Public Health

Some notes on the knowledge to inform the practice

I am primarily a practitioner, I spent 10 years as an academic and I have a healthy regard for knowledge and theory, occasionally for its sheer elegance but more commonly because it helps me explain and understand a situation and from that plan what to do about it.

As a practitioner then I am drawn towards the area of knowledge we call praxis

In Ancient Greek the word praxis (πρᾱξις) referred to activity engaged in by free men. Aristotle held that there were three basic activities of man: theoria, poiesis and praxis. There corresponded to these kinds of activity three types of knowledge: theoretical, to which the end goal was truth; poietical, to which the end goal was production; and practical, to which the end goal was action. Aristotle further divided practical knowledge into ethics, economics and politics

In this section I want to offer some observations and cautions on Public health theory, discuss some current terms and have us all begin or continue constructing the underpinnings of our own public health theory for gambling here in Nova Scotia.

☐ This theory is emerging, it is not completely formed, not completely tested and is a long way from becoming doctrine. One of the reasons we began with Barnga, the card game this morning was to tap into our creative abilities to manage in uncertainty. The skills of suspending judgement, taking time to understand, using humour and metaphor are all important in managing in uncertainty. Certainty in this context should not be confused with accountability. I stand ready to be fully accountable but my blood runs cold when I see public health plans predicated on mechanistic certainty, we will come back to uncertainty as a theme but for now we need to be excited about the idea that our Public Health theory in this field is emerging and part of our job is to be as creative as possible as we think, dream and try out new interventions

☐ Things that look the same are the most confusing. I have lived in a number of cultures, 2 years in remote Papua New Guinea, Graduate school in both the USA and Bangladesh. I worked in England, Australia, Fiji Samoa, Vanuatu and a host of other places and one of the most important lessons I learned was to be on guard if things seemed too familiar. I can walk into a store in any exotic country find what I need to make for lunch and get out in 5 minutes even though I don't know the language but send me to an American supermarket and you may need to send in a search party. Honestly I am from a diary nation but you go into their supermarket and there is a chiller from here to china stocked with, looks like butter, smells like butter, wrapped like butter, cooks like butter, spreads like butter, doesn't spread like butter, bakes like butter, melts like butter, flavoured like butter, cuts like butter and then a tiny row of butter, which is like no butter I have ever met before. All of which is a long way of saying be careful, this is not tobacco, it is not alcohol and it sure isn't malaria.

We can learn from other public health issues and in particular hazardous consumptions but we should avoid blueprinting, using the cut and paste keys on the computer to transfer models and practices from one area to another however expedient and tempting that might be. Our health

Ministry did that in NZ and it has made a devil of a mess. In alcohol treatment we have a reportedly highly successful program called brief and early intervention, it's cheap, its fast and it works we are told. So when government developed its purchasing strategy for problem gambling, deep in the bowels of the bureaucracy , far from the gaze of anyone who had ever been involved in treatment, it was decided brief and early treatment interventions in gambling would be a major service purchased. There is no evidence base for the efficacy of early interventions in gambling treatment and that is because, nice idea that it is,…….Early in the gambling cycle the gambler is having too much fun to see any harm or seek treatment. In our experience it is quite rare to have an early intervention but because of a thoughtless cut and paste the whole treatment sector was re-orientated towards this. Millions were spent developing and making available a service no one really wanted, then agencies were crucified for not meeting the targets set for the service.

☐ Emerging fields demand robust critical analysis of the lessons learnt from elsewhere: When the ministry of health announced a purchasing strategy based on the much larger and better funded field of alcohol we were incredulous. Incredulous not because there are not similarities but because the ministry alcohol strategy must rate as one of the great public health failures of our time. The past decade has seen an unprecedented growth in availability and thus supply. There have been no credible attempts to reduce or restrict supply. The drinking age was lowered to 18 amidst a debate not about the maturity and responsibility of the alcohol industry and whether it should be trusted unfettered with a vulnerable new market, but instead an emotive debate about the rights of youth. The policy has been a disaster, the industry flooded the market with cheap Alco-pops and the carnage has been a national disgrace. Equally the lack of any local controls has seen the industry move to flood our poorest and most vulnerable communities. Running a wholly demand side program, peppered with public health messaging which is dwarfed by industry promotion is not a great model to follow, but more of this later.

☐ There are untested tensions, in our theory, tensions between local and central; professional and community; demand and supply side interventions. The language of Public health, particularly post Ottawa Charter is the language of local empowerment, local decision-making and local action. The reality, if we are honest is much more likely to be centralized determination and centralized prescription with the local action component closely circumscribed by central authorities.

☐ Sunlight really is the best disinfectant, untainted and incorruptible

☐ No informed and empowered community anywhere has voted for an increase in gambling supply

☐ Gambling harm it is everyone's problem.

☐ Gambling: Treatment works but prevention is better

Some terms:

- ☐ Demand side: Borrowed from economics, measures aimed at reducing gambling demand. Measures include gambling harm awareness raising through Public education, abstinence programs including GA groups

- ☐ Supply side: Also from economics, measures aimed at reducing the availability of gambling (gambling opportunities (number of games, hours, number of bets per hour) gambling venues, often aimed at reducing supply in vulnerable communities which are often over supplied.
- ☐ Harm minimization: measures to reduce identified harm, may include educative or awareness raising measures, technical solutions such as self limiting and pre commitment cards
- ☐ Health promotion: Building community capacity, knowledge and resilience
- ☐ Political determinants: Increasing accountability and reducing conflicts of interest
- ☐ Advertising and promotions: Gambling is frequently heavily promoted, Public health messaging should be measured against this, codes of responsible advertising may be developed

Obstacles in the road to a Public Health approach, these are fixable btw

The A word

The Reno model

Compromised politics

Draw on strengths of previous public health sucesses