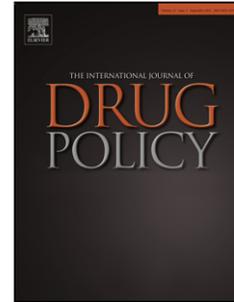# Accepted Manuscript

Title: The role of evidence and the expert in contemporary processes of governance: The case of opioid substitution treatment policy in England

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The role of evidence and the expert in contemporary processes of governance: the case of opioid substitution treatment policy in England

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The role of evidence and the expert in contemporary processes of governance: the case of opioid substitution treatment policy in England

Abstract

Background

This paper is based on research examining stakeholder involvement in substitution treatment policy which was undertaken as part of the EU funded FP7 ALICE-RAP (Addictions and Lifestyles in Contemporary Europe – Reframing Addictions Project). In England, the research coincided with a policy shift towards a recovery orientated drug treatment framework and a heated debate surrounding the role of substitute prescribing. The study aimed to explore the various influences on the development of the new 'recovery' policy from the perspectives of the key stakeholders involved.

Methods

The paper is based on documentary analyses and key informant interviews with a range of stakeholders, including representatives of user organisations, treatment providers, civil servants, and members of expert committees.

Results

Drawing on the theoretical insights offered by Backstrand's 'civic science' framework, the changing role of evidence and the position of experts in the processes of drugs policy governance are explored. 'Evidence' was used to problematise the issue of substitution treatment and employed to legitimise, justify and construct arguments around the possible directions of policy and practice. Conflicting beliefs about drug treatment and about motivation for policy change emerge in the argumentation, illustrating tensions in the governance of drug treatment and the power differentials separating different groups of stakeholders. Their role in the *production* of evidence also illustrates issues of power regarding the definition and development of 'usable knowledge'. There were various attempts at greater representation of different forms of evidence and participation by a wider group of stakeholders in the debates surrounding substitution treatment. However, key national and international experts and the appointment of specialist committees continued to play dominant roles in building consensus and translating scientific evidence into policy discourse.

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Conclusion

Substitution treatment policy has witnessed a challenge to the dominance of 'scientific evidence' within policy decision making, but in the absence of alternative evidence with an acceptable credibility and legitimacy base, traditional notions of what constitutes evidence based policy persist and there is a continuing lack of recognition of 'civic science'.

The role of evidence and the expert in contemporary processes of governance: the case of opioid substitution treatment policy in England

Introduction

The rhetoric of evidence-based policy and practice emerged strongly and gained currency across policy domains throughout the Labour government's period of office in the UK (1997-2010). It occurred in parallel with a drive towards de-centralisation of policy (or localisation) and the establishment of a variety of new networks and structures, such as partnerships, intended to facilitate the implementation of evidence based policy at local level and widen participation in governance (Newman, 2001). Within a rational knowledge-driven model of the relationship between policy and evidence, 'scientific' evidence was offered as the appropriate foundation for legitimising policy options at all levels. Scientific evidence was held to derive from particular forms of research with randomised controlled trials (RCTs), meta-analyses, systematic reviews, epidemiological analyses and 'modelling' studies being valued above research adopting what was seen as less rigorous methodologies. In this model, the 'expert', as interpreter (and sometimes the producer) of evidence is at the forefront.

However, the notion of 'scientific' or research based evidence as the dominant factor in policy decisions has long been criticised as divorced from the realities of policy making (Pawson and Tilley, 1997) and more recently questions have been raised regarding how some particular forms of knowledge come to be regarded as 'evidence' while other forms are rejected or seen to be of lesser value and, therefore, less deserving of policy attention (Williams and Glasby, 2010). In particular, as local decision makers are increasingly responsible for policy and practice development, the

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question of what kind of evidence or knowledge is appropriate and useful in deciding on local issues becomes especially pertinent. The localism agenda has helped to create new layers of stakeholders concerned with the production and use of evidence to develop locally appropriate policy and implement 'best practice'. Local service commissioners, for example, are expected to conduct regular needs assessments and to base decisions on service provision on evidence of local needs and service providers are expected to provide evidence of outcomes and of success in meeting set targets. As a result, an increasing number of stakeholders have become involved in policy debates and governance networks and have drawn on evidence to argue their case.

A parallel development has been the call for a broader notion of knowledge-based policy and practice, which includes the experiential knowledge of practitioners and the lived experiences of service users (Glasby and Beresford, 2006), and stretches even to the inclusion of 'citizens' (Backstrand, 2004a). This highlights a challenge to the traditional dominance of scientists, experts and policy makers as the main stakeholders within the science-policy interface. Backstrand (2004a) points out that, although top down models of the science-policy relationship grant power to networks of scientific experts, specialists and bureaucrats, the boundaries between scientific evidence and non-scientific evidence, expert and lay knowledge, global and local knowledge are not clear cut and can be negotiated in the course of the policy process. The production, source and use of evidence (or knowledge) thus become a core strategic element within governance networks.

The changing relationship between scientific evidence, expert, professional and lay knowledge has coincided with the rise of a 'civic science' framework which helps to

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conceptualise the 'various attempts to increase public participation in the production and use of scientific knowledge' (Backstrand, 2004a, p. 24). Within this perspective, citizens have a stake in the science-policy nexus. Backstrand (2004a) argues that the science-policy interface requires reframing as a triangular interaction between scientific experts, policy makers and citizens. She points to the different agendas relating to democratizing scientific expertise including increasing public and stakeholder participation in science; complementing scientific with alternative forms of knowledge; ensuring accountability and transparency within science; and transforming the hierarchical relationship between scientific expert and lay non scientists (Backstrand, 2004b, p. 656). These processes have been examined principally in the field of sustainability science (ie. climate change, management of natural resources and bio-safety) but provide a framework for examining trends in other policy domains. However, in many policy areas, the framework requires adaptation to account for the different role of 'citizens' within the debates. Within drugs policy and the substitution treatment debate more specifically, the wider public does not have the same interest or stake as they do within the environmental science debates. Nor do they play a role in the production and use of evidence other than as the subjects of research or as the recipients of 'evidence based' policy and practice or as the target group for media information and professional messages. 'Citizens' therefore need to be defined widely to include, for example, professional groups, non-governmental organisations (NGOs) or user groups, as well as the general public. Drawing on these theoretical insights, we consider the changing role of evidence and the position of experts in drugs policy governance in England.

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The rhetoric of evidence-based policy and practice has been emphasised in the drugs field for many years. The 'gold standard' is systematic reviews of mainly RCTs conducted by the Drugs and Alcohol Group of the Cochrane Collaboration. The Cochrane Collaboration is an international, independent, non-profit organisation funded by various sources including governments, universities, hospital trusts and charities. In addition to producing systematic reviews, Cochrane scientists engage in advocacy for evidence-based decision making. Day (2013, p.19) argues that this form of review 'strives to present the whole picture, and to do so in a way that invites critique and improvement. This puts vested interests to one side and can only benefit the consumer'. Although the drugs field is dominated by the 'expert', top down model of production and use of scientific evidence in the policy process, we can see examples of widening participation and representation; for instance, through consultation exercises and consensus conferences arranged in an attempt to reach agreement around the future direction of policy. Similarly, a wide range of stakeholders provided evidence to the recent House of Commons Home Affairs Committee inquiry into drug policy, including the traditional medical 'experts' as well as advocacy and activist organisations, think tanks, a range of treatment providers, academics, pharmaceutical companies, user groups and users representing themselves, including the recovering celebrity, Russell Brand who provided evidence in person as a key witness (Home Affairs Committee, 2012). There is some indication, therefore, of broadening out towards a more inclusive concept of 'evidence' and 'expertise'. As MacGregor (2012, p. 14) argues, the evidence has increased in both volume and complexity over time which relates to the increase in the stakeholders involved and the growing public attention to drugs issues.

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However, at the heart of stakeholders' discourses lie different types of evidence, produced and disseminated by these groups. Boundaries or borders may be established between scientific and 'lay' knowledge within the policy space through the maintenance of the legitimacy, credibility and authority of scientific knowledge (Gieryn, 1995). But even among experts differences of opinion arise over the significance, interpretation and sufficiency of the evidence; sometimes the same body of evidence is used to advocate different policy solutions to a perceived problem. Within this dynamic, some expert stakeholders are able to exert power and influence in determining what evidence gets used, how it is used and when it is used. They also decide how different types of evidence and sources are balanced against one another. Other voices have to struggle for policy attention and some may be excluded altogether. As Backstrand (2004a, p. 30) states, 'Scientific knowledge is in many areas provisional, uncertain and incomplete. Thus, competing expert knowledge has in many instances given rise to a battle between experts and counter experts'. The notion of 'civic science' is useful, therefore, to understand how various types of 'evidence' have been employed in recent drugs policy debates and to consider the extent to which the traditional expert scientist-policy bureaucrat dominance has been challenged and, possibly, opened up by stakeholders who both question the science and produce alternative forms of evidence. Recent debates between stakeholders surrounding the role of 'recovery' in drugs treatment, particularly regarding the place of opioid substitute prescribing in treatment policy provides a window into examining both the nature and role of evidence and the role of 'experts' in influencing policy. The debate on opioid substitution treatment has raised questions regarding the concept of *recovery* and in particular has focussed attention on recovery goals. It has tended to polarise arguments into two camps – those who advocate abstinence as the goal and

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those who stress the need for harm reduction approaches (including substitution treatment). In reality, the issues are more complex and many commentators have opposed the view that harm reduction and abstinence are mutually exclusive (cf. special section in Drugs: education, prevention and policy, 2012)

This paper will explore the participation of stakeholders (including citizens) in the production and use of scientific knowledge/evidence in the shift towards a recovery based framework for drug treatment policy. It will examine how advocates or 'policy entrepreneurs', in alliance with research advocates, used 'new' knowledge to challenge the status quo in drug treatment policy. It will be argued that the area of substitution treatment policy has witnessed a challenge to the dominance of 'scientific evidence' to policy decision making but in the absence of alternative evidence with an acceptable credibility and legitimacy base, traditional notions of what constitutes evidence based policy persist and there is a continuing lack of recognition of 'civic science'. In short, the expert still plays a central role in translating scientific evidence into policy discourse through a number of mediums, such as expert committees, although inclusive approaches – such as consultations – have opened doors to some extent to other voices and other forms of evidence. The analysis indicates that, despite the new policy governance structures and processes espoused by recent governments and visible to varying degrees across health and social care domains, with regard to drug substitution treatment issues, control has remained largely under central authorities and their traditional 'expert' advisors, drawing on accepted forms of scientific evidence rather than being devolved down to professional networks or wider groups of stakeholders.

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Research Design and Methodology

Substitution treatment was chosen as the topic for study because it has been a highly contested area within drug policy governance and highlights the divergent interests and stakeholders in this field over time (see Thom et al, 2013 for further background to the case study). Following the work of Brugha and Varasovsky (2000) on stakeholder analysis, a broad definition of 'stakeholder' was adopted: an individual, group or network of people involved with, or with interests in, or affected by a particular area of activity or a particular policy. Stakeholders for this study were classified into the following broad categories: policy makers (includes civil servants, career bureaucrats, and politicians); advocacy organisations (includes interest/pressure groups, drug user organisations, family/carer organisations); professional and/or scientific associations/societies; treatment sector (includes public/private, non statutory/statutory and mutual aid); researchers/scientists; and economic stakeholders (includes pharmaceutical industry, and 'social enterprises' or businesses with primarily social objectives).

Stakeholders in the area of substitution treatment policy were identified initially from a review of policy documents, relevant literature and the personal knowledge of the authors. The majority of the documents consulted were written or published within the last ten years from 2001 to the present day. The focus of the documentary analysis was to identify key stakeholders, to examine the discourse surrounding the role of substitution treatment over time; to examine the contribution and influence of key stakeholders in the production and dissemination of the documentation, and to develop appropriate question domains for the interviews. Starting with selection from the initial list generated from documentation, interviewees were asked to identify

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other groups or individuals who were seen as important players in the recovery debate. Selection of interviewees aimed to include most (if not all) of the categories listed above but was determined in part by purposive sampling to cover themes and explore theoretical insights. The stakeholders selected for interview were also defined by their knowledge, experience, seniority and position within their organisations. Although some of the stakeholders also play key roles at regional and local levels of policy and practice, the majority of those interviewed operate at the national level of policy-making. A total of 20 interviews were conducted; two with policy-makers, six with representatives from advocacy organisations, five with representatives from the treatment sector, five with researchers/scientists, and two with economic stakeholders.

A qualitative approach was chosen as best suited to gaining insight into the different ways in which individuals understand and interpret the world in which they live – in this case, their relationship with the substitution treatment arena (Maxwell, 2012). The purpose of the interviews was to provide in-depth understanding of the more recent shifts in the development of stakeholder's interest and influence, particularly in the movement towards a recovery-based framework in drugs policy. The interviews were semi-structured but used open ended discussion to allow interviewees to express their thoughts and experiences in their own way (Rubin and Rubin, 2011). The discussion focused on the activities and influence of the various stakeholders on policy development, the impact of policy change on stakeholders' positions and influence in the policy space and on the dynamics between stakeholder groups and on the factors which influence their activities. Depending on the interviewee, questions on 'evidence' were sometimes, but not always, asked directly. However, in most cases, issues regarding research and evidence emerged in the course of the discussion, for

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instance, in accounts about how organisations and individuals presented their case for or against substitution treatment and from broad questions such as, 'What factors have been driving policy on substitution treatment over the last 10 years?'

The interviews were conducted from January to September 2012, took place either in the respondent's place of work, at the university or by telephone, and lasted between one and two hours. All interviews were recorded and transcribed. Respondents were guaranteed confidentiality and anonymity. All identifiers such as details about the organisation, agency, or department of the respondents have been removed in order to ensure that information is non-attributable.

At the end of the fieldwork, all interview transcripts and notes were read carefully and systematically. All themes and categories emerging from the data were noted and coded on the transcripts. Some themes had been derived from existing theory, literature, and the documents and had been covered systematically within the interviews, while others had been generated spontaneously and were subsequently developed inductively during analysis. We began with our initial thematic framework but, in examining the topic of evidence and stakeholding, the themes were largely those emerging from interviewees' accounts.

Challenging the consensus in treatment policy

MacGregor (2011) argues that research has tended to have had impact where there is a direct link to the policy market and where a window of opportunity is open, for example a particular 'crisis' or change of government. She traces how research helped to frame the harm reduction approach adopted in British drugs policy in the

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late 1980s and then helped to construct the criminalisation of drug policy from the mid 1990s onwards. Within the drug treatment debate, evidence showing the crime reduction and public health benefits of substitution treatment was used to argue for its expansion. The development of the harm reduction approach was underpinned by 'an alliance of evidence and activism leading to radical policy change' (MacGregor, 2011, p. 44). The International Harm Reduction Association (IHRA), which was fundamental to these developments, deliberately promoted a form of 'civic science' which was characterised by a fusion of research, policy and legal analyses, knowledge exchange between a wide range of stakeholders and advocacy work around harm reduction and drug policy reform. Byrne and Albert (2009, p. 111) describe the opportunities afforded by the IHRA to users and user groups as "a key ideological shift from an exclusively public health to a more inclusive human rights focus" which allows for the incorporation of evidence based on 'lived experience'.

However, this does not meant that there were no challenges to the place of methadone maintenance within drug treatment during this particular period. There is a long history of conflict regarding the role of substitute prescribing between those who advocate a harm reduction approach and those who promote abstinence only treatment (see Mold, 2008 for an indepth historical analysis). In 1996 in light of criticism of maintenance prescribing, the Polkinghorne Review of Treatment Task Force collected evidence supporting its effectiveness which led to the funding of the longitudinal National Treatment Outcomes Research Study (NTORS) (MacGregor 2011). Based on the reviews of evidence, the consensus was that 'treatment works', and the importance of harm reduction within drug treatment, was re-affirmed (Department of Health, 1996).

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In 2001, the National Treatment Agency for Substance Misuse (NTA) was set up as a special health authority within the National Health Service (NHS) to improve treatment for drug misuse in England. With the establishment of the NTA, the allocation of unprecedented amounts of funding for drug treatment, and mounting research evidence for the cost effectiveness of treatment, increasing numbers of drug users were prescribed methadone on a maintenance basis. A director of an advocacy organisation described the expansion of bureaucracy for drug treatment policy and how the evidence base around substitute prescribing was used to legitimate its increase:

> "*It sets up the National Treatment Agency...so you have a bureaucratic system with targets, able and being held accountable...that's how we've got that dynamic for prescribing and its expansion. You've got the legitimacy through the evidence base, you've got the money coming into the system and a means to dispense it, and you've got performance targets...so how do you deliver interventions quickly? Substitute prescribing is stuff that you can do fairly rapidly.*"

The comment highlights the role of research (scientific evidence) in legitimating government action. This positioning of scientific evidence within established policy approaches and bureaucratic systems makes it difficult to challenge and the more vital it becomes to the raison d'etre of the establishment, the more likely it is to provide a basis for the production of similar types of research linked to the function of the established system and to achieving its targets. Following the set up of the NTA, the power bestowed by the established system on large stakeholders who subscribed to substitution treatment was reflected on by a stakeholder allied to the

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abstinence/recovery philosophy. This respondent noted that there were "*four main stakeholders, the four charities that grew on the back of Government treatment money.*" The allocation of government money was linked with the fact that the existing approach, substitution treatment, was protected by powerful authority figures in government and in the House of Lords who "had never advocated rehab."; this made it "*very difficult to get a policy shift unless you get a budget shift*".

Nevertheless, during this phase of policy, the numbers of stakeholders involved in drug treatment policy expanded to include a diverse mix including medical professionals, statutory services, voluntary organisations, universities, private companies, drug action teams, primary care trusts, specialist treatment services, general practices, nursing teams, mental health groups, prisons, probation, drug user groups, social enterprises, and pharmaceutical companies (Mold, 2008). This expansion was the result of more resources being made available for drug treatment, particularly via the criminal justice system, as well as the increase in methadone prescribing as a key tool in crime reduction (Duke, 2006). There was a new drive to include service user groups in policy making circles from the late 1990s, for instance, the Experts by Experience programme established in 2003 by the NTA (see Mold and Berridge, 2010, pp. 149-150). These groups began to provide evidence to expert committees and 'lay knowledge' began to be viewed as 'evidence'. These developments are indicative of increasing both representation and participation in the science-policy nexus. A greater range of stakeholders, including user groups, were invited to participate and contribute to the debates surrounding drugs issues. At the same time, others still felt excluded; they saw their exclusion as a reflection on their policy position and on the lack of evidence which would be credible in policy circles:

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> "*I gave up with the NTA…once this Government got in, XX invited me in, which was very nice…. I'd always been treated as some sort of - well not quite persona non grata, but someone that didn't understand what was happening ... I was beyond the pale basically I think.*" The respondent went on "*If I had all the money in the world, I could generate a whole load of useful evidence to back up my policy ideas, do you know what I mean?*"

However, from 2005, substitution treatment became re-defined as a 'problem' in itself (Duke et al, 2013). Evidence from existing research underwent subtle re-interpretation to focus on exit from treatment rather than on harm reduction gains and formerly excluded voices began to find a window of opportunity for their views. Research evidence and treatment outcome data was used by some stakeholders to argue that methadone maintenance prescribing was failing to help individuals become 'drug free' and exit the treatment process. New forms of evidence and discourse began to penetrate the policy debate. The right wing Conservative think tank, the Centre for Social Justice, drew on selected pieces of research and argued that the whole treatment system required reform and that abstinence based treatment was the way forward (Centre for Social Justice, 2007). Quantitative survey research indicated that the treatment goal for many drug users was abstinence rather than prolonged maintenance prescribing (McKeganey et al, 2004). One researcher described how this research was used as 'ammunition' by recovery groups and politicians:

> "*That was tremendous ammunition to recovery groups, the politicians...they could say look this is what the patients want....that was a case of very questionable research asking an extremely leading question of people coming to a door which says abstinence based treatment service....of course they are*

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> *going to say abstinence...So this very questionable finding was used....they took what they wanted from them to justify their positions and ignored the rest or didn't ask the questions.*"

The media also became involved in the construction of the 'methadone problem' in 2005. Using NTA statistics, the British Broadcasting Corporation (BBC) reporter, Mark Easton, reported that only 3% of drug users had exited treatment 'drug free', meaning free from substitution drugs such as methadone. This particular reading and interpretation of the statistics became the focus of heated debate. This provided an opportunity for some stakeholders who wanted to break the harm reduction consensus to influence the direction of policy towards an abstinence based framework. This external threat to the established harm reduction consensus was important as it helped to facilitate a shift within the final drug strategy published by the Labour government in 2008 (HM Government, 2008). The focus of this strategy was on ensuring drug users exit treatment and reintegrate back into society.

Research published later began to highlight the shortcomings of treatment sessions which focused primarily on prescription and testing issues rather than counselling and therapy (Best et al., 2010). However, further qualitative research with recovering heroin users conducted by Neale et al. (2011) highlighted the importance of asking what drug users meant when they said they wanted to be abstinent. For example, they might not mean abstinence from all drugs and they might want to continue with harm reduction for a period before moving towards abstinence. Moreover, the research revealed that drug users have broader treatment goals which extend beyond their drug consumption including improved personal relationships, engaging in meaningful activities and improved mental and physical health.

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McKeganey (2012) notes the changing narrative around the use of methadone in drugs treatment from 2005 onwards and the use of the 'methadone parking lot' metaphor. Methadone shifted from being seen as a highly effective treatment to a failing treatment. Despite the lack of 'hard data' on the actual time individuals had been prescribed methadone, this imagery of drug users being 'parked' on methadone was powerful (McKeganey, 2012). Similarly another researcher (interviewee) argued that there was a backlash against the accumulated scientific evidence base which showed that treatment worked:

> *"...there is really a lack of evidence...what's interesting about the backlash is that all this scientific evidence which showed that treatment worked, was thrown out of the window and back to anecdote and slogan, these dreadful slogans, 'parked on methadone' and so on. People being zombies in the clinics, I mean dreadful language. So very non scientific and a highly contentious debate."*

Other stakeholders also had this view regarding the move away from scientific evidence, including one of the representatives from a user organisation:

> "*one of the good things about the last ten years...the clinical side of things was actually based on evidence and a lot of evidence that was backed up and the same evidence is still there to this day, which backs up Methadone as the gold standard of the treatment of heroin addiction...now there seems to be a worrying turn away from the evidence and to look at things where there is no evidence base...The biggest change since the Coalition (government) is to ignore evidence or going back to ignoring advice from the ACMD (Advisory*

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Council on the Misuse of Drugs). It seems that politicians think they know best and they don't actually need experts or anyone to advise them"

However, some researchers saw the lack of research devoted to the question of aftercare in Britain as problematic. This left a huge gap in the evidence base and no alternative to the evidence surrounding the efficacy of methadone. There was little research which had tracked those who had 'recovered' successfully from drug problems:

> "*I couldn't find anything anyone in Britain had done about what happens to people who get better. Does anyone get better? Do we have contact with them? And the answer was pretty much they were either disbelieved about whether they got better or they were ignored. So essentially what we'd done was we had created a science of pessimism.*" (interview with researcher).

Relating back to Backstrand's dimensions of civic science, we see greater participation of different interest groups (including user groups) in the debates surrounding the evidence on substitution treatment during this phase. There were also attempts to ensure greater representation of different forms of evidence and perspectives within the deliberations. However, these different forms of evidence were used in directly political ways. Neale (2013, p. 1059) argues that this period was characterised by a 'cynical manipulation of research findings: a triumph of politics and ideology over science and scholarship'.

Re-affirming the importance of 'scientific' evidence and expertise

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In the lead up to the general election in May 2010, the debate regarding the goals of drug treatment policy and the place of substitute prescribing continued to rage. The concept of 'recovery' and how it could be defined began to take hold within the treatment debates. This was aided by international and national policy frameworks as well as key international experts and policy entrepreneurs who advocated a recovery position (see White, 2007). For example in the United States, the Betty Ford Institute Consensus Panel (2007) consisting of researchers, policy makers, clinicians and members of the recovering community held a conference to discuss the definition of recovery and how it could be measured. This included the influential recovery advocate William White as well as Dr Thomas McLellan, who was the Deputy Director of the White House Office of National Drug Control Policy from 2009 to 2010. They defined recovery as 'a voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship' (Betty Ford Institute Consensus Panel, 2007, p. 222). This work was influential in the UK and led to a similar exercise under the auspices of the United Kingdom Drug Policy Commission (UKDPC) drawing on the knowledge of key international experts. As one UK expert recalls:

> "*We did that in a more modest way than they had done in the States, but we involved Tom McLellan from the States who very generously came over and helped us with that exercise, and it led to UKDPC doing a report about recovery, trying to reconcile probably the two big stakeholders within that - the Twelve Step Abstinence territory and then there was also methadone maintenance treatment providers and recipients.*"

The development of this Consensus statement in the UK drawing on the American panel's work represents a type of policy or 'ideas' transfer. The influence for a

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recovery based policy also came from Scotland where they had already adopted this type of strategy. In 2008, the Scottish government put forward a new drug strategy entitled: 'The Road to Recovery: a new approach to tackling Scotland's drug problem' (The Scottish Government, 2008). However, this strategy, drawing substantially on insights from the mental health field, adopted a broader definition of recovery following the statement that, "recovery may not involve abstinence – all services and commissioning partners must put service users at the heart of their activities" (Scottish Advisory Committee on Drug Misuse, 2008, p4).

As the election approached, 'recovery' had been successfully embedded within policy and practice discussions although, as one researcher commented there was still an

> "*uneasy relationship between those who are defining drug use as a medical problem for which medical intervention is needed and those who define drug use as elements of a lifestyle which needs intervention from a wider range of professional and non-professional groups.*"

Despite various attempts to reach consensus around the term 'recovery' and the ways in which it would be measured, it was not explicitly defined within the new drug strategy of the Conservative/Liberal Democrat Coalition government (HM Government, 2010). This was a key tactic to temper the debate and calm the field (Duke et al, 2013). However, in order to settle the debates around the future role of substitution treatment within the new drug strategy, the NTA appointed Professor John Strang, a leading addiction psychiatrist, to chair an expert group which would examine the evidence base for different forms of substitute prescribing. This would include the hotly debated issue of time limited prescriptions. The expert group included stakeholders from a wide range of different professional backgrounds and

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ideological positions (NTA, 2012b) - psychiatrists, researchers, physicians, psychologists, nurses, commissioners, representatives from advocacy organisations (carer/families of users), service directors, service users, and representatives from 12 steps and residential rehabilitation sectors. It is clear that the different stakeholders were chosen carefully to ensure that a wide range of perspectives were represented. However, the degree of 'real' participation by some members was questioned. Some of the stakeholders we interviewed saw the group as representing the 'old world order' ie. dominated by 'doctors' and organised by the NTA. As one researcher argued:

> "*One of the interesting things is how disenfranchised many of the people who would regard themselves as community recovery people felt and fell from that group...This was the 'old world order' of the way the NTA did things. In direct contrast to that was the Recovery Group UK with a very different supposedly much more of a grass roots level of representation.*"

The goals of the expert group were to develop a clinical consensus and appropriate clinical protocols for opioid substitution treatment (OST) which support long-term recovery and prevent 'unplanned drift into long-term maintenance' and to develop a model for 'segmentation' of the treatment population and suitable treatment placement indicators, both in the context of the developing treatment framework' (NTA, 2011, p. 8). The expert group was supported by an international advisory group including a member from the Cochrane Drugs and Alcohol Group (Dr Laura Amato), a key researcher from Australia (Professor Wayne Hall), and recovery advocates from the United States (Professors Keith Humphreys, Thomas McLellan and William White). This international dimension was seen to be important by key

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members of the group in terms of *'tying into this international scientific objectivity mindset...the reason for having the group was to connect with that wider constituency'.* (interview with member of the expert group)

The 'scientific' evidence was fundamental to the work of the expert group. A key task was to review the national and international evidence on OST and its effectiveness. The work of the expert group was to be underpinned by scientific objectivity and rigour. As one member of the expert group put it, they wished to '*avoid the abuse of science, where you just cherry pick it for things that support your prejudices*.' The review of the evidence attempted to 'integrate, as far as is possible, the discourse of evidence-based practice (built on observation and measurement), with the humanitarian, recovery-based discourse based on values (such as responsibility, choice and empowerment) and [it] identifies where the optimism which is central to recovery discourse needs to be tempered with evidence, and where the energy and focus on self-improvement associated with recovery can enhance the effectiveness of evidence-based practice.' (NTA, 2012b, Appendix C p. 1). This suggests an attempt at fusing or merging the traditional 'scientific' evidence with other forms of 'non-scientific' evidence. The starting point of the review however was the empirical evidence on the effectiveness of OST and the factors associated with treatment effectiveness based on Cochrane criteria. A secondary aspect was to explore 'where the insights and dynamism of recovery can enhance effectiveness of treatment (NTA, 2012b, Appendix C, p. 1). Although this represents a break from the norm, the adherence to the hierarchy of evidence (ie the dominance of RCT studies) is apparent in the review.

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Some of the stakeholders we interviewed viewed these developments as maintaining the status quo, evidence of the continued dominance of psychiatry in addiction and the 'professionalization' of recovery. The final report of the expert group concluded that OST should continue to have 'an important and legitimate place within recovery-orientated systems of care' (NTA, 2012b, p. 5). Although the value of OST with no time limits was emphasised, they recommended a more rigorous and ambitious system of monitoring, review and assessment of those on prescriptions in order to check and stimulate their readiness to change and to use and develop their recovery capital. Best and Laudet (2010: 2) define recovery capital as 'the sum of resources necessary to initiate and sustain recovery from substance misuse'. Recovery capital can be broken down into four types: social, physical, human, and cultural (see Cloud and Granfield, 2008). Within a recovery-orientated treatment system, the expert group concluded that a full range of treatment interventions are required and emphasised that treatment services cannot operate in isolation from other support such as employment, training and housing.

In conclusion, it is clear that the use of 'scientific' evidence was of paramount importance to their conclusions, as was the endorsement of the international network of experts. The lack of focus on other non-medication aspects of the recovery arena was a direct result of the brief given to the expert group at the beginning of the project which was to examine the relationship between medications and recovery. This emphasises the influence of those who establish national advisory or expert groups over the inclusion or exclusion of bodies of evidence and illustrates how parameters are set which tend to perpetuate the types of evidence and science which are given legitimacy and credibility in policy and practice debates. In comparison to the strong

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evidence base demonstrating the effectiveness of OST, there is a paucity of research on the different aspects of 'recovery' and other forms of treatment and support. Much of the existing research in these areas is not considered 'scientific'. As one of the representatives from an advocacy organisation argued in relation to the evidence base on residential rehabilitation:

> "*The ones I know who have gone to the Lee or Providence Projects or up at Phoenix Adult Residential – they stay, they create a new network, a new environment. That's evidence based, but it's not the evidence that the Department of Health is interested in. It's not the evidence that NICE (National Institute for Health and Care Excellence) is interested in. They are interested in RCTs for methadone*".

Leighton (2013) argues that there is discontent in the drug and alcohol fields regarding psycho-social interventions and complex social programmes (ie therapeutic communities and mutual help/aid). The key problem is that these types of interventions do not have causal powers in themselves, rather the causes of change in participants are processes of changing reasoning and are dependent on wider social and cultural features. Although the literature on the mechanisms behind these interventions has been accumulating, it has been pushed aside in favour of the evidence generated from RCTs. As this study, along with other work has illustrated, some forms of evidence have succeeded in accumulating greater credibility, legitimacy and authority than other forms (Gieryn, 1995) and, as we have argued above, due to their powerful location within established policy and bureaucratic systems, they are difficult to oppose.

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Conclusion

As in other policy spheres, drugs policy is shaped by a number of competing influences including politics, ideologies, values, the media, perceived public opinion and pragmatic constraints such as funding (Ritter, 2009; MacGregor, 2011; 2013; Stevens, 2011; Monaghan, 2011). As we have seen, these are reflected in the discourses and policy demands of different stakeholder groups – different treatment professionals and occupational groups, user groups, bureaucrats representing different government departments, NGO's and researchers. Even those working as experts within the core of the policy bureaucracy are not always successful in promoting their preferred policy option despite the nature of the available evidence. One example which illustrates the competing influences and pressures on government was the dismissal of the Chairman of the Advisory Council on the Misuse of Drugs (ACMD) in October 2009 because he was deemed to have crossed the line from science to policy (Nutt, 2012). On this occasion, the expert and his translation of the evidence was not acceptable within the existing framework of understanding (and policy) around drugs. While this challenge came from within the policy bureaucracy, from the analyses above, it is clear that there has also been a challenge to the top down model of 'scientific evidence' and expertise.

There has been some shift away from belief in the knowledge-driven model where the expert – and research-derived evidence – is granted a central role in policy consideration, towards the enlightenment model where research is separate from policy making and policy is evidence *informed*, rather than evidence *based*, thus granting a less powerful, less determining role to expert advice (Young et al., 2002). We have illustrated attempts at greater representation of different forms of evidence

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and participation by an increasing number of stakeholders, including user groups, in the treatment debates in England. However, as Backstrand (2004b, p. 709) argues, representation and participation do not necessarily lead to democratisation of science: "the experiments of citizen participation do not necessarily amount to democratic governance of science. In some instances, the turn to public participation represents cosmetic adjustment that does not challenge trenchant policy techniques." As we have noted, in some policy domains, the notion of full citizen participation may be unrealistic, although the expansion of stakeholder groups within new networks of governance opens up opportunities for wider representation and participation at least among relevant professional and policy relevant groups.

This case study of debates surrounding opioid substitution treatment policy illustrates that the drugs field in England is only beginning to grapple with representation and participation; moreover, there seems to have been a limited 'window' for these processes to emerge and develop. The case study has highlighted the close relationship between what is perceived and accepted as policy relevant evidence and how that form of evidence becomes firmly embedded within dominant policy structures and systems. As an integral part of established systems, supported by powerful stakeholders, the evidence itself becomes the basis for attracting resources and extending the evidence base, thus making it less likely that challenges will be successful.

Given the recent shift towards recovery within English drugs policy, a key question is what will be the role of the various different forms of 'evidence' and use of 'experts' in the shaping of the implementation and evaluation of the policy? With the economic recession and public sector funding cuts, funding for 'scientific' research is

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likely to be affected. Will different forms of 'evidence' and expertise be used more in the policy debates and decision making? Research on 'recovery' lends itself to qualitative and participatory methodologies, but will these types of studies be funded by the research councils and government departments in England when, with the Payment by Results initiative (ie. where drug agencies are paid only for 'successful' outcomes in treatment), there continues to be an obsession with outcomes and with measuring 'recovery'. The indication from this case study is that new governance structures will strive to adopt a rational-knowledge driven model of the policy-evidence relationship despite awareness of a much more complex picture of the role of science and the expert in policy.

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