EVIDENCE BRIEF

THE PUBLIC HEALTH APPROACH AND CHILD PROTECTION

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KEY MESSAGES

- The public health approach promotes an ethos of support and recovery and a systematic, scientific approach to earlier intervention at every point along the continuum of risk and need.
- When correctly applied, a public health approach offers a valuable theoretical framework for informing a systemic approach to preventing and responding to abuse or neglect along a continuum of risk and need.
- Responsive regulation is a theoretical framework specific to systems including statutory powers and is a useful compliment to the public health approach.
- As coercive intervention can be harmful or counterproductive, the principle of least intrusive intervention required must be upheld.
- The threshold for child protection needs to explicitly consider degree of safety concerns, family needs and the purposeful assessment of the degree of regulation needed to facilitate children's safety.

PURPOSE

This evidence brief provides an overview of the Public Health Approach and Responsive Regulation Framework. It applies these approaches to a proposed continuum that considers child safety and intensity of family need and explicitly engages with the degree of regulation required to facilitate children's safety along that continuum.

THE PUBLIC HEALTH APPROACH

Addressing the needs of children and families where there are identified vulnerabilities, such as exposure to risk, harm, or complex life circumstances, requires a system of supports that varies in intensity. No single service or program can meet the needs of all children. Instead, a coordinated and tiered approach is required, tailored to the specific developmental, relational, and environmental needs of each child and family.

As a preventative strategy, the public health model provides a framework for guiding early intervention. It focuses on addressing issues *earlier in the life of the problem*, before risks escalate or become entrenched, by delivering targeted supports at varying levels of intensity across the population. The definitions of early intervention and prevention are discussed in further in the evidence brief titled *Early Intervention and Prevention* (Bromfield et al., 2026) In the context of child protection, this model has been

advocated as a foundation for system-level change (O'Donnell et al., 2008), including by the World Health Organization (WHO).

The WHO (2025) outlines four steps in applying the public health approach to violence prevention (inclusive of child abuse and neglect):

1. **Surveillance – Defining the problem**
   - Collect and analyse data to understand the nature and scale of the issue.
2. **Identifying risk and protective factors**
   - Conduct research to understand why the problem occurs and what protects against it.
3. **Developing and evaluating interventions**
   - Design, implement, and assess what works, for whom, and under what conditions.
4. **Scaling and implementing interventions**
   - Expand successful approaches and assess their broader impact and cost-effectiveness.

Core Assumptions of the Public Health Model

- Problems can be prevented through timely, evidence-based interventions.
- Data collection and population-level analysis help identify who is most at risk and what supports are needed.
- Prioritising earlier intervention and targeting high impact intervention points is more beneficial to the affected community and more cost efficient
- Interventions should be delivered according to a continuum of need, ensuring resources are matched to vulnerability.
- Unnecessary intervention can cause harm and should be avoided.

The primary, secondary and tertiary 'levels of prevention' were first conceptualised by public health researchers Leavell and Clark in the 1940s (Pandve, 2014).

- **Primary prevention** targets the whole population, regardless of risk, to stop problems before they occur (for example, SunSmart campaigns or immunisations).
- **Secondary prevention** focuses on people who have been identified as being at higher risk of a problem (for example, diet and medication for those at risk of heart disease).
- **Tertiary prevention** supports people who are already experiencing the problem to reduce its impact (for example, physical therapy for stroke survivors).

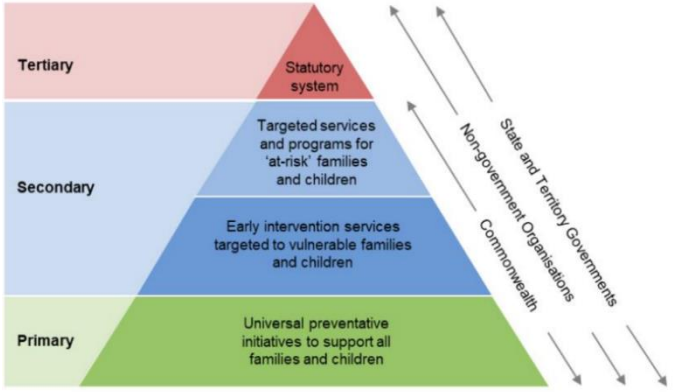
In most situations, the largest population or group is those with no known risk (primary prevention), while the smallest group is those already affected (tertiary prevention).

Some frameworks also include **quaternary prevention**, which refers to identifying individuals at risk of overmedicalisation, protecting them from unnecessary or excessive interventions, and offering only ethically appropriate, person-centred care (Jamoulle, 2015; Martins et al., 2018).

In visual terms, Leavell and Clark did not represent the levels of prevention in a pyramid, but others subsequently did so. For example, in the field of child protection, the public health model has often been represented as a pyramid (COAG, 2009) with segments that match the level of risk in different groups within the population.

Figure 1

Public Health Pyramid Applied to Child Protection



Note. From *National Framework for Protecting Australia's Children 2009-2020* by COAG, 2009. www.dss.gov.au/sites/default/files/documents/child_protection_framework.pdf

Within Australia, the public health approach was applied to child abuse and neglect prevention from the early 2000s (O'Donnell et al., 2008), and was widely applied to inform systemic reforms (Council of Governments, 2009; Wood, 2008). An example of this application is shown above in Figure 1, reproduced from the first National Framework for Protecting Australia's Children.

A core assumption of systemic reforms using this pyramid has been that the size of the pyramid segments representing the levels of prevention accurately represented the size of the primary, secondary and tertiary populations. However, these assumptions were made without reliable epidemiological data.

The best available data now indicates that child abuse and neglect is common (Octoman et al.,

2026). The Australian Child Maltreatment Study estimates the majority of Australians (61%) have experienced one or more types of child abuse or neglect; and one quarter of Australian have experienced between three and five types (Haslam et al., 2023).

This means that we now know that the public health pyramid does not reflect the relative sizes of the primary, secondary and tertiary prevention populations. While the levels of prevention remain important, a continuum rather than a pyramid is a more accurate way of representing the populations indicated for each of the levels of prevention.

For example, Figure 2 illustrates an application of the public health approach to the existing service system, using a continuum rather than a pyramid. Figure 2 also differentiates populations (primary, secondary and tertiary) from service types (universal, targeted, statutory).

Challenges in Using the Public Health Approach to Describe the Existing Service System

The public health model is a helpful framework for understanding how to meet the needs of children and families across varying levels of risk and vulnerability. It allows policymakers and practitioners to think in terms of universal (primary), targeted (secondary), and intensive (tertiary) prevention efforts, matched to the needs of different populations. However, there are challenges in applying this framework to describe the existing service system, particularly when trying to classify services as primary, secondary or tertiary child abuse prevention.

One major risk is oversimplifying the function of services by assigning them to a single, fixed category. Many community-based services, such as childcare, parenting programs, or mental health supports, may support families across all levels of prevention. For example, mental health services may promote wellbeing in the general population (primary prevention), support individuals at risk of harm (secondary prevention), or assist individuals who have experienced abuse or neglect (tertiary prevention).

Applying the prevention categories too rigidly can unintentionally reinforce narrow ideas about responsibility. For example, it can contribute to the view that tertiary prevention is only the responsibility of highly specialised or statutory services. This perception is not only inaccurate, but potentially harmful.

Families experiencing complex challenges often have multiple and complex needs. When community services do not see themselves as part of the tertiary response, families may be excluded from essential support. This can weaken the system's ability to prevent harm and promote safety and recovery.

Instead, arguments have been put forward that a universal base of preventative services should be developed to establish a collective responsibility towards protecting children (Daro & Karter, 2019).

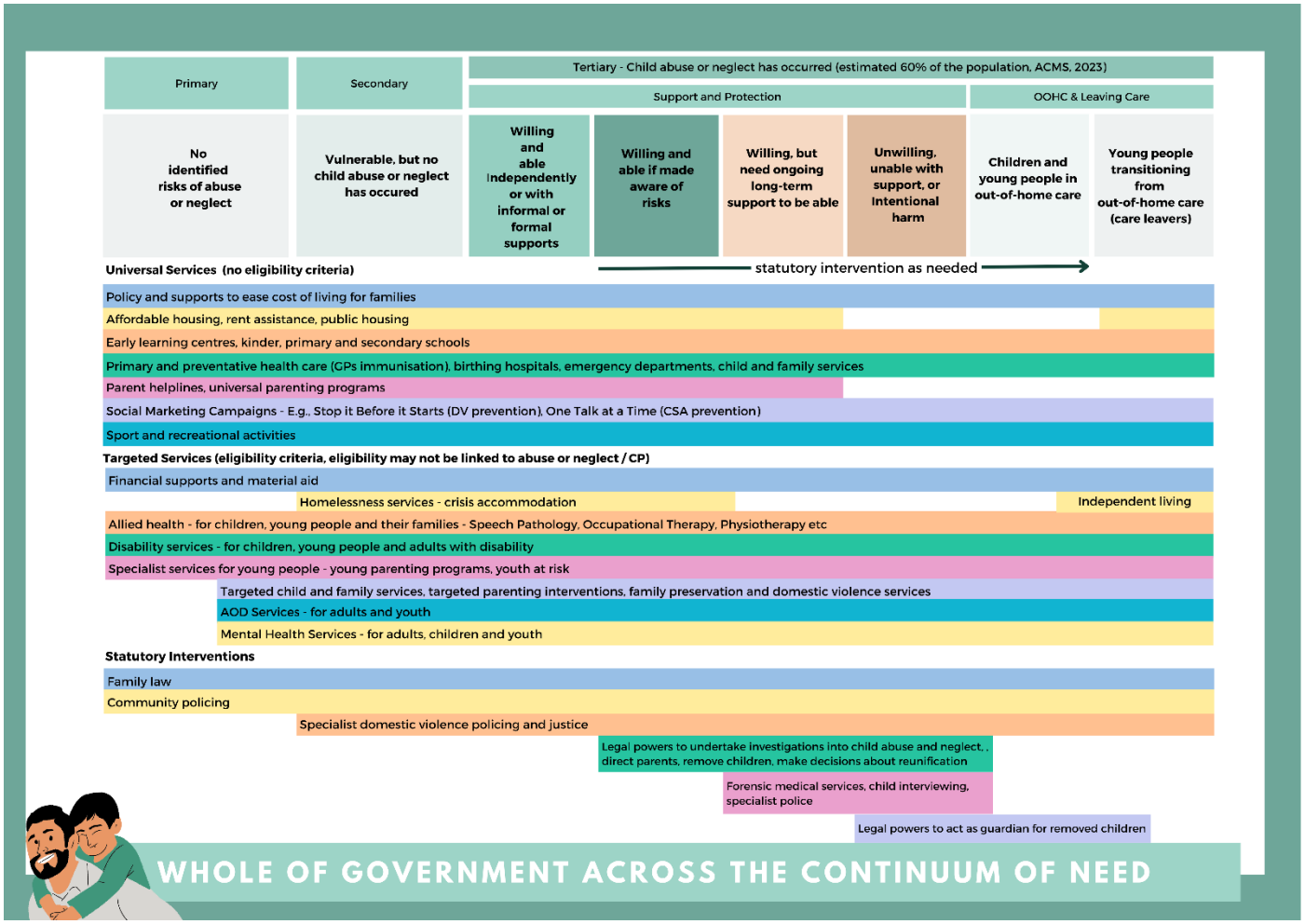
To meet the needs of children and families at all points on the continuum of vulnerability, the service system must remain flexible and connected. This means ensuring access to:

- **Trauma-informed universal supports** – such as early childhood education and care, general practitioners, maternal and child health services, and parenting helplines.
- **Targeted services** – including mental health care, alcohol and other drug services, disability supports, therapeutic services, and culturally responsive family support.
- **Statutory and legal services** – such as Police, Family Court, and Child Safety Services, where legal authority may be required to manage risk and ensure safety.

In short, a strong public health approach depends on an integrated system where services are not siloed or restricted by labels, but collaboratively to support children and families before, during, and after times of difficulty. Families need to be supported to connect with the right intensity of services at the right time, without over complicated referral processes or eligibility criteria.

Figure 2

Whole of Government and Non-Government Across the Continuum of Need



Note. From "*Whole of government across the continuum of need*" *by* L. Bromfield, D. Perfect, and M. O'Donnell, 2024, Australian Centre for Child Protection, University of South Australia.

Figure 2 illustrates how child and family needs across a continuum.

To interpret the image:

- The top row shows three broad prevention levels: primary, secondary, and tertiary (public health approach).
- Tertiary prevention population is separated into two groups:
  - i. support and protection; and
    ii. OOHC and leaving care.
- It uses the term 'willing and able' to incorporate the recognition of voluntary and involuntary tertiary intervention (responsive regulation).
- The vertical headers refer to universal services, targeted services and statutory services.
- The coloured lines across the figure show which services apply to each population.
- Services/functions are specified rather than Departments to encourage innovative thinking about different systems and structures.
- The presentation of services in this way is intended to demonstrate a whole of government system and its role in preventing and responding to child abuse and neglect.

Responsive Regulation: A Framework for Statutory Intervention

While the public health approach offers a strong foundation for designing preventative supports and services, it is primarily rooted in voluntary, non-statutory intervention. As such, it does not address how systems should respond when legal powers are required, particularly in situations responding to abuse and neglect. Many high risk families may remain 'invisible' to services as they do not voluntarily engage with supports or actively avoid services with perceived stigma (Daro & Karter, 2019). These families may only come to the attention of service providers once concerns have reached the point of a formal report to statutory services.

In these circumstances, **responsive regulation** provides a complementary framework that guides how and when to use statutory powers in a way that is proportionate, ethical, and effective (Ayres & Braithwaite, 1992).

Responsive regulation is based on the idea that most people will comply with rules and expectations when supported to do so voluntarily. Rather than beginning with heavy-handed enforcement, this model encourages services to build trust, provide education, and work collaboratively with individuals and families. When this approach is unsuccessful, such as in cases of continued risk, unwillingness to engage, or serious non-compliance, the response escalates in a structured, purposeful way.

At the heart of responsive regulation is the principle of minimal intervention: ***the least intrusive, most respectful action should always be used first***. More coercive or directive measures are only used if necessary, and only after less intensive options have been tried or ruled out. Responsive regulation also needs to account for people's cultures, behaviours, and environments Figure ***3*** shows a proposed model that incorporates the degree of concern about a child's safety, the intensity of family needs and explicitly engages with the level of regulation required to facilitate child safety along a continuum. The continuum of need reflected on Figure 3 represents an incorporation of the public health model levels of prevention with responsive regulation.

when considering the best response (Hamilton et al., 2022).

The regulation options are often represented in a pyramid:

- The base represents voluntary measures, such as, education, support, and persuasion.
- The middle includes more directive tools, such as, formal monitoring, case plans, and warnings.
- The top contains the strongest interventions, such as, statutory powers, court involvement, or enforced orders (Braithwaite et al., 2019).

This approach is flexible and relational, with the implementation of the approach just as important as the choice of response (Hamilton et al., 2022). The pyramid allows services to scale their response up or down based on the individual or family's willingness and ability to engage. It also recognises that coercive intervention can be harmful or counterproductive if used unnecessarily, especially in vulnerable communities.

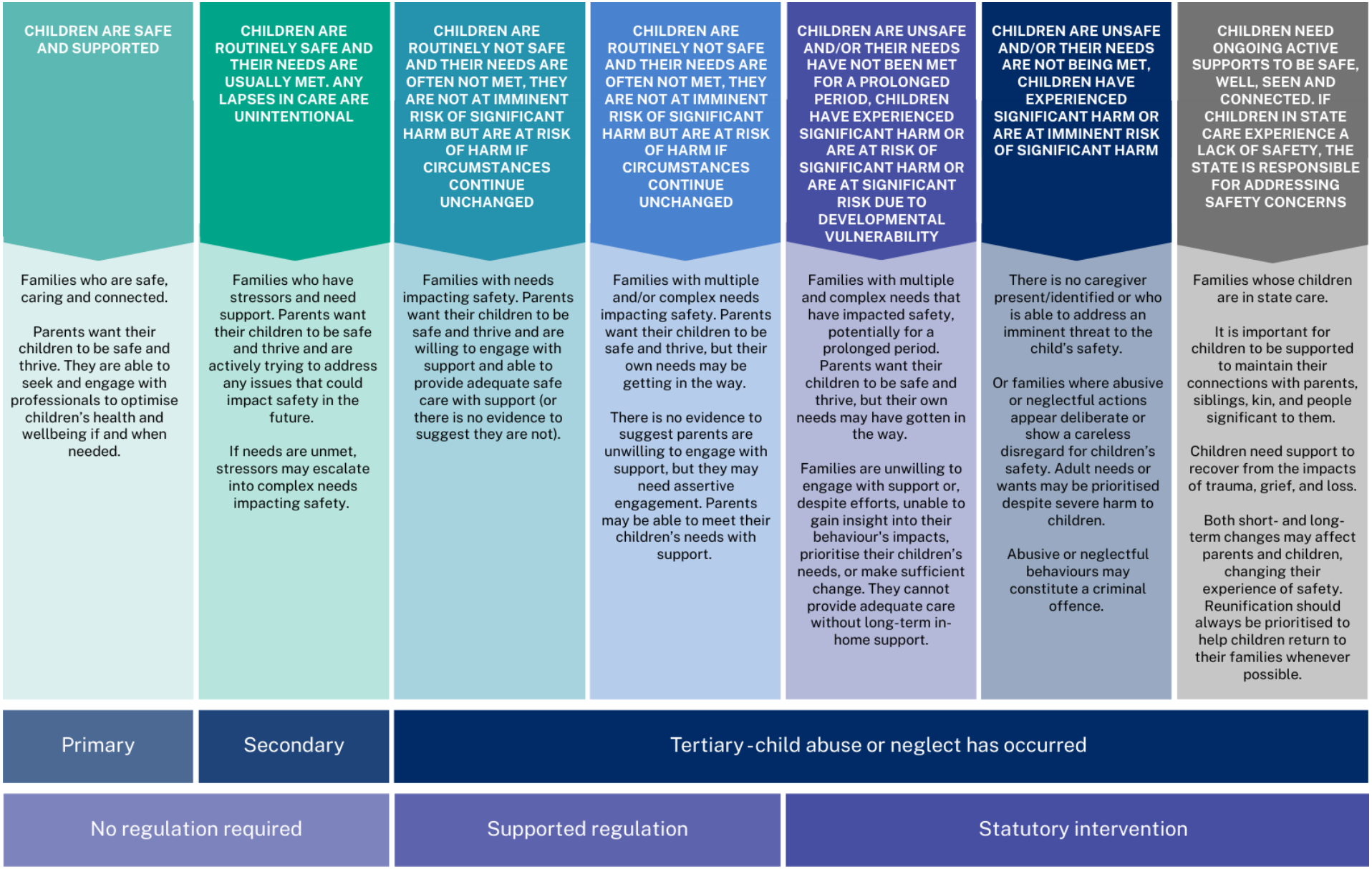
Responsive regulation has been used across different sectors, including:

- road safety and transport;
- occupational health and safety;
- juvenile justice; and
- statutory child and family services (Harris et al., 2009).

Applied correctly, responsive regulation ensures that statutory systems act with fairness, transparency, and proportionality, and that legal powers are only used when truly required. When used alongside the public health model, it strengthens a system's capacity to promote safety, support change, and respond to complexity without defaulting to punitive or over-reaching measures.

Figure 3

A Proposed Intake Model Integrating Responsive Regulation Based and a Public Health Approach



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ACKNOWLEDGMENTS

The authors acknowledge Aboriginal and Torres Strait Islander peoples as the traditional owners of the lands across Australia and pay respects to Elders past and present. In particular the authors acknowledge the Palawa people of Lutruwita (Tasmania).

This development of this Evidence Brief was funded by the Tasmanian Department for Education, Children and Young People to provide evidence to inform the ARL Renewal project.

SUGGESTED CITATION

Bromfield, L. Cox, S., Perfect, D., Bromley, A., and O'Donnell, M. (2026). *The Public Health Approach and Child Protection,* Australian Centre for Child Protection, Adelaide University: Adelaide.

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