Is there ever enough evidence?
The Benefits and Limits of Evidence-Based Public Health Policy:
The Case of the Victorian Children’s Health and Wellbeing Project

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Abstract
This paper analyses the issues arising from the collection and use of evidence in the formulation of public health policies, now accepted practice in many countries. The reasons for this widespread acceptance are fairly self-evident. An evidence-based approach allows policy makers to proceed on the basis of what is known and what works, rather than guess-work and speculation. This approach thus reduces the risks inherent in policy making in the politically-sensitive area of public health by providing policy makers with a sound rationale for taking a selected course of action. Notwithstanding its strengths and benefits, however, a purely evidence-based approach has some intrinsic shortcomings. Because it proceeds on the basis of what is known and proven, it has considerable difficulty in dealing with the unknown and untested. It therefore undervalues the importance of risk-taking and experimentation, often the very things that are called for in effective policy making in the public health field. And in situations where there is no evidence or where the evidence is highly unreliable, an evidence-based approach can lead to inaction and passivity even when prompt and decisive action is needed. This paper will take up these themes by considering in detail the case of the recently-completed Victorian Children’s Health and Wellbeing Project. The authors were members of the team from the University of Wollongong’s Centre for Health Service Development contracted to work on the project by the Victorian Department of Human Services.

Introduction
This paper is concerned with evidence-based policy making in the field of public health. Its aim is to shed light on the complex issues involved in the use of evidence in this important area of public policy. It seeks to illuminate not only the epistemological and methodological challenges that arise in the collection and use of evidence in formulating public health policy but also the political and public policy questions that are invariably thrown up. The paper begins with a critical review of the literature dealing with evidence-based public health policy, highlighting its strengths and identifying any weaknesses and lacunae. It then moves on to consider in some detail the Victorian Children’s Health and Wellbeing Project, focusing on issues relating to the collection and use of evidence in public health policy (and promotions) that were thrown up by the project. The Centre for Health Service Development of the University of Wollongong won the tender to undertake this project for the Victorian Department of Human Services, the authors having served as members of the project team.

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1 Grateful acknowledgement to our colleagues in the Centre for Health Service Development for their help with this paper, in particular to Nick Marosszeky and Kate Williams for suggesting some very useful references.
This paper focuses on two of the eighteen priority areas that were identified by the Victorian Department of Human services (DHS), namely, child abuse and overweight and obesity. In search of the evidence the project team reviewed the Australian and international literature to identify initiatives or strategies for delivering improved outcomes for children in these two areas, including their so-called ‘actionable determinants’. Interestingly, both of the selected priority areas were identified by DHA as being in the ‘immediate action’ category. For such priority areas it was determined that strategies should offer a balance between a population-wide focus and strategies that address disadvantage within specific population sub-groups. In the final section of the paper, consideration will be given to the general issues arising in evidence-based public health policy that are analysed in the critical literature review but with particular reference to the two priority areas.

Evidence-based public health policy: a critical literature review

According to Huw Davies and Sandra Nutley, in the field of health care policy aims are fairly clear and uncontroversial. As will be demonstrated in this paper, this is itself a highly contentious point of view on health care policy and its aims. In this field they claim, ‘both policy and practice are aimed at increasing longevity and decreasing morbidity (adding years to life and life to years)’ (Davies, Nutley, Smith, 1999: 4).’ If this is true, the task of assessing ‘what works’ is rather more simple in health care than in many other fields where there are often competing and multiple objectives that, to complicate the situation even more, often have no fixed or generally agreed order of priority. In these circumstances, evaluating what works is a contested and politicised process. While research evidence can assist in ranking and selecting between alternatives, ultimately the choice is a political one with many other compelling considerations relegating the available evidence to one amongst numerous factors in reaching a decision. What is more, there is rarely a consensus regarding the criteria that should be used for assessing what works and for judging success. Thus, the conditions enabling the development of a cumulative and publicly accessible database of research evidence and findings to which researchers and practitioners can readily refer for lessons about what interventions work and which don’t in diverse settings do not exist in many fields outside of health. In health, the research database (really, multiple databases) is dispersed over numerous sites with internet resources enabling researchers and practitioners (and others, including consumers) scattered around the globe to gain fairly prompt and relatively easy access. The Cochrane Collaboration is a very good case in point (for assessments of the Cochrane Collaboration see Green, McDonald 2005, Volmink et al 2004, Grimshaw 2004).

Notwithstanding the obvious benefits of having a database of research evidence at hand, as in health and medicine, there is considerable and growing debate regarding whether the methods that are used to grade evidence derived from clinical and epidemiological research are as suited to the evaluation of the evidence produced in studies of public health policies and programs (see, for example, Rychetnik, 2003; see also Kirkwood 2005). Reports, evaluations and reviews of clinical and epidemiological research, and the evidence produced in this research, account for a large proportion of what is available in
the publicly available health literature. It is generally agreed that in clinical and epidemiological research there is an over-reliance on study design as the main criterion for judging the quality and credibility of evidence. A well-designed study will, at a minimum, minimise selection and information bias, control and limit confounding, and attempt to rule out chance (Last 1995). Randomised controlled trials (RCTs) are widely believed to be successful in meeting these standards and are thus considered the ‘gold standard’ for design validity (Victoria, et al. 2004; Speller, 1997). Nevertheless, there is persistent controversy regarding the reliance on the quality of the study design in RCTs rather than the quality of the intervention (Rychetnik, 2002; Speller, et al 1997). There is widespread acknowledgement among the authorities that fund public health interventions of the multifactorial basis of many health outcomes and, accordingly, of the need for more sophisticated, multidimensional, community-based designs (Chaulk and Kazandjian, 2004; Ansari et al 2003; Keller et al 2004 and 2004a).

RCTs are obviously vital for evaluating the efficacy of clinical interventions, where the causal chain between the agent and the outcome is relatively short and simple and where results can perhaps be safely extrapolated to similar settings. However, causal chains in public health interventions are complex, leaving RCTs subject to effect modification in different populations (Victoria, et al. 2004) and, therefore, unable to accommodate the complexity and incommensurability that characterise the results of such interventions. The complexity of causal pathways in public health interventions is due to a number of factors including, but not limited to, operational changes in provider behaviours that are required to deliver the intervention, compliance by recipients, and biological effects (Victoria et al 2004; Ansari et al 2003; see also Keller et al 2004 and 2004a).

In light of these concerns, Victoria et al. (2004) make a strong argument that evidence-based public health policy should involve the use of research designs other than RCTs (see also Kirkwood 2005). They contend that RCTs are often not either practical or ethical (for an amusing, but nevertheless serious, discussion of the merits and problems of RCTs see Smith, Pell 2003; see also Moher, Bernstein 2004). Observational studies, for example, may represent a more feasible, acceptable and appropriate study design for evaluating health interventions intended to inform and direct public health policy (Black, 1995; but see also Smith, Pell 2003). There are, moreover, important restrictions on the external validity of RCTs in the public health arena (Victoria et al 2004). It simply cannot be taken for granted that interventions which have proven to be efficacious in controlled trials can be generalised to other, often significantly dissimilar, settings. This is particularly true in international health studies where it will never be possible to carry out RCTs in all countries where the intervention will be applied. It should also be noted that well conducted RCTs are rare in public health, operational and ethical considerations preventing such studies being carried out.

Negative RCT findings warrant careful exploration. Has the research failed to find an effect where one exists (evaluation failure)? Or, is there truly no effect (programme failure) (Hawe et al 2004)? In the event of programme failure, can the failure be attributed to an inherent inadequacy in the intervention (that is, a failure of intervention theory and background preparation), or, is it attributable to poor implementation? Shefer
(1999) reveals that authors of a number of systematic reviews of RCTs have acknowledged that in several cases crucial factors such as stability of the programme being evaluated, the quality of the implementation, and the adequacy of the outcome measures relative to programme goals were not taken into account (see also Moher, Bernstein 2004). Rychetnik et al (2002) observe that without this information it cannot be concluded that negative results mean an intervention is ineffective.

The inputs to the policy process vary widely across the different domains of public policy, with the influence and legitimacy of those inputs also varying considerably in the different domains. Walshe and Rundall observe that while the research traditions in areas of policy such as education, social work and criminal justice are very different from those in health care and health service delivery, they have in common ‘the same need for a better link between research, policy and practice (Walshe and Rundall 2002: 436).’ However, Davies and Nutley make the pretty obvious and fairly unexceptionable remark that in many policy areas ‘Ideology, expediency and public preferences compete with scientific evidence for the ears of Ministers (Davies, Nutley, Smith 1999: 4).’ Geraldine Macdonald observes that politicians generally believe that their competencies are more suited to dealing with so-called ‘social’ than so-called ‘medical’ issues. Indeed, she claims, in social care unlike health, political and ideological considerations dictate both policy and practice (Macdonald 1999: 27). As most would readily agree, the boundary between health and social care is blurred, unsettled and contested. But beyond this, politics and ideology (and much more besides) can be every bit as influential in medical practice and health policy as they are in social care—as the case of euthanasia and assisted suicide clearly demonstrates (see, e.g., Kemmelmeier, Wieczorkowska, Erb, Burnstein 2002, Schwartz, Curry 2002, Chao, Chan, Chan 2002). And, as Lavis et al point out, in moving ‘from citizen, patient, and clinical (i.e., individual) decision-making environments to managerial and policy decision-making environments the organizational and political factors with which research knowledge must compete to influence the decision-making process become more apparent (Lavis et al 2003: 224-225).’ Indeed, across all policy areas, and even in cases where the available body of evidence rests on sound epistemological and methodological foundations, policy makers, consumers and other non-expert stakeholders may have entrenched and cherished views regarding what interventions are effective and acceptable and those that are not. These views may be in conflict with the ‘expert evidence’ or be founded in other domains of knowledge such as tacit knowledge, lived experience, custom and practice, and shared oral or folk traditions (which may even be sustained and disseminated by the Internet).

According to Davies, Nutley and Smith, what they regard as ‘extraneous’ factors—by which they mean factors that are not grounded in or derived from an expert evidence base—are less influential in medicine than in other areas because the expert knowledge required by competent practitioners for effective interventions is generally beyond the reach or understanding of consumers. Nevertheless, they do concede that even in the case of medicine ‘client perspectives’ are becoming more important and influential in determining the nature and scope of professional practice because (as cursorily alluded to above) tools such as the Internet are expanding and deepening the knowledge base of consumers. As the knowledge base grows throughout the community, lay people are
increasingly able to challenge the professional expertise of practitioners and in this way hold them more accountable for their actions—or, inaction (for a progressive (some might think radical) perspective on these issues see, e.g., Moynihan, Smith 2002). Wendy Rogers notes with regard to evidence-based medicine and its capacity for enhancing individual patient choice and autonomy, ‘Striking the right balance between evidence-informed patient choice and equitable use of health-care resources requires political as well as practical solutions (Rogers 2002: 102).’ Too great an emphasis on patient choice and autonomy runs the risk of catering to the preferences of those with the loudest and best-funded voices rather than those with the greatest health-care needs (on this point, see Freemantle, Hill 2002; see also Leibovici, Lievre 2002).

Davies, Nutley and Smith make another fairly obvious point when they remark that the methodologies and criteria for determining what works and what doesn’t differ according to whether interventions are pitched primarily at an individual or a community level. Policy areas can be differentiated on the basis of whether they tend to focus more on the individual or the community, with ‘education’ being in the former camp and housing in the latter (Davies, Nutley, Smith 1999: 4). How education ends up in the camp of the individual is an interesting and important question in its own right, but unfortunately it is beyond the scope of this paper. However, what can safely be said is that medicine and health, as with education and housing, are simultaneously individual and community concerns with individual choices being constrained and conditioned by decisions taken in policy making councils that are for the most part well beyond the reach or influence of the lone individual. In all policy areas, evidence can be an important guide or basis for action for senior policy makers and decision makers just as it can be for the individual consumer. However, it is seldom if ever their only or most important consideration.

Just like the consumers of health services, whose individual consumption choices are shaped by a range of factors over many of which they have little or no control, the practitioners who supply these services are also faced with organisational, institutional and other constraints over which they may exert little influence. As Davies and Nutley point out, ‘Health care may be delivered by individual practitioners, but they do so largely within the context of various organizational structures (Davies and Nutley 1999: 9).’ Operating within these structures, policy makers and managers also frequently require evidence to assist their decision making in such matters as: the allocation of resources between competing priorities (health and other); managing and assessing individual and organisational performance against key indicators; developing a quality and safety culture particularly in clinical practice; determining appropriate organisational structures; and, managing change (a number of these issues are canvassed in Walshe and Rundall 2001; they are particularly concerned with promoting the development of evidence-based management in health care and health service delivery). Evidence can also be important in assessing whether health systems, organisations and programs deliver equitable outcomes to consumers and whether they are successfully directed to disadvantaged target groups and sub-populations.

Graham Leicester identifies what he calls the ‘seven enemies’ of evidence-based public policy, concerned that despite the rhetoric to the contrary evidence-based policy is more
often the exception than the rule. A number of his observations are relevant in the field of public health policy and to the use of evidence in developing health policy. The seven enemies identified by Leicester are bureaucratic logic, the bottom line, consensus, politics, civil service culture, cynicism, and time, or the lack of it (Leicester 1999: 5). Bureaucratic logic—the view that everything’s okay, there’s no need for change or anything new, that we’ve ‘always done it this way’—naturally gives preference to existing frameworks for understanding policy problems and thus favours evidence that confirms the effectiveness of current practice. This is closely linked with the problems of consensus, politics and civil service culture. Consensus forms around the lowest common denominator, the proposed solution to a problem on which all interested parties agree or about which there is least disagreement. After all, what matters is what works and what works is what everyone can agree on. The link with politics is obvious: politics, the ‘art of what is possible’, favours the consensus solution because this is the most workable or least unworkable outcome. Civil service culture refers to a climate of suspicion and distrust of information and ideas originating from sources external to the system. As Leicester admits, this may well be changing. It would be astounding if this weren’t the case given the rise of the contract state and the privatisation, outsourcing of public services, and contracting out of service delivery that have led to its emergence (see, e.g., Rix 2005). Nevertheless, Leicester has identified a significant obstruction to the development of evidence-based public policy that exists even in the new lean, mean and corporatised public sector. Merging with civil service culture is cynicism, a tendency ‘to go along with the “company view” or the “conventional wisdom”, even when we know it to be false, since our professional lives and career advancement depend on maintaining the lie (Leicester 1999: 6).’ Like bureaucratic logic, it favours evidence that confirms the correctness of the company view of the world. Time, more correctly the inadequate supply of it, requires little explanation: a major factor in the modern public service that militates against the development and use of evidence-based policy.

So, what are the lessons and, given the prevalence of these obstructions, is it possible to move forward? Interestingly given his scepticism, Leicester calls for a much closer relationship between government and evidence derived from research (but, for a sharply opposing view, see Crichton 2003). Deploying Ulrich Beck’s notion of the ‘risk society’, Leicester points to the need for greater understanding of the role of evidence and research in public administration and the making of public policy. As he notes, the BSE and CJD crisis has demonstrated that in the risk society the political management of evidence is more important than the evidence itself. Researchers obviously have a duty to be as rigorous as possible, but at the same time have to acknowledge the political implications of the results and findings that their research throws up. For, ‘What we choose to investigate, how and when we present the findings are part of the risk management process (Leicester 1999: 6).’

Focusing on the priority areas of child abuse and overweight and obesity, the following section provides an overview of the Victorian Children’s Health and Wellbeing Project. This overview illuminates a number of the issues regarding evidence-based public health policy that have been raised in the critical literature review. As far as this paper is concerned, the most significant of these is that evidence is only one among many of the
inputs into the various domains of public policy including health. It follows that what Davies and Nutley call ‘extraneous factors’ are always influential in the formulation, implementation and evaluation of public policy programs in health as in any other domain. As noted above, the evidence no matter how compelling can never completely close political space or eliminate risk. And, even at its most compelling, the evidence may legitimately be ranked below other factors shaping policy particularly when, for example, the costs of program implementation are prohibitive but the expected returns are small or limited to a handful of individuals. In cases where the available evidence is inadequate or unreliable, the space left open for debate, dissent, and so-called extraneous factors to enter the policy making picture expands accordingly. As should become obvious, child abuse and overweight and obesity are two areas where extraneous factors are frequently more influential than evidence in the formulation of public policy. They are also areas in which the careful handling of the evidence by policy makers is an extremely important part of the risk management process.

The Victorian Children’s Health and Wellbeing Project
Introduction and overview

The purpose of this project was to guide and structure the efforts of the Department of Human Services to support and improve the health, development, learning and wellbeing of Victorian children. The project also sought to assist DHS in determining strategic investments (or, ‘best bets’) for improving the health and wellbeing of children in Victoria. The project was designed to contribute to the Department’s Children’s Health and Wellbeing Policy Flagship project, the specific objectives being to:

1. Identify evidence-based strategies for delivering improved outcomes in the designated priority areas for gain for all children in Victoria; and

2. Present the strategies for each priority area in a format that, amongst other things, identifies how strategies will deliver more equitable outcomes for different target groups of children within Victoria’s child population.

In accordance with these objectives, the strategies recommended in the project report were those that were judged to be applicable and practicable in the Victorian context (for the full report of the project, see Eagar K, Brewer C, Collins, J, et al 2005).

The project covered 18 ‘priority areas for gain’ selected by DHS after consultation with key stakeholders prior to commencement of the project. DHS had assigned the priority areas to one of two categories, those suited to immediate action (such as child abuse and overweight and obesity, with which this paper is concerned) and those in which to maintain effort (including congenital heart disease and melanoma). With respect to areas suited to immediate effort, the goal was that strategies should offer a balance between a population-wide focus and strategies that address disadvantage with specific population sub-groups. For areas in which to maintain effort, the focus was on strategies that relate particularly to selected sub-population(s). In addition, DHS provided a preliminary list of the actionable determinants for each priority area. These are factors that militate against health and well being but which may be amenable to intervention.

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2 The 18 priority areas for gain are: asthma, child abuse, child behaviour problems, dental caries, disability, injury, language and literacy, low birth weight, overweight and obesity, parental mental health, congenital heart disease, infant mortality, melanoma, PKU/cystic fibrosis/HT, spina bifida, sudden infant death.
One of the key objectives of the project was to identify evidence-based strategies for delivering improved outcomes for all Victorian children in the identified priority areas. Over the life of the project, it became obvious that many of the priority areas were, in fact, actionable determinants for other priority areas. A good example is child behaviour problems for which child abuse, parental mental illness, communication (language and literacy) problems and low birth weight are all actionable determinants. Thus, effective interventions in these priority areas can be expected to have flow-on effects that ameliorate child behaviour problems.

**Methodology and evidence**

1. **Electronic databases and search strategies**

Accessible electronic databases were employed to compile a list of the relevant literature in each of the priority areas, including actionable determinants. The databases used were chosen for their relevance and breadth of coverage, and included Meditext, CCRT, Cochrane, DARE, and ACP Journal Clubs. Exceptions were only made in cases where a database did not index the literature relevant to a particular priority area. A list of search terms was also compiled for each priority area and its actionable determinants. The initial list was later refined, for in almost all priority areas it was found that this list was far too broad. A manageable list of the most relevant and up-to-date literature was then compiled and an Endnote library was created for each priority area. Article abstracts were then scrutinised for possible inclusion in the library. For those articles deemed to be potentially eligible, the full text was read by one reviewer. The reference lists of these articles were then searched for other possible citations. The ‘grey literature’ in each priority area was also searched and included in the review if relevant. Studies in non-English journals were excluded. The Endnote libraries for all priority areas were imported into a Microsoft Access research database.

A standard Excel template for all priority areas was developed with input from DHS staff. The template was used for the collection and presentation of the literature reviews and critical evaluations of the evidence on interventions and strategies in each of the priority areas. Information from the articles reviewed was entered using this standard template and then incorporated into the Access database for analysis. The database is a novel deliverable in that it is not a finished product, but rather a policy making tool that is subject to ongoing development and improvement by DHS.

2. **Sub-populations and possible interventions**

The template enabled the strategies for each priority area to be presented in a standard format describing the purpose of the intervention, the site or focus of the intervention, the identified target groups, and identifying how strategies would produce more equitable outcomes.

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3 According to the National Library of Australia Preserving Access to Digital Information Initiative (PADI), ‘Grey literature, also known as the grey or hidden web, is information that is not searchable or accessible through conventional search engines or subject directories and is not generally produced by commercial publishing organisations. It can include publications issued by government, industry, business and academia occurring in databases and intranets. The development of electronic scholarly publishing such as e-print archives has led to increased access to this type of information.’ Available at [http://www.nla.gov.au/padi/topics/372.html](http://www.nla.gov.au/padi/topics/372.html)
outcomes for different target groups in the overall population. The relevant target groups included ATSI children, children living in rural and remote areas, children from families of low socio-economic status, children from culturally and linguistically diverse backgrounds and children in specific age groups. The level of an intervention was also identified, ranging from the individual child at one end of the spectrum, through parents, child and family, environment/community, service system and structures to policy and regulation at the other end. Interventions at the child, parent and family levels were further classified according to the setting of the intervention, e.g. home, GP schools, hospital ED, inpatient. They were also classified by service type: mainstream or specialist; universal or targeted; if targeted, whether the intervention was intensive or routine/standard care. A list of likely actionable determinants relevant to more than one priority area was built into the literature review template. Actionable determinants specific to a priority area (e.g., fluoridation as a protection against dental caries) were also recorded. Thus, the template provided a common framework for proposing evidence-based strategies operating across a range of service and interventions settings relevant to the Victorian context.

3. Level and type of evidence; a standard schema for evaluating the evidence

The Cochrane hierarchies of study design and levels of evidence were modified and expanded to summarise and present the nature of the evidence presented in the literature. These are in rank order from highest to lowest: systematic study of all relevant RCTs; at least one properly designed and randomised controlled trial; well-designed pseudo-RCT; comparative study with concurrent controls and allocation not randomised; case control studies, or interrupted time series with a control group; cohort study; analysis of routine data; economic evaluation; expert opinion; systematic review—other; literature review; service evaluation; and, other (specified). Drawing on the work of Rychetnik et al (2002), a standard schema was developed to evaluate the strength of the evidence and significance of the reported effects. The schema had three components:

1. Is there evidence in the article of an impact or change on the actionable determinant? (Conclusive, inconclusive, no, not applicable)
2. What is the (self-reported) strength of the impact or change on the priority area? (High, modest, low, not applicable)
3. Is there evidence of service/system change? (Yes, short term or long term; no; not applicable).

In the following sub-section, the priority areas for gain of child abuse and overweight and obesity are reviewed in some detail. Beginning with child abuse, the review provides an overview of the priority area that identifies the current scope of the problem and related issues and the status of the available evidence. The priority area’s actionable determinants and risk factors are then analysed and existing and potential interventions highlighted. The key messages for policy makers emerging from the literature review and evaluation of the evidence are then identified. The same format is followed for overweight and obesity. Discussion of the two priority areas follows that considers the general issues arising in evidence-based public health policy which were raised in the critical literature review with particular reference to the two priority areas.
Child abuse

Overview

Every year, thousands of young children come into contact with Victoria’s Child Protection system due to suspected or confirmed abuse or neglect. On average, around 2000 cases of physical abuse and 600 of sexual abuse are substantiated annually (DHS 2001). More than 70% of these children come from families of low-socio-economic status, and those in which substance abuse, parental mental health problems, intellectual disability and family violence are prevalent. Poor parenting and social isolation have been identified as other risks factors for child abuse.

ATSI children are nine times more likely to have experienced substantiated abuse or neglect. 10 times more likely to be placed on a protective order and 13 times more likely to be placed in out-of-home care than non-Aboriginal children (DHS 2004a). Disabled children are also at increased risk, particularly those that are highly dependent, have communication difficulties, and/or are in institutional care (Westcott and Jones 1999).

The number of children exposed to domestic violence in Australia is unknown. A recent survey of Australian youth found that one-quarter of those surveyed reported having witnessed physical domestic violence against their mothers or step mothers. An earlier Victorian study revealed that children were present in 79 per cent of domestic disputes involving the use of a weapons (usually a knife) (Kovacs and Tomison 2003). It is widely acknowledged that abuse is likely to recur in families in which maltreatment has already occurred (Geeraert et al 2004). In such cases, the critical variable in determining outcomes for children involved appears to be the level of disturbance in parenting.

Parenting capacity, rather than the category of abuse or its physical severity, is the best predictor of the future wellbeing and safety of an abused child (Donald and Jureidini 2004).

Actionable determinants/risk factors

Child abuse interventions are targeted at three distinct population groups, which are defined by the level of risk of harm that is prevalent. At the first level, primary preventative efforts are aimed at all children and their parents and include efforts to enhance parenting skills and to provide children with knowledge and effectiveness training (see, e.g., Sanders et al 2003, Kovacs and Tomison 2003, Kaplan et al 1999). At the second level, families at risk are offered additional support through home visiting or parenting skills training (Geeraert et al 2004, Olds 2002, Rubin et al 2001, Hodnett and Roberts 2004). Various screening and evaluation methods have been evaluated. For example, a systematic review of instruments (such as checklists and clinical interview protocols) designed to predict future child maltreatment found that their predictive capacity was limited, suggesting that they should only be used to focus on non-punitive interventions (Peters and Barlow 2003). Tertiary prevention involves minimising harm to children in cases of confirmed abuse. This is the largest and most diverse group of interventions, incorporating various types of therapeutic support for abused children, education or counselling for both abusive and non-offending parents, and support for foster parents or the family of origin (see, for example, (Thomlison 2003, Chaffin et al 2004, Brown 2003, Kovacs and Tomison 2003).
Key messages for policy makers

- Community-wide interventions offering several layers or ‘tiers’ of support to parents are promising, although few evaluations have been published to date.
- Child education programs, although intended as a primary prevention measure, have proved most useful in helping to prevent recurrence of maltreatment by encouraging children to report abuse.
- Home visiting for at-risk families is well supported as a useful approach to reducing the risk of child abuse and neglect. Home visiting may be less beneficial where there is domestic violence. Enhancements such as group sessions or cognitive retraining appear to increase the effectiveness of home visits.
- The available standardised tools for screening and early detection of child abuse have poor predictive accuracy.
- A set of early indicators of child abuse based on clinical experience has consensus support among academics and practitioners in Britain but it is unclear how useful these might be in the Australian context.
- Legislation requiring professionals to report suspected child abuse has led to increased notification of cases of abuse and neglect nationally. However, there is no evidence that mandatory reporting legislation in Australia or elsewhere has been effective in protecting children from abuse.
- Cognitive behavioural therapy is effective in reducing trauma among children and parents in cases of confirmed abuse.
- Family preservation strategies focusing on improving parent-child interactions in families where abuse has occurred appear to have promise.
- There is clearly a need for more and better quality evaluations of Australian programs supporting children exposed to domestic violence.

Overweight and obesity

Overview

Many government reports have documented the increasing trend towards child and adult obesity, identifying factors (mainly social and environmental) that are thought to be influential in these changes. Social trends leading to a higher incidence of overweight and obesity in children include: increased car travel to and from school; increased traffic hazards for walkers and cyclists; the popularity of computer and video games and other sedentary activities; the greater quantities of fast foods consumed; and, increased popularity of fast food chain restaurants (Lobstein et al 2004). As the problem of childhood obesity has grown and become widely acknowledged, there has been much research undertaken and reported in the literature. However, reviews of intervention trials have not to date been able to identify reliable evidence for successful strategies (Campbell et al 2001; Lobstein et al 2004).

As part of the scholarly and practitioner debate in the area, the role of RCTs in providing evidence has been critiqued (Lobstein et al 2004; WHO 2004). The critique is similar to the misgivings expressed about RCTs in many other health promotion areas. A number of limitations with RCTs have been identified, several of which were rehearsed above in the critical literature review. Formal monitoring of programs and local benchmarking that are
linked with interventions and which assess sustainability, reach and population impact have shown some potential for overcoming several of the problems with RCTs (Lobstein et al 2004).

Australian researchers are at the forefront of obesity prevention work. They have developed a framework for translating evidence into action in this area (Swinburn et al 2004) and identified levels of intervention that balance individual approaches with organisational, national and international policies and programs that address the social and environmental factors which have significantly contributed to the increase in the prevalence of childhood obesity around the world (Lobstein et al 2004).

**Actionable determinants/risk factors**

Evidence exists demonstrating the effectiveness of childhood overweight treatment programs that focus on positive lifestyle changes for the whole family and that incorporate principles of behaviour modification and provide caregivers and children with diet and exercise education, and the tools required to put this knowledge into practice (Drohan 2002). Programs to address severe childhood obesity are mainly palliative, designed to manage and control the situation rather than to attain a more appropriate body mass index (BMI) in the first instance. Improved self-esteem may have positive outcomes in other areas, such as depression and social isolation.

A major limitation in assessing the effectiveness of population-wide interventions intended to reduce overweight and obesity is the lack of regular, comprehensive, consistent monitoring of children’s health indices, and food intake more generally. Such monitoring could be used for identification of trends and needs as well as for comparative purposes, either before or after interventions or across areas. Monitoring should occur through existing infrastructure, e.g. health services (early childhood nurses or GPs) or childcare centres and schools. School-based monitoring, for example, could be mandatory and reported on in a similar fashion to basic skills testing, allowing schools to benchmark against each other and state averages and to monitor their own initiatives over time. Support is advocated for formal monitoring programs and local benchmarking linked with interventions that assess sustainability, reach and population impact (Lobstein et al 2004).

**Key messages for policy makers**

- Victoria should continue to maintain a high profile in initiatives that aim to prevent overweight and obesity in children. The evidence clearly indicates that whole-of-government, multi-level, population-focused interventions are required, supported by a realignment of research funds and initiatives to policy-based interventions.
- Prevention of childhood overweight and obesity has been identified as a national priority in Australia and requires a whole-of-government approach if it is to be successful.
- Reviews of intervention trials have to date not identified reliable evidence for successful strategies.
• The reliance on RCTs for evidence to proceed with particular initiatives has been critiqued, such trials being unlikely to provide the evidence required. Formal monitoring of programs and local benchmarking linked with interventions that assess sustainability, reach and population impact have shown more promise.
• Evidence does exist for effective childhood obesity treatment programs that focus on positive lifestyle changes for the whole family and that incorporate principles of behaviour modification and that provide caregivers and children with nutrition and exercise education and the tools required to put knowledge into practice.

Discussion and conclusion
Child abuse and childhood overweight and obesity are both highly charged political and social issues. The public policy issues they raise, and the interventions and strategies with the potential for treating them or ameliorating their effects, go well beyond the jurisdiction of DHS or, indeed, of any single ministry or government. Effective interventions and strategies in the treatment and prevention of childhood obesity and overweight include, for example, safer cycle ways and public roads, more appropriate numbers and locations of fast food outlets, higher and more rigorously enforced standards for children’s broadcasting and the advertising it attracts, and more effective children’s nutrition and diet education campaigns targeted on schools, sporting clubs, youth centres and so on. As noted, many of these fall well outside the DHS portfolio area. Child abuse raises even more difficult and complex issues than overweight and obesity, including the portrayal of children in the media, the roles played particularly by fathers and other male caregivers in the family, and the monitoring and policing of relationships between children and trusted figures in the community such as teachers, priests, and doctors. Many of these are also outside DHS’ direct portfolio responsibilities.

Public policies targeted on the two priority areas, and the interventions and strategies they include to treat them or ameliorate their effects, often cannot simply be founded in the available evidence. As noted above, for example, there is little or no evidence at present that the mandatory reporting by professionals of suspected cases of child abuse to the appropriate authorities has been effective in protecting children from such abuse. Nevertheless, in this case governments and policy makers have to be seen to be taking decisive action whether or not there is evidence to support the action in question. The political risks in not taking the action are far too great. Common sense, if not the evidence, would suggest that community-wide interventions offering several layers of support to parents are promising in protecting children from abuse in the home. In this case, common sense is far more compelling, and far more risk averse, than evidence or the lack of it both from a political and public health point of view. In the case of overweight and obesity, the evidence supports whole-of-government, multi-level, population-focused interventions. Even with such evidence at hand, governments can face considerable political hurdles in taking the appropriate action whether that involves higher and better enforced broadcasting standards for children’s television or stricter guidelines for the location of fast food outlets. Powerful lobby groups in these two areas apply effective brakes on bold and brave policy initiatives that are genuinely in the public interest. These groups can also exert subtle (and not so subtle) influence over the same
voters who might otherwise demand action from government based on the available evidence, or populist interpretations of it.

In the field of public health, the calculation of political risk entails the computation of other risks, including of course the risk to public health of taking any of the options for action that are viable in the circumstances or of not taking any action at all. As for evidence, it may help in reducing risks, political and other, but it cannot eliminate them altogether. For, in the field of public health, as in almost all others, even the most certain and compelling evidence does not completely close political space or make risks disappear, leaving no room for political judgement, debate and decision. On the contrary, producing evidence may be only the first action in a prolonged political and public information campaign that seeks to manage risk by astutely manipulating that evidence.

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