Public Health Understandings of Policy and Power: Lessons from INSITE

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ABSTRACT *Drug addiction is a major public health problem, one that is most acutely felt in major cities around the globe. Harm reduction and safe injection sites are an attempt to address this problem and are at the cutting edge of public health policy and practice. One of the most studied safe injection sites is INSITE located in Vancouver, British Columbia. Using INSITE as a case study, this paper argues that knowledge translation offers a limited framework for understanding the development of public health policy. This paper also argues that the experience of INSITE suggests that science and social justice, the meta-ideas that lie at the core of the public health enterprise, are an inadequate basis for a theory of public health policy making. However, on a more positive note, INSITE also shows the value of concepts drawn from the ways in which political science analyzes the policy process.*

KEYWORDS *Knowledge translation, Urban health, Policy-making, Drug policy, Harm reduction*

Use and abuse of street drugs is a recurring issue for urban health. Cities serve as laboratories for discovering, implementing, and evaluating different ways of addressing mortality and morbidity associated with drug use. However, harm reduction as it applies to street drugs leaves governments in the position of putting in place facilities to allow the use of drugs that are deemed to be illegal and, for some, threatening. Harm reduction is therefore a controversial measure for some voters and therefore for some politicians. In the Canadian context, this is manifest in the debate over the merits and the politics of INSITE, a facility that allows for supervised drug use in Vancouver, British Columbia. Proponents of the facility argue that even though they implemented a comprehensive knowledge translation (KT) strategy, such a strategy was ineffective because the Government of Canada made decisions about INSITE based on “politics” and “ideology” rather than science.^{1–4} In this paper, I will argue that this interpretation is based on a misunderstanding of the policy-making process, the nature of politics and government, and of the basis of state power and authority. More generally, I will try and show that the public health enterprise, of which harm reduction is a part, operates with an inadequate theory of government decision making and indeed of the nature of political power. I suggest that public health actors will remain frustrated with government decisions as long as

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they assume policy is mostly about evidence or is the result of acting on their particular conception of social justice.

WHAT IS INSITE?

In the late 1990s, public health officials in British Columbia began to notice an increase in the rates of HIV in the Downtown East Side (DES) of Vancouver. This was in addition to the exponential growth in deaths from illegal drugs in British Columbia during the early 1990s the majority of which occurred in the City of Vancouver, almost all associated with heroin.⁵ The official response took several forms including a report by the Chief Coroner that called for the legalization and decriminalization of drugs and a shift from seeing drug use as a matter of crime and more as a matter of health. Yet, the public health challenge continued to grow through the 1990s and became more complex as injection drug use became the leading cause of new HIV infections.⁶ This led to the decision by the Chief Medical Health Officer in Vancouver to declare a public health emergency in the DES in September 1997 and, less than a year later, a report by the provincial health officer for the Government of British Columbia calling for the implementation of harm reduction initiatives.^{5,7} Eventually, mortality and morbidity associated with injection drug use became a high-profile political issue, and harm reduction became part of the strategies endorsed and funded by the local, provincial and, for a time, federal governments. Following the lead of the City of Vancouver, all governments agreed to make harm reduction one of four pillars of their drug strategy.^{5,7,8}

In addition to more formal political change, community efforts to address the growing incidence of HIV and deaths associated with injection drug use were also growing. Community groups expanded their efforts to both raise public awareness and understanding as well as put pressure on governments to take action.⁹ As harm reduction initiatives took hold, these groups expanded needle exchange programs and other initiatives designed to address the immediate negative effects of drug abuse and the risk of infectious disease. They also began to make the case for a safe injection site.

In 2003, the Government of Canada agreed to exempt the Vancouver Coastal Health Authority from the *Controlled Drugs and Substances Act*, to allow for a medically supervised safe injection facility. INSITE was granted a 3-year exemption linked to a rigorous evaluation of what was styled as a pilot project. However, less than 18 months later a Conservative government was elected with a clear intention to take a harder line on issues of crime and illegal drug use.¹⁰ Faced with the decision whether or not to renew the exemption of INSITE, the new federal minister of health announced a renewal only until December 31, 2007.⁹ In turn, faced with the threat of closure, the proponents of INSITE launched a legal challenge arguing that closure of the facility would constitute a violation of the rights of users of the facility. This legal challenge eventually landed before the Supreme Court of Canada. In September 2012, the Court upheld the right of the Minister to enforce the *Controlled Drugs and Substances Act* and rejected the argument that provincial jurisdiction over health trumped federal jurisdiction over the criminal law. However, in the case of INSITE at least, the Court also ruled that the individual rights of drug users as protected by the Canadian Charter of Rights and Freedoms required the Minister to exempt the facility from federal drug control legislation. Thus, the court decision represents a victory, albeit a very narrow one, for proponents of safe injection sites in Canada.¹¹

This court decision notwithstanding, as suggested earlier, the proponents of INSITE argue that even though they implemented a comprehensive KT strategy, supplemented that strategy with a long process of coalition building, and eventually resorted to legal challenges, their KT strategy was ineffective because the Government of Canada made decisions about INSITE based on “politics” and “ideology” rather than science. In order to evaluate this claim, it is essential to take a closer look at the KT activities associated with INSITE.

KNOWLEDGE TRANSLATION AND INSITE

What is Knowledge Translation?

Knowledge translation (KT) has become a hallmark of contemporary medical, health services, and public health research. KT frameworks for health are premised on perceived structural and/or cultural gaps between the individuals and organizations responsible for health care delivery, and those responsible for conducting research. The KT goal is to bridge these gaps and increase opportunities for scientific work to contribute to health and health care improvement.¹² Scientific publication in peer-reviewed journals is a necessary step that legitimizes the quality of evidence and contributes to scholarly knowledge creation, but it is considered too passive a dissemination practice.

The literature on KT strategies for health research is extensive. However, most of the published literature suggest that tailor and target approaches are the best strategies for enhancing the practical influence of research evidence. In essence, conventional KT for researchers means a series of strategies based on three boilerplate KT principles. First, understand the decision maker’s problem, from the decision maker’s point of view. Second, interact closely with that decision maker individual or organization, to ensure the research project explores aspects of the problem and potential solutions that matter to the decision maker. Finally, explain the research results to the decision maker in terms that are meaningful and actionable, and that help the decision maker to solve the problem.¹³

With these principles in mind, the evidence suggests that conventional KT was more or less part of the INSITE project. In effect, the link between research, knowledge, and the health program that is INSITE can be divided into three phases.

Phase 1—Before INSITE Opened: Coalition Building, Weak KT, and Policy Emulation

The initial idea that a safe injection site should be introduced in Vancouver was not the result of scientific research as such. Rather, INSITE was a pragmatic decision to emulate the experience of other cities experiencing similar problems. In the late 1980s and early 1990s, beginning in Zurich, there developed what became known as the four pillars approach to addressing drug use: prevention, treatment, enforcement, and, more controversially, harm reduction.^{7,8,14} The fact that authorities in the City of Vancouver and in the provincial government were willing to imagine introducing what was for them a radical innovation was the result of at least three factors. First, the severity of the crisis demanded action. In addition to the rapid rise in HIV/AIDS among injection drug users, there was the continuing and growing problem of fatal overdoses. Second, political leadership and the work of what we might want to call policy entrepreneurs were critical. A number of groups and individuals, looking for a way of addressing what they saw as a public health crisis, took action. Some of these were from the local

community (e.g., the Portland Hotel Society, the Vancouver Area Network of Drug Users). Others were from local government (e.g., Philip Owen and Larry Campbell, Mayors of Vancouver from 1993 to 2005). Leadership also came from officials from the Vancouver Coastal Health, the local regional health authority, the Government of British Columbia, and, for a time, from the Government of Canada. Finally, INSITE was the culmination of a long period of coalition building and efforts to shift public opinion. Proponents of a harm reduction strategy and a safe injection site for the DES initiated a relentless effort to convince decision makers to embrace a new approach to dealing with drug addiction and the associated harms. This effort included lobbying, protests and other direct action, extensive media-related events, and even the quite aggressive decision to open safe injection sites in the absence of government approval.^{7,9}

In effect, INSITE was the result of many decisions by multiple decision makers over a period of several years. However, many of these decisions were based not so much on a desire to act based on the accumulation of research evidence but rather as a pragmatic effort to emulate the experience of other cities in an effort to address what was seen to be a public health crisis. Moreover, the impetus to make these decisions was the result of community pressure from a coalition of actors drawn from service agencies, groups representing injection drug users and their families, and researchers.⁸

Phase 2—INSITE as a Research Project and Dissemination of Research Results

INSITE opened in 2003 as both a service to the community and as a research project led by the British Columbia Centre of Excellence for HIV/AIDS. Notwithstanding the intensely public and political nature of the project, it would appear that the research program for INSITE was not designed with classic knowledge translation as a first-order consideration. Or, more precisely, while the research program included extensive collaboration with the community organizations, the actual operators of INSITE, and some local decision makers, the initial plan does not appear to include some of the hallmarks of contemporary conventional KT activities such as plain language summaries and knowledge brokering.¹² To some extent, such activities could be deemed unnecessary since most (but as we now know, not all) key decision makers were supportive of the project. Rather, the research team focused on the traditional route of disseminating their research through scholarly journals. Thus, the research on INSITE has appeared in the major scholarly journals devoted to the study of addictions and drug use³ as well as in some of the most prestigious and/or high-impact scholarly journals devoted to health policy and practice.^{2,15}

Phase 3—INSITE as a Political Project

It was apparently only in the face of the decision by a newly elected Conservative government to force the closure of INSITE that prompted the research team to explore conventional and unconventional KT activities. They implemented an extensive KT strategy that involved, among other things, additional media engagement, plain language summaries, oral presentations, and “political commentaries in academic journals.”¹ This last element of the strategy is somewhat surprising insofar as political commentary or advocacy is not generally included in the standard lists of KT activities.

The proponents of INSITE judged their KT strategy to be somewhat successful based on public support for the facility as demonstrated by public opinion polling,

endorsements by (some) medical bodies, elected officials, and local police. Again, this is a somewhat unconventional evaluation metric as it extends well beyond decision makers per se to groups and individuals (i.e., the media, voters) who may exert pressure on decision makers. However, in the face of continuing opposition by the Conservative government to the facility, the authors conclude that, “KT was not equipped to overcome the systematic disregard of scientific evidence by the federal government.”¹

The response on the part of defenders of INSITE was to supplement ongoing research dissemination with an explicit and highly visible legal strategy. The response also involved a less explicit, but equally important shift from arguing their case based on the benefits of safe injection sites to a more expansive argument based on social justice. INSITE, so the argument goes, must continue in order to meet the needs of drug users who suffer from an illness, addiction, to which the only fair, just, and effective response must be a health services response. The alternative is to return to portraying drug users as criminals who are less than full citizens and to deny them their fundamental human rights.^{16,17} This social justice argument was a key part of the case put before the courts. Indeed, whether and to what extent ending INSITE would constitute a violation of the rights of drugs users under the Canadian *Charter of Rights and Freedoms* was a critical part of the legal case made by the defenders of the safe injection site.

The characterization of the decision by the Government of Canada to try and close INSITE as being “ideological” and “political” is paradoxical to say the least. All complex policy decisions are based on some combination of politics and ideology. The case of INSITE and other cases where “politics” is deemed to get in the way of “good” decision suggest that the public health enterprise¹⁸ needs a more robust theory of policy making. For the most part, the prevailing model is one that sees the policy-making process through the two lenses or ideas that animate public health—science and social justice, neither of which provides an adequate account of policy making in a democratic society.

THE LIMITS OF POLICY MAKING AS SCIENCE

When health sciences researchers turn their attention to public policy they, not surprisingly, adapt their existing explanatory models. In particular, insofar as public health is meant to be a scientific discipline, the implicit goal is to apply models that inform clinical or intervention research to the policy process. Thus, public health and health policy researchers often rely, if only implicitly, on a linear model of policy making where, if good data are provided, good policy decisions will follow.^{19,20} In this model, a policy decision is seen as an exercise in applied problem solving. A problem is defined and evidence is gathered or generated that offers a solution to the problem; this evidence is transferred to a decision maker who acts on the basis of the best available evidence.

This dominant model has been modified to encourage what some call “integrated knowledge translation”: collaboration between researchers and decision makers on how the problem is defined. A second modification has been to acknowledge that things other than evidence may be deemed relevant so that rather than speaking in terms of evidence-based policy decisions, it is perhaps better to speak in terms of “evidence informed” policy making.^{21,22} However, there are several characteristics of this model that continue to make it ineffective for understanding decision making about public policy. For example, there is little or no attempt to define the concept of

“policy”²³ or, alternatively, a policy is simply an intervention or a decision by another name. This obscures the differences between policy, program, and practice.^{24,25} This model also tends to focus on a single decision made by a single (usually undefined) “decision maker.” In fact, as demonstrated by the INSITE case, public policies are invariably the result of many decisions, by many people, over a period of time.²⁰ In other words, policy making is a process, not a matter of discrete decisions.¹³ Finally, a problem-solving model of policy making assumes a shared definition of the problem. As demonstrated quite dramatically by the case of INSITE and harm reduction more generally, in policy making, the definition of the problem is often contested. Proponents of harm reduction often conceive of addiction as a matter of health policy and/or are concerned, first and foremost with the needs (if not the rights) of addicts. Opponents of harm reduction, on the other hand, at least as it applies to currently illegal drugs, conceive of addiction not only as a health matter but also as an issue of the criminal law. Opponents of harm reduction as applied to street drugs also emphasize the interests of the broader community.

To summarize, the proponents of INSITE marshalled the scientific evidence for a safe injection site and engaged in KT but did so in an unconventional manner and modified the classic model (e.g., use of mass media). However, both their model and their application of same were doomed to fail because they were based on a model of decision making as evidence-based problem solving which bears little resemblance to the realities of decision making about policy. Thus, when the proponents of INSITE tell their story using the concept of knowledge translation, their account has no operative theory of the policy-making process.

THE IMPLICATIONS OF THE SOCIAL JUSTICE ORIENTATION OF PUBLIC HEALTH

The case of INSITE also points to a broader problem with how to think about public health and policy change. The proponents of INSITE were and are concerned about the rights and broader interests of the drug users of the Downtown East Side of Vancouver. The decision to deploy the four pillars strategy and make the effort to push governments to allow for the creation of a safe injection site were based, to a great extent, on a deep concern for the persons being harmed by injection drug use.

This normative impetus of INSITE is not at all surprising given that social justice lies at the heart of the public health enterprise and by extension is core to the harm reduction movement itself. The social justice orientation of public health is hard to ignore. While much of what is done in the name of public health is rooted in science, specifically epidemiology and biostatistics, the social justice roots of the public health enterprise are never very far away.^{26–28} As Alderman puts it, “Social justice is often the primary organizing moral principle behind public health arguments, and dialogue about public health policy has been biased towards this perspective”²⁹ or as Powers and Fadden put it, “social justice is the foundational moral justification of public health.”³⁰ Moreover, and not surprisingly, the social justice roots of harm reduction, safe injection sites, and, by extension, the INSITE project, are also quite clear.^{31–33}

But to say that social justice is at the core of the public enterprise and or harm reduction is to invite the question of precisely what conception of social justice are we talking about? For both philosophically and practically, there are many ways of conceiving what constitutes a just society. There is no space here to offer even a basic survey of the intersection of public health and social justice.^{31,34,35} For this

presentation, it is only necessary to make the rather simple observation that different philosophers and, by extension, different people, hold quite different conceptions of social justice. Some allow for different degrees of inequality based on either liberal³⁶ or, more radically, libertarian³⁷ conception of social justice. Others argue that social justice requires a radical redistribution of resources so as to, as much as possible, minimize inequality or mitigate its negative effects.^{38,39}

The public health enterprise rests, to a considerable extent, on an egalitarian conception of social justice. As Beaglehole and Bonita assert, “the value system of public-health professionals tends to be egalitarian and supports collective action.”⁴⁰ This is not surprising given the orientation of the public health enterprise to population health and the centrality of government action to addressing public health challenges. The point is not to challenge the egalitarian impulse of public health. Rather, it is simply to underscore the basic observation that there are others who do not share this conception of justice, and that this disagreement is deeply rooted and fundamental. Indeed, it is to some extent hardwired into our political system. Thus, it is inevitable that the egalitarian and collective orientation of public health will and does come into conflict with other conceptions of the good life, and that this conflict can and should be resolved by means of the political process. Politics and political conflict is one of the ways that we manage the fact that we hold different conceptions of the good, have different understandings of what is required to achieve a just and fair society, and how to reconcile social justice with other basic concerns like individual rights.

In this light, it is not particularly remarkable that the Conservative government elected in 2006, unlike the Liberal government that preceded it, is opposed to INSITE and the general philosophy of harm reduction, at least when it comes to illegal drugs. The newly elected government reflected and continues to reflect a point of view that is concerned with a particular definition and approach to public safety and, in the face of public anxiety and fear, a desire to be “tough” on crime. Again, the point is not whether this conception of drug use is accurate. Rather, the key thing to emphasize is that enough people share this conception of drug use that it shows up in political debate and discussion. Thus, it is by means of politics (not science or a particular conception of social justice) that we eventually reconcile divergent views about drug use in general and safe injection sites in particular.

CONCLUSION

The case of INSITE suggests that knowledge translation is not a particularly effective strategy for encouraging policy change, particularly in highly contested areas like drug use. Public policies are not simply a more complex or larger type of intervention, analytically commensurate to other public health interventions. As a result, shifting public policy requires more than even the most skilful implementation of the standards KT toolkit. Public policy decisions are not, and can never be, simply the result of a problem-solving exercise and the gathering and application of research evidence. The case of INSITE also demonstrates that it is not enough to supplement the science with a concern for social justice. Reasonable people can and do disagree on what constitutes a just society, and the egalitarian and collective orientation of the public health enterprise must be reconciled in some fashion with other conceptions of social justice. This is the stuff of politics.

If knowledge translation is not an effective tool for thinking about public policy decision making and public health labors under a sometimes blinding focus on some combination of science and social justice, what are the alternatives available to

public health advocates who want to foster policy change? Once again, the case of INSITE offers some clues. The success of INSITE and harm reduction generally is the result of the fact that it was never only or even primarily a straightforward application of evidence to a public health intervention. On the contrary, INSITE is the result of coalition building, the mobilization of public opinion, lobbying, and political and ideational struggle. Rather than being the translation of scientific evidence to a decision maker leading to a binding decision, INSITE is perhaps better understood as the result of the policy entrepreneurs taking advantage of windows of opportunity for policy change.⁹ Alternatively, the major policy change that INSITE requires might be best understood as the work of an advocacy coalition, a concept that others have used to explain public health policy change.^{41–43} Still another alternative might be to emphasize less policy change as the result of application of scientific knowledge and more as the result of changing conceptions of citizenship. If, when thinking about those who use street drugs we ignore their addiction and therefore their health needs and focus more on their illegal behavior, it is a short step to challenging the rights of drug users (as was the case for prostitutes in nineteenth-century Britain) to the benefits of full and equal citizenship and therefore access to the public health regime.¹⁷ Each of the alternative ways of thinking about the policy change required to advance public health is drawn from contemporary political science theories of politics, policy making, and ultimately state power. In effect, policy change is so much more than an intervention; it is the exercise of political power. There is, therefore, arguably scope for mutual learning between public health and political science for the latter remains, to a large extent, the study of the use and abuse of political power.

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