure to deliver have remained largely unexamined.

When incompatibilities between public health and child protection have been acknowledged, they have been framed as technical problems to be solved. For example, there have been repeated calls and attempts to implement surveillance systems to track the incidence of maltreatment the way public health authorities track reportable diseases (Gibbs et al. 2013; Rivara and Johnston 2013; Malvaso et al. 2020). The World Health Organization has suggested that operational definitions of child maltreatment should be "clearly set out and agreed on between the different sectors involved in the data collection. . . . Case definitions should be both *sensitive* and *specific*—resulting, respectively, in few false-negative and false-positive cases—and should be simple and unambiguous" (Butchart and Harvey 2006, 28). Considerable resources have been dedicated to finding technical solutions to develop and implement such definitions across disparate data sources and jurisdictions to collate comprehensive data over time (Gibbs et al. 2013). Despite this, no jurisdiction has successfully

established anything like the surveillance systems that are commonplace in the field of public health. This lack of fit between the field of child protection and public health is not merely a technical problem; it conceptually does not make sense to count the confluence of behaviors and circumstances that constitute maltreatment as unambiguous, discrete events located in individual children and caused by identifiable perpetrators. There is an irreconcilable lack of fit between the concepts of disease and maltreatment. This is not to suggest that attempts to quantify the extent of maltreatment should be abandoned. Just that, with an appropriate level of awareness, it would be acknowledged that the precise and comprehensive surveillance that is critical to the field of public health cannot be achieved and should not be attempted in the field of child protection.

The tendency to focus only on utility and overlook or downplay the lack of fit between public health and child protection demonstrates a lack of awareness. This has allowed the analogy of child protection as public health to be stretched too far. Indeed, child protection is often described in literal terms as a public health problem, and, as noted previously, key responsibility for addressing child maltreatment has been handed to public health agencies. These agencies, in turn, have tried to replicate approaches taken to illness and injury, no matter how unsuitable they may be for the problem of child maltreatment. Misguided application of the analogy also explains why researchers and policy makers have persevered with an approach that has, after decades of research, advocacy, and policy, failed to deliver on its lofty promises. If knowledge is to be imported from the field of public health to the field of child protection in a useful way, a more critical engagement with the equivalences and differences in the two fields will be required.

## NEED

Kellert's (2008) final criterion for the use of an analogy in science is the extent to which the analogy is needed. Analogies can structure thinking in useful ways, but they can also import the conceptual limitations of the source field. Undoubtedly, public health has had major successes, but it has also been criticized as being too focused on proximal causes in oversimplified linear models of causality, for relying on high levels of individual agency in subpopulations targeted for intervention, and for failing to consider how interventions in complex systems might be implemented

and evaluated (Rutter et al. 2017). These limitations are only magnified when imported to the field of child protection, which is a more complex system that aims to address a less definable problem. Furthermore, analogies are inherently imperfect and can therefore lead to erroneous conclusions. These blind spots and erroneous conclusions can be avoided with a careful approach to transferring knowledge from one field to another based on an awareness of the equivalences and differences between the source field and target field. An alternative is to avoid the analogy altogether if the desirable structuring or restructuring of thinking can be achieved without it. The analogy of public health allows the problem of maltreatment to be conceptualized as preventable rather than merely treatable, as a social problem rather than a moral failure, and as a feature of populations rather than an aberration in an individual. The question, then, is whether it is possible to conceptualize maltreatment in this way without relying on the analogy of child protection as public health.

Whether this analogy was needed over the last 50 years of child protection is a hypothetical question beyond the scope of this article. A more useful question is whether it is needed now. Without the analogy of child protection as public health, it is likely that child protection policy and practice would continue to draw on nonmoralistic and preventative approaches anyway. As Beck (1992) has argued, risk has become the organizing principle of late-modern societies. Traditional approaches to adverse outcomes of morality and blame have been supplanted by scientific understandings and technocratic solutions that aim to calculate, mitigate, and avoid risk. The effects of this shift go beyond public health and child protection. Nonmoral, preventative, risk-based approaches are pervasive in public policy and scientific disciplines. For example, these features are evident in prevention science, described by Coie and colleagues (1993, 1013) in their seminal article as "a new research discipline . . . at the interfaces of psychopathology, criminology, psychiatric epidemiology, human development, and education." Prevention science has much in common with and draws upon theory and research in public health, but it does so without treating every problem as equivalent to a disease, every affected person as equivalent to a consumer of health services, and every system as an apparatus of service delivery divided into primary, secondary, and tertiary interventions. Similarly, complexity science and systems thinking, which has been applied within the field of child protection (Jenkins et al. 2017), offers an alternative approach to addressing questions about prevention (Lich et al. 2013). Of course, these

approaches have blind spots and conceptual baggage of their own. Prevention science has been criticized for its narrow focus on what works and a tendency to treat contestable and socially constructed problems like drug use (and arguably child maltreatment) as "distinct and bounded objects, situated outside the scientific practices that define them" (Roumeliotis 2015, 748). Complexity science is better at producing descriptive rather than predictive models; tends to rely on contestable equivalences between physical, biological, and social systems (Allen 2011); and itself has a particular tendency to be applied poorly by way of analogy (Kellert 2008). The point here is not that the unarticulated problematic assumptions that underpin the analogy of child protection as public health should be replaced with some other set of assumptions from a different field. The point is that it is possible to structure thinking about child protection around nonmoralistic, population-level prevention without relying on public health as an analogy. There is limited need for public health as an analogy for child protection.

## CONCLUSIONS AND FUTURE DIRECTIONS

The longstanding analogy of child protection as public health has some value. It is useful in framing policy around prevention rather than merely around response to maltreatment when it arises. It is also useful in highlighting the broad prevalence of maltreatment as a social problem, in contrast to popular conceptions of maltreatment as the aberrant, morally corrupting behavior of a few individuals; this emphasis highlights in turn the possibility of population-level interventions. However, false equivalences between the field of public health and child protection implied by this analogy can lead to erroneous conclusions. Maltreatment is not a clearly definable condition with a known etiology; it is not an attribute of an individual child like a disease or injury. Given this difference, the important distinction between secondary health interventions (i.e., targeted prevention) and tertiary health interventions (i.e., treatment once a condition or injury has developed) is not meaningful in the field of child protection. Furthermore, without known linear causal pathways underpinning child maltreatment, it is not possible to implement the kinds of sustained and focused interventions that have led to cost-effective, population-wide improvements in the field of health. Perseverance with the analogy of child protection as public health has meant that ostensibly preventative services have targeted families where maltreatment is already present and, conversely, where maltreatment would never

have eventuated. And these interventions have addressed problems that may or may not be causally related to maltreatment. Calls for child-focused, voluntary, and nonstigmatizing services have been predicated on false equivalences between child protection clients and consumers of health services. These calls ignore the family and community dynamics that underpin maltreatment and child safety, the level of coercion inherent in child protection practice even in ostensibly voluntary services, and the extent to which child maltreatment is and will remain stigmatized. Within the analogy of child protection as public health, child protection systems, which are complex and organic, have been conceptualized as networks of service providers. This perspective has overstated the direct influence of policy makers and obscured the range of policy levers that do not fit within the classification of primary, secondary, and tertiary service provision.

A lack of awareness of the limitations of the analogy of child protection as public health has thus overstretched the analogy. New calls for a public health approach do not acknowledge similar calls made over decades or the failures to deliver promised benefits even in jurisdictions that have strong track records in public health. Indeed, it has not even been possible to build the infrastructure that would underpin a public health response, such as an agreed-upon definition of the problem or a surveillance system to monitor prevalence. The extent to which the analogy of child protection as public health has influenced policy by focusing on preventative, nonmoralistic approaches that consider the full breadth of the problem at a population level is moot. At a time when these principles are accepted by researchers, policy makers, and practitioners in the field of child protection, and are embedded in a range of social scientific disciplines and broader contemporary culture, this overstretched analogy does more harm than good. It is time to move on from calls to treat maltreatment like a disease, child protection systems like health-care systems, and child protection clients like health consumers.

The goal of addressing child and family welfare needs at a population level is worthwhile, even if it is not possible draw to straight lines between these needs, interventions, and future child maltreatment. Likewise, addressing problems that are statistically or theoretically related to child maltreatment remains worthwhile. However, these interventions should be justified and evaluated primarily according to the good they achieve rather than according to their estimated effect on a potentially unrelated problem or, worse still, whether they keep families away from another set of potentially useful services. Services can still be targeted toward families

most in need and most likely to benefit without the drawing of arbitrary distinctions between services designed for children who have been maltreated and services designed for children yet to be maltreated. It is broadly accepted that coercion and the effects of stigma should be minimized out of respect for human autonomy and dignity. It is not necessary to pursue the unachievable goal of creating services that are directly connected to child maltreatment but are somehow free from coercion and stigma. Rather than importing knowledge from other fields, it is time to develop knowledge endemic to the field of child protection. Freed from the constraints of the false equivalences that support this necessarily imperfect analogy, the field of child protection can work toward more apt description and more useful understandings of maltreatment, child protection systems, and families.

## NOTE

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