

Problematizing the 'evidence-based' drug policy paradigm

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Problematizing the ‘evidence-based’ drug policy paradigm

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BA, LLB (Hons), MPP

A thesis in fulfilment of the requirements for the degree of
Doctor of Philosophy

Drug Policy Modelling Program

National Drug and Alcohol Research Centre

School of Public Health and Community Medicine

Faculty of Medicine, University of New South Wales

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<p>'Evidence-based policy' has become the catch-cry of the drug policy field. A growing literature has been dedicated to realising the goal of 'evidence-based' drug policy: to maximise the use of quality research to inform decision-making and help answer the question of 'what works.' The aim of this thesis was to problematise the premise of the 'evidence-based policy' paradigm and, by interrogating underlying taken-for-granted assumptions, consider the implications and effects of this dominant mode of governance for drug policy. This research was informed by a range of critical perspectives, particularly the work of Carol Bacchi (whose Foucauldian-influenced approach is underpinned by social construction theory, poststructuralism, feminist body theory and governmentality studies). A qualitative multiple-case study design was employed, comparing three drug policy issues in Australia: (i) discussion of 'recovery' approaches to drug treatment; (ii) the development of approaches to extend distribution of injecting equipment through peers in Sydney; and (iii) processes leading to the establishment of programs to make naloxone available to opioid overdose witnesses in Canberra and Sydney. The case studies drew on documentary sources and semi-structured interviews (n=41) with policy makers, advocates, researchers and clinicians closely involved in these processes.</p> <p>By examining the productive techniques and constitutive effects of both drug policies and 'evidence-based policy' discourse, this research revealed how policies constitute the 'problems' they purport to address (Paper 1) and the discursive, subjectification and lived effects that flow from particular problem representations (Paper 2); how knowledge ('evidence') is legitimised (Paper 3) and constituted by specific performances (Paper 5); and how political subjects (such as 'consumers') are enacted in the material-discursive practices of 'evidence-based policy' (Paper 4). A reflexive account of the research is also given (Paper 6). By scrutinising the premise and effects of 'evidence-based policy,' and highlighting the contingent nature of 'problems,' 'subjects' and the object of 'evidence' itself, this research contributes to a body of poststructuralist scholarship which has used the 'problematisation' framework to examine the political implications of the taken-for-granted status of 'evidence-based policy' discourse, leading to considerations for how drug policy and 'evidence' may be otherwise enacted.</p>

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Signed

Professor Alison Ritter

Date.....

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Abstract

‘Evidence-based policy’ has become the catch-cry of the drug policy field. A growing literature has been dedicated to realising the goal of ‘evidence-based’ drug policy: to maximise the use of quality research to inform decision-making and help answer the question of ‘what works.’ The aim of this thesis was to problematise the premise of the ‘evidence-based policy’ paradigm and, by interrogating underlying taken-for-granted assumptions, consider the implications and effects of this dominant mode of governance for drug policy. This research was informed by a range of critical perspectives, particularly the work of Carol Bacchi (whose Foucauldian-influenced approach is underpinned by social construction theory, poststructuralism, feminist body theory and governmentality studies). A qualitative multiple-case study design was employed, comparing three drug policy issues in Australia: (i) discussion of ‘recovery’ approaches to drug treatment; (ii) the development of approaches to extend distribution of injecting equipment through peers in Sydney; and (iii) processes leading to the establishment of programs to make naloxone available to opioid overdose witnesses in Canberra and Sydney. The case studies drew on documentary sources and semi-structured interviews (n=41) with policy makers, advocates, researchers and clinicians closely involved in these processes.

By examining the productive techniques and constitutive effects of both drug policies and ‘evidence-based policy’ discourse, this research revealed how policies constitute the ‘problems’ they purport to address (Paper 1) and the discursive, subjectification and lived effects that flow from particular problem representations (Paper 2); how knowledge (‘evidence’) is legitimised (Paper 3) and constituted by specific performances (Paper 5); and how political subjects (such as ‘consumers’) are enacted in the material-discursive practices of ‘evidence-based policy’ (Paper 4). A reflexive account of the research is also given (Paper 6). By scrutinising the premise and effects of ‘evidence-based policy,’ and highlighting the contingent nature of ‘problems,’ ‘subjects’ and the object of ‘evidence’ itself, this research contributes to a body of poststructuralist scholarship which has used the ‘problematization’ framework to examine the political implications of the taken-for-granted status of ‘evidence-based policy’ discourse, leading to considerations for how drug policy and ‘evidence’ may be *otherwise* enacted.

Table of contents

Acknowledgements	vi
Abstract	viii
List of publications included in this thesis	xii
Introduction	1
References	12
Paper 1	17
Producing the ‘problem of drugs’: A cross national-comparison of ‘recovery’ discourse in two Australian and British reports	17
Copyright Statement	18
Preamble	19
Abstract	20
Key words	20
Introduction	21
Method	22
Background to UKDPC Recovery Consensus Group ‘Vision of Recovery’ Report	24
Background to the ANCD 1 st Recovery Roundtable Report	26
Themes	28
Conclusion	36
Acknowledgements	39
References	40
Paper 2	45
Laws prohibiting peer distribution of injecting equipment in Australia: A critical analysis of their effects	45
Copyright Statement	46
Preamble	47
Abstract	48
Key words	48
Introduction	49
Approach	51
Laws, regulations and guidelines governing the distribution of injecting equipment in NSW	53
The distribution of injecting equipment in NSW: problematisation and effects	56
Conclusion	64
Acknowledgements	67
References	68
Paper 3	73
“Naloxone works”: The politics of knowledge in ‘evidence-based’ drug policy	73
Copyright Statement	74
Preamble	75
Abstract	76
Key words	76
Introduction	77
Background	78
Approach	80
Method	82
Legitimizing speakers	84
Resources for resistance	87
	ix

Conclusion	90
Acknowledgements	93
References	94
Paper 4	99
The productive techniques and constitutive effects of ‘evidence-based policy’ and ‘consumer participation’ discourses in health policy processes	99
Copyright Statement	100
Preamble	101
Abstract	102
Key words	102
Introduction	103
Approach	104
Method	108
Analysis	109
Conclusion	116
Acknowledgements	119
References	120
Paper 5	124
Performing the evidence-based drug policy paradigm	124
Copyright Statement	125
Preamble	126
Abstract	127
Key words	127
Introduction	128
Method	131
Performatively constituting ‘evidence’ as a ‘tool’ for ‘use’	134
Conclusion	140
Acknowledgements	142
References	143
Paper 6	146
Confidentiality, anonymity and power relations in elite interviewing: Conducting qualitative policy research in a politicised domain	146
Copyright Statement	147
Preamble	148
Abstract	149
Key words	149
Introduction	150
Interviewing policy ‘elites’	152
Confidentiality, anonymity and ‘vulnerable elite’ participants	157
Conclusion	163
Acknowledgements	165
References	166
Conclusion	168
References	179
Appendix – Data collection methods	182
Case sampling	182
Data collection	183
Coding and data organisation	188
References	189
Appendix – Interview and participant observation guides	191

Recovery case study semi-structured interview topics	191
Extended distribution case study semi-structured interview topics	193
Naloxone case study semi-structured interview topics	195
Participant observation guide	198
Appendix – List of other publications during candidature	199
Appendix – List of presentations during candidature	202

List of publications included in this thesis

1. **Lancaster**, K., Duke, K., & Ritter, A. (2015). Producing the 'problem of drugs': A cross national-comparison of 'recovery' discourse in two Australian and British reports. *International Journal of Drug Policy*, 26(7), 617-625.
2. **Lancaster**, K., Seear, K., & Treloar, C. (2015). Laws prohibiting peer distribution of injecting equipment in Australia: A critical analysis of their effects. *International Journal of Drug Policy*, 26(12), 1198-1206.
3. **Lancaster**, K., Treloar, C., & Ritter, A. (under review). "Naloxone works": The politics of knowledge in 'evidence-based' drug policy. *Health*.
4. **Lancaster**, K., Seear, K., Treloar, C., & Ritter, A. (under review). The productive techniques and constitutive effects of 'evidence-based policy' and 'consumer participation' discourses in health policy processes. *Social Science & Medicine*.
5. **Lancaster**, K. (2016). Performing the evidence-based drug policy paradigm. *Contemporary Drug Problems*, 43(2), 142-153.
6. **Lancaster**, K. (2016). Confidentiality, anonymity and power relations in elite interviewing: Conducting qualitative policy research in a politicised domain. *International Journal of Social Research Methodology*, Advance online publication, DOI: 10.1080/13645579.2015.1123555.

Introduction¹

‘Evidence-based policy’ has become the catch-cry of the drug policy field. A growing literature has been dedicated to better realising the goal of ‘evidence-based’ drug policy: to maximise the use of the best quality research to inform policy decision-making and help answer the question of ‘what works’ (see Babor, et al., 2010; Strang, et al., 2012). As valentine (2009, p.444) notes, “[b]ecause it is based on medical treatments, and because the language of ‘evidence-based’ policy emerged from medicine, drug policy is an arena of social policy in which arguments for evidence-based policy have been especially strong.” The focus of the ‘evidence-based’ drug policy endeavour has been two-fold. First, attention has been given to the production of ‘gold-star evidence’ (primarily through randomised controlled trials) and the generation of ‘policy-relevant research.’ This is particularly true of domains within drug policy where perceived ‘knowledge-gaps’ have been identified, for example in relation to the effectiveness of drug law enforcement and policing responses (for discussion see Ritter & Lancaster, 2013). Secondly, efforts have been made to increase the uptake of evidence in policy decision-making through ‘research translation’ activities. Groups such as the Drug Policy Modelling Program (of which I am a part) have been dedicated to this pursuit (Ritter, Bammer, Hamilton, Mazerolle, & The DPMP Team, 2007). This two-fold approach draws heavily on the extant evidence-based policy and research translation literature (e.g. Nutley, Walter, & Davies, 2007; Walter, Nutley, & Davies, 2005) and is premised on the assumption that the increased uptake of ‘evidence’ within policy decision-making processes will improve outcomes and increase the legitimacy of decisions made. However, as has been noted by drug policy scholars previously, “the assumption that evidence of effectiveness is the only criterion for policy is both naive and untrue. [...] [Evidence] is one component of complex policy-making processes” (Ritter, et al., 2007).

Alternative accounts in the policy processes literature conceptualise policy activity as an ambiguous and contested process (e.g. Colebatch, 2002; Kingdon, 2003; Sabatier, 1988, 2007), and the role of evidence as being only marginally influential. From this perspective, multiple participants jostle for influence and seek to define “what is problematic and worthy of attention, what bodies of knowledge are relevant, what technologies of governing can be

¹ An earlier version of the Introduction to this thesis has been published as a commentary: Lancaster, K. (2014) Social construction and the evidence-based drug policy endeavour, *International Journal of Drug Policy*, 25(5), 948–951.

applied, and which actors are allowed to speak” (Colebatch, 2010, pp.32-33). These alternative accounts begin to challenge taken-for-granted assumptions underpinning the ‘evidence-based policy’ paradigm: first, that a particular kind of knowledge (called ‘evidence’) is inherently useful and superior for policy decision-making; and, secondly, that ‘problems’ objectively exist ‘out there’ waiting to be solved through the application of ‘evidence’ (Bacchi, 2009). Although some research within the drug policy field has engaged with the notion of the complexity of the policy process and the multiple influences on it, less work has questioned the *premise* of the ‘evidence-based’ drug policy endeavour. Such critique would raise questions about whether ‘evidence’ can, and should, be conceptualised as fixed, stable and inherently valuable in policy and, more than this, how ‘evidence’ is enacted in a specific policy context (here, a policy world where ‘problems’ are treated as exogenous to policy processes).

The aim of this thesis is to problematise the premise of the ‘evidence-based policy’ paradigm and, by interrogating underlying taken-for-granted assumptions, consider the implications and effects of this dominant mode of governance for drug policy. To do so, I draw on and combine a range of critical perspectives, particularly the work of policy theorist Carol Bacchi (whose approach is underpinned by social construction theory, poststructuralism, including poststructuralist discourse psychology, feminist body theory and governmentality studies, see: Bacchi, 2009; Bacchi & Eveline, 2010). Although social construction has a long and varied history in sociological inquiry with multiple applications and internal debates, constructionist perspectives have been adopted in political science more recently as discussion turned to focus on the processes of public policy (Best, 2008). The research of Schneider and Ingram (1993, 2005) in relation to the social construction of target populations, and how these constructions are produced and reproduced in the policy making process, is one example. The critical turn in policy studies (including the work of Fischer (2003), Stone (2002) and others) has also drawn attention to these questions by examining the “symbolic, interpretative, and multiple understandings found in policy discourse” (Schneider & Ingram, 2008, p.190). Within the policy literature which draws on constructionist premises there are disagreements about the degree to which participants in the policy process “shape the nature of the discourse” (Colebatch, 2010, p.33). Bacchi’s Foucauldian-influenced approach (which I follow in this thesis) emphasises that all actors are *within* discourses (understood as “socially produced forms of knowledge that set limits on what it is possible to think, write or speak about a given social object or practice”: Bacchi, 2009, p.35). While policy theory in the interpretivist tradition tends to focus on the competing perspectives of policy actors (or how participants in the policy

process understand, define or frame a ‘problem’), Bacchi’s poststructuralist approach shifts the analytic focus towards the *constitutive* character of policy and practice (Bacchi, 2016).

Bacchi’s (2009) “What’s the Problem Represented to be?” approach brings into question the dominant assumption that the function of policy is to ‘solve problems’ by revealing the ways in which ‘problems’ are not clear-cut or self-evident, but rather *made in* policy. Policies constitute (or bring into existence) the ‘problems’ they purport to address (Bacchi, 2009). The ways in which drug policy “does not merely identify and respond to a pre-existing condition” (Moore & Fraser, 2013, p.922) but rather *produces* the ‘problem of drugs’ has been the subject of critical analysis. For example, by examining the treatment of causation and evidence within amphetamine-type stimulant policy documents, Fraser and Moore (2011b) have demonstrated how amphetamine-type stimulant use has been produced as being simultaneously (and paradoxically) both dangerous and poorly understood. Bacchi (2016, p.9) argues that such representations of problems “are not images or imagined states; they are interventions.” They do not merely represent the ‘real’ but rather constitute a particular policy problem *as the real* (Bacchi, 2012, 2016).

Rather than assuming the existence of a single, fixed and anterior reality, this approach highlights the political, contingent and emergent nature of ‘things.’ The ‘problems,’ ‘objects’ and ‘subjects’ which form the basis of policy analysis are not taken-for-granted but understood to be constituted through practices (Bacchi, 2016). As such, this conceptual framework has potential for generating insights about how the thing we call ‘evidence’ is rendered legitimate within the policy process. Rather than seeing ‘evidence’ or ‘policy-relevant knowledge’ as an objective tool for decision-making, we are driven to question the processes of knowledge construction, how particular kinds of knowledge are constituted as ‘useful,’ and how knowledge-producers secure privileged positions of influence. This approach also has potential for generating insights about the kinds of ‘subject’ that it is possible to become in ‘evidence-based’ drug policy. Within this approach political subjects are not seen as fixed, but rather emergent types elicited through policies and discourses (Bacchi & Eveline, 2010a). As Bacchi (2016, p.9) argues, “who we become forms part of a continuing process, in which policies play an active role through making certain subject positions available.”

Furthermore, this approach refocuses analysis to help reveal the ways in which these enactments rely on professional and ‘expert’ knowledges, which brings into question the taken-for-granted status and political effects of such knowledges (Bacchi, 2009, 2016). This

perspective challenges the dominant 'evidence-based policy' paradigm which positions researchers as depoliticised producers of 'policy-relevant knowledge' (that is, as offering 'objective' 'evidence' to solve pre-defined 'problems'). Bacchi (2009, p.253) has noted that "by producing 'knowledge' for pre-set questions, researchers become implicated in particular modes of governance." Thus, a turn from 'problem-solving' to 'problem-questioning' challenges the fundamental presupposition in 'evidence-based' approaches (which assumes that reality precedes practices, and suggests that 'problems' are 'there' to be solved) by revealing how policy 'problems,' 'subjects' and 'objects' are constituted and the modes of governance which produce them, questioning the assumptions which 'lodge within' policies, and opening them up for debate (Bacchi, 2009).

Applied to the 'evidence-based' drug policy endeavour, constructionist and poststructuralist ontologies and epistemologies shift our focus from the inherent value of 'evidence' for addressing 'drug problems' to the "productive capacity" (Bacchi & Eveline, 2010b, p.9) of both drug policies and 'evidence-based' drug policy discourse: how policies constitute the 'problems' they purport to address; how policy knowledge is made and legitimised; and, through these processes, how political subjects are produced. We have limited knowledge in the drug policy field about how this happens; how ambiguity about "the problems to be addressed, which voices should be heard, and what activities may be appropriate" (Colebatch, 2010, p.33) is not only contested, but how 'problems,' 'subjects' and 'objects' are continually *shaped and produced* through material-discursive practices. Studies which have focussed on the use of evidence in dynamic drug policy processes (e.g. Monaghan, 2008, 2009; Stevens, 2011) provide some insight, but by stopping short of problematising concepts like 'evidence,' leave many questions unanswered.

Green's (2000) study of accident prevention alliances in the UK provides one example in the context of a multi-disciplinary, inter-professional and inter-agency context not unlike drug policy. Green examines the way 'evidence' is used by participants in health policy decision-making, highlighting the ways that 'evidence' becomes inextricably linked with particular agendas, and how its credibility is differentially constructed within, and contested between, professional cultures. Drawing on an empirical case study, Green (2000, p.472) argues that "such phenomena as 'knowledge,' 'evidence' and 'practice' are not natural or necessarily distinct, but are constituted through local and contingent practices." Even when organisations are explicitly committed to the goal of instituting 'evidence-based practice,' achieving this goal

is not straightforward because “it is practice which, in part, *constitutes* that evidence” (Green, 2000, p.472, emphasis added). Such insights have the potential to fundamentally recast the emphasis of the ‘evidence-based’ drug policy endeavour. The focus shifts from how to better translate ‘policy-relevant research’ into policy, to instead interrogating the processes and practices through which policy knowledge is *made as* relevant within a specific context. It suggests that other voices or a multiplicity of knowledges can be legitimised because the thing we call ‘evidence’ is constituted *within* the policy process. Such an assertion is pertinent when we consider the influence of professional judgment or the usually marginalised role of ‘consumers’ in drug policy deliberation.

Opening up this debate and acknowledging not only the dynamic and ambiguous nature of the ‘evidence-based’ policy process, but also its productive techniques and constitutive effects, is not without its challenges. First, such a perspective creates a quandary for how policy decisions may be assessed as justifiable. The dominant discourse of ‘evidence-based’ policy contributes to the way an authoritative story of governance is articulated, because narrative accounts of policy are *part of* the policy process (Williams, 2010). Evidence is part of an account of policy making as a process of authoritative choice. As such, conceptualising ‘policy-relevant knowledge’ or ‘evidence’ as being constructed *within* policy processes has implications for the way policy actions may be defended. However, as some commentators have noted, the tension between the rhetoric of ‘evidence-based policy’ and the contested and negotiated realities of the policy process is already acutely felt by those who participate in real-world policy making. Williams (2010, p.197) has suggested that the rhetoric of ‘evidence-based policy’ is “a potential constraint on the policy worker’s room to manoeuvre, to be treated with ‘cautious scepticism’ when it does not fit comfortably into the interactive reality of daily activities. Policy workers must contend with a core dilemma: if they acknowledge the messiness of policymaking [...] will the policies that are the outcomes of these contests be seen as legitimate?”

Secondly, acknowledging the ambiguous nature of the policy process, and the construction of ‘policy knowledge’ within it, also brings into question the claim that researchers can make to possessing superior knowledge about ‘what works.’ The notion that research can claim superior, objective and privileged expertise has already been critiqued extensively by social scientists (including through the burgeoning field of science and technology studies, for discussion see: Latour & Woolgar, 1979; Law, 2004; Restivo & Croissant, 2008). As tools for

knowledge production, research methods do not merely measure and describe the ‘real-world’ but rather *produce* and help to *make* the phenomena they observe (Law & Urry, 2004). Arguably, in light of the rigorous questioning of the objective status of research evidence, the claim to superiority has already been lost. In the policy context “[r]esearchers are thus required to exchange their findings on equal footing with practitioners, both in terms of their status and in the validity of their data. This type of equality questions both the validity of academic research and the demand that evidence be the basis of policy” (Williams, 2010, p.199). Although these arguments have been mounted by critical scholars working in the drug policy field (including those whose work is theoretically informed by science and technology studies, e.g. Dwyer & Moore, 2013; for further discussion see Fraser & Moore, 2011a; Fraser, Moore, & Keane, 2014; Keane, Moore, & Fraser, 2011; Moore, 2011), the objective and superior status of research evidence is ground which has yet to be conceded by many who advocate for ‘evidence-based’ drug policy.

Part of the unwillingness to concede this ground may come from the highly politicised nature of policy making in the drug arena. Drug policy decisions are frequently driven by morality politics, sensationalist media and public opinion (for discussion see Lancaster, Hughes, Spicer, Matthew-Simmons, & Dillon, 2011; Lawrence, Bammer, & Chapman, 2000; Reinerman & Levine, 1989; Wodak, 1997). The claim to know ‘what works’ is therefore already highly contested, and vigorously defended by proponents of the ‘evidence-based’ drug policy paradigm. However, a shift from focussing on the competing perspectives of actors, or the instrumentalist role of evidence to ‘solve problems,’ to instead critically analysing *problematizations* in policies and practices, may help to illuminate the ongoing frustrations in drug policy development in a different way. In this form of analysis, the focus shifts towards teasing out and interrogating “‘unexamined ways of thinking’” (Bacchi, 2016, p.11) and “meanings that are in place” (Bacchi, 2015, p.5). By critically analysing *how* we are governed, we can begin to reflect on how the cry for ‘what works’ conceptualises “contexts, subjects, and problems” (Bacchi, 2016, p.6); that is, how ‘evidence-based policy’ discourse itself may be limiting the possibilities of what can be thought and said, and the political implications of the taken-for-granted status of this discourse. By unpicking the assumptions which underlie the call for ‘evidence-based’ drug policy, how problems are constructed and represented, and the ways in which different voices and knowledge(s) are legitimised or delegitimised through drug policy processes, we may begin to see avenues for reform which may not at present seem obvious. We may begin to see that drug policy may be *otherwise* enacted (Mol, 1999). This

conceptual shift may well cause us to question the pursuit of science's privileged role in drug policy, and by ceding that privileged position, encourage more 'diplomatic' arrangements whereby other ways of knowing may co-habit within drug policy (Fraser, et al., 2014; Latour, 2013).

Adopting constructionist and poststructuralist ontologies and epistemologies in the study of 'evidence-based' drug policy means acknowledging that 'policy problems,' 'policy-relevant knowledge' and political subjects are not fixed, but rather constituted by context, discourses and practices. This perspective challenges the assumption that 'values,' 'common sense' or 'local knowledges,' for example, are necessarily the antithesis of 'evidence' within drug policy processes, and encourages us as valentine (2009, p.444) has posited to "consider the limits of distinguishing science from the social." This conceptual shift might allow for a fundamental reconsideration of the nature of 'evidence' and open up space for remaking the subjectivities of participants in policy processes. Quite differently to the arguments which have dominated the research translation literature, bemoaning the barriers to research uptake in drug policy, this perspective potentially repositions the way 'evidence' and 'participation' are understood within a dynamic and evolving process where 'problems,' relevant knowledge(s), technologies of governing, and participants are constantly remade.

Case studies

To explore these ideas, a qualitative multiple-case study design was employed, comparing three contemporary drug policy issues in Australia: (i) discussion of the notion of 'recovery' in drug policy and drug treatment provision; (ii) the development of approaches to extend distribution of injecting equipment through peer networks (also called 'secondary supply' or 'peer distribution') in Sydney, NSW; and (iii) processes leading to the establishment of two programs to make naloxone available to potential opioid overdose witnesses in Canberra, ACT and Sydney, NSW. The three cases were selected on the basis that they were all prominent, keenly debated and contentious issues of concern in the Australian drug policy field at the time of the commencement of this research in 2013. All three case studies shared concern about a particular kind of drug use, that is, what would ordinarily be referred to in the drug policy field as 'problematic drug use' (recognising here that the use of opioids and injecting as a route of administration may or may not be 'problematic' or associated with 'harms'). The case studies were informed by a range of qualitative data including documentary sources, and semi-structured in-depth interviews (n=41) with policy makers, advocates, researchers, non-

government organisation representatives, consumer representatives and clinicians closely involved in these policy processes. The three cases are introduced briefly below, and described in detail (along with approaches to analysis) in the six papers which follow. An account of the data collection methods used is given in the Appendix.

Case 1: 'Recovery'

The first case examined discussion of 'recovery' approaches to drug policy and drug treatment provision in Australia, at the national level. Although the notion of 'recovery' within drug policy is not new (Berridge, 2012), in recent years the concept of 'recovery-oriented systems of care' has become the focus of drug treatment in the UK (Best, 2012; Duke, 2013; Duke, Herring, Thickett, & Thom, 2013; HM Government, 2010) and has been the subject of discussion in Australia (AIVL, 2012; ANCD, 2012; Anex, 2012). The concept of 'recovery' is controversial within the drug policy field, and there has been concern about the implications of this shift in emphasis for the continued provision of harm reduction and pharmacotherapy treatment services. It has been argued that "[t]he purpose of treatment and the meaning—and history—of 'recovery' is being negotiated" and that "[h]ow 'recovery' differs from 'cure,' 'rehabilitation,' or a 'hierarchy of objectives' will depend on the changing context within which the new language operates, and the political and professional interests who negotiate to establish its meaning in policy and in practice" (Berridge, 2012, p.23). To date, there has been limited research in Australia examining the notion of 'recovery'; how this concept has emerged in drug policy deliberation, where and how it has been discussed, and the possible implications of this debate for Australian drug policy.

Case 2: Extended distribution of injecting equipment

The second case examined the development of approaches to extend distribution of injecting equipment through peer networks (also called 'secondary supply' or 'peer-distribution') in Sydney, NSW. Multiple legislative and policy barriers restrict access to needle and syringe programs (NSPs) and sterile injecting equipment (Australian Injecting & Illicit Drug Users League, 2010; NSW Users and AIDS Association, 2009). In most Australian jurisdictions it is illegal to distribute or to provide injecting equipment to another person, unless formally authorised to do so through legal exemptions (Australian Injecting & Illicit Drug Users League, 2010). In recent years there have been calls from drug user organisations and the Australian National Council on Drugs to remove legislative barriers to peer-distribution of sterile injecting

equipment as a way of improving coverage, reducing equipment reuse and enhancing peer education activities (ANCD, 2013; Australian Injecting & Illicit Drug Users League, 2010; NSW Users and AIDS Association, 2009). In NSW the legal provision and distribution of injecting equipment is made possible under exemptions outlined in section 19 of the *Drug Misuse and Trafficking Regulation 2011*, whereby the Director-General of the Department of Health may exempt “authorised persons” to “participate in an approved needle exchange program,” which until recently had been limited to approved authorised staff and workers of non-government organisations (NGO) and government services including NSPs, and through pharmacies. In October 2013, NSW Health implemented a two-year pilot project with the NSW Users and AIDS Association (NUAA) for peer distribution of sterile injecting equipment (a commitment previously mentioned in the NSW HIV Strategy 2012-2015: NSW Ministry of Health, 2012). This pilot has been made possible not by amending legislation through parliament, but rather by the Director-General amending the regulation to extend “authorised persons” to include clients of NUAA’s Crown Street NSP. In 2015 and 2016, three other Australian jurisdictions (Tasmania, the Northern Territory and the Australian Capital Territory) reformed their laws to allow for the onward supply of sterile injecting equipment.

Case 3: Peer-administered naloxone (opioid overdose prevention and management)

The third case examined the development of opioid overdose prevention and management strategy, with a particular focus on the processes leading to the establishment of two recently implemented programs to make naloxone available to potential overdose witnesses in Canberra, ACT and Sydney, NSW. Naloxone (trade name, Narcan®) is a short-acting opioid antagonist, which temporarily reverses the effects of opioids and respiratory depression. It has been used for over 40 years by medical professionals, particularly in emergency medicine, and has been shown to be “safe, reliable and effective” in these settings (Dietze & Lenton, 2010, p.1). For more than two decades, researchers have argued that naloxone should be widely available to potential overdose witnesses, particularly people who inject drugs, to help prevent morbidity and mortality associated with opioid overdose (Darke & Hall, 1997; Lenton, Dietze, Degenhardt, Darke, & Butler, 2009). Until recently, naloxone was not distributed for peer-administration anywhere in Australia. In December 2011, Australia’s first overdose prevention and management program providing naloxone on prescription to potential overdose witnesses was launched in Canberra (ATODA, 2013). Soon after, in June 2012, Sydney’s first naloxone program was established through the Kirketon Road Centre and the Langton Centre. In 2015,

the Therapeutic Goods Administration (TGA) announced its decision to reschedule naloxone, allowing over-the-counter purchase in Australian pharmacies (Lenton, Dietze, & Jauncey, 2016).

Thesis overview

This thesis is presented as a series of six publications. The first three papers analyse each of the case studies separately. Cross-case analysis is undertaken in the final three papers.

Paper 1 applies Bacchi's 'What's the Problem Represented to be?' approach to policy analysis to the recovery case study. Situating the recovery case study in its international context, a cross-national analysis of two key reports on the place of 'recovery' in drug policy in Australia and the UK is undertaken. In this paper, I examine the ways in which 'recovery' discourse casts the 'problem of drugs' into its particular problematisation, how people who use drugs are constituted as particular kinds of political subjects, and consider the practices and processes of 'evidence-based policy' through which these particular problematisations emerge and achieve legitimacy.

Paper 2 further explores Bacchi's approach, by extending its application from policy to law. In this paper, I critically consider the material-discursive 'effects' of laws prohibiting peer distribution of needles and syringes in Australia. By analysing the laws and regulations governing possession and distribution of injecting equipment in NSW, I interrogate the assumptions and presuppositions underpinning this legislative and regulatory framework, with a particular focus on examining the discursive, subjectification and lived effects of these laws.

Paper 3 examines how particular kinds of knowledge are legitimised and rendered 'useful' in drug policy debates. Drawing on the naloxone case study, in this paper I seek to destabilise taken-for-granted 'truths' implicit within the 'evidence-based policy' paradigm and consider the productive power of 'evidence-based policy' discourse. In doing so, I also take up Bacchi's entreaty to consider how discourses may be regarded as resources for re-problematisation and resistance.

Paper 4 draws on all three case studies to interrogate the productive techniques and constitutive effects of 'evidence-based policy' discourse and the 'consumer participation' agenda in the context of drug policy processes. Drawing on and combining a range of critical perspectives (including Foucault's concept of subjugated knowledges, the work of feminist

theorists, and recent work regarding conceptualisations of emergent policy publics), I explore how the subject position of 'consumer' might be seen as enacted in the material-discursive practices of 'evidence-based policy' and 'consumer participation,' and consider the centralising power-effects of the dominant 'evidence-based policy' paradigm.

Paper 5 takes the work of science and technology studies (STS) scholars as a springboard for analysis. Through the lens of performance, I examine how 'evidence' and the 'evidence-based policy' paradigm are constituted in drug policy processes, enacted through the telling of policy stories. By analysing participants' accounts drawn from two case studies, I argue that the thing we call 'evidence' is not fixed, but rather constituted by specific performances and practices. These performances make and sustain (or at times interfere with) a set of assumptions about knowledge and rationales for policy action.

Paper 6 is a postscript to the other five papers. In this paper, I provide a methodological and reflexive account of the challenges associated with conducting qualitative interviews with 'elite' participants (such as policy makers, researchers and clinicians) in a highly politicised policy domain. Drawing on all three case studies, I examine issues associated with anonymity and confidentiality produced through power relations between researcher and participant, and reflect on the practical and political implications for data collection, analysis and reporting of policy research.

The final section of the thesis draws together the themes examined across these six papers and opens up avenues for future research and conceptual strategic intervention.

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Paper 1

Producing the 'problem of drugs': A cross national-comparison of 'recovery' discourse in two Australian and British reports

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Preamble

In this thesis, I draw on and combine a range of critical perspectives to interrogate the assumptions underpinning the 'evidence-based policy' paradigm and consider the implications and effects of this dominant mode of governance for drug policy. The work of feminist policy theorist Carol Bacchi, in particular, has been central to this exploration. Bacchi's (2009) 'What's the Problem Represented to be?' approach draws on Foucault's (1977) work on 'problematization' and 'thinking problematically.' Foucault used the term 'problematization' in two ways: first, to describe his method for interrogating taken-for-granted assumptions; and secondly, to refer to the discursive and non-discursive practices that constitute something as "an object for thought" (Foucault, 1988, p.257). Thus, as Bacchi (2012b, p.4) explains:

problematization as a method (thinking problematically) involves studying problematized 'objects' ('problematizations') and the (historical) process of their production. It involves 'standing back' from 'objects' and 'subjects,' presumed to be objective and unchanging, in order to consider their 'conditions of emergence' and hence their mutability.

Bacchi (2009) insists that problematizations are ubiquitous, not rare. In this sense, we are governed through problematizations (Bacchi, 2009, 2012b, 2016). The interrelated questions which comprise the 'What's the Problem Represented to be?' approach provide a framework for identifying, opening up and interrogating the problematizations contained within *all* policies and proposals for change. Applied to the 'evidence-based' drug policy endeavour, this approach fundamentally challenges the assumption that the 'problem of drugs' objectively exists 'out there' waiting to be 'solved' through application of 'evidence.'

In this paper, I apply Bacchi's approach to the notion of 'recovery.' In recent years, there has been renewed and contentious discussion internationally about the place of 'recovery' as an organising concept in national drug policy and treatment service delivery. While the emergence and implications of 'recovery' oriented drug policy have been analysed in the UK context, this paper is the first to examine the Australian discussions. By comparing the constitutive effects of 'recovery' discourse in both Australia and the UK, this paper is also the first to apply Bacchi's approach to international comparative policy analysis in the drug policy field.

Abstract

The notion of 'recovery' as an overarching approach to drug policy remains controversial. This cross-national analysis considers how the problem of drugs was constructed and represented in two key reports on the place of 'recovery' in drug policy, critically examining how the problem of drugs (and the people who use them) are constituted in recovery discourse, and how these problematisations are shaped and disseminated. Bacchi's poststructuralist approach is applied to two documents (one in Britain and one in Australia) to analyse how the 'problem of drugs' and the people who use them are constituted: as problematic users, constraining alternative understandings of the shifting nature of drug use; as responsibilised individuals (in Britain) and as patients (in Australia); as worthy of citizenship in the context of treatment and recovery, silencing the assumption of unworthiness and the loss of rights for those who continue to use drugs in 'problematic' ways. The position of the organisations which produced the reports is considered, with the authority of both organisations resting on their status as independent, apolitical bodies providing 'evidence-based' advice. There is a need to carefully weigh up the desirable and undesirable political effects of these constructions. The meaning of 'recovery' and how it could be realised in policy and practice is still being negotiated. By comparatively analysing how the problem of drugs was produced in 'recovery' discourse in two jurisdictions, at two specific points in the policy debate, we are reminded that ways of thinking about 'problems' reflect specific contexts, and how we are invoked to think about policy responses will be dependent upon these conditions. As 'recovery' continues to evolve, opening up spaces to discuss its contested meanings and effects will be an ongoing endeavour.

Key words

Recovery, drug policy, Australia, Britain, problematisation, Carol Bacchi

Introduction

The proposition that policies do not react to pre-existing problems which exist ‘out there’ waiting to be solved, but rather *create* particular kinds of problems is particularly challenging in a field like drug policy, where the notion of ‘drug problems’ is so embedded. As Goodwin (2012, p.27) observes, “[t]he suggestion that ‘social problems’ are brought into being, rather than simply existing, waiting to be solved, corrected or addressed by government can be unsettling for those who spend a good deal of their time attempting to have situations regarded as oppressive, intolerable, or simply untenable ‘addressed’.” Nonetheless, as previous research has argued, interrogation of the construction of concepts such as ‘drug use’ and ‘addiction’ (and their ‘causes’ and ‘effects’) is essential if the stigmatising and marginalising effects of laws and policies are to be disrupted (Seear & Fraser, 2014). Such scrutiny is important not only in relation to well-established policies and practices (as have been examined in previous drug policy research: Fraser & Moore, 2011b; Lancaster & Ritter, 2014; Seear & Fraser, 2014), but also as a way of critically reflecting on contemporary and emerging ideas about the governance of drug problems. ‘Recovery’ is one such idea.

Although the notion of ‘recovery’ is not new (Berridge, 2012), in recent years recovery has become the focus of drug policy in Britain (HM Government, 2010; Inter-Ministerial Group on Drugs, 2012; Scottish Government, 2008) and the subject of polarised discussion in Australia (AIVL, 2012; ANCD, 2012a; Anex, 2012; Best, 2013). Drug policy scholars have begun to examine the emergence, meaning and implications of ‘recovery’ debates in Britain (Duke, 2013; Duke, Herring, Thickett, & Thom, 2013; Duke & Thom, 2014; McKeganey, 2014; Monaghan, 2012; Monaghan & Wincup, 2013; Neale, 2013; Neale, et al., 2014; Neale, et al., 2015; Wardle, 2012), but there has been no analysis to date in the Australian context.

Despite having been formally embedded into national drug policy in Scotland (Scottish Government, 2008) and in England (HM Government, 2010), and into treatment services in one Australian state (State of Victoria Department of Health, 2012; Victorian Government Department of Human Services, 2008), the notion of ‘recovery’ as an overarching approach to drug policy remains controversial. As Neale et al. (2014, p.310) note, “concerns and differences of opinion persist, with recovery routinely described as a contested concept.” In particular, there has been ongoing concern about the implications of this shift in emphasis for the continued provision of harm reduction interventions and pharmacotherapy treatment (AIVL, 2012; McKeganey, 2012, 2014; Stimson, 2010). Aside from these debates, a widely accepted

definition of recovery within the drug policy field also remains elusive (Neale, et al., 2014). Indeed, recovery is often put forward as a term which seemingly eschews definition. It has been said that recovery can be defined in a myriad of ways (Laudet, 2007; White, 2007), and that “as an ideological term, it has a variety of definitions and can mean different things to different people” (MacGregor, 2012, p.351).

It is in this context of diffuse and multiple definitions that ‘recovery’ lends itself to analysis. As the recovery debate continues to unfold and gain prominence internationally, critical examination of how the problem of drugs (and the people who use them) are constituted in recovery discourse, and how these problematisations are shaped and disseminated, is imperative.

International comparative policy analysis can help to reveal the ways in which *ideas* about the problem of drugs, and how it could be managed, are dependent on context. Thus through a critical lens, cross-national comparisons can help us recognise “that certain ways of thinking about ‘problems’ reflect specific institutional and cultural contexts and, hence, that problem representations are contingent” (Bacchi, 2009, p.14). By applying Bacchi’s (2009) poststructuralist approach, we consider how the problem of drugs was constructed and represented in two key British and Australian reports on the place of ‘recovery’ in drug policy. Our purpose in doing so is not to ‘define’ or better understand what recovery “really means” (Bacchi, 2009, p.181). Rather, in using this form of analysis, we aim to investigate the emergence of the meanings produced by recovery discourse in Britain and Australia, and interrogate the processes and taken-for-granted assumptions which have made this thinking possible.

Method

Bacchi’s (2009) ‘What’s the problem represented to be?’ approach is a poststructuralist mode of policy analysis grounded in the concept of ‘problematisation.’ Bacchi (2009, p.30) uses the term ‘problematisation’ in two ways: firstly, to signal the need for critical interrogation of taken-for-granted assumptions; and secondly, to refer to the ways that issues are put forward and thought about as ‘problems’ in policy, as a way of identifying the thinking behind particular forms of rule (for further discussion see: Bacchi, 2012b).

Central to the approach is the proposition that policy is *productive*; it constitutes and gives shape and meaning to ‘problems’ rather than merely addressing them. Bacchi (2009, 2012a)

argues that because policies by nature make proposals for change, every policy contains implicit representations of what may be considered 'problematic' and how these 'problems' ought to be thought about. By observing that problems are "endogenous – created within – rather than exogenous – existing outside" policy processes, Bacchi (2009, p.x) challenges the 'problem solving' paradigm which dominates many conventional modes of policy analysis. As an alternative, Bacchi (2009; 2012a, p.23) makes the case for a new "problem-questioning" paradigm as a "critical form of practice." This shift from the conventional 'problem solving' paradigm to one of 'problem questioning' means scrutinising the ways in which 'problems' are thought about, rather than simply accepting "the shape they are given" in proposals for change (Bacchi, 2009, p.46). In saying this however, the approach is not concerned with identifying the intentional framing of political arguments. Instead, the aim is to illuminate the underlying presuppositions and conceptual premises which lodge within problem representations and make a particular policy intervention possible. Bacchi argues that this mode of critical analysis is crucial, because how 'problems' are thought about and represented in policy matters greatly. Problem representations have real and important effects for "what can be seen as problematic, for what is silenced, and for how people think about these issues and about their place in the world" (Bacchi & Eveline, 2010, p.112), that is, "for what gets done or not done, and how people live their lives" (Bacchi, 2012a, p.22). Using Bacchi's (2009) questions as tools for analysis (see Table 1), we systematically interrogated the problem representations contained within two documents ("practical texts": Bacchi, 2009, p.54): the United Kingdom Drug Policy Commission Recovery Consensus Group 'Vision of Recovery' report (UKDPC, 2008) and the Australian National Council on Drugs '1st Recovery Roundtable' report (ANCD, 2012a). Bacchi (2009, p.54) notes that text selection is in and of itself an interpretive exercise. We acknowledge that we have taken a focussed approach by limiting our analysis to these two documents. These documents were selected as they were both produced following formal meetings which brought together invited stakeholders with multiple perspectives at particularly significant points in recovery drug policy discussions in the two jurisdictions, with both seeking to articulate a position on 'recovery' at that time. As will be discussed below, both documents emerged following heated debate in Britain and Australia, and aimed to bring clarity to an increasingly divided field.

The nine-page UKDPC report provides a detailed background to the reasons for convening the Recovery Consensus Group, lists the members of the group, and describes the processes undertaken. The report ends by outlining 'next steps' for continued discussion. A list of

references is also provided. The three-page ANCD report is comparatively brief. Although it lists the Roundtable attendees, it provides little information about why the group was brought together, or the processes leading to the generation of the points contained within the report.

Our analysis of these two documents emphasised questions 1, 2, 4 and 6 in Bacchi’s approach, with a focus on identifying the assumptions and conceptual premises which lodge within the identified problem representations, critically considering their limits and silences, and reflecting upon the processes and means through which these problem representations have been produced, disseminated and defended. Before examining the themes identified in detail, we first provide some background to the two documents analysed.

Table 1 Bacchi’s (2009, p.2) ‘What’s the Problem Represented to be?’ approach to policy analysis

<ol style="list-style-type: none"> 1. What’s the ‘problem’ represented to be in a specific policy? 2. What presuppositions or assumptions underlie this representation of this ‘problem’? 3. How has this representation of the ‘problem’ come about? 4. What is left unproblematic in this problem representation? Where are the silences? Can the ‘problem’ be thought about differently? 5. What effects are produced by this representation of the ‘problem’? 6. How/where has this representation of the ‘problem’ been produced, disseminated and defended? How could it be questioned, disrupted and replaced? <p>Apply this list of questions to your own problem representations.</p>
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Background to UKDPC Recovery Consensus Group ‘Vision of Recovery’ Report

In July 2008, the UKDPC (a self-described independent body that provided objective analysis of the evidence concerning drug policy and practice: see <http://www.ukdpc.org.uk/>) published a report which put forward a ‘vision for recovery’ based on the work of a Consensus Group. Their work was a response to the growing polarisation within the drugs field between harm reductionists and abstentionists around the definitions of ‘recovery’ and the role of substitute prescribing, particularly methadone maintenance, within a recovery-oriented treatment system. Historical analyses of British drug policy have illuminated the longstanding conflicts between abstinence versus harm reduction in the development of drug treatment policy at various junctures (Berridge, 1991; Mold, 2008). During the period from 2005 to 2010 however,

these conflicts became vitriolic and more public than in the past. In 2006 and 2007, the right wing Centre for Social Justice led by the Conservative politician, Ian Duncan Smith, published reports which were highly critical of Labour drugs policy (Centre for Social Justice, 2006, 2007). The 2007 report argued that the Labour drugs policy of harm reduction had failed and produced “entrenchment” and “intergenerational cycles” of addiction (Centre for Social Justice, 2007, p.10). An alternative approach based on total abstinence was proposed by the Centre which stirred debate regarding the goals of drug treatment. The media also became involved in questioning treatment outcomes. Using National Treatment Agency statistics, Mark Easton, a BBC journalist, highlighted that only 3% of clients had exited treatment ‘drug free’ (Easton, 2008). This opened up a public debate which began to question the harm reduction consensus that had operated within drug policy following concerns about HIV in the 1980s. It provided a window of opportunity for those advocating abstinence-based treatment to put forward their views (Duke, et al., 2013; Duke & Thom, 2014).

Some key stakeholders referred to the division within the drugs field at this time as an “abstinence versus maintenance civil war” (Hayes & Dale-Perera, 2010, p.9). The UKDPC's view was that the debate was becoming “divisive, with little reference to the evidence on treatment effectiveness which indicates that a treatment system should be composed of a range of different services to meet different needs” (UKDPC, 2008, p.2). There were also fears that support and funding for drug treatment would be undermined. Thus, the establishment of a Consensus Group was an attempt to locate the debate in a ‘rational’ framework. There was a lack of agreement surrounding the goals of treatment and a lack of clarity regarding the term ‘recovery.’ The task of the UKDPC Consensus Group was “to identify the common-ground and develop a clearer understanding of recovery that could be applied to *all* individuals tackling problems with substance misuse, and *all* services helping them, without reference to particular treatment modalities” (UKDPC, 2008, p.2, emphasis original).

The Consensus Group consisted of sixteen people representing a wide range of demographics, types of treatment (e.g. rehabilitation, substitute prescribing, GP care, and support groups), disciplines (e.g. GP, psychiatry, psychology, nursing, management and lay people) and perspectives (e.g. consumers, families, practitioners, commissioners and researchers). They were invited to participate as ‘individuals’ rather than as ‘representatives’ of their respective organisations. The group met initially for two days. The commencement point for the group was the report of the Betty Ford Institute Consensus Panel convened in the US, which defined

recovery as “a voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship” (Betty Ford Institute Consensus Panel, 2007, p.222). The group was also influenced by the work on recovery in the mental health fields and in Scotland. Their discussions were facilitated by Thomas McLellan, a recovery advocate from the US, who had played a key role in the Betty Ford Institute Consensus Panel. The focus for the Consensus Group was on outcomes for the individual, not the treatment services required to achieve these outcomes. It was acknowledged that a ‘consensus’ might not be achieved through this process, but the goal was to identify specific areas where there was agreement. The group identified and agreed to a number of key features of recovery and developed these into a statement which was put forward as a ‘vision’, rather than a ‘definition.’ The group then consulted with the ‘wider field’ through meetings and presentations to ascertain whether this statement and key features accorded with others’ views and to identify areas for clarification and amendment. After this period of consultation, the group met again to agree minor changes to the wording of the statement. There are no details in the UKDPC document of what particular amendments were made and who requested these. However, the UKDPC (2008, p.4) stressed that the “core points identified at the initial two-day meeting have withstood this scrutiny well and remain largely unchanged.” The vision statement agreed by the group is as follows:

The process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use which maximizes health and well-being and participation in the rights, roles and responsibilities of society. (UKDPC, 2008, p.6, emphasis original)

Background to the ANCD 1st Recovery Roundtable Report

In June 2012, the ANCD (then, the principal advisory body to the Australian Government on drug policy: see <http://www.ancd.org.au/>) convened the ‘1st Recovery Roundtable’ in Canberra. This meeting was conducted under Chatham House Rules with the purpose of “bringing together a number of stakeholders in the alcohol and other drug sector to discuss the concept of recovery” (ANCD, 2012a, p.1). In the context of the changing drug policy landscape in Britain, the increasing popularity of the notion of recovery in the local mental health sector, the arrival of an influential recovery advocate (David Best) in Australia, and intensifying discussion of whether recovery was relevant in an Australian drug policy context, the Roundtable aimed to “explore and understand the concept of recovery within the alcohol and other drug field” (ANCD, 2012a, p.1).

Similar to Britain, there was a perception at this time of a growing division within the alcohol and other drug (AOD) sector in Australia as debates about what was meant by the term 'recovery' ensued. There was concern about what recovery could mean for Australian drug policy and the 'harm minimisation' framework which had provided its foundation since 1985. The National Drug Strategy 2010-2015 approved by the Ministerial Council on Drug Strategy had reiterated 'harm minimisation' as the overarching approach for Australian drug policy, despite the challenges mounted under the previous government by those advocating for more abstinence-based and 'zero tolerance' approaches (for discussion see Bessant, 2008; Lancaster & Ritter, 2014; Mendes, 2001, 2007; Rowe & Mendes, 2004). Contrary to the very public and political debates about drug policy which had occurred in the media and parliamentary inquires during the conservative Howard Liberal-National Coalition's time in government, emerging discussion about the 'New Recovery' movement remained mainly internal to the AOD sector. In early 2012 documentation arising from the British recovery drug policy experience and discussion papers were circulated in the Australian AOD field (e.g. AIVL, 2012; Anex, 2012; Best & Lubman, 2012). These papers generated significant combative debate within the sector and in online discussion forums (such as the Alcohol and Other Drugs Council of Australia's email lists) in the months prior to the Roundtable being convened. The ANCD saw its role as "[e]stablishing a collaborative approach with key stakeholders in the AOD sector to appropriately define and describe the place of 'Recovery' within the Australian framework of supply, demand and harm reduction given that this is Australia's strategic response to drug and alcohol problems" (ANCD, 2012b).

In total, eighteen people attended the one-day Recovery Roundtable meeting. The format of the day included a series of short presentations "to promote discussion on the history, definition, purpose, international experiences, goals, advantages, and disadvantages that are potentially associated with the use of the term recovery in alcohol and other drug policy, programmes and practices" (ANCD, 2012a, p.1). These short presentations were followed by in-depth discussion. The invited attendees represented a range of stakeholders including professional organisations, advocacy groups (including harm reduction, family support, and consumer advocates), peak bodies, researchers, and treatment services.

In contrast to the UKDPC process which aimed to "identify the common ground" (UKDPC, 2008, p.2), the ANCD Roundtable was exploratory and "not intended to achieve an agreed position or resolution at the first meeting" (ANCD, 2012a, p.1). It was noted that the "views of

participants were diverse and discussion was robust and informative" (ANCD, 2012a, p.1). According to the report, the definition of recovery was "a key contention" for the group and "views ranged from existential to empirically-based opinions and information, including opposition to the use of the term at all and questioning its legitimacy if it could not be defined" (p.1). It is not stated how the list of consensus points and issues contained within the report was generated, and who participated in the writing of the public report. Although a second Recovery Roundtable bringing together a wider range of stakeholders was intimated in the report, to date we are not aware of further steps in this regard.

In comparing the background and contexts of these two documents, both similarities and differences can be identified. Perhaps the most significant difference to note is the positioning of the recovery paradigm within these processes. While the British process adopted an expansive understanding of recovery and aimed to "identify the common-ground and develop a clearer understanding of recovery that could be applied to *all* individuals tackling problems with substance misuse, and all services helping them" (UKDPC, 2008, p.2, emphasis original), in the Australian context, 'recovery' itself was constituted as problematic. In the Australian document, recovery was viewed as a politicised, disruptive and destabilising idea which "should not be the sole basis for a national drug strategy" (ANCD, 2012a, p.2). Below, we consider how the conceptual logics underpinning the problematisations produced through these two documents contribute to these differences, despite the apparent similarities in the processes which led to the documents' creation.

Themes

In applying Bacchi's questions, four themes emerged from the texts: (1) 'recovery' and 'problematic drug use'; (2) 'recovery' and the 'responsibilised' or 'patientised' individual; (3) 'recovery,' well-being and the worthiness of the lives of people who use drugs; and (4) contesting or legitimising 'recovery.' The first three of these themes emphasise Bacchi's first, second and fourth questions, while the final theme focuses on question six (see Table 1).

'Recovery' and 'problematic drug use'

To begin, Bacchi's approach leads us to ask: how is the problem of drugs represented in the two documents? Throughout the UKDPC (2008, pp.3-9) report, terms such as "problematic substance use" and "problems with substance misuse" are used. The ANCD (2012a, p.1) report similarly refers to "people with alcohol and other drugs problems" or "dependence." There is

only one instance across both documents, in the ANCD report, where drug use is referred to in an unqualified way ("history of drug and alcohol use" p.2). Hence the focus of both documents is squarely directed towards 'problematic' or 'dependent' drug use (and not drug use per se), thus producing drug use as a particular kind of policy problem: one of 'dependence' or 'addiction.' This highly specific use of language, common to both documents, invokes a particular drug using subject, and produces a dichotomy between drug use behaviour which is regarded as 'problematic' (and therefore should be ameliorated through recovery and treatment) and 'non-problematic' drug use. It is important to consider how this binary distinction shapes how drug use (and the 'problem of drugs') may be thought about. By focussing only on 'problematic' drug use, it is implied that not all illicit drug use is necessarily problematic. In doing so, these documents seemingly eschew the moralising discourse which often lodges within discussions of illicit drug use. Indeed, it is explicitly stated that substances could potentially be used "in a way that is not problematic for self, family or society" or in a "consistently moderate" way (UKDPC, 2008, p.5).

However, as Bacchi (2009, p.xii) argues, problematisations "necessarily reduce complexity." We suggest that the invocation of a binary distinction between 'problematic' and 'non-problematic' use constrains an alternative understanding of the transient or shifting nature of use between those two states over time, and in various settings, within the experiences of one individual. That is, the notions of a 'continuum of use' and of drug use as a complex sociocultural practice are silenced. Moreover, while there is acknowledgement that "recovery will differ between individuals" and that there will be "variation in the causes and extent of the problems associated with problematic substance use" (UKDPC, 2008, pp.4-5), silence about what constitutes 'problematic drug use' suggests that this concept is fixed, known and incontrovertible (an assumption which has been challenged: see Fraser & Moore, 2011a). While it is stated that it was difficult to "define a single-end point that satisfactorily captured the diversity of experiences of recovery," the starting point of 'problematic substance use' was not questioned. The silences here signal taken-for-granted assumptions about what the characteristics and effects of "problematic substance use" or "dependence" may be.

'Recovery' and the 'responsibilised' or 'patientised' individual

By delving deeper, and interrogating the presuppositions underlying the problematisations identified, we begin to see the ways in which the reports offer two distinctly different views despite both being focussed on 'problematic substance use' or 'dependence.' In the UKDPC

report, the notion of recovery as being “characterised by voluntarily-sustained control over substance use” (UKDPC, 2008, p.6) (defined as meaning “comfortable and sustained freedom from compulsion to use,” p.5) emphasises individual agency whereby people who use drugs are responsible for their own lives. Here, ‘recovery’ from ‘problematic substance use’ becomes the responsibility of the individual who is expected to take control of her or his own health, presumably by seeking and engaging with drug treatment and “mak[ing] the *choice* to use a substance in a way that is not problematic for self, family or society” (p.5, emphasis added). In this way, the UKDPC recovery statement represents individual drug using subjects as responsible, rational, self-controlled and autonomous people.

Responsibility has become a key construct in neoliberal forms of governance, underpinned by an emphasis on self-regulation, self-discipline, self-motivation, control and rationality. In terms of citizenship, there has been a shift away from ‘rights’ to a focus on ‘responsibilities,’ as well as a movement away from collectivised risk management to an “individualisation of risk” where individuals, families and local communities are expected to “take upon themselves” responsibility for more aspects of their lives (Rose, 1999, p.247). This shift can be observed in the context of health, and drug policy in particular. As Race (2009, p.15) observes, “what is striking about the neoliberal context is that health is now deemed to be a goal actively embraced by autonomous subjects.”

However by constructing individuals as rational agents who are capable of control over their ‘problematic’ drug use, the UKDPC statement also implicitly attributes responsibility for the ‘problem of drug use,’ ‘problematic use’ or ‘dependence’ to individuals themselves. That is, people who have not ‘chosen’ to use drugs in a ‘non-problematic’ way (that is, those not ‘in recovery’) are constructed as being responsible for their own problems. This construction has significant implications, as it stigmatises and ‘marks’ a targeted minority group. Through these “dividing practices” (Foucault, 1982, p.777) this group is characterised as deviant or incapable. This in turn serves a broader governance objective by encouraging desirable behaviour (self-regulation and responsibility) among the rest of the population who seek to avoid this stigma (an observation which has also been made in the context of policies addressing ‘excessive’ gambling: Bacchi, 2009). This subjectification arguably has profound effects for how this group perceives themselves, and what they can and should expect from government (Lancaster, Santana, Madden, & Ritter, 2015).

The construction of the 'responsibilised' individual in the UKDPC recovery statement also delimits the ways that drug use can be thought about. It silences perspectives such as those focussed on the 'social determinants of health,' which acknowledge the social, economic and cultural conditions which influence health outcomes and direct prevention efforts towards societal and institutional interventions (rather than towards the individual) (Munro & Ramsden, 2013). The emphasis on "freedom from compulsion to use" (p.5) also invokes binary categories of 'choice' and 'compulsion,' thus silencing alternative accounts of drug use practices. For example, 'controlled loss of control' has been documented by researchers as a social phenomenon in weekend drinking sessions (Fraser, Moore, & Keane, 2014; Measham & Brain, 2005).

The individual subject is invoked differently in the ANCD Recovery Roundtable report. Here, rather than being 'responsibilised,' the individual is 'patientised.'¹ In sharp contrast to the neoliberal discourse of the UKDPC report identified above (where non-problematic substance use and the avoidance of harm are deemed to be within the control of autonomous individuals), the Australian report invokes a medical discourse. Throughout the ANCD (2012a, pp.2,3) report, there is a focus on treatment and interventions provided by "the drug and alcohol sector" and provision of "programs, and effective treatment options and interventions" (p.3). Terms such as "serious adverse outcomes" (p.2) and "continuity of care" (p.2) reinforce the medical discourse underpinning the document. This emphasis produces 'dependence' as a medical problem, to be addressed through a range of specialist services. Whereas the UKDPC statement emphasises individuals' choice and agency, the language of "care" (p.2) and "support" (pp.1,2) in the ANCD report constructs people experiencing drug "dependence" (p.1) more passively as 'patients' in need of 'help.' Recovery discourse is not granted a place in this 'patientised' problematisation (unlike the place granted within the 'responsibilised' construction identified in the British document, which is underpinned by individual rationality). The dominance of medical discourse and the privileging of the expertise of treatment services in the Australian document stands in contrast to the UKDPC statement which, by stating that "neither 'white-knuckle abstinence' [...] nor being 'parked' on prescribed drugs [...] constituted recovery" (UKDPC, 2008, p.6), challenges the discourse of both medicalised pharmacotherapy treatment and self-help movements.

¹ While 'medicalised' is a more commonly used term, we have chosen to use the term 'patientised' here. We suggest that being constituted as a 'patient' suggests something distinct and more specific than being produced as a medicalised subject.

Similar to the dividing practices at work in the UKDPC statement, by positioning “people with alcohol and drug problems and their families” (p.3) as having “needs” (p.3) which require “help” (p.2) “assistance and support” (p.1), the ANCD report discursively divides populations into two groups: those in the general population who can responsibly manage their own health, and others who are ‘at risk’ and therefore targeted for intervention and ‘help’ by services. In the ANCD report’s summary, it is noted that “[p]articipants agreed that people want harm to self and the community to be minimised (including reducing or eliminating use) but that this requires a range of programs, and effective treatment options and interventions to be readily available” (ANCD, 2012a, p.3). The consensus expressed in this statement illustrates that despite the apparent contestation between those advocating for recovery-oriented systems and those advocating for harm minimisation and the existing treatment system (including pharmacotherapy), both positions in their Australian context produce individual drug using subjects as being in need of curative intervention.

‘Recovery,’ well-being and the worthiness of the lives of people who use drugs

Following from this analysis of the conceptual logics underpinning problem representations, and particularly the people categories produced, we may also consider the political implications of these subjectivities. The UKDPC report says that “recovery is more than reducing or removing harms caused by substance misuse as it must also encompass the building of a fulfilling life” (UKDPC, 2008, p.6). Here, recovery inextricably links drug using behaviour with the worthiness of the lives of people who use them. By stating that “their relationship with the wider world (family, peers, community and wider society) is an intrinsic part of the recovery process” (p.6), recovery itself becomes the very means through which these people may be regarded as truly worthy citizens. Until a “fulfilling life” (p.6) is achieved, these people are, by implication, represented as somehow separate from “the wider world” (p.6) in which they live. The focus is not on drug use behaviour (or harms arising from it) but on the actual lives of the individual drug using subjects. Drug use is not represented to be a distinct problem to be managed (for example through reducing the harms associated with use) but rather is tied to the attainment of a meaningful existence for these citizens.

The concept of individual responsibility for one’s drug use, health and well-being is closely related to ideas about citizenship, productive roles, and what it means to make a meaningful contribution to society. In the UKDPC (2008, p.6) statement, “control over substance use” is linked to “maximis[ing] health and well-being and participation.” Here, control over substance

use necessarily *precedes* well-being which is said to encompass “both physical and mental good health,” as well as “a satisfactory social environment” (p.6). ‘Uncontrolled drug use’ then is produced as the problem underlying poor health and social relations. It is not entirely clear what a ‘satisfactory social environment’ refers to in this context, but the implication is that its attainment is contingent upon reducing or ceasing drug use and “mov[ing] on” from treatment which is, in turn, required to “achieve lives that are as fulfilling as possible” (p.6). Aspiring to, and ‘achieving,’ a fulfilling life is therefore predicated on an individual’s capacity to ‘attain’ good health. This construction fails to problematise multiple barriers which may contribute to poor health outcomes and lack of participation such as poverty, equity of access, stigma and discrimination.

The final strand of the UKDPC group’s vision for recovery focuses on an individual’s “participation in the rights, roles and responsibilities of society” (p.6). This social dimension underscores the emphasis placed on wider ‘citizenship’ issues, particularly relating to employment, productivity and ‘contribution’ to society. The UKDPC group noted that ‘rights’ were included in order to acknowledge the stigma and discrimination “often associated with problematic substance use” (p.6). The ANCD document also points out that “there is a need to eradicate stigma and discrimination so that people can talk more openly about their drug and alcohol use” (ANCD, 2012a, p.2). Despite these statements, the pairing of ‘rights’ with ‘roles’ and ‘responsibilities’ nonetheless suggests that such rights are conditional upon making a contribution, being fit for work and ‘productive.’ Inclusion and “re-entry into society” (p.6) is dependent on this productivity and process of restitution. Issues surrounding stigma and the reluctance of employers to employ people ‘in recovery’ are not addressed. Moreover, the emphasis placed on a particular set of neoliberal norms surrounding work and responsibility fail to acknowledge that recovery may be culturally, socially and personally specific. There is silence around the impact or consequences for different groups. For example, Thom (2010) argues that the emphasis on individual responsibility and ownership of recovery silences the differences in the social and normative contexts of men and women’s lives, and therefore the differential impacts of mental health and substance use.

Similar to the UKDPC statement, in saying that Australia’s National Drug Strategy “already has an objective to support people to recover from alcohol and drug dependence and assist their *reconnection* with the community” (p.1, emphasis added) the ANCD report implies that people who are drug dependent are ‘outside’ of the community, effectively producing them as

'separate' or 'non-citizens.' The assumptions underpinning this 'other-ing' construction of the drug-using subject in many ways silences a counter-discourse in which the problem of drugs could be thought about differently: for example as a broad population health issue or one in which social factors may play a role in determining the health of a community.

Contesting or legitimising 'recovery'

Bacchi's (2009) approach encourages consideration of the practices and processes through which problem representations emerge and achieve legitimacy. In this section we focus on Bacchi's sixth question to analyse how the UKDPC and ANCD produced, disseminated and defended the constructions examined above.

The UKDPC operated from 2007 to 2012, commissioning research and collecting evidence on issues relating to drug policy and practice. It was a charity that aimed to "provide *independent* and *objective* analysis of drug policy; and to ensure this was used by UK governments when considering policy, and by the media and the public to encourage a wider, informed debate" (UKDPC, n.d., emphasis added). The UKDPC (n.d.) was self-described as "independent of government and special interests, both in its funding and work programme. It was not a campaigning body and did not come from any particular standpoint." The 'independence' of the UKDPC may be considered particularly important in dealing with the heated debates around 'recovery' which emerged from 2005 onwards. Their respected position within the drug field ensured that the representation of recovery put forward by the Consensus Group was promoted, legitimised, and most importantly defended in the event of any challenge. The ANCD, similarly, held a respected and privileged position within the drug field in Australia, reporting directly to the Prime Minister. From 1998 to 2014, the ANCD (n.d.) provided "*independent, strategic advice to government*" (emphasis added). The ANCD (n.d.) saw itself as representing members from government and non-government sectors across "treatment, medicine, research, law enforcement, Indigenous health, local government, education, mental health, consumers, and the magistracy from around Australia" and claimed to have the capacity to access "an extensive range of expertise." In this way, the ANCD was positioned as an authoritative 'opinion-leader' in drug policy in Australia.

The processes surrounding the UKDPC's vision statement and the ANCD's Recovery Roundtable were both responses to perceptions of increasing division and lack of unity within the drug field. Both reports can be viewed as documents of appeasement which attempted to reach a middle ground between those advocating an abstinence-only treatment policy and

those wishing to maintain a harm reduction ethos within drug treatment. Both the UKDPC and the ANCD were seen as legitimate arbitrators of this debate, with the authority and means to bring together a range of stakeholders from across the respective sectors. The UKDPC aimed to ensure that the interests of all stakeholders were taken on board and concessions were made to both sides of the debate within the final drafting. In the UK, the timing of the publication of the vision statement in 2008 was important and ensured that this representation of recovery was embedded into the field prior to the election in May 2010. This helped to pave the way for the development of the recovery-oriented drug policy in England under the Coalition Government (HM Government, 2010). It is clear from the Australian report that such consensus was not possible, and ongoing discussion in the form of a second Roundtable was intimated. It could be argued that the report released by the ANCD did little to progress discussion, or indeed change dominant ways of thinking. But by engaging in the process, the concerns and agendas of various stakeholders were given a ‘legitimate’ forum, thereby providing a moment of articulation for drug policy discussion in Australia. However, it is worth critically considering the range of effects produced by processes which aim to reach a ‘middle ground.’ The notion of ‘middle ground’ assumes that this kind of compromise is both achievable and desirable, which is not in itself a neutral position. Indeed, what it means to be neutral or objective in the context of drug policy is itself a complex and contested question. In addition, the language of ‘middle ground’ constructs critics and those who resist dominant problematisations as being somehow extreme or unreasonable, thus shaping the field of debate (that is, making it difficult to “think differently”: Bacchi, 2009, p.16).²

Applying a critical lens to these processes, the legitimacy of both organisations rests on their ability to project themselves as rational, independent, apolitical bodies providing ‘evidence-based’ advice. These organisations are good examples of institutions which become ‘enlisted’ in the task of governing “through the knowledges they produce” (Bacchi, 2009, p.157). Paired with this is the dominance of ‘evidence-based policy’ discourse in nations such as Britain and Australia, which has been embraced with gusto by the drug policy field (for discussion see Lancaster, 2014). The recovery discussions thus provide fertile ground for critically examining what gets to count as valid knowledge in drug policy debates, and which voices may be heard. Both the UKDPC and ANCD processes selectively brought together specialised knowledge producers, many of whom were researchers, clinicians and sector representatives. Both

² We thank one of the anonymous reviewers for their thoughtful comments on this point.

reports positioned research as having a particular privileged status, either through citing research papers or explicitly mentioning the need for 'knowledge translation' and 'research investment.' These organisations secure positions of influence by claiming a position of 'objectivity' through deploying scientific evidence-based policy discourse.

It is worth further reflecting on the way 'policy knowledge' was constructed in these recovery debates. Given their commitment to the importance of 'scientific evidence' and 'rationality' in drug policy debates, it is noteworthy that the UKDPC and the ANCD became involved in trying to develop consensus in an area with very little evidence on what constitutes recovery in the drugs field and the effectiveness of recovery-oriented treatment systems. The Scottish review of recovery literature concluded that there was a paucity of British research on recovery and that the international evidence base was limited by being out-of-date, based on alcohol rather than illicit drugs, and almost exclusively American (Best, et al., 2010). The review identified three areas which required significant research commitment (recovery-specific research, treatment and interventions, and prevention and public policy) to ensure that innovations in recovery practice were evidenced for the future (Best, et al., 2010). However, this merely speaks to the way particular kinds of knowledge come to be rendered valid or useful in policy discussion, highlighting the contested and constructed nature of policy-relevant knowledge in different contexts (Lancaster, 2014). The singular focus on producing evidence of 'what works' in drug treatment eschews a range of prior questions about how things may be 'known' and how the 'problem' to be 'solved' by drug treatment may be understood.

Conclusion

By applying Bacchi's approach we have identified similarities and important distinctions in the way that the problem of drugs has been shaped in two specific recovery policy discussions in Britain and Australia. The institutional and cultural contexts of the recovery discussions in the two jurisdictions allowed particular problem representations to emerge at particular points in time. While the reports have been compared as products of two separate processes, they are also overlapping and intersecting. The context in which the Australian debates took place was in many ways contingent upon the problematisations produced in 'recovery' discourse in the British context. It appears that it was in response to the meanings produced in the British debates that the proposal of 'recovery' *itself* was constituted as problematic in the Australian context, where recovery was not granted a place within the dominant medical discourse. In many ways, the positions put forward in the two reports raise a mirror to each other: the

British 'vision for recovery' problematises a particular way of thinking about drug treatment; while the vigorous defence of the existing treatment system proffered in the Australian context constitutes recovery as a threat. What we can conclude from this observation is that the problem of drugs is not fixed, but rather malleable and shaped by contextual factors; it is constituted by the very processes which seek solutions.

By unpicking the presuppositions underpinning the problem representations contained within the two documents, we identified distinctions in the ways that people who use drugs have been constructed as 'responsible agents' and 'patients' in need of curative attention, through the respective neoliberal and medical discourses at play. The potentially stigmatising effects of the dividing practices embedded within these constructions, and the silencing of alternative accounts of drug use practices and alternative social paradigms of health is important. The analysis here in many ways accords with previous research which has examined notions of 'responsible' and 'irresponsible' drug use within drug policy (see Bacchi, 2009, p.83). Our analysis now extends this to recovery discourse, which we suggest stands in contrast to the biomedical discourse of some contemporary neurobiological accounts of addiction as a 'chronic relapsing brain disease' by emphasising that people who use drugs have agency in their lives. Constituting people who use drugs in this way as rational and controlled neoliberal subjects may have intuitive appeal insofar as it apportions to people who use drugs the same respect and capabilities afforded to other citizens who, too, are expected to take responsibility for their health. However, as Moore and Fraser (2006) have noted, engaging with and perpetuating such neoliberal constructions is not without risk and must be understood as a political decision. In weighing up the desirable and undesirable political effects, in the context of the ongoing recovery debate one approach may be to acknowledge the "strategic value of adopting the status of neo-liberal subject while remaining sceptical of it" (Moore & Fraser, 2006, p.3045).

Fraser et al. (2014, p.55) have argued that although the brain disease model produces addiction "as a physiological rather than psychological phenomenon, as incontrovertible, concrete and physically present in the body as heart disease" it simultaneously relies on the social and behavioural assumptions which underpin both psychological and popular notions of 'drug dependence' and 'addiction.' This too is evident in the documents analysed, insofar as what it means to 'recover' from 'dependence' was also intertwined with morally-weighted concepts of what it means to live a 'productive life.' The inclusion of social and life-style factors

assumes that a 'satisfactory social environment' or 'connection with the community' cannot co-exist with drug dependence or addiction (see also Keane, Moore, & Fraser, 2011). Moreover, inextricably linking 'recovery from alcohol and drug dependence,' health and well-being with the attainment of a meaningful and productive existence problematises people who use drugs *themselves*, and not just their drug using behaviour. In this sense, recovery is not a wholly new way of thinking about drug policy insofar as it reproduces many of the assumptions and conceptual logics underpinning dominant drug-related public discourse.

Policy processes create communities which produce and constitute ideas about drug policy, and institutions become 'enlisted' in the task of governing through the knowledges they produce and deploy. There is a lack of transparency about who actively participated in the writing of the UKDPC and ANCD reports, and how disagreements about language and conceptual logics were resolved. Such practices aim to communicate neutrality and a position unbiased by individual interests, thus privileging the authority of the expert group or committee and distributing responsibility (Fraser & Moore, 2011b). The perceived authority of the UKDPC and ANCD was critical to the recovery debates at the time these reports were produced. The analysis here illuminates the ways in which these organisations secured positions of legitimacy and influence through the deployment of 'evidence-based policy' discourse. By seeking 'evidence of effectiveness' of recovery interventions, or indeed by seeking consensus about how to define, implement and measure the outcomes of recovery-oriented systems of care, the processes assumed that the problem of drugs was fixed, known and uncontroversial.

To our knowledge, this is the first time Bacchi's approach has been applied to international comparative policy analysis in the drug policy field. As Bacchi (2009, p.209) argues, "[a]sking how the 'problem' is represented in select contexts allows us to identify 'discursively constructed practices' that extend beyond singular geographical sites while keeping space open to reflect on contextual variation [...] [T]he focus is on how these issues are conceptualised and with what effects in different sites." As noted in other analyses of this kind (see Bacchi & Eveline, 2010), it must be recognised that the documents were produced and analysed at a fixed time, while recovery discourse continues to evolve in different constantly changing contexts (consider, for example, the re-orientation of drug treatment services from 'rehabilitation' to 'recovery' in Ireland: Keane, McAleenan, & Barry, 2014; or the ongoing efforts to generate new 'measures' of recovery: Neale, et al., 2014). These were also complex

documents, capturing the outcomes of contested discussion and a range of perspectives, and thus do not contain a single meaning. It is not unusual for policies to contain more than one problem representation within them and, as Bacchi (2009, p.4) notes, at times they may conflict and even contradict each other. This analysis has teased out some of the multiple representations in the two documents. There are other elements which have not been analysed here and which could be examined in future research. For example, what does it mean to use the language of 'a vision' for recovery? Or what fails to be problematised as a result of the 'consensus' process itself? How is the problem of drugs constituted in recovery discourse in other geographic and temporal sites? Finally, in making these observations, we are not suggesting that participants in the processes analysed (or indeed others engaged in wider drug policy discussions) have been in any way intentional or manipulative in their particular use of language and how it constructs the problem of drugs. As Bacchi (2009, p.91) notes, "[t]here is no suggestion of conspiracy in this kind of analysis."

The meaning of 'recovery' and how it could be realised in policy and practice is still being negotiated. By comparatively analysing how the problem of drugs was produced in 'recovery' discourse in two jurisdictions, at two specific points in the policy debate, we are reminded that ways of thinking about 'problems' reflect specific contexts, and how we are invoked to think about policy responses will be dependent upon these conditions. As 'recovery' continues to evolve, opening up spaces to discuss its contested meanings and effects will be an ongoing endeavour.

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Paper 2

Laws prohibiting peer distribution of injecting equipment in Australia: A critical analysis of their effects

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Preamble

As a critical (and not merely descriptive) form of policy analysis, Bacchi's 'What's the Problem Represented to be?' approach involves identifying the assumptions and presuppositions underpinning particular problematisations, as well as assessing the implications and effects which accompany them. This approach counters a relativist presumption "that any one 'truth' is as good as any other" (Bacchi & Eveline, 2010, p.115) and, by directing attention towards the history and struggle through which problematisations emerge and gain prominence, invites us to assess the implications of problematisations for power relations. Bacchi (2009, p.267) suggests that three ideas are central to this kind of critique: "dividing practices that operate in current dominant modes of governance; subjectification processes within current modes of governance that produce us as particular kinds of subjects; and, lived effects that harm some and benefit others." Applied to the 'evidence-based' drug policy endeavour, this approach highlights the productive capacity of drug policies and laws, and the political, contingent and emergent nature of the 'problems,' 'objects' and 'subjects' which form the basis of policy analysis. Counter to dominant modes of 'evaluation' which focus on measurement of 'outcomes,' by emphasising the relationship between discourse, power and effects, this approach provides a different way of considering the impacts of drug policy.

In this second paper, I use this approach to analyse the *discursive, subjectification* and *lived effects* of current laws governing the distribution of sterile injecting equipment in NSW, highlighting the multifarious deleterious effects of the problematisations produced within these laws. Australian laws prohibiting peer distribution of injecting equipment have been criticised by several advisory groups and drug user organisations in recent years (AIVL, 2010; ANCD, 2013; Legal and Discrimination Working Party of MACBBVS, 2013; NSW Users and AIDS Association, 2009). In this paper, I take a novel approach by analysing the material-discursive effects of these laws. Importantly, this analysis demonstrates that problematisations are not merely considerations of political rhetoric; they delimit what can be thought and said, constitute people as particular kinds of political subjects, and materially affect people's lives.

This research was presented at a Roundtable ("Public health and legislative amendments focussed on people who inject drugs and their families and friends") convened by the Alcohol Tobacco & Other Drug Association ACT in Canberra in 2015, and formed an important background to the subsequent legislative amendments which came into effect in the ACT in 2016. Reform is still pending in NSW, the jurisdiction of focus for this case study.

Abstract

The law is a key site for the production of meanings around the 'problem' of drugs in public discourse. In this article, we critically consider the material-discursive 'effects' of laws prohibiting peer distribution of needles and syringes in Australia. Taking the laws and regulations governing possession and distribution of injecting equipment in one jurisdiction (New South Wales, Australia) as a case study, we use Carol Bacchi's poststructuralist approach to policy analysis to critically consider the assumptions and presuppositions underpinning this legislative and regulatory framework, with a particular focus on examining the *discursive*, *subjectification* and *lived effects* of these laws. We argue that legislative prohibitions on the distribution of injecting equipment except by 'authorised persons' within 'approved programs' constitute people who inject drugs as irresponsible, irrational, and untrustworthy and re-inscribe a familiar stereotype of the drug 'addict.' These constructions of people who inject drugs fundamentally constrain how the provision of injecting equipment may be thought about in policy and practice. We suggest that prohibitions on the distribution of injecting equipment among peers may also have other, material, effects and may be counterproductive to various public health aims and objectives. However, the actions undertaken by some people who inject drugs to distribute equipment to their peers may disrupt and challenge these constructions, through a counter-discourse in which people who inject drugs are constituted as active agents with a vital role to play in blood-borne virus prevention in the community. Such activity continues to bring with it the risk of criminal prosecution, and so it remains a vexed issue. These insights have implications of relevance beyond Australia, particularly for other countries around the world that prohibit peer distribution, but also for other legislative practices with material-discursive effects in association with injecting drug use.

Key words

Peer distribution, needle and syringe program, law, Australia, problematisation, Carol Bacchi

Introduction

The burden of disease associated with blood borne viruses (BBVs) such as hepatitis B (HBV), hepatitis C (HCV) and HIV is substantial. In Australia alone, HCV costs the Australian health care system \$156 million annually (based on 2004-5 data), with those costs predicted to reach more than \$476 million per year over the next 30 years (National Centre in HIV Epidemiology and Clinical Research, 2010b). The economic burden of HBV is also expected to rise over the next two decades (Butler, Korda, Watson, & Watson, 2009). As a result, the prevention of new BBV infections is a major public health priority in Australia. Public health and BBV prevention education campaigns designed to reduce new BBV infections have a number of different components, many of which are designed to encourage safer injecting practices among people who inject drugs. The reason for this is that a large number of new BBV infections are attributable to unsafe injecting practices, particularly reuse and sharing of needles, syringes and ancillary injecting equipment (Razali, et al., 2007).

Public access to sterile needles and injecting equipment has been identified as central to the public health objective of reducing rates of new BBV transmissions (World Health Organization, 2004, 2012). To this end, Australia has a formal policy of harm minimisation and a national network of needle and syringe programs (NSP) (van Beek, 2013). Sterile injecting equipment is distributed for free through these publically funded, fixed and mobile NSP sites, as well as through emergency departments, automated dispensing machines (which sometimes require payment by consumers), community health programs, and community-based pharmacies (Australian Government, 2010). It is ordinarily unlawful to distribute sterile needles and syringes in Australia, but NSPs are able to operate through special exemption laws enacted in all states and territories (van Beek, 2013). These exemptions authorise specific categories of people (such as NSP workers and pharmacists) to distribute sterile needles and syringes without risk of criminal conviction (van Beek, 2013). While needle and syringe distribution efforts have been shown to effectively control rates of HIV transmission among people who inject drugs in Australia, this coverage was found to be inadequate for controlling HCV infections (Kwon, Iversen, Maher, Law, & Wilson, 2009). Kwon et al. (2009, p.467) have argued that distribution of sterile injecting equipment "is limited by supply rather than demand and that increased coverage is possible." They estimate that needle and syringe distribution needs to double in order to reduce annual incidence of HCV infections by 50% (Kwon, et al., 2009). Australian governments have recently committed to increasing access to

sterile injecting equipment (Australian Government, 2010; NSW Ministry of Health, 2012), but questions remain as to how this can best be achieved.

Peer distribution of injecting equipment (also called 'secondary supply', 'extended distribution', 'satellite exchange' or 'secondary exchange') is tacitly acknowledged as an "unofficial adjunct" to NSPs (Bryant & Hopwood, 2009, p.324). Peer distribution is defined as "the giving or receiving of new sterile needles and syringes to/from another individual that were originally obtained from formal or 'safe' sources" and may include "trading, purchasing or selling of needles and syringes for money, drugs or other commodities or services; or it can simply involve the giving or receiving outright of needles and syringes" (Bryant & Hopwood, 2009, p.324; see also Lenton, Bevan, & Lamond, 2006; Tyndall, et al., 2002; Valente, Foreman, Junge, & Vlahov, 1998). A national survey of NSP clients in Australia found that over one third (37%) of participants admitted distribution (onward supply) of needles and syringes (National Centre in HIV Epidemiology and Clinical Research, 2010a). Peer distribution is regarded by some as an important low cost strategy for preventing BBV transmission, with potential for a wider geographic reach than is achieved through existing services (Anderson, Clancy, Flynn, Kral, & Bluthenthal, 2003). Crucially, even though it is recognised as both a common and important harm reduction practice in Australia (Bryant & Hopwood, 2009; Fisher, Wilson, & Bryant, 2013; NSW Users and AIDS Association, 2009), peer distribution is illegal. This is because distribution is only permitted, as noted earlier, where one of the statutory exemptions for authorised persons applies (Legal and Discrimination Working Party of MACBBVS, 2013).

In recent years, this situation has been the subject of analysis and critique by several expert drug policy advisory and advocacy groups (AIVL, 2010; ANCD, 2013; Legal and Discrimination Working Party of MACBBVS, 2013; NSW Users and AIDS Association, 2009). These policy experts and advocates have raised concerns about the public health implications of laws prohibiting peer distribution, suggesting that they may undermine Australia's capacity to reduce new BBV infections. In this article, we extend this analysis further through a consideration of some of the other unexamined material-discursive 'effects' of laws prohibiting peer distribution of needles and syringes in Australia. We argue that laws and regulations governing the distribution of needles and ancillary injecting equipment are a key site for the production of meanings around the 'problem' of drug use in public discourse (see Seear & Fraser, 2014), and that these laws demand critical interrogation as a result. We suggest that

the ongoing legislative prohibition of peer distribution simultaneously produces and reproduces problematic constructions of injecting drug use (IDU) and people who inject drugs (PWID). In this respect, these laws compromise both the stated aims of NSPs as well as the harm minimisation framework of Australia’s *National Drug Strategy* 2010-2015 (Ministerial Council on Drug Strategy, 2011), the National Strategies on HIV, HCV and HBV (Australian Government, 2014a, 2014b, 2014c) and a range of other campaigns and practices designed to improve the lives of people who inject drugs and reduce the stigmatisation and marginalisation associated with IDU. We develop this argument using Carol Bacchi’s (2009) poststructuralist approach to policy analysis. Taking the laws and regulations governing possession and distribution of injecting equipment in one Australian jurisdiction (New South Wales) as a case study, we critically consider the assumptions and presuppositions underpinning this legislative and regulatory framework, with a particular focus on examining the *discursive*, *subjectification* and *lived effects* of these policies. By critically interrogating the conceptual logics underpinning laws prohibiting peer distribution, we suggest that there is a need for timely policy and legislative reform in New South Wales and other Australian jurisdictions that prohibit peer distribution. These insights have implications of relevance beyond Australia, particularly for other countries around the world that prohibit peer distribution, but also for other legislative practices with material-discursive effects in association with IDU.

Approach

Carol Bacchi is an Australian poststructuralist theorist and policy analyst. Her innovative approach to policy analysis draws upon Michel Foucault’s (1977) work on ‘problematism’ and ‘thinking problematically.’ According to Foucault (1988, p.257), problematisation:

doesn’t mean the representation of a pre-existing object, nor the creation through discourse of an object that doesn’t exist. It is a set of discursive and non-discursive practices that makes something enter into the play of the true and the false and constitutes it as an object for thought (whether under the form of moral reflection, scientific knowledge, political analysis, etc.).

Extending this idea to policy analysis, Bacchi argues that policies “*give shape* to ‘problems’; they do not *address* them” (Bacchi, 2009, p.x, emphasis original). From this perspective, policy ‘problems’ are not fixed or stable phenomena that exist ‘out there’ waiting to be ‘solved.’

Rather, 'problems' are *constituted* and *given meaning* through the implicit representations contained within public policy. The goal of this mode of critical analysis is to interrogate the problem representations which lodge within policies and, in doing so, open up and critically consider the presuppositions and conceptual logics which underpin governing practices. Bacchi (2009) argues that the ways in which conditions are constituted as 'problems' in policy shape the way we live in a range of specific ways. The way problems are constituted has important effects for "what can be seen as problematic, for what is silenced, and for how people think about these issues and their place in the world" (Bacchi & Eveline, 2010). Here, the term 'effects' does not refer to "evaluation" or measurement of "outcomes" (Bacchi, 2009, p.15). Rather, for Bacchi, assessing 'effects' means being attuned to the repercussions of particular problem representations for power relations.

Thus, the proposition that policy is *productive* directs our attention towards those effects that flow from particular problem representations. Bacchi identifies three main 'effects' of problem representation: discursive, subjectification and lived effects. These are, respectively: the ways in which problem representations delimit what can be thought or said; the ways in which particular kinds of political subjects and subject positions are discursively produced; and the real, material repercussions in people's lives (Bacchi, 2009; Bacchi & Eveline, 2010).

As tools for critical analysis, Bacchi (2009, pp.xii, 48) outlines six questions accompanied by a directive to reflexively scrutinise the assumptions underpinning one's own analytic process. These questions have been used to examine a range of drug policy issues (see Fraser & Moore, 2011; Lancaster, Duke, & Ritter, 2015; Lancaster, Hughes, Chalmers, & Ritter, 2012; Lancaster & Ritter, 2014). This emerging body of research has begun to identify the multiple ways that drug policies do not simply 'respond to' the 'problem' of 'drug use' and 'addiction' but discursively produce the 'problem' of drug use in particular ways.

Our analysis builds on recent research which has used Bacchi's approach to critically examine the ways the law enacts taken-for-granted assumptions about the 'problem' of 'drug use' and 'addiction,' thus further entrenching the stigmatisation and marginalisation of people who use drugs through the subjectivities produced (see Seear & Fraser, 2014). By considering the law through Bacchi's lens of problematisation, we can begin to see the ways the law produces (and reproduces) "particular categories of transgression" in particular contexts and times, thus "reflecting, and in turn re-enacting, the (always changing) values of a given society" (Seear & Fraser, 2014, p.828).

In this article, we critically examine the laws governing possession and distribution of injecting equipment in the state of New South Wales (NSW), Australia. As in other Australian states and territories, the law in NSW prohibits peer distribution of injecting equipment. This case study has been selected because debate about both the merits and ‘effects’ of this approach is now in progress in NSW. A pilot program is currently underway whereby people who access injecting equipment from selected NSP services are authorised by the Director General to pass on sterile needles and syringes to their peers (NSW Users and AIDS Association, 2013, 2014). As noted in the *NSW Needle and Syringe Program Guidelines* (NSW Ministry of Health, 2013, p.5), pilots of alternative models of distribution are made possible through the authorisation of the Director General, NSW Ministry of Health, under the *Drug Misuse and Trafficking Regulation 2011*. Commencing in late 2013, this two-year pilot program is being conducted in partnership with the NSW Users and AIDS Association (NUAA) and is the first formal peer distribution project in Australia. The findings of the evaluation are still pending at the time of writing. Analysing the effects of laws prohibiting peer distribution while legislative and regulatory reform is being contemplated is timely to bring to light some of the potential ‘effects’ of this legislation, including those that may have been hitherto neglected in previous debates, and which might bear upon the necessity or otherwise of law reform.

In the following section, we provide a brief overview of the laws governing the distribution of injecting equipment in NSW. Bacchi’s questions are then used as a departure point to critically analyse the legislative framework, with a particular focus on Bacchi’s (2009, pp.xii, 2) fifth question: “what effects are produced by this representation of the ‘problem’?” We draw on a corpus of texts including the laws, regulations, parliamentary debates (Hansard), discussion papers and research literature to inform our analysis.

Laws, regulations and guidelines governing the distribution of injecting equipment in NSW

Legislative provisions governing possession of injecting equipment are situated within the *Drug Misuse and Trafficking Act 1985* (NSW) (‘the Act’). It is stipulated at s. 11.1 of the Act that “a person who has in his or her possession any item of equipment for use in the administration of a prohibited drug is guilty of an offence.” Over time a series of amendments and exemptions have been introduced. The *Drug Misuse and Trafficking (Amendment) Act 1987* No. 145 (NSW) subsequently amended the Act allowing for the possession of hypodermic syringes and

needles (s. 11.1A).¹ The Act was further amended under the *Criminal Legislation Amendment Act 1995* No. 23 (NSW), to permit the operation of NSPs as a public health intervention (which had emerged as publicly-funded and sanctioned health services from 1986). This amendment to the Act (s. 11.1B) specifies that:

Subsection (1) does not apply to or in respect of a person prescribed by the regulations, or a person who is of a class of persons prescribed by the regulations, who has in his or her possession any item of equipment that is required to minimise health risks associated with the intravenous administration of a prohibited drug.

A range of further exemptions are also provided in s. 11.2a-e which allow for the lawful possession of injecting equipment by a range of 'licensed', 'authorised' or 'professional' persons including medical practitioners, dentists, veterinary practitioners, pharmacists, registered nurses and midwives, or any other profession 'acting in the ordinary course of that profession.'

As our interest here is not in the mere possession of injecting equipment, but rather its *distribution*, the regulations are of particular relevance. Part 4 of the *Drug Misuse and Trafficking Regulation 2011* (NSW) ('the Regulation') provides exemption from the provisions of s. 11 of the Act for "authorised persons participating in [an] approved needle exchange program." This exemption has been in place since it was first introduced under Part 2 of the *Drug Misuse and Trafficking Regulation 2000* (NSW). Part 4 s. 19.1 of the Regulation permits 'authorised persons':

- (a) to have in his or her possession, *and to distribute*, hypodermic syringes and hypodermic needles, and any associated equipment,² for use in the administration of a prohibited drug capable of being so administered; and
- (b) to give out information concerning hygienic practices in the use of hypodermic syringes and hypodermic needles to prevent the spread of contagious disease.
(emphasis added)

¹ It is notable that other associated injecting equipment is not exempted here, for example tourniquets, wheel-filters etc.

² 'Associated equipment' is included in the Regulation, though, as noted above, it is not exempted under s. 11.1A of the Act.

According to s. 19.2, the exemption applies “only for the purpose of enabling the authorised person to participate in an approved needle exchange program.” An ‘authorised person’ is defined at s. 19.3 as “a person who is authorised by the Director-General of the Department of Health to participate in an approved needle exchange program.” Further exemptions for pharmacists and staff are also included. Under s. 22, the Director-General of the Department of Health is permitted to authorise “a specified person or a specified class of persons to participate in a program approved by the Director-General to facilitate”:

- (a) the supply to intravenous drug users of sterile hypodermic syringes and sterile hypodermic needles, and any associated equipment, to prevent the spread of contagious disease and minimise health risks associated with intravenous drug use; and
- (b) the giving out of information concerning hygienic practices in the use of hypodermic syringes and hypodermic needles to prevent the spread of contagious disease.

The *NSW Needle and Syringe Program Guidelines* (‘the Guidelines’: NSW Ministry of Health, 2013) provide another layer of governance in relation to the distribution of injecting equipment and the delivery of NSP services across NSW. The Guidelines specify that “[t]he aim of the NSP in NSW is: to reduce the transmission of blood borne viruses among people who inject drugs” and “[t]he objective of the NSP in NSW is: to minimise risk behaviours that have the potential to transmit blood borne viruses” (NSW Ministry of Health, 2013, p.3). The Guidelines also state that “[t]he NSP works within the harm reduction pillar to enhance the capacity of people who inject drugs to initiate solutions for their own health needs” (NSW Ministry of Health, 2013, p.3). The Guidelines outline processes for the approval of NSP outlets. It is stated that the “provision of sterile injecting equipment, and information regarding the use of the equipment, are tasks that must not be performed by unauthorised persons. Performing these duties without authorisation may leave individuals exposed to prosecution” and that “unpaid workers (including students and volunteers) are not routinely eligible to be authorised to perform NSP duties. However the Director General, NSW Ministry of Health may authorise any person or class of persons to perform NSP duties, with appropriate training and supervision” (NSW Ministry of Health, 2013, p.11).

The distribution of injecting equipment in NSW: problematisation and effects

The *Drug Misuse and Trafficking Bill* was introduced to the NSW Parliament in 1985 with the stated intention that it would “cover the criminal activity involving prohibited drugs” (NSW Government, 1985a, p.11123). Prior to this, illicit drug issues had been governed through a series of amendments to the *Poisons Act 1966* (NSW), a law “originally designed as a public health measure” (NSW Government, 1985a, p.11123). The public health framework of the *Poisons Act* came to be regarded as ‘inadequate’ for addressing illicit drug use. As the Attorney General stated in his second reading speech of the Bill, “[t]here is now a clear recognition of the distinction between, on the one hand, the public health concern of regulating the medical and pharmaceutical use of drugs, and, on the other, the serious criminal activity which involves the distribution and use of prohibited drugs” (NSW Government, 1985b, p.10615). This conceptual separation between pharmaceutical drug use as ‘public health concern’ and illicit drug use as ‘serious criminal activity,’ produced through the dichotomy of the legislative structure of the *Poisons Act 1966* (NSW) and the *Drug Misuse and Trafficking Act 1985* (NSW), constitutes illicit drug use as an inherently criminal activity, thus fundamentally delimiting the way *all* aspects of IDU may be thought about and discussed. That is, although pharmaceutical drugs and illicit drugs were initially captured under the one piece of public health focussed legislation, by removing illicit drugs from its ambit and enacting new, separate legislation, the possession and trafficking of drugs *and* the possession and distribution of equipment which ‘enables’ drug use were constituted as *thoroughly criminal* objects and activities. In Bacchi’s terms, equipment itself becomes a ‘problem.’ The inclusion of provisions relating to injecting equipment within an Act designed to address the use and trafficking of drugs speaks to the way the objects themselves become imbued with meaning; in other words, this legislation constitutes injecting equipment as both *facilitator* and *signifier* of criminality. The constitution of *all* aspects of IDU as a criminal issue, and not a public health issue, unintentionally fundamentally shapes BBV transmission and prevention in ways that are problematic, by limiting access to sterile equipment through restrictions on peer distribution of this equipment and by criminalising individuals in possession of this equipment and/or those who choose to distribute it.

The assumptions underlying the constitution of possession and distribution of injecting equipment as a criminal issue can be examined further in the context of subsequent legislative

amendments. The Act was introduced before HCV was named (in 1989, see: Choo, et al., 1989), without any consideration of the role that distribution of sterile injecting equipment might play in BBV transmission or prevention. It was in the context of growing concern about HIV/AIDS that the NSW Legislative Assembly debated the *Drug Misuse and Trafficking (Amendment) Bill* on 14 May 1987. The then Minister for Health and the Minister for the Drug Offensive³ at the time expressed concern about the “cases of acquired immune deficiency syndrome transmitted through use of shared needles and syringes” and noted that amendment to the Act would “mean that drug users participating in various schemes to encourage addicts to use clean needles and syringes will not risk arrest and prosecution for having done so” (NSW Government, 1987a, p.12222). Thus, it was in the context of concern about HIV/AIDS that an amendment to the Act permitting possession of needles and syringes, and their distribution through approved NSPs, was made possible. Despite in principle bipartisan support, the amendments to allow provision of injecting equipment via NSPs were nonetheless regarded as a “drastic and unpalatable action,” with one member of Parliament emphasising the “enormous moral dilemma facing the community” (NSW Government, 1987b, p.13058). The Honourable J. C. J. Matthews, speaking in the NSW Legislative Council noted:

We have been painted into a corner by the circumstances, the disease AIDS, and the behaviour of drug users, particularly the intravenous drug users. The result has been most unfortunate. Years ago if anyone had asked me whether I would support the supply of clean needles or clean syringes, or both, to a drug addict, to facilitate use of a narcotic, I would have raised my hands in horror. (NSW Government, 1987c, p.13273)

Thus even in the context of HIV/AIDS concern, the legislative amendments were underpinned by an assumption that access to and distribution of needles and syringes is *always already problematic* because it facilitates ‘criminal’ and ‘immoral’ activity. In problematising needles and syringes in this way, they become, in Bacchi’s terms, simultaneous public policy and public health ‘problems’ seemingly necessitating careful monitoring and governance. Indeed, it was suggested that any distribution should be “closely monitored” due to the “*dangers* to public health [which may] emanate from it” (NSW Government, 1987c, p.13276, emphasis added). This constitution of the ‘problem’ obscures the important public health function of sterile needles and syringes, and their role in helping to mitigate BBV transmission, and places

³ The masculine metaphor of ‘offensive’ could itself be interrogated (see, Moore, Fraser, Törrönen, & Tinghög, 2015).

emphasis only on those people who are dependent on illicit drugs (the 'addicts' to which numerous documents refer), thereby rendering invisible any notion of pleasure in drug use or infrequent IDU.

These amendments also constituted people who inject drugs as carriers and transmitters of infection, and – by virtue of their 'behaviour' – responsible for their own health problems. The 'drastic' measures taken in amending the legislation to allow for the provision of injecting equipment were not driven by a change in values about the right to access public health interventions, but by the seemingly urgent need to contain a feared (and at this time, largely unknown) disease. That disease was thought to be located within the individual bodies of people who inject drugs which, along with sex workers, could be seen as a bridge to spread HIV to the general population (for discussion see Waldbry, 1996). Indeed, in debating the amendments, the Opposition asked for "assurance that the program will be one of needle and syringe exchange, rather than further distribution of needles and syringes," ostensibly seeking to contain the program from the general population, noting that "[t]he drug scene is sordid, degrading, disgusting and destructive of the health and welfare of society" (NSW Government, 1987c, pp.13275-13276). Through these "dividing practices" (Bacchi, 2009, p.16; Foucault, 1982, p.777), HIV/AIDS came to be constituted as the disease of the aberrant 'other.' Thus even as legislative amendments allowing for the provision of injecting equipment through NSPs were introduced and passed, the dominant construction of people who inject drugs as criminal and diseased subjects was reproduced, arguably limiting the way that NSP models could develop.

Within discussion of these amendments, we can also identify the emergence of the category of 'the addict' in drug- and BBV-related public discourse. In one particularly oppositional speech, NSW parliamentarian The Reverend The Honourable Fred Nile argued:

The legislation before the House assumes that such people will be responsible enough to go to Bondi Beach or somewhere else, and inject their heroin with a clean needle to get high, or whatever the result is, from using the heroin. Obviously such a person will not be rational or sensible at that point. It is supposed that that person will put the dirty needle in a little plastic bag, look for a pharmacy, and then exchange the dirty one for a clean one. If the person involved were that responsible he or she would not be using heroin in the first place. The Government seems to adopt the view that that is

a normal behaviour pattern and that such a person will respond in the same way as rational people. (NSW Government, 1987c, pp.13287-13288)

This extract speaks and in turn, reiterates, a range of assumptions about drugs, addiction, 'responsibility' and 'rationality,' including the assumption that one cannot be simultaneously responsible, rational, and a drug 'addict,' and that IDU and concern for others are mutually exclusive. Here, the 'addict' is produced as a particular kind of drug using subject: one who is irresponsible, irrational, 'abnormal,' selfish, illegitimate and chaotic. There is a tension here, however. Discussions about whether or not people who inject drugs can be trusted to appropriately *dispose* of used injecting equipment are predicated on the assumption that they will *collect and use* sterile equipment from an NSP in the first place. The provision of sterile injecting equipment via NSPs assumes that people who inject drugs care enough about their own (and public) health to use these services, which contradicts assumptions that these same people are not capable of acting responsibly in its disposal. A similar tension can be observed in another second reading speech discussing the involvement of pharmacists in the program:

they are apprehensive about people under great stress and perhaps mentally irresponsible coming into their places bearing dirty needles and creating havoc amongst their more legitimate clients and staff. (NSW Government, 1987c, p.13276)

Again, people who inject drugs are contradictorily constituted as 'irresponsible' and chaotic *even in the moment* in which they are described entering a pharmacy to exchange injecting equipment in the interests of responsibly caring for their health and the health of the community. From these parliamentary debates, it can be observed that the legislative amendments introduced to allow for the operation of NSPs in NSW were reluctantly implemented as a risk management strategy in the context of fear of a broader population-wide epidemic of HIV/AIDS. Along the way, these debates and legislative changes produced and reproduced 'addiction,' IDU and people who inject drugs as intrinsically irrational, chaotic, untrustworthy and risky. As these examples begin to show, the production of stereotypes about the 'drug-using subject' cannot be separated out from the legislative practices designed to govern them as ostensibly 'pre-existing subjects.' We will return to these issues shortly.

The constitution of injection as an 'irrational' and 'irresponsible' behaviour is invoked again in the exemption of 'authorised persons' from the provisions of s. 11 of the Act, under s. 19 of the *Drug Misuse and Trafficking Regulation 2011* (NSW). The exemption "only for the purpose of enabling the *authorised person* to participate in an *approved needle exchange program*" (s.

19.2, emphasis added) produces 'authorised persons' as a category of inherently responsible and trustworthy persons. That the exemption is limited to those "authorised by the Director-General of the Department of Health" (s. 19.3) (which is further qualified under the NSP Guidelines to include only those with "appropriate training and supervision": p.11) speaks to assumptions about what makes a person responsible and trustworthy. Here, qualifications deemed appropriate within a medicalised framework underpin ideas about who may be regarded as the most 'responsible' and 'trustworthy' stewards of injecting equipment. That "unpaid workers (including students and volunteers) are not routinely eligible to be authorised to perform NSP duties" (NSW Ministry of Health, 2013, p.11) also speaks to a range of normative assumptions about the legitimacy of tasks performed by a professionalised workforce, as opposed to tasks which may be performed for altruistic reasons within a community. The provisions of s. 11.2 of the Act which allows the possession of injecting equipment by medical practitioners and other 'prescribed professions' further reinforces this assumption.

As such, the construction of 'authorised persons' as a responsible, qualified and trustworthy category of people gives particular meaning to the distribution of injecting equipment. This is because the law (like policy) has various effects, delimiting what can be thought and said, and making certain subject positions available (Bacchi, 2009). It suggests that the distribution of injecting equipment is a specialised act, which must be tightly controlled by government through 'approved programs.' Dividing practices (Bacchi, 2009; Foucault, 1982) are once again at work here. Producing a particular category of 'authorised persons' as trustworthy, qualified and responsible distributors of injecting equipment, invokes a dichotomy which, by implication, constitutes people who inject drugs as untrustworthy, unqualified and irresponsible people who cannot be permitted to engage in the same distribution activities as those 'authorised' to do so. This dichotomy reinforces and reenacts the dominant construction of the 'irrational' and 'irresponsible' 'addict' (see also Fraser & Seear, 2011; Keane, 2002). It places significant limitations around injecting equipment which are not placed around other health promotion technologies (for example: condoms, sunscreen, or breast self-examination guidelines). Within other health promotion technologies, the consumer may be regarded as a key partner in prevention, rather than being excluded from what is seen by other sectors as a virtuous cycle (one where an individual may, for example, take responsibility for acquiring and applying sunscreen to their children thereby teaching them also to self-regulate). There is no room for this discourse within the legislative and regulatory framework governing needle and

syringe distribution. Indeed, the existing regulations arguably produce a tightly controlled, highly risk-averse and bureaucratic service system, where NSPs become responsible not only for distributing sterile equipment, but also for a range of other tasks including police relations, mandatory reporting of child protection issues, and even “deter[ing] unfavourable media attention” (NSW Ministry of Health, 2013, pp.8, 12-14, 18).

Paradoxically, the constructions identified above operate at cross-purposes with one of the explicit aims of NSPs, which is “to enhance the capacity of people who inject drugs to initiate solutions for their own health needs” (NSW Ministry of Health, 2013, p.3). It is in these guidelines that we again see that the drug-related discourses produced by these governance structures are “plural, complex, and at times, inconsistent” (Bacchi, 2009, p.19). On the one hand, the legislative and regulatory framework produces people who inject drugs as irresponsible, untrustworthy and ‘irrational,’ while in the aims of the program people who inject drugs have agency and the capacity to actively participate in determining their own (as well as public) health outcomes. The tension is evident here; people who inject drugs are constituted simultaneously as chaotic and self-controlled, as both irresponsible and capable of responsible choices, as both diseased bodies to be controlled and neoliberal agents in pursuit of their own successful health outcomes. Given that the subject positions produced through policy affect the ways people feel about themselves and others (see subjectification discussed in Bacchi, 2009), these complex and inconsistent discursive constructions have potentially major implications for how people who inject drugs are viewed, as well as for how they view themselves. Through the subject positions made available in this legislative and regulatory framework, people who inject drugs may simultaneously see themselves as rational citizens making safe, harm-reducing, responsible choices in accessing sterile injecting equipment, and irrational devalued, non-citizens, whose conduct is constituted as always already unsafe, dangerous, risky and irrational (this has been demonstrated in previous studies exploring the views of people who inject drugs towards harm reduction interventions: Lancaster, Santana, Madden, & Ritter, 2015). This complex duality raises major political and ethical questions, in part because it represents a fundamental tension between harm reduction policies which very often enjoin people who inject drugs to participate in safer injecting practices, but in ways that simultaneously put them at risk of criminal sanction.

Aside from the significant discursive and subjectification effects examined above, it is important to consider the lived and material impact of the problem representations produced

by this legislative framework. As Bacchi (2009, p.17) argues, “how problems are represented directly affects people’s lives.” As has been previously noted (NSW Users and AIDS Association, 2009), under this legislative and regulatory framework it is possible for a person who passes on sterile equipment or advice about safer injecting practices to be convicted of an offence, as peers are not regarded as participating in an ‘approved program’ nor are they an ‘authorised class of persons.’ That said, peer distribution is regarded as a “legal grey area in the harm minimisation field” (AIDS Projects Management Group, 2010, p.3) given that the onward supply of sterile injecting equipment is a common practice (National Centre in HIV Epidemiology and Clinical Research, 2010a) and that the legislative and regulatory provisions restricting distribution are rarely enforced. Even in 1987, it was noted by the NSW Parliament that “mere possession of needles and syringes has never been seen by law enforcement authorities as a major weapon in their armory against drug abuse” (NSW Government, 1987b, p.13058). However, on one occasion the provision of injecting equipment did lead to a manslaughter charge and conviction in NSW. In the case of *R v Cao*,⁴ Mr Quoc Cao was found guilty of manslaughter. Cao had provided sterile injecting equipment to a person who subsequently injected heroin and died. He was found to be complicit in the victim’s death through facilitating the unlawful act of self-administration of a prohibited drug. In his analysis of the case, Schimmel (2002, p.136) argued that the formulation of the charge was “contrived and inappropriate” and had significant implications for harm reduction and public health policies. To our knowledge this is the only documented Australian case of this kind.

Nonetheless, the confusion created by the ‘legal grey area’ appears to impact at the street level. Drug user organisations have suggested that possession of injecting equipment sometimes gives rise to body searches for illicit drugs by police, and that people who inject drugs are often reluctant to carry more equipment than necessary as a result; they may also be discouraged from accessing services for fear of identification and stigma (NSW Users and AIDS Association, 2009; see also Schimmel, 2002; Treloar & Cao, 2005). The mere ‘threat’ of prosecution and the uncertainty produced by these laws may severely curtail harm reduction opportunities. A working paper examining the impacts of discrimination and criminalisation on public health approaches to BBVs noted that a range of complex factors create barriers to injecting equipment access. These include negative attitudes towards IDU and people who inject drugs, inconsistent application of evidence in policy making, concerns about public

⁴ *R v Cao* (Unreported, District Court of New South Wales, Ford ADCJ, 21-22 October 1999).

opinion generating risk aversion in policy making, and the complex and layered nature of legislative, policy and service delivery environments (Legal and Discrimination Working Party of MACBBVS, 2013, pp.61-63). NUAA (2009, pp.14-15) have argued that:

[L]aws which run contrary to the government's own public health initiatives and serve to confuse are one of the major barriers to more widespread access to NSPs, to safe disposal of used equipment and to the lowering of hepatitis C rates amongst people who inject drugs.

Arguably, laws prohibiting peer distribution of injecting equipment may play a role in shaping the materiality of BBV epidemics.

While barriers to injecting equipment access and its multiple effects have been documented, some people who inject drugs act in ways that resist the limitations placed on them. There is evidence that people who inject drugs *do* pass on sterile injecting equipment within their communities *despite* these prohibitions (Bryant & Hopwood, 2009; National Centre in HIV Epidemiology and Clinical Research, 2010a). Indeed we may wonder what the rates of BBV transmission would be if some people who inject drugs did not resist these limitations. This resistance may be regarded as a crucial way for dominant drug-related discourses to be disrupted and replaced. The everyday practices of people who inject drugs in assisting one another to make choices that may minimise injecting-related harms serve to partially reconstitute them as responsible health subjects. What is performed in these everyday practices is akin to what Fox (1995) has described as an alternative model of caring (that is, 'care-as-gift'), which stands in contrast to the controlled and authoritative model of care enacted in the formal, 'authorised and approved' structure of NSPs. In doing so, the kind of care enacted in peer distribution opens up the possibility of "resistance to discourse, and a generosity towards others" (Fox, 1995, p.122).

Furthermore, the act of passing on sterile equipment shifts the focus from the construction of the 'diseased' individual body to an understanding of IDU as being situated within networks and social worlds (see Fraser, Treloar, Bryant, & Rhodes, 2014). Maher (2002) questions the epidemiological lens which constructs risk as a deeply individualised concept, rather than as being shaped by social conditions and lived realities. The individualisation of injecting 'risk behaviour' produced through laws governing the provision of sterile injecting equipment is one clear example of where attempting to disrupt practices within social networks (by placing legal restrictions on the distribution of equipment) in fact increases the risk of transmission of

BBVs. While within the law people who inject drugs are constituted as irresponsible, irrational, selfish risk-takers and carriers of infection, the practice of distributing sterile injecting equipment partly remakes people who inject drugs as active, responsible and rational social agents. Here, BBVs are also remade as just one part of an assemblage of drug use practice, neither an inevitable nor 'natural' consequence of injecting behaviour. But despite these practices opening up space for resistance and reconstituting people who inject drugs as responsible health and social agents, a duality and power imbalance remains. Whatever positive effects may flow from these practices of resistance and care, the authority of the problematisations constituted within the law remain, strongly defended and continually disseminated through the legitimacy of legislative, regulatory and bureaucratic (as well as health and medical) institutions. Within the law these practices of resistance (despite whatever public health benefits may flow from them) are constituted as criminal acts, performed by criminal, 'unauthorised' and 'addicted' individuals; practices that within the dominant discourse cannot be encouraged, acknowledged or rewarded. As such, the law delimits what can be thought and said, closing off opportunities for different and innovative harm reduction intervention with (we would suggest) real and devastating effects.

Conclusion

Thirty years after the introduction of the *Drugs Misuse and Trafficking Act* in NSW, our knowledge about the transmission of BBVs has changed, but legislative prohibitions on peer distribution of injecting equipment remain. In this article, following the work of Carol Bacchi (2009), we have argued that legislative prohibitions on the distribution of injecting equipment except by 'authorised persons' within 'approved programs' have discursive, subjectification and lived effects. They constitute people who inject drugs as irresponsible, irrational, risky and untrustworthy and re-inscribe a familiar stereotype of the chaotic and selfish drug 'addict.' We have also argued that these constructions of people who inject drugs – as irresponsible, untrustworthy, unqualified and risky – fundamentally constrain how the provision of injecting equipment may be thought about in policy and practice. We have argued that prohibition of the distribution of needles and syringes among peers may also have other, material effects, and that it may be counterproductive to various public health aims and objectives in Australia, including various efforts designed to reduce new BBV transmissions among people who inject drugs. However, we suggest that the actions undertaken by some people who inject drugs to distribute equipment to their peers (despite the legislative barriers) may also operate to

disrupt and challenge these constructions, through a counter-discourse in which people who inject drugs are constituted as active agents with a vital role to play in BBV prevention in the community. However, such activity continues to bring with it the risk of criminal prosecution, and so it remains a vexed issue.

We suggest that the apparent contradiction identified in this dual constitution of peers who distribute inject equipment as both responsible public health agents and as criminals opens up a discourse which is plural and complex, and may be regarded as a “resource for re-problematisation” (Bacchi, 2009, p.45). It is important that this highly stigmatised and marginalised group be able to participate in practices that challenge dominant conceptualisations of them and remake the stereotype of the irresponsible ‘addict.’ However this re-problematisation is not fully possible at the moment, partly because peer distribution of injecting equipment happens covertly, without authorisation, under the (real or perceived) threat of criminal sanction. Our analysis demonstrates that one likely effect of legalising peer distribution would be a symbolic and discursive recognition of people who inject drugs as responsible and rational public health agents. But, as Moore and Fraser (2006, p.3045) have noted, the political effects of this neo-liberal position (though seemingly empowering) must also be considered, lest that people who inject drugs are “further stigmatised by the perception that they are ‘failing’ the test of neoliberalism” due to their unequal circumstances.

Bacchi (2009, p.10) enjoins us to reflect on developments and decisions that contribute to the formation of problem representations, and recognise that “things could have developed quite differently.” We suggest that the separation between pharmaceutical drug use as ‘public health’ and illicit drug use as ‘criminal’ produced through the dichotomous legislative structure of the *Poisons Act 1966* (NSW) and the *Drug Misuse and Trafficking Act 1985* (NSW), is especially significant. Constituting illicit drug use as an inherently criminal activity fundamentally delimited the way *all* aspects of IDU could be thought about and discussed, silencing the important public health function of sterile injecting equipment in mitigating BBV infection. The legacy of this legislative schism is thus significant insofar as *all* aspects of IDU that fell within the ambit of the *Drug Misuse and Trafficking Act* became constituted as criminal ‘problems,’ rather than ‘public health’ ones, as they might have stayed if they had continued to be governed in some way by provisions under the *Poisons Act*. The way this constitution of the ‘problem’ of illicit drugs delimited what could be thought and said about injecting drug use, *even after* HIV and HCV were named, is palpable and has arguably severely

limited opportunities for subsequent law reform and harm reduction innovation. For example, despite recommendations to repeal sections of the Act following a review by the Attorney General's Department and discussion at the NSW Drug Summit in 1999, these recommendations were not taken up as they were regarded as "politically unsaleable" due to their "symbolic significance" (Schimmel, 2002, p.150). As Schimmel (2002, p.150) notes, despite "the maintenance of NSPs, the dominant political rhetoric remains rooted in notions of zero tolerance, law and order and a 'war on drugs'." We suggest that reluctance to engage with law reform both reflects and reproduces the aforementioned discourse of the drug 'problem' (and of 'problematic' drug using subjects) and demonstrates the way these laws continue to impose limits on what can be thought and said (Bacchi, 2009). These are not merely considerations of political rhetoric; as Bacchi (2009, p.16) argues "if some options of social intervention are closed off by the way in which a 'problem' is represented, this can have devastating effects for certain people." Closing off the option of legal peer distribution of injecting equipment because of the way that drugs (and the people who use them) are constructed in public discourse has human rights implications, and likely perpetuates high rates of BBV transmission among this population. These are not trivial 'political' issues, but practices with real, material implications for people who inject drugs, and indeed, the wider community.

While legislative and policy change in NSW is being considered, we suggest that critical examination of the effects of laws governing the distribution of injecting equipment is timely, and may provide insights for other jurisdictions. Further research is required to examine the extent to which understandings of the illegality of peer distribution impacts on the practices of people who inject drugs, how these restrictions shape the way people who inject drugs feel about themselves and others, how interactions between NSP workers and clients are shaped by these regulations, and what may occur if the legal restrictions were to be removed. Given that it is relatively common practice for peers to collect and distribute sterile injecting equipment within their community, and that these practices likely play an essential role in preventing the transmission of BBVs, there is a "strong argument against criminalising the conduct of an injecting drug user [sic] who gives a clean syringe to another" (Schimmel, 2002, p.149). As Schimmel (2002, p.154) argues, "in an area of law and public policy which is contentious, politically volatile and in which symbolism has achieved iconic status, what is needed is to see the situation with reason, perspective and pragmatism." To this, we would

add that a keen eye to scrutinising the discursive, subjectification and lived effects of existing (and proposed) legislative and regulatory frameworks is imperative.

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Paper 3

“Naloxone works”: The politics of knowledge in ‘evidence-based’ drug policy

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Paper 3 has been submitted to Health (Lancaster, Treloar & Ritter, under review)

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Preamble

By applying Bacchi’s approach and shifting the analytic focus towards the *productive techniques* and *constitutive effects* of ‘recovery’ discourse and laws governing distribution of injecting equipment, in Papers 1 and 2 I analysed how policies constitute the ‘problems’ they purport to address, and the discursive, subjectification and lived effects that flow from particular problem representations. In doing so, this research takes aim at one of the central tenets of the ‘evidence-based policy’ paradigm: the assumption that policy problems objectively exist ‘out there’ waiting to be ‘solved’ through application of ‘evidence.’ In this paper, I destabilise the ‘evidence-based policy’ paradigm further by bringing into question the presumed-to-be privileged status of both research evidence and researchers themselves. Taking the debate surrounding peer-administered naloxone as a case study, I explore how ‘evidence-based policy’ discourse shapes the limits of what can be thought and said, privileges ‘rationality,’ and elicits subjectivities, thus legitimising and delegitimising particular voices in policy debates. Here, ‘knowledge’ is taken to be a contested concept with a range of political effects.

The relationship between knowledge, power and resistance is central to this thesis. This concern owes much to Foucault (1980), and in particular his conceptualisation of power as *productive*. From a poststructuralist perspective, power is “immanent (occurs internally) to actions” (Eveline & Bacchi, 2010, p.144), and while power is “always already there” (Foucault, 1980, p.141) so too are points of resistance. Drawing on semi-structured in-depth qualitative interviews with individuals who have been closely involved in the development of programs to make naloxone available in the ACT and NSW, in this paper I explore the ways in which “those who ‘do’ policy [...] are both *subjected* and *resistant* to policy discourses” (Eveline & Bacchi, 2010, p.139, emphasis original). To do so, I use Bacchi’s approach in a different way by applying it not to analysis of policy per se, but rather to scrutinise theoretical ‘knowledges’ more generally. I explore possibilities for resistance by highlighting the “plural, complex and, at times, inconsistent” (Bacchi, 2009, p.45) nature of ‘evidence-based policy’ discourse and, in doing so, identify discursive resources for re-problematisation. I suggest that the ways in which ‘evidence-based policy’ discourse has become a barrier to the implementation of peer-administered naloxone has left this discourse open to challenge.

Abstract

For over twenty years drug policy experts have been calling for the wider availability of naloxone, to enable lay overdose witnesses to respond to opioid overdose events. However, the ‘evidence base’ for peer-administered naloxone has become a key point of contention. This contention opens up critical questions about how knowledge (‘evidence’) is constituted and validated in drug policy processes, which voices may be heard, and how knowledge producers secure privileged positions of influence. Taking the debate surrounding peer-administered naloxone as a case study, and drawing on qualitative interviews with individuals (n=19) involved in the development of naloxone policy in Australia, we examine how particular kinds of knowledge are rendered ‘useful’ in drug policy debates. Applying Bacchi’s poststructuralist approach to policy analysis, we argue that taken-for-granted ‘truths’ implicit within evidence-based policy discourse privilege particular kinds of ‘objective’ and ‘rational’ knowledge and, in so doing, legitimate the voices of researchers and clinicians to the exclusion of others. What appears to be a simple requirement for methodological rigour in the evidence-based policy paradigm actually rests on deeper assumptions which place limits around not only what can be said (in terms of what kind of knowledge is relevant for policy debate) but also *who* may legitimately speak. However, the accounts offered by participants reveal the ways in which a larger number of ways of knowing are *already* co-habiting within drug policy. Despite these opportunities for re-problematisation and resistance, the continued mobilisation of ‘evidence-based’ discourse obscures these contesting positions and continues to privilege particular speakers.

Key words

Evidence-based policy, drug policy, naloxone, knowledge, problematisation, Carol Bacchi

Introduction

The idea that naloxone could be distributed for administration by drug-using peers was first put forward in the medical literature in 1992 (Strang & Farrell, 1992). Naloxone is an antagonist which reverses the effects of opioids, including heroin, and has been used by medical practitioners for over forty years. Given that naloxone has no abuse potential, clinical researchers expressed confidence that the possible risks associated with making naloxone available to peers would be “minimal” and that “considerable benefit may accrue if drug users could give emergency doses of antagonist to fellow injectors who inadvertently overdose” (Strang & Farrell, 1992, p.1128). Since then, there have been repeated calls for the wider availability of naloxone (Bigg, 2002; Darke & Hall, 1997; Dietze & Lenton, 2010; Lenton, Dietze, Degenhardt, Darke, & Butler, 2009a, 2009b; Strang, Darke, Hall, Farrell, & Ali, 1996; Strang, Kelleher, Best, Mayet, & Manning, 2006). However, the question of the ‘evidence base’ for peer-administered naloxone became a key point of contention for the drug policy field. Was there sufficient ‘evidence’ to demonstrate the effectiveness of naloxone in the hands of lay overdose witnesses and thus provide an adequate rationale for implementing this intuitively appealing intervention? In the absence of a randomised controlled trial (RCT), did knowledge claims about the effectiveness of peer-administered naloxone satisfy the rigours of ‘evidence-based drug policy’? How could we know that naloxone ‘works’?

It is the assumptions underlying these questions that we seek to interrogate herein. We suggest that the contentious discussion surrounding the ‘evidence base’ for peer-administered naloxone opens up critical questions about how knowledge (‘evidence’) is constituted and validated in drug policy processes, which voices may be heard, and how knowledge producers secure privileged positions of influence (Bacchi, 2009; Lancaster, 2014). Taking the debate surrounding peer-administered naloxone as a case study for analysis, and drawing on qualitative interviews with individuals (n=19) closely involved in the development of naloxone policy in Australia, this article critically examines the ways in which “particular *kinds of knowledge*” (Bacchi, 2009, p.240) are rendered ‘useful’ in drug policy debates. Following key themes explored in Bacchi’s (2009) poststructuralist approach to policy analysis, we seek to destabilise taken-for-granted truths implicit within the ‘evidence-based drug policy’ paradigm, consider the productive power of ‘evidence-based policy’ discourse, and in doing so, also take up Bacchi’s entreaty to consider how discourses may be regarded as resources for re-problematisation and resistance.

Background

Given its long history of use in emergency medicine, naloxone was unequivocally regarded as a “tried and tested product” (Strang, et al., 1996) but questions were raised about the possible effectiveness of this medicine in the hands of lay overdose witnesses and drug-using peers including: concerns about the shelf-life of the drug outside of medical settings; whether overdose would reoccur in the absence of medical follow-up due to naloxone’s short half-life; whether peers would be able to administer naloxone while intoxicated; whether the availability of naloxone would discourage ambulance call-outs; and, more controversially, whether the removal of the “deterrent effect of overdose” would encourage opioid use (Darke & Hall, 1997; Lenton & Hargreaves, 2000; Strang, et al., 1996, p.1435). Throughout the 1990s researchers and clinicians in the UK and Australia called for “trial and evaluation” (Strang, et al., 1996, p.1435), and began ‘pre-launch’ studies to establish both the acceptability of naloxone distribution amongst people who inject drugs and the likely impact of such an intervention (Strang, et al., 1999). While it was suggested that the best way to respond to remaining “uncertainties” would be to conduct a controlled evaluation, it was acknowledged that “it may not be easy to conduct a randomized controlled trial of sufficient size to detect any effect of naloxone, should it occur” (Darke & Hall, 1997, p.1198) due to the low base population rate of overdose and difficulty ensuring that the naloxone was not used in the comparison group. Despite the methodological difficulties, researchers nonetheless asserted that “[i]t is only by a trial of naloxone distribution that empirical answers to the questions raised [...] could be obtained” (Darke & Hall, 1997, p.1199).

By the early 2000s, some sectors of the drug policy field were questioning the ‘stalemate’ which had emerged in the naloxone debate, suggesting that the “fears, anxiety and ethical implications being voiced” against peer-administered naloxone were “reminiscent of those expressed in the past” regarding needle and syringe programs (Oldham & Wright, 2003, p.113). Describing preliminary positive outcomes observed through the Chicago Recovery Alliance’s program, Bigg (2002, p.678) railed against the prevailing stasis: “Being opposed to a potentially lifesaving practice in the absence of data proving it wrong is a dangerous proposition.” In the absence of RCTs or systematic evaluations, researchers and clinicians began gathering together a body of observational evidence from a series of pilots and small-scale programs. By February 2006, more than 900 opioid overdoses had reportedly been

reversed using peer-administered naloxone, but the lack of formal evaluation precipitated still more calls for “structured, scientifically sound evaluations” (Sporer & Kral, 2007, p.175).

In 2009, Australian researchers stopped calling for trials and began advocating for swift implementation:

In our view, the international evidence clearly indicates that increased naloxone availability will prevent many cases of fatal overdose, that conducting a trial in Australia is now unnecessary, and that naloxone should be made available without delay. (Lenton, et al., 2009a, p.469)

However not everyone agreed with these conclusions. As one clinician opined: “The only evidence for naloxone distribution so far comes from observational studies, which are considered among the weakest form of research design. The abundance of such studies does not compensate for their inherent lack of rigour” (Wodak, 2013).

While momentum slowly built towards implementing programs in Australia (Lancaster & Ritter, 2014b; Lenton, et al., 2015), and Scotland adopted peer-administered naloxone as a funded public health policy in 2011 (Bird, Parmar, & Strang, 2015; McAuley, Best, Taylor, Hunter, & Robertson, 2012), attempts to gather ‘conclusive’ RCT evidence continued in the UK through the establishment of the N-ALIVE trial (Strang, Bird, & Parmar, 2013). Despite the policy movement in Scotland, modelling showing the hypothetical cost-effectiveness of naloxone distribution (Coffin & Sullivan, 2013), and new reports from the USA of 10,171 overdose reversals through peer-administered naloxone programs (Wheeler, Davidson, Jones, & Irwin, 2012), those conducting the trial nonetheless argued that the “clarity of conclusions from a suitably well-designed and objectively undertaken randomized trial would be a powerful influence on key decision-makers” (Strang, et al., 2013, p.989). But as researchers noted, the need to test “the extent to which this intervention *actually* reduces deaths” necessarily “poses challenges for study design” (Strang, Bird, Dietze, Gerra, & McLellan, 2014, emphasis added). In December 2014, six years after the Medical Research Council had awarded funding for the trial, it was announced that the N-ALIVE trial had stopped randomising participants and could not go ahead as planned. Investigators found that “twice as many people who are given naloxone-on-release use it to save another person’s life as to save their own,” meaning that the trial would have needed to be much larger than was practicable to render meaningful results (N-ALIVE, 2014).

While the quest for ‘enough’ ‘scientifically rigorous’ ‘gold star’ evidence continued, a grass-roots counter-movement emerged. In 2011 the Eurasian Harm Reduction Network and the Harm Reduction Coalition founded a social media campaign disseminated through Facebook, YouTube and campaign websites (Eurasian Harm Reduction Network, 2014, 2015; Harm Reduction Coalition, 2015; Open Society Foundations, 2013). Their message was a simple declaration in response to the ongoing quagmire of scientific debate: “I’m the Evidence! Naloxone Works!” (Harm Reduction Coalition, 2015). The video on the landing page provided a campaign overview; a compilation of personal “success stories” of overdose reversals, told directly to camera by people who use drugs. The compilation of short videos was introduced by a woman stating:

These are stories of people that have witnessed overdose, and most of them have been trained in the use of naloxone and able to administer it, saving the life of their friend, family member or a stranger. *The scientific evidence is developing, that naloxone works. It is important that you also hear these stories in order to better see its impact.* (Harm Reduction Coalition, 2015, emphasis added)

Approach

Our analysis takes as its starting point the poststructuralist work of Australian policy theorist, Carol Bacchi. A growing body of drug policy research has applied Bacchi's (2009) ‘What’s the Problem Represented to be?’ (WPR) approach, illuminating the ways in which the problem of drugs is not fixed and stable but rather constituted in policy and practice (Bacchi, 2015; Fraser & Moore, 2011; Lancaster, Duke, & Ritter, 2015; Lancaster & Ritter, 2014a; Lancaster, Seear, & Treloar, 2015; Pienaar & Savic, 2015; Roumeliotis, 2014; Seear & Fraser, 2014). In doing so, this research has also begun to raise critical questions about the concept of ‘knowledge’ in drug policy, demonstrating how knowledge is both “central to the constitution of political problems” and active in “the production and transformation of relations of power” (Roumeliotis, 2014, p.337).

The WPR approach takes a “sceptical stance toward ‘knowledge’” (Bacchi, 2009, p.249). The relationship between ‘knowledge’ and power, and the place of science in governing, are key themes explored in Bacchi’s work and the focus of our analysis here. Bacchi scrutinises the concept of ‘knowledge production’ in contemporary modes of governance and challenges the ‘problem-solving’ premise of the dominant ‘evidence-based policy’ paradigm. Following a

Foucauldian governmentality perspective (Dean, 1999; Foucault, 1991; Rose, O'Malley, & Valverde, 2006), Bacchi contends that academic knowledge (what we might call 'evidence') is not merely an objective resource for governments to use in policy decision-making, but rather central to the way we are constituted and governed as political subjects. From this perspective, 'knowledge' is a contested concept with a range of political effects. The question of "who is best placed to produce 'knowledge' that will count as 'truth,' and how they secure their position/s of influence" (Bacchi, 2009, p.235) is of central concern. Both "the power of discourses" (to limit what can be thought and said) and "the power to *make* and/or to *deploy* discourses" (to determine who may speak authoritatively) must be considered (Bacchi, 2009, p.236, emphasis original). We apply this perspective here to 'evidence-based policy' discourse.

'Evidence-based policy' developed out of the evidence-based medicine (EBM) movement which sought a rational approach to clinical decision-making through the application of 'gold star' research (Davies, Nutley, & Smith, 2000; Lin & Gibson, 2003). This movement is regarded as one of the most significant developments in medicine in the last two decades, and has dramatically affected policy and practice far beyond the scope of health (Bell, 2012). But as Harrison and Checkland (2009) observe, EBM and its subsequent expression in the broader notion of evidence-based policy and practice are *political* phenomena. The dominant model of 'evidence' espoused in contemporary medical discourse is one based on the primacy of particular research methods (systematic comparisons, randomisation of research subjects to control and intervention groups, and aggregation of research findings in the form of reviews and meta-analyses) as the source of valid and unbiased knowledge about the effectiveness of health care interventions, over and above other ways of 'knowing' (Harrison & Checkland, 2009). Such methods have come to form what is known as the 'hierarchy of evidence,' with systematic reviews of RCTs occupying the peak of the pyramid. Throughout the 1990s, this approach became *de rigueur* in medicine as well as academic and policy circles (for further discussion see: Harrison & Checkland, 2009; Marston & Watts, 2003). The seemingly incontestable "self-evident value" of using evidence as an 'objective' and 'accountable' basis for decision-making allowed 'evidence-based' discourse to "creep" out of the scope of clinical medicine and into diverse policy domains (Bell, 2012, p.314).

While 'evidence-based' discourse has been taken from the domain of medicine and applied more broadly to the pursuit of 'evidence-based policy' in Western democracies, the disciplinary and methodological roots of EBM have a number of implications (Marston &

Watts, 2003). Two in particular are pertinent to our current study. Firstly, where there is a preference for a particular kind of ‘evidence,’ and what counts as valid knowledge is narrowly conceptualised, other voices and knowledge(s) are necessarily marginalised. As Marston and Watts (2003, p.145) note “[i]f knowledge operates hierarchically, we begin to see that far from being a neutral concept, evidence-based policy is a powerful metaphor in shaping what forms of knowledge are considered closest to the ‘truth’ in decision-making processes.” Secondly, given that public health and drug policy are closely related to medicine and the role of clinicians is prominent, evidence-based policy discourse holds significant purchase in these domains (Smith, 2013; valentine, 2009). However whether or not the principles espoused within EBM and the ‘hierarchy of evidence’ are necessarily appropriate for responding to complex policy problems (like illicit drug use) remains contested given the strong normative and ethical dimensions of these issues (Smith, 2013). Nonetheless, given its prevailing dominance within drug policy, ‘evidence-based’ discourse is likely to significantly shape the limits of what can be thought and said and also who may speak authoritatively (Bacchi, 2009) and therefore deserves close analysis.

Method

In this paper, we take up Bacchi’s challenge to use her approach not only for the interrogation of policy proposals, but also as a way to scrutinise theoretical stances more generally so as to highlight the “*political implications* of theoretical ‘knowledges’” (Bacchi, 2009, p.233, emphasis original). We focus on the sixth question in Bacchi’s (2009, p.48) approach, examining how assumptions implicit to ‘evidence-based policy’ discourse have been “produced, disseminated and defended,” and how they could be “questioned, disrupted and replaced.” The purpose of this question is to destabilise taken-for-granted ‘truths’ by directing attention to practices and processes which allow these ‘truths’ to dominate and achieve legitimacy, thereby opening up opportunities for challenge and resistance (see Bacchi, 2009, p.19; 45).

We critically analysed a corpus of discourse drawing on 19 semi-structured in-depth interviews with policy makers, advocates, clinicians and researchers closely involved in discussions surrounding the establishment of peer-administered naloxone programs in Sydney and

Canberra, Australia.¹ Interviews were on average one hour in length (ranging from 30 minutes to over 2 hours). The interview guide focussed on eliciting participants' perceptions of policy activity, the processes through which policy activity occurs, and the roles of multiple knowledge(s) and 'voices.' Participants were also asked what information or knowledge ('evidence') they found compelling in the naloxone discussions. The interviews were audio-recorded and transcribed verbatim. Participants were sent a copy of their transcript to review for the purposes of verifying accuracy, correcting errors or inaccuracies, and providing clarifications.

Transcripts were de-identified and then initially analysed thematically with the assistance of NVivo 10 software. This initial coding identified and categorised a range of knowledge(s) and voices at work within the naloxone discussions, as well as modes and locations of knowledge production including academic publication, evaluation structures, international naloxone programs, and grass-roots advocacy. Each of these categories was then explored in more detail using Bacchi's (2009, pp.37-38) Foucauldian-influenced approach, which turned our attention to the functioning and institutionalisation of discourses, as well as to the operations of power. Initial themes were refined accordingly, thus tracing the struggles over the production and deployment of knowledge(s) in naloxone discussions and interrogating the productive power of evidence-based policy discourse through attention to practices and processes. Underpinning this analysis was a critical assessment of the conceptual logics of evidence-based policy discourse. If, as Bacchi (2009, p.xi) argues, "what we propose to do about something indicates what we think needs to change" then implicit within the evidence-based policy paradigm are a number of assumptions. The call for drug policy to be 'evidence-based' is underpinned by the implicit assumption that a particular kind of knowledge ('evidence') should be taken up and used by policy makers to make sound policy decisions. Within this paradigm, policy makers are constituted as rational, authoritative 'problem-solvers'; knowledge is constituted as instrumental and objective; and the 'problems' to be addressed are constituted as fixed and known, that is, "the 'problem' against which 'evidence' is to be 'applied' is presumed to exist separately from deliberations about how to 'solve' it" (Bacchi, 2009, p.107). In this way,

¹ The case study necessarily involved a small sampling frame, given the specific focus on particular policy development processes and the relatively defined group of key figures involved in discussion of naloxone in the Australian drug policy field. As such, titles, sex and age of participants are not reported to protect anonymity (see Lancaster, 2016a). This study received ethical approval from the UNSW Human Research Ethics Advisory Panel (approval number: 9_13_018).

'evidence-based policy' discourse is productive and constitutive. It produces 'truths' both about the policy process and the kind of knowledge and voices which may be legitimately invoked to inform policy.

In the following sections we examine two related themes: (i) legitimating speakers; and (ii) resources for resistance.

Legitimizing speakers

Evidence-based policy discourse constitutes instrumental and 'objective' knowledge as relevant for policy, thereby legitimating speakers with access to this particular kind of knowledge in policy processes. In this case study we identified how evidence-based policy discourse legitimated the voices of researchers and clinicians, and gave force to knowledge claims made from these domains. In making this observation, we are not suggesting that researchers and clinicians always occupy privileged positions (that is, that they 'possess' power by virtue of their roles) but rather that the productive power of evidence-based policy discourse *makes* them so (see Bacchi, 2009, pp.37-38). This is by no means fixed or consistent, however, as discourses are not homogenous (Bacchi, 2009). By understanding power as productive, and not as possessed, our attention turns in this case study to how it operates, and the effects of legitimating particular speakers.

The need to publically present an 'evidence-based' argument generated a perception that particular kinds of people should be the 'face' and 'voice' of drug policy discussions:

You've got to keep it calm, have it evidence-based; you need reliable - someone like [names a public health professor] is perfect, this man of science with a beard. [...] He said, 'You know, if you want to get something politically across, and change the laws on an issue' he said, 'You look at when the hemp spokespeople get on television, they always have the dreadlocks, or unkempt beards and that.' [...] He said, 'What you want is someone out there with a certain attire, clean cut, saying, "Well, this is a health issue."' And that's what [this professor] was. [...] He's always logical, he's unflappable, he's not an advocate. [...] You've got to do it softly softly, bit by bit, and evidence-based. (Researcher)

Here, taken-for-granted 'truths' about the kind of knowledge which is relevant for policy legitimates a particular kind of 'rational' speaker, and excludes other 'less legitimate' voices. In

this researcher’s account, demeanour, appearance and institutional position are intertwined markers of legitimacy for policy debates, trumping any argument or knowledge the advocate may have put forward (indeed, in this account the voice of the advocate is silenced; we are offered an image of an advocate on television, but not what she or he may say). This particular professor is constituted as a ‘scientific,’ ‘rational’ and ‘objective’ voice, and therefore a legitimate speaker in drug policy debates. One effect of this legitimating process is that other voices, by contrast, are constituted as spurious or less reliable:

I wasn’t sure that [the other clinician] was necessarily the sort of person I would have chosen. [The other clinician is] certainly a very passionate advocate, but as a sort of very sane, sage and sober doctor-type like myself, [the other clinician] kind of reeks of all of the things that make me nervous about drug policy, where it’s a lot of emotion and not a lot of hard evidence behind it. (Clinician)

Here the participant describes herself as a “sane, sage and sober doctor-type” and contrasts her own subject position with that of the “passionate advocate.” In doing so, this participant highlights the privileging of ‘objectivity’ and ‘rationality’ in evidence-based policy discourse, indicating that it is not enough to simply hold a medical position to be legitimate; one must also be “sane, sage and sober” (that is, ‘rational’ and objective’). This highlights the complexity of the subjectivities produced through evidence-based policy discourse and the way it legitimates particular speakers and excludes others, through appeals to rationality and objectivity.

As participants described the development and establishment of the peer-administered naloxone programs in both Sydney and Canberra, the privileging of ‘objective’ and ‘rational’ perspectives over and above the knowledge brought to the process by drug user organisations² was a common theme. As noted by one participant: “consumers aren’t treated very well, nor are their ideas, and stuff tends to be shut down.” Although most participants (clinicians, researchers, policy makers and advocates alike) spoke of the importance of including the voices of people who use drugs (and their families and communities) in policy processes, there was a sense in which the involvement of researchers and clinicians was

² In Australia, drug user organisations are peer-based organisations that represent and advocate for the health and human rights of people who use illicit drugs.

nonetheless required to legitimise processes and reassure decision makers. As one advocate noted, reflecting on a committee process which brought a group of stakeholders together:

I think that gave the government confidence that there was – it wasn't just a drug user group coming up with a harebrained scheme. It was across the board of researchers, doctors, nurses, ambulance, drug user organisations, users themselves. (Advocate)

Without the legitimacy afforded by researchers, clinicians and other professional medical personnel, the drug user organisation's proposal may not have been seen as authoritative in the eyes of government. Legitimising some voices to the exclusion of others had effects for participants engaged in these processes. As another participant recalled:

we were at a meeting and [a drug user organisation representative] would say something and somebody like [one of the researchers] would say, 'Actually they're correct' and then the government would be reassured. (Advocate)

The de-legitimisation of the drug user organisation representative mentioned in this exchange was acutely felt by the individual involved, who in reflecting on this same process said:

They just speak differently to me. Like we're sitting around in a meeting and people have differing views and I'm saying something and I'm being sort of being spoken to in this really horrible way and then being disagreed with and then someone else will speak up and then [the policy maker] will change their mind and go, 'oh okay maybe I'll consider that.'

Here, we see the ways in which evidence-based policy discourse places boundaries not only around what is said (in terms of what kind of knowledge is relevant to policy discussions), but *who* delivers the message. While it may be intuitive to assume that researchers and clinicians are better placed to produce and deploy the kind of 'objective' and instrumental knowledge that will count as 'truth' (due to their institutional access to research processes, ethics boards, qualifications, and modes of dissemination in academic fora and medical journals), from these interviews we can also see the ways in which discursive practices continually position and sustain researchers and clinicians as 'objective' and 'rational' legitimate speakers, while excluding 'advocates' as irrelevant or illegitimate.

Resources for resistance

Closer analysis revealed resources for re-problematisation and resistance. Across the interviews, it was the ‘legitimate speakers’ who most frequently articulated their frustrations with the problematic barriers that the requirement of “high level evidence” (Clinician) had created for the implementation of peer-administered naloxone programs. While policy makers, drug user organisations and advocates discussed the importance of gathering together a convincing ‘evidence base’ (perhaps attempting to legitimise their own voices through appeals to objective knowledge), many of the researchers and clinicians interviewed offered critiques of the notion of a hierarchy of evidence or unbiased knowledge, and expressed frustration at calls for ‘more evidence’ or RCTs:

I found the debate around evidence-building and RCTs interesting and a bit infuriating actually. [...] I think to hold RCTs as the gold standard is very problematic. (Researcher)

It could be argued that it is from the position of legitimacy afforded to researchers and clinicians from within evidence-based policy discourse that this critique is made possible.

In critiquing the pre-eminence of RCTs and articulating their frustrations, researchers and clinicians appealed to other ways of knowing. As another researcher argued:

The sort of people that say RCTs are the only way to go, I just think are breathtakingly stupid, because *there are other ways to knowledge*; and there are some questions, that by their very definition, will never, ever, be amenable to an RCT. And I will go back to that wonderful BMJ satirical piece. [...] We’ve never done an RCT of parachutes, says the BMJ, and under the guise of absolutely cutting edge satire, they made a very important point; that, one, how would you do it; and, two, why would you do it? *We know it works*. (Researcher; emphasis added)

This researcher was one of several participants (clinicians and researchers) who mentioned the *British Medical Journal* article, which satirically notes that the effectiveness of parachutes has not been established through RCTs, and that the extant observational evidence is insufficient to satisfy proponents of evidence-based policy and practice (see Smith & Pell, 2003). In invoking this satirical piece, participants argued that there were *other ways* of ‘rationally’ ‘knowing’ that ‘naloxone works’ thus re-deploying and re-problematising the ‘instrumental rationality’ concept at the heart of evidence-based policy discourse. So while ‘instrumental

rationality' is based on the notion of a particular kind of 'objective' and 'instrumental' knowledge being used by 'rational' decision makers to 'solve problems' (as discussed above), appeals to other ways that we might 'rationally' 'know' 'what works' here destabilise this particular representation, highlighting that it is not fixed, and thereby altering relations of knowledge and power. The concept of 'rationality' itself, and how we might otherwise 'rationally' 'know' 'what works,' becomes a "discursive resource" (Bacchi, 2009, p.45) which can be raised and re-deployed in response to what is seen as a problematic practice (one which, in this case study, was perceived to be creating barriers to the field supporting the implementation of peer-administered naloxone programs). This is not about the strategic framing of arguments but rather opening up "one position" that evidence-based discourse "makes available" thus allowing a contesting stance to be developed (Bacchi, 2009, p.46).

Invoking this contesting stance, participants made appeals to a number of other ways in which we might 'rationally' 'know' 'what works.' 'Common sense' and 'logic' were prominent themes:

In some areas *common sense* can – must prevail. I don't see what the benefit of a high order, high level random controlled trial would achieve. Naloxone has got significant evidence that it reverses overdose. If it's in a pharmacist's cupboard, it won't. But if it's in a drug user's cupboard, and taken out at the event of an overdose, it might. That's the *painfully obvious* evidence from my point of view. *It's the laws of physics* that a mini-jet of naloxone, won't, of its accord, jump up and run across the street and find somebody who's just overdosed. (Clinician, emphasis added)

This clinician re-deploys assumptions about rationality implicit within the evidence-based policy paradigm to create a new space from which to consider the effectiveness of naloxone. Here, 'evidence' of 'what works' is remade as a 'common sense logic' argument formed not from the scientific methods reified within the evidence-based policy paradigm which 'prove' effectiveness, but rather from a particular ontological view of the world. The clinician presents this account of 'what works' not as an anecdotal observation, but rather as a 'rational' and 'logical' response to the world as he sees it. These appeals to logic, the observed world and "laws of physics" *remakes* the notion of rationality into a different way of knowing.

The "obvious common sense" rationality and objectivity of observation was invoked by another clinician:

sometimes I think we make it hard for ourselves at the altar of wanting to have evidence-based policy, letting it get in the way of doing things that just make *obvious common sense*. You see it with the naloxone thing as well, that yes people are overdosing, they're using naloxone, they're reversing the overdose, people aren't dying. Surely that's enough. That's what I liked about the 'I'm the Evidence' campaign because that really struck at the heart of that nonsense of 'We need experimental evidence.' It's like *look* at these people, they had overdoses, they're still alive. (Clinician, emphasis added)

Here, the empiricism at the heart of methods occupying the peak of the 'hierarchy of evidence' is simultaneously challenged and remade. The clinician likes the way the "I am the Evidence" campaign (described earlier) challenges the call for experimental evidence but in doing so points to a different way of observing and 'seeing' effectiveness. Again, 'common sense' observation is remade as sufficient and relevant knowledge for policy because it is 'logically' 'obvious' and 'rational.'

Nonetheless, despite the critique and other ways of knowing put forward, participants continued to mobilise and defend the evidence-based drug policy paradigm through their every day practices. While the articulation of their vociferous frustrations highlighted the ways in which evidence-based policy discourse does make available a contesting position and create room for re-problematisation and resistance, the clinicians and researchers interviewed did not completely resist the paradigm or fully destabilise taken-for-granted 'truths' about the value of particular kinds of knowledge for policy. Rather, they continued through their day-to-day practices to preserve the implicit notions of rationality and objectivity, and thus maintain their legitimacy. Participants still continued their pursuit of 'objective' 'evidence' through the evaluation structures they built around the new naloxone programs and saw their contributions to academic literature as important. As one clinician said (after earlier saying "we make it hard for ourselves at the altar of wanting to have evidence-based policy"):

we still thought that it would be good to do that [evaluate the program], also by way of disseminating our results and adding to the evidence-base down the track. And we also felt that then we would have to put it through ethics and that that would sort of give it a bit of extra imprimatur. So as part of the ethics process, scientific merit is assessed and so that would also give us something to fall back on should we find ourselves in a bit of a storm. (Clinician)

Despite their critique, participants perceived a need to mobilise evidence-based policy discourse, and continued to appeal to notions of 'scientific merit' and processes of formal evaluation in order to justify their actions and retain legitimacy.

Conclusion

Taken-for-granted 'truths' implicit within evidence-based policy discourse privilege particular kinds of 'objective' and 'rational' knowledge and, in so doing, legitimate the voices of researchers and clinicians to the exclusion of others. We suggest that what appears to be a simple requirement for methodological rigour in the evidence-based policy paradigm actually rests on deeper assumptions which place limits around not only what can be said (in terms of what kind of knowledge is relevant for policy debate) but also *who* may legitimately speak. As we noted earlier, we are not suggesting that researchers and clinicians always occupy privileged positions, but that the productive power of evidence-based policy *makes* them so. As calls for the voices of people who use drugs to be included in policy deliberation continue to gain traction in the drug policy field (Jürgens, 2008; Lancaster, Ritter, & Stafford, 2013), these findings raise a critical question: to what extent is the reifying of 'evidence-based policy' limiting opportunities for participation, through the way its practice legitimates particular voices to the exclusion of others? This silencing effect applies not only to people who use drugs themselves, but also their families, communities and those who advocate from within academia and the medical profession. This is a key question not only for drug policy, but also for the consumer participation agenda in health.

Given the dominance of 'evidence-based' policy discourse in drug policy and more broadly as a contemporary mode of rule, it is difficult to problematise or bring into question what is meant by the seemingly incontrovertible concept of 'evidence.' However, we have identified points of rupture which make it possible to appeal to other ways of knowing. The way in which evidence-based policy discourse has become a barrier to the implementation of peer-administered naloxone has left this discourse open to challenge. In turn, this has opened up the opportunity to redeploy the notion of 'rationality' thus making it possible to argue that there are other 'common sense' or 'logical ways' of 'seeing' and 'knowing' that naloxone 'works.'³ So while the central tenet of evidence-based policy (that good policy decisions should

³ These 'other ways of knowing' will, in turn, require critical interrogation (recognising, for example, that 'common sense' understandings are often invoked in drug policy, sometimes with problematic effects: Seear and Fraser, 2014).

be based on rational assessments of effectiveness) may seem incontrovertible, there are tensions present which may be regarded as resources for re-problematisation and resistance.

It is important to note here that redeploying the notion of ‘rationality’ does not necessarily devalue ‘gold star’ research evidence but rather “revalues upwards” (Bacchi, 2009, p.73) other ways of knowing (other ‘evidences’). As Law (2004, p.4) notes, it is not the case that standard research methods are “straightforwardly wrong.” Indeed, they have been the basis of significant developments in drug policy and public health more broadly. The critical question is whether reifying particular methods or ways of knowing places the drugs field in “a set of constraining normative blinkers” (Law, 2004, p.4) by claiming authority.

This analysis illuminates how other ways of knowing can be relevant for policy, and suggests that the notion of the thing we call ‘evidence’ needs to be further opened up, problematised and questioned (Lancaster, 2016b). The challenge posed to scientific method and the limits of the concepts of ‘objectivity’ and ‘instrumental rationality’ at the heart of the evidence-based policy paradigm are beginning to be explored in different ways in the drugs field but require further critical consideration. For example, drawing on Bruno Latour’s work, Fraser (2015) has problematised taken-for-granted distinctions between scientific fact and self-observation. Along with Fraser (2015, p.18), our analysis provides a “corrective” to the catch-cry of ‘evidence-based drug policy’ by revealing contradictions and points of resistance. As the idea of ‘objective evidence’ faces increasing public scrutiny, Latour (2013, p.11) has suggested a new way of thinking about scientific knowledge which remakes and redefines science in such a way that it may also “allow us to give more space to *other values* that are very commonly encountered but that did not necessarily find a comfortable slot for themselves within the framework offered by modernity.” Latour’s (2013, pp.7, 11) goal is to create an arrangement that he describes as a “diplomatic” mission, making room for other knowledges and bringing “a larger number of values into cohabitation within a somewhat richer ecosystem.” The accounts offered by our participants reveal the ways in which a larger number of ways of knowing are *already* co-habiting within drug policy. Like the notion of addiction examined by Fraser (2015, p.17), naloxone provision is another issue within the drug policy field which “refuses resolution by recourse to scientific evidence.” Time and time again, participants bemoaned the limitations of the ‘hierarchy of evidence’ and the barriers it produced, turning instead to other ways of knowing. By applying Bacchi’s approach in this analysis, we have identified resources for re-problematisation (positions that evidence-based policy discourse

makes available) which provide another way of thinking about how to make Latour’s “diplomatic” mission possible within the drug policy field and produce avenues for different kinds of action.

Despite these opportunities for rethinking the ‘evidence-based’ drug policy paradigm, we have also identified how the continued mobilisation of ‘evidence-based’ discourse within the field obscures these contesting positions and continues to privilege particular speakers and modes of engagement. As Fraser et al. (2014, p.236) contend, perhaps as a field we are so dependent on the ‘evidence-based policy’ paradigm that we are “obliged” to present our views “in the taken-for-granted modes of evidencing, that is, in the format of scientific knowledge” despite its obvious limitations. As Bacchi (2009) notes, it has become virtually impossible for those in the research community to speak outside of the confines of ‘evidence-based’ discourse.⁴ So while researchers and clinicians bemoan the demands of the hierarchy of evidence and highlight the limits of evidence-based policy, they continue to mobilise it thus becoming “enlisted” in the task of governing through the knowledges they produce and deploy (Bacchi, 2009, p.157).

While we have analysed this case study through Bacchi’s WPR lens, other critical approaches would yield further insights. For example, valentine (2009, p.460) suggests that “a critical values-based approach directs us to questions of political power, ideology and marginalisation of drug users” while a science and technology studies approach invokes additional questions such as “how is it we know what we do about drugs?” thus disallowing established divisions between science and the social. Another approach might be to explore the ‘making’ of naloxone itself as an intervention. As has recently been proposed by Rhodes et al. (2016, p.18) “what constitutes an intervention, and knowledge about it, is not given but made,” recognising that evidence-based sciences are only one part of its constitution. We suggest the naloxone debates provide fertile ground for such examination.

Given the seeming incontrovertibility of ‘evidence-based policy’ discourse, we recognise that suggesting a shift away from such a dominant paradigm may appear unlikely or impractical. But as Fraser (2016, p.9) notes, it is important to recall that “major shifts in thinking do occur.” Our analysis herein has sought to continue to explore the basis on which such a shift may be

⁴ Indeed, we note that even the “I am the Evidence” campaign state in their landing page video that “the scientific evidence is developing” *before* turning to personal accounts of overdose reversal to demonstrate naloxone’s effectiveness (Harm Reduction Coalition, 2015).

considered, by highlighting the already present possibilities for re-problematisation and resistance.

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Paper 4

The productive techniques and constitutive effects of 'evidence-based policy' and 'consumer participation' discourses in health policy processes

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Preamble

In the previous papers, I demonstrated the ways in which problematisations may be seen as “powerful and yet contingent ways of producing the ‘real’” (Bacchi, 2012, p.7) and hence, the importance of opening them up and revealing the possible deleterious effects they set in motion. To this end, in Paper 3 I raised a critical question: to what extent is the reifying of ‘evidence-based policy’ limiting opportunities for participation, through the way its practice legitimates particular voices to the exclusion of others? Paper 4 takes up this question by further interrogating the co-constitutive power-effects of ‘evidence-based policy’ and the ‘consumer participation’ agenda.

The extent to which the voices of the ‘affected community’ are included in drug policy has been the focus of much research in the drug policy field, but these concerns are rarely considered alongside the ‘evidence-based’ drug policy endeavour. In all three case studies examined in this thesis, people with lived experience of drug use (including not only people who use drugs, but also treatment service ‘consumers,’ those who identified as being ‘in recovery,’ and family members) were involved in policy discussions. In Paper 3, I identified the delegitimisation of the voices of drug user organisation representatives as one possible deleterious effect of ‘evidence-based policy’ discourse. Here, in Paper 4, I examine how the practices of ‘evidence-based’ drug policy and ‘consumer participation’ elicit and shape ‘consumer’ subjectivities. To do so, I draw on a range of critical perspectives including Foucault’s concept of subjugated knowledges, the work of feminist theorists (including Judith Butler and policy theorist Carol Bacchi), as well as recent research in the drug policy field regarding conceptualisations of emergent policy publics (building on Michael Warner’s work regarding ‘publics’ and ‘counterpublics’). Through analysis of 41 semi-structured in-depth interviews collected across all three case studies, I explore how ‘consumers’ are enacted as particular kinds of political subjects within the specific practices of an ‘evidence-based drug policy’ world, and consider how the centralising power-effects of this dominant paradigm might be limiting opportunities for participation and restricting modes of engagement.

Abstract

For over twenty years there have been calls for greater 'consumer' participation in health decision-making. While it is recognised by governments and other stakeholders that 'consumer' participation is desirable, barriers to meaningful involvement nonetheless remain. It has been suggested that the reifying of 'evidence-based policy' may be limiting opportunities for participation, through the way this discourse legitimates particular voices to the exclusion of others. Others have suggested that assumptions underpinning the very notion of the 'affected community' or 'consumers' as fixed and bounded 'policy publics' need to be problematised. In this paper, drawing on three case studies and interviews (n=41) with individuals closely involved in Australian drug policy discussions, we critically interrogate the productive techniques and constitutive effects of 'evidence-based policy' and 'consumer participation' discourses in the context of drug policy processes. To inform our analysis, we draw on and combine a number of critical perspectives including Foucault's concept of subjugated knowledges, the work of feminist theorists, as well as recent work regarding conceptualisations of emergent policy publics. First, we explore how the subject position of 'consumer' might be seen as enacted in the material-discursive practices of 'evidence-based policy' and 'consumer participation' in drug policy processes. Secondly, we consider the centralising power-effects of the dominant 'evidence-based policy' paradigm, and how resistance may be thought about in this context. We suggest that such interrogation has potential to recast the call for 'consumer' participation in health policy decision-making and drug policy processes.

Key words

Evidence-based policy, consumer participation, subjectivity, drug policy, poststructuralism, Australia

Introduction

For over twenty years there have been calls for greater ‘consumer’ participation in health policy decision-making, and in drug policy processes more specifically (Australian Injecting and Illicit Drug Users League, 2008; Charles & DeMaio, 1993; Crawford, et al., 2002; Forster & Gabe, 2008; Harrison, Dowswell, & Milewa, 2002; Jürgens, 2008; Lancaster, Ritter, & Stafford, 2013; Latkin & Friedman, 2012; Rance & Treloar, 2015; Tritter & McCallum, 2006; Wait & Nolte, 2006; WHO Regional Office for Europe, 1994). The slogan of “nothing about us without us” has been taken up by diverse groups including disability activists, non-government organisations, and drug user advocacy organisations, to signal the intent that no policy decision should be made without meaningful engagement with the ‘affected community’ (Canadian HIV/AIDS Legal Network, International AIDS Alliance, Open Society Institute, & International Network of People Who Use Drugs, 2008; Charlton, 1998; Gaventa & Cornwall, 2008; Jürgens, 2008). ‘Consumer’ participation in health policy is seen to promote greater local-level accountability (Conklin, Morris, & Nolte, 2015; Duckett & Willcox, 2011; Tritter & McCallum, 2006; Wait & Nolte, 2006) but, more than this, reflects a broader trend towards inclusive democratic participation and pluralisation of knowledge in the policy process (Gaventa & Cornwall, 2008). For example, the development of the concept of ‘deliberation’ in policy processes, whereby different participants “deliberate to arrive at decisions which neither party would reach on their own” (Gaventa & Cornwall, 2008, p.183), has arguably opened up possibilities for new understandings of science and knowledge. This move towards democratic participation and pluralisation of knowledge can, in some ways, be seen as a counterpoint to the privileging of ‘objective’ scientific knowledge within ‘evidence-based policy’ discourse, which has dominated health and drug policy since the late 1990s (Ritter, 2015).

While it is generally recognised by governments and other stakeholders that ‘consumer’ participation is desirable, barriers to meaningful involvement are continually documented (for examples at the service level in the Australian drug treatment sector, see: Australian Injecting and Illicit Drug Users League, 2008; Bryant, Saxton, Madden, Bath, & Robinson, 2008; Treloar, Fraser, & valentine, 2007; Treloar, Rance, Madden, & Liebelt, 2011). Even where participation is encouraged, “access to new spaces does not automatically imply greater presence or influence of new voices within them” (Gaventa & Cornwall, 2008, p.184). The relationship between participation, knowledge and power is pivotal, and leads to critical questions

regarding not only what kind of knowledge is considered relevant for the policy process, but also *who* may legitimately speak (Bacchi, 2009). In this context, we suggest that the ‘evidence-based policy’ paradigm and ‘consumer participation’ agenda ought to be considered together, given their potentially co-constitutive power-effects. As Jasanoff (2013, p.26) argues, the “practices of depoliticisation that bound science off as an apolitical space often go hand in hand with the construction of lay publics as scientifically illiterate, and hence unfit to participate fully in governing societies in which scientific knowledge matters.” In the drug policy field, it has been suggested that the reifying of ‘evidence-based policy’ may be limiting opportunities for participation, through the way that taken-for-granted ‘truths’ implicit within this discourse privilege particular kinds of ‘objective’ and ‘rational’ voices to the exclusion of others (Lancaster, Treloar, & Ritter, under review). Others have suggested that assumptions underpinning the very notion of the ‘affected community’ or ‘consumers’ as pre-existing, fixed and bounded ‘policy publics’ need to be problematised (Fraser, Seear, & valentine, in press).

Building on this poststructuralist critique, in this paper we draw on three case studies and interviews (n=41) with individuals closely involved in Australian drug policy discussions, to critically interrogate the productive techniques and constitutive effects of ‘evidence-based policy’ and ‘consumer participation’ discourses in the context of drug policy processes. Drawing on a range of critical perspectives (outlined in detail below), the aims of our analysis are twofold: first, to explore how the subject position of ‘consumer’ might be seen as enacted in the material-discursive practices of ‘evidence-based policy’ and ‘consumer participation’ in drug policy processes; and secondly, to consider the centralising power-effects of the dominant ‘evidence-based policy’ paradigm, and how resistance may be thought about in this context. We suggest that such interrogation has potential to recast the call for ‘consumer participation’ in health policy decision-making and, moreover, contribute to a growing body of research within the drug policy field which has questioned the privileging of particular scientific modes of “evidencing” in drug policy deliberations (Fraser, 2015; Fraser, Moore, & Keane, 2014, p.236; Lancaster, 2014, 2016b; Lancaster, et al., under review).

Approach

To inform our analysis, we draw on and combine a number of critical perspectives including Michel Foucault’s concept of subjugated knowledges, the work of feminist theorists (including Judith Butler and policy theorist Carol Bacchi), as well as recent work in the drug policy field regarding conceptualisations of emergent policy publics (Fraser, et al., in press).

Foucault used the term 'subjugated knowledges' in two ways, and it is the second of his meanings that is of relevance to this paper. 'Subjugated knowledges' are local knowledges which have been "kept in the margins," that is, "a whole series of knowledges that have been disqualified as nonconceptual knowledges, as insufficiently elaborated knowledges: naïve knowledges, hierarchically inferior knowledges, knowledges that are below the required level of erudition or scientificity" (Foucault, 2003, pp.7-8). These are "ways of thinking and doing that have been eclipsed, devalued, or rendered invisible within dominant apparatuses of power/knowledge" (Sawicki, 2005, pp.381-382). Foucault (2003, p.8) argued that "it is the reappearance of what people know at a local level, of these disqualified knowledges, that made the critique possible." Applying Foucault's concept to policy, Bacchi suggests that subjugated knowledges "provide points of rupture to challenge conventional 'knowledges'" (Bacchi, 2009, p.36) and "create the space for challenge" (Bacchi & Eveline, 2010, p.6). This point regarding *resistance* connects intimately with Foucault's conceptualisation of power. Foucault's writings eschew the assumption that particular people or groups are in 'possession' of power. Foucault (1980) argues that power is *productive* rather than repressive, constituting and shaping subjectivities.

In describing the "insurrection of knowledges," Foucault stresses that the resistance which accompanies the uncovering of 'subjugated knowledges' is not so much about rejecting knowledges or the "contents, methods, or concepts of a science" but rather "an insurrection against the *centralizing power-effects* that are bound up with the institutionalization and workings of any scientific discourse organized in a society such as ours" (Foucault, 2003, p.9, emphasis added). Following Bacchi (2009), and building on our own work (Lancaster, 2016b; Lancaster, et al., under review), we take up these ideas to consider the effects of the dominant 'evidence-based policy' paradigm on the call for greater consumer participation in health policy processes, and how resistance may be thought about in this context.

Our interest in subjugated knowledges and the constitutive effects of 'evidence-based policy' discourse accords in many ways with the interests of feminist researchers and theorists who have sought to uncover subjugated knowledges, and asked critical questions about who gets to delineate and decide what knowledge may be regarded as legitimate (Bacchi, 2009; Haraway, 1988; Harding, 1986; Hartsock, 2004; Hesse-Biber, 2012; Oakley, 1990). Bacchi (2009, p.239) suggests that in contemporary society, the concept of 'knowledge' is produced in narrow and instrumental ways which has a range of political effects including "reinscribing

objectivist criteria for identifying 'knowledge' [and] privileging some 'knowledges' – e.g. scientific, evidence-based – over other (subjugated) 'knowledges' – e.g. contextualised, embodied, lay 'knowledges.'" It is the idea that particular kinds of knowledge are more "useful" than others which "stands behind and legitimates *evidence*-based policy processes" (Bacchi, 2009, p.241, emphasis original).

We suggest that these perspectives have important implications for how we think about the call for greater 'consumer' participation in health and drug policy processes. If, as Foucault (1980) argues, power circulates and is not possessed, it is not simply a matter of wresting power from the medical profession or policy makers and 'giving' more to 'consumers' through greater participation in policy processes (Lupton, 1997). Evaluative critiques of 'consumer' participation which have concluded, for example, that "the success of public involvement is contingent on policy makers' genuine willingness to yield power to the public and the public's genuine engagement in the health policy process" (Wait & Nolte, 2006, p.159) do not resonate with a Foucauldian approach which sees power as diffuse, circulating, and productive of forms of subjectivity. A more complex view of how policy processes constitute particular political subjectivities, and gives legitimacy to some voices and not others, is required. More specifically, in the contemporary policy environment, a critical view of how 'evidence-based policy' discourse produces relations of power and constitutes subject positions is necessary.

The notion that subjectivities are produced, not given, links to another important point regarding the fixing of particular categories of participants in policy processes. In many ways, the call for greater 'consumer' participation in healthcare assumes that there is a discrete and identifiable 'affected' (usually 'marginalised') community who should be consulted and included, separate or distinct from the category of 'policy maker' or 'expert.' It assumes that there are fixed and bounded categories of political subjects who can be engaged to perform particular roles within the policy process, and that these groups have inherent interests and similarly bounded knowledges on which to draw. However, as Bacchi and Eveline (2010, p.7) explain, from a Foucauldian perspective, political subjects are not 'fixed' but "emergent 'types' shaped in interaction with discourse and other practices." This argument has also been taken up by feminist theorist Judith Butler (1990) in her account of performativity, which takes as its starting point a critique of 'political representation' and what this notion assumes about the stability of what constitutes the category of 'women.' As Butler (1998, p.273) argued:

On the one hand, *representation* serves as the operative term within a political process that seeks to extend visibility and legitimacy to women as political subjects; on the other hand, representation is the normative function of a language which is said either to reveal or to distort what is assumed to be true about the category of women.

Likewise, the category of ‘consumer’ can be seen as a type which emerges from, and is reinforced by, material-discursive practices including ‘consumer participation’ and ‘evidence-based policy.’ We draw on these ideas to explore the ways in which ‘evidence-based policy’ discourse and the ‘consumer participation’ agenda partially shape these emergent ‘types’ in health policy processes, unpick what is assumed to be true about the category of ‘consumers,’ and explore possibilities for alternative constructions and resistance.

As has been argued by Fraser et al. (in press), the notion of pre-existing bounded ‘publics’ obscures a more complex process by which these ‘publics’ are imagined and thus constituted by the policy-making endeavour. Drawing on Warner’s (2002) work on ‘publics and counterpublics,’¹ Fraser et al. (in press) argue that publics do not precede but rather are *made in* policy and, in doing so, reframe ‘publics’ as “emergent collectivities of interest.” Fraser et al. (in press) critique the assumptions underpinning the call for greater ‘consultation’ of ‘affected communities’ in drug policy processes, and reconceptualise the ways in which multiple and emergent publics of drug use may be “*thrown up* and their knowledges both aired and opened to revision.” Thus, this reconceptualisation brings into question the idea that stable, bounded population groups should (or could) be ‘consulted’ or ‘included’ in policy processes. While Warner’s enacted publics are necessarily unstable, Fraser et al. suggest that this very instability may be regarded as an opportunity for new and different modes of engagement. Importantly for our analysis here (and in many ways resonating with the theoretical approaches outlined above), Fraser et al. note that both the emergence and the legitimacy of particular publics are produced through discourse and are effects of power. From this perspective, we consider the ways in which ‘evidence-based policy’ discourse and the ‘consumer participation’ agenda produce ‘publics,’ and, more specifically, how ‘consumers’ (so often presumed to be a bounded and anterior public) are enacted in the practice (and our participants’ accounts) of policy processes.

¹ Warner’s theorisation of ‘publics’ has also been taken up in other drugs, HIV and sexual health research (e.g. Bell & Aggleton, 2012; Duff & Moore, 2015; Farrugia & Fraser, 2016; Race, 2009).

Method

To explore these questions, we analysed interview data gathered to inform case studies which documented the development of three contemporary drug policy issues in Australia: (i) the development of opioid overdose prevention and management strategy, with a particular focus on examining the processes leading to the establishment of two programs to make naloxone available to potential overdose witnesses in Canberra, ACT and Sydney, NSW; (ii) the development of approaches to extend distribution of injecting equipment through peer networks (also called 'secondary supply' or 'peer-distribution') in Sydney, NSW; and (iii) the development of 'recovery' approaches to drug policy and drug treatment provision.² Across the case studies, 41 semi-structured in-depth interviews were conducted with policy makers (n=5), advocates (n=2), non-government organisation representatives (n=5), consumer representatives (n=7), researchers (n=11) and clinicians (n=7) closely involved in these policy processes. Four of these participants (two clinicians, one advocate, and one consumer representative) were interviewed across two of the cases, given their close involvement in different policy processes. Interviews were on average one hour in length (ranging from 30 minutes to over 2 hours). The interview guide focussed on eliciting participants' accounts and perceptions of policy activity pertaining to one of the three case studies, the processes through which policy activity occurred, and the roles of multiple knowledge(s) and 'voices.' The interviews were audio-recorded and transcribed verbatim. Participants were sent a copy of their transcript to review for the purposes of verifying accuracy, correcting errors or inaccuracies, and providing clarifications.

Transcripts were de-identified and then coded with the assistance of NVivo 11 software. Initial coding identified a range of knowledges and voices at work within the policy processes, the roles of various participants, and the practices of policy activity. Coded data were then re-analysed for the purposes of this paper, paying close attention to the roles of those with lived experience of drug use, the kinds of knowledge(s) invoked by these participants, and how their roles and knowledge(s) were perceived by others involved in policy discussions. This re-analysis and subsequent identification of themes was informed by close reading of the data and the theories outlined above. This process of coding and re-analysis emulated an approach which has been described as 'adaptive coding' (Radcliffe & Stevens, 2008). Ethical approval for

² A methodological and reflexive account of this research is given elsewhere (Lancaster, 2016a).

this study was given by the University of NSW Human Research Ethics Advisory Panel (HREA Approval Numbers: 9_12_002; 9_13_018; 9_14_008; HC15145) and NSW Ministry of Health (HREC Reference Number 14/029). Written informed consent was obtained from all participants, and participation was voluntary.

Analysis

Enacting difference; constituting ‘consumers’

Across the interviews, there was widespread discussion of the notion of ‘participation’ and ‘representation.’ Bringing “the key players together” (Researcher) was regarded as a commonplace practice in Australian drug policy, and participants often discussed formal mechanisms such as committees, roundtables, working groups and meetings as being a central part of policy activity. As one participant noted:

I think the idea that having consumers, researchers, government policy people, and an NGO policy person, like a peak³ or something, and then a practitioner, is a really nice example of bringing the pieces of the sector together. And I think often people try and form their committees based on possibly that type of representation. (Non-government organisation representative)

In this participant’s comments we see how the drug policy ‘sector’ is imagined as a fragmented collection of different, pre-existing groups and interests which need to be ‘brought together.’ The notion of ‘representation’ relies on this assumption and in so doing produces each of these groups or types as discrete, each with separate and distinct interests to bring to the process. So while the participant speaks of ‘bringing the pieces of the sector together,’ the account implicitly enacts the notion of difference and separateness, and assumes that different perspectives, knowledges and fixed interests precede the policy process.

‘Consumers’ were thought to be one of these pre-existing groups requiring ‘representation’ in drug policy processes. Participants frequently expressed the idea that ‘consumers’ ‘see differently’:

³ The term ‘peak’ is used in Australia to describe an advocacy association which represents the interests of an affiliated group of industry members or non-government organisations.

[It] is the perspective of the affected community and if you're not within that affected community sometimes there's things you don't see. (Consumer representative)

Here, the 'affected community' is enacted as a single, pre-existing, bounded group which is separate to and distinguished from others 'not within' that group. Underpinning the notion of 'representation' in these processes was the assumption that it was possible to 'speak from' this pre-existing, homogenous 'affected community perspective':

She's speaking from an affected community perspective; she brings all that to it.
(Researcher)

By saying "she brings *all that* to it," in this participant's short-hand comment we also see how it is expected that the interviewer will know and share assumptions about what the 'affected community perspective' might be; what constitutes 'all that' as the 'affected community perspective' is taken-for-granted and may go without saying. This comment also assumes that the 'affected community perspective' is uniform and consistent, and that it is possible for one person to 'represent' that single, bounded interest.

As participants discussed the need to incorporate the 'perspective' of the 'affected community' in drug policy activities, it was almost universally assumed that 'consumers' would be less powerful actors than others engaged in the policy process:

[Consumer representatives] represent a very marginalised group that don't necessarily have that weight in terms of votes or what not. (Policy maker)

While we do not deny that there are real socio-economic, cultural and political conditions which mean that people who use drugs are often marginalised in society, we suggest that the notion of 'representation' in drug policy processes is one practice which partially shapes and compounds this marginalisation, by producing the difference of 'consumer' interests and restricting the possibilities for imagining how the category of 'consumer' might be otherwise constituted. For example, the very structure and membership of committees often reinforced this different, marginalised positionality:

Yeah it's a bit of a minority voice; at most of these committees or meetings I go to I'm often the only drug user voice there. [...] Depending on the group or the committee I sit on it can be intimidating in some respects being the only voice there, particularly with the bigger more formal networks and committees that I sit on. Sometimes I'm

there with 25 other people who may be all clinicians or professors. (Consumer representative)

The ways in which 'evidence-based policy' discourse privileges the 'objective' and 'rational' knowledge of clinicians and researchers, over and above other ways of knowing, is reflected here in the make-up of the committee. The committee membership is heavily weighted towards 'scientific voices' which necessarily constitutes the 'consumer voice' as marginalised and lesser even before the work of the committee has begun.

The constitution of 'consumers' as less powerful or necessarily marginalised had implications for whether or not their voices could be regarded as legitimate in policy discussion:

Participant: Poor [participant names a consumer representative] would say something and government would just be like [participant indicates a silent pause] – and it's not the people that would do that, it's just the system would be like "no we can't accept this from you because of who you are."

Interviewer: Right, so it wasn't the content it was...

Participant: It was the messenger. It was all about the messenger. (Non-government organisation representative)

The distinction made here between 'the people' and 'the system' points towards the productive and constitutive power of the process itself. While the government policy maker seemingly does not know how to respond, and cannot accept the legitimacy of the consumer's voice and knowledge, the participant suggests that this is not a personal failing of the government policy maker but an effect of the way 'the system' sees the 'consumer representative.' In this 'system' the 'consumer's' knowledge cannot be seen as legitimate not because it is not relevant, but because of the 'consumer representative's' political subjectivity. We suggest that it is this 'system,' the 'evidence-based policy' process itself, which partially shapes and constitutes this 'illegitimate' subjectivity and which keeps consumer knowledge (or other ways of thinking and doing policy) "in the margins" (Foucault, 2003, p.8).

Given these assumptions about the stability of what constitutes the category of 'consumers,' even those participants who explicitly said they valued the idea of 'consumer participation' sometimes found it difficult to articulate how the knowledge and expertise brought to the policy process by 'consumers' could be regarded as legitimate within the dominant 'evidence-based policy' paradigm:

It's not always common to value expert knowledge from your community base as opposed to a professional base, even though I think peer organisations are professional, but you know what I'm getting at? (Researcher)

This participant's struggle to articulate what is meant by the notion of 'professionalism' reveals a tension between 'evidence-based policy' and the 'consumer participation' agenda. Although the participant wants to emphasise that she regards consumer representatives (here, peer-based drug user organisations) as professional, she has already set up a distinction between 'community' and 'professionals'; that is, between what is assumed to be true about 'consumer representatives' and what is assumed to be true about others (such as researchers and clinicians, who are rendered legitimate through 'evidence-based policy' discourse). In doing so, the participant invokes an implied binary distinction between 'professional' and its antonym 'amateur,' where 'professionalism' is privileged. The construction of consumer representatives as 'amateur' ('not professional') is particularly interesting in the Australian context, given that the consumer representatives who generally do this policy work are paid employees of formally constituted peer-based drug user organisations which are funded by the Australian government or state and territory health departments. 'Not professional' in this context is not taken to mean 'unpaid' or 'voluntary' (as the ordinary antonym of 'professional' would imply) but rather 'non-expert,' which is a more significant construction in the context of 'evidence-based policy' discourse. Returning to the participant's own words, 'not professional' becomes synonymous with less *valued* and less valid.

Given that the category of 'consumer' was enacted as 'different' to 'experts,' and assumed to be a less valid, valuable, powerful or 'professional' voice, participants were somewhat surprised when consumers took the lead in drug policy processes. In two of the case studies under investigation (naloxone provision and extended distribution of injecting equipment), consumer representatives played a key role. Some participants reflected on why this should be surprising:

We are remarking on it as different and unusual and also fantastic. But [...] in the HIV field it would be expected that the community organisations are taking the lead. So why do we see it as so remarkable here? (Researcher)

This contrast between the HIV field and the drug policy field was mentioned by more than one participant. This observation demonstrates the ways in which *it is possible* for disqualified, subjugated knowledges to come to the fore in health policy, and how resistance can lead to

different forms of subjectivity. It also illustrates how “what is assumed to be true” (Butler, 1998, p.273) about ‘consumers’ is crucially important for the way that individuals within the policy process think about capabilities and capacity for contribution (that is, who may legitimately speak and what kinds of knowledges are ‘policy-relevant’), and highlights how ‘consumers’ can be otherwise enacted in different policy contexts. For example, another participant compared the drug policy field to the youth sector:

Our sector has unbelievably bad participation and actually we don't believe that people can do stuff and the whole way that we talk about things is in the deficit, and it's all about peoples' problems and stuff and you know, you look at other sectors [such as] youth [...] and all you ever talked about was young peoples' strengths, their potential, the skills that they have. You never ever talked about their problems. (Non-government organisation representative)

From this analysis we can see that the enactment of ‘consumers’ as a different pre-existing group, as well as taken-for-granted assumptions underlying what constitutes the category of ‘consumer,’ had implications for how people with lived experience of drug use could participate within drug policy processes. Where these assumptions and presumed-to-be anterior political subjectivities intersected with the practices of ‘evidence-based policy’ in government bureaucracy, ‘consumer’ knowledge was delegitimised. Participants’ reflections on other sectors where the centralising power-effects of dominant scientific discourses have been resisted also reveals the ways in which ‘consumer’ subjectivities could be made *otherwise*.

Difference and resistance

We suggest that the enactment of the pre-existing difference of ‘consumers,’ and the taken-for-granted assumptions accompanying that category, sets up an oppositional dynamic in the context of ‘evidence-based policy.’ This oppositional dynamic played out in two ways: first, by ‘consumers’ invoking the ‘evidence-based policy’ paradigm; and secondly, as a seemingly unresolvable problematic which generated tension (but which, we suggest, may provide the grounds for resistance against the centralising power-effects of ‘evidence-based policy’ discourse).

Cast into a position of difference, in some cases ‘consumers’ deliberately invoked the language of the ‘evidence-based policy’ paradigm in order to be seen as legitimate voices:

I think we constantly need to be stating the evidence or highlighting the evidence because it supports the very thing that we do [...] If we're quoting the evidence then *it makes us stronger, it can't be argued with*. (Consumer representative; emphasis added)

Here, we see the dominance of the evidence-based policy paradigm: evidence “can't be argued with.” By performing ‘evidence-based policy’ and invoking the language of ‘objective’ and ‘rational’ evidence, it was thought that consumer subjectivities could also be remade as strong, legitimate voices that could not be discounted. In one sense, this might be read as a form of resistance insofar as ‘consumers’ sought to take up and reverse techniques of power and formal discourse (here, ‘evidence’ and ‘rational’ argument). Multiple participants regarded this as a crucial way for consumer representatives to be seen as legitimate in policy processes, but ascribed this skill set to only a handful of consumer representatives in the Australian drug policy sphere (perhaps highlighting the limitations of these techniques to open up sites for resistance):

That kind of skill set that a couple of individuals hold, that are seen as legitimate to government bureaucracies or funders or whatever, compared to the other skill sets that people who have vast lived experience [hold]. (Researcher)

The ‘other skill sets’ presumed to be held by people with lived experience of drug use were not seen by government as legitimate, and were therefore kept “in the margins” (Foucault, 2003, p.8). Indeed, it was because particular consumer representatives could seemingly divorce themselves from other ways of thinking and doing, and instead practice modes accepted within ‘evidence-based policy,’ that they could be made legitimate:

Her presentation at meetings is just so thoughtful and considered and inclusive. Yeah she becomes passionate and sometimes angry, but the foundation of her arguments are always so clear, and I think that helps her have that credibility with the bureaucrats who may have seen her function as – like, *she's not entirely embedded in her own lived experience*. You know, she thinks systemically and she thinks organisationally and she thinks research and she thinks HR, and all those things are on display. (Researcher; emphasis added)

Here, lived experience and passion are constituted as the antithesis of clear and systematic reasoning. Considered, rational argument and objectivity divorced from lived experience fit

with the dominant apparatuses of the 'evidence-based policy' paradigm and its outworking in bureaucratic processes. Lived experience (and indeed emotion) is devalued.

Where people with lived experience of drug use were engaged in policy processes, but did not perform in the modes expected by the 'evidence-based policy' paradigm, seemingly unresolvable tensions emerged. In these situations, the knowledge of consumer representatives clashed with 'expert' knowledge and was seen as problematic:

What was particularly frustrating about it [the process undertaken to design the program], I think, was that we had bureaucrats telling us to change wording because it didn't make sense to them, and we were saying "But this is not a program for you. You don't need to understand this. Any injecting opioid user is going to understand this language" and you know, wanting us to include definitions for, like, if someone 'drops' and they're like, "Oh you need to include a definition" and we're like, "No we don't need to include a definition. Anybody at the training program knows what that means." (Consumer representative)

Here, epistemological tensions between what may be known through embodied, lived experience and what may only be known through scientific or 'evidence-based' definition are evident. But it is in these moments of tension between the requirements of the 'evidence-based policy' paradigm and one of the central tenets of the 'consumer participation' agenda that we see points of rupture and the opening up of space for resistance against the centralising power-effects of scientific discourse. 'Consumer representatives' would be engaged to ensure that the program was acceptable for the intended recipients of the intervention, and yet it is on this very point that 'expert' and 'consumer' knowledges clash. Other ways of knowing butt up against the requirements of 'evidence-based policy' discourse (and its emphasis on objective measurement and definition) thereby producing 'consumers' as oppositional political subjects because they do not acquiesce to dominant and privileged ways of thinking and doing. Ways of knowing which have been rendered invisible in 'evidence-based policy' discourse reappear here, and make critique possible.

The oppositional subjectivity produced through the apparent clashing of the dominant 'evidence-based policy' paradigm with the purported aims of the 'consumer participation' agenda meant that it was assumed that 'consumers' would occupy argumentative positions in policy discussion:

Sometimes I feel in the policy debate, at meetings or whatever, *I'm the person who's expected to say the stuff* that they all - everyone else wants to say around the table but they're kind of too afraid to for repercussion of that. People will come up to me after and say, "Thank god you said that. I thought it was really important." And I turn around and say, "Well, if it's that important you should say it because why am I just the squeaky wheel in the corner?" (Consumer representative)

From these data we see that 'consumers' are somewhat stuck between a rock and a hard place. By engaging in particular modes endorsed by the 'evidence-based policy' paradigm in order to become legitimised political subjects, 'consumers' paradoxically uphold and sustain material-discursive practices which ultimately devalue other ways of thinking and doing. When consumers seek to deploy knowledge gleaned through lived experience (knowledges 'disqualified' within the scientific modes of 'evidencing' endorsed by the 'evidence-based policy' paradigm) as the 'consumer participation' agenda requires, they are constructed as oppositional political subjects. In this analysis, we see the ways in which 'consumers' are "complicit" in the reproduction of power, as well as "frequently seeking to challenge it" (Lupton, 1997, p.106). However, we suggest that it is in this very tension that we see the *immanence of resistance to power*. This tension brings back into play devalued or disqualified knowledges and creates the space to resist against the centralising power-effects of 'evidence-based policy' discourse which has devalued 'consumers.' In these examples, we see the ways in which the co-constitutive effects of 'evidence-based policy' and 'consumer participation' discourses produce power relations characterised by struggle where although it may not be possible to completely escape the centralising power-effects of these dominant discourses per se, 'consumers' find ways to "escape the particular strategy of power relation that directs one's own conduct" thus opening up the possibility for reversing a discourse of power into one of resistance (Simons, 1995, pp.84-85).

Conclusion

While the 'consumer participation' agenda may be understood as emerging in response to the privileging of 'objective' scientific knowledge in the 'evidence-based policy' paradigm, seeing 'consumer participation' and 'evidence-based policy' as separate movements denies the co-constitutive power-effects of these contemporaneous discourses. It is not enough to inquire into how people with lived experience of drug use ('consumers') can be more fully engaged in drug policy processes (Fraser, et al., in press), we also need to interrogate how the category of

'consumer' is "produced and restrained" (Butler, 1998, p.275) by the structures through which representation is sought. While, in theory, the aim of 'consumer participation' has been to broaden modes of engagement and pluralise the kinds of knowledge which may come to bear on policy processes, our analysis demonstrates the ways in which the productive techniques and constitutive effects of both 'evidence-based policy' and 'consumer participation' discourses may be restricting opportunities for doing so.

In this paper, we have identified the ways in which 'consumers' are "formed, defined, and reproduced in accordance with the requirements" (Butler, 1998, p.274) of both 'evidence-based policy' and the given representational politics of the 'consumer participation' agenda in health, and the complex ways in which these discourses intersect to produce subjectivities in the day-to-day practices of policy activity. We found that 'consumers' are *made as* 'different' and their interests (along with their apparent difference) understood to precede the policy process. Drug policy processes restricted possibilities for imagining the multiple ways in which 'consumers' (and their interests) might be understood. In a social and political environment where policies and practices already constitute people who use drugs as irrational and illegitimate political subjects (for example, see Fraser & valentine, 2008; Harris & McElrath, 2012) we suggest that the very processes which purport to engage people who use drugs in making decisions about policies governing their own health may also be partially shaping these subjectivities. To overcome what we see as being problematic subjectification effects, finding modes of engagement which allow for multiple possibilities and emerging political subjectivities would appear to be an essential endeavour. As Butler (1990, p.viii) argued, "[o]ne might wonder what use 'opening up possibilities' finally is, but no one who has understood what it is to live in the social world as what is 'impossible,' illegible, unrealisable, unreal, and illegitimate is likely to pose that question." So long as the practices of drug policy continue to contribute to the shaping of 'consumer' identities as necessarily marginalised, illegitimate, oppositional and less valid, the possibilities for truly deliberative processes (whereby relations of knowledge and power, as well as political subjectivities, may be remade) seem unattainable.

By turning our attention to the productive techniques and constitutive effects of 'evidence-based policy' and 'consumer participation' discourses (as they are practiced together in policy processes), our analysis has opened up possibilities for considering how resistance against these centralising power-effects might be conducted. What both discourses share is an emphasis on *seeking knowledge* in the policy process; that is, the presumption that knowledge

is accessed from places or people external to the locations of bureaucratic policy-making. By problematising this shared taken-for-granted assumption, it may be possible to open up spaces for rethinking the constitution of both 'consumer' subjectivities and 'policy-relevant knowledge.' Fraser et al. (in press) have suggested that the model of 'consultation' (and may we suggest, also 'participation' and 'representation') ought to be reconsidered so that "its complicity in the present economy of restriction might be displaced." Our extension of this analysis, to include examination of the constitutive effects of 'evidence-based policy' discourse alongside representational politics, opens up further questions still. By drawing on Warner's conceptualisation of emergent 'publics,' Fraser et al. (in press) have proposed the notion of 'conference' (over 'consultation') as a way of unfixing the presumed stability of political subjectivities, and opening up a temporary and flexible space to gather around an issue of concern. While we agree that there is much to be explored from that perspective, we suggest that there may be additional ways to "theorise the 'space for challenge'" (Bacchi, 2009, p.237).

As Bacchi and Eveline (2010, p.8) note, "mainstream institutional practices are not the only practices that involve people, and hence they are not the only factors that shape them. Practices 'from below,' such as participation in advocacy or community activities, are also constitutive, creating new subject positions and the potential to challenge dominant discursive constructions." This point highlights the potential for treating 'consumer participation' discourse as a resource for reproblematisation. The problematic effects identified in our analysis may help to create space to reframe the 'evidence-based policy' and 'consumer participation' agendas in such a way that produces political subjectivities which are not seen as fixed and, in the case of 'consumers,' always already different and therefore, by extension, problematic if not seen to be playing by the rules of the bureaucratic policy-making game. As we have observed above, too often 'consumers' were outnumbered on committees or engaged in tokenistic ways, which sustained their constitution as marginalised subjects. Given the dynamic and contextual nature of political subjectivities, there is potential to reconfigure the notion of 'consumer participation' in such a way that *other* 'consumer' 'types' might be produced. For example, consider how subjugated knowledges might re-emerge and subject positions might be remade if one 'scientific' voice were to sit on a committee alongside 25 people with lived experience of drug use, and a diverse multiplicity of knowledges brought to bear; or if drug user organisations (as was discussed by participants in the case of the HIV field) were to routinely lead policy processes. Through such processes, how might the assumptions underpinning the privileging of particular kinds of knowledge as relevant and legitimate for

policy processes then be reconfigured and continually opened to revision? As we noted earlier, this is not a matter of wresting power from 'experts' and 'giving' power to 'consumers,' but rather seeking new modes of engagement (that is, different ways of thinking and doing). As Foucault (1980, p.82) argues, it is through the reappearance of disqualified, subjugated knowledges "that criticism performs its work" and resistance in opposition to the centralising power-effects of formal and scientific discourse can occur. Subjugated knowledges are local, discontinuous and "incapable of unanimity" (Pickett, 1996, p.461); an instability which gives rise to different modes of engagement and enactment. Such practices may lead to different modes of "evidencing" (Fraser, et al., 2014, p.236; Lancaster, 2016b), and produce different emergent subjectivities. In saying this, it is important to note that these are no more 'true' and also require critical interrogation and a key eye to their effects (Bacchi, 2009). While our analysis points to more complexities rather than resolutions to the question of how to involve people with lived experience in health policy processes, like Lupton (1997, p.108), we would suggest that "awareness of these difficulties is itself an important outcome that has emerged" from the entrée of poststructuralist perspectives into the debate.

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Paper 5

Performing the evidence-based drug policy paradigm

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August, 2016

Preamble

In the first four papers I highlighted the political, contingent and emergent nature of 'things,' and the ways in which the 'problems' and 'subjects' which form the basis of policy analysis are not fixed but rather constituted in policy and practices. Here, I examine the ways in which the 'object' of 'evidence' is enacted in drug policy practices. As I noted in the Introduction to this thesis, while many studies have focussed on the use of evidence in drug policy processes, few have problematised the concept of 'evidence' itself.

In Paper 4, I drew on Judith Butler's account of performativity and engaged with the notion of emergent policy publics. In Paper 5, I extend this focus on *performance* by turning to the work of science and technology studies (STS) scholars. STS scholars, including Bruno Latour and Steve Woolgar (1979), have argued that the practice of science *produces* specific realities through inscription devices. The suggestion that methods do not simply discover or describe realities and social worlds but rather participate in their *enactment* (Law, 2004; Law & Urry, 2004) fundamentally challenges one of the central tenets of 'evidence-based policy.' This perspective destabilises the 'objectivity' of research 'evidence' and the superior status of this kind of knowledge for policy decision-making. But more than this, the idea of reality as enacted rather than fixed also raises questions about the stability and singularity of the thing we call 'evidence.' Annemarie Mol (1999, 2002) has argued that one implication of the reshaping of ontology as reality performed through practices is that *reality itself is multiple*. This opens up the possibility that "realities might in some measure *be made in other ways*" (Law, 2004, p.66). Mol (1999, p.79, emphasis original) raises a series of questions about the kind of *politics* that might accompany ontological multiplicity: "Where are the options? What is at stake? Are there really options? How should we choose?" By arguing that participants' accounts do not simply describe the drug policy process but rather *performatively constitute* the thing we call 'evidence,' in this paper I suggest that 'evidence-based drug policy' can be (and is already being) enacted in other ways.

Abstract

Through the lens of *performance*, this paper critically examines how 'evidence' and the 'evidence-based policy' paradigm are constituted in drug policy processes, enacted through the telling of policy stories. I argue that policy stories do not simply describe the drug policy process, but rather frame the notion of 'evidence' and 'evidence-based policy' in particular ways. Drawing on two Australian case studies and interviews with policy makers, advocates, researchers and clinicians involved in the establishment of harm reduction programs to extend distribution of injecting equipment through peer networks and make naloxone available for administration by overdose witnesses, I ask: what do participants' accounts of drug policy perform? And what might this imply? Through this analysis of participants' accounts, I argue that what we call 'evidence' is not fixed, but rather constituted by specific performances and practices. I suggest that these performances of the evidence-based drug policy paradigm are important, as they work to make and sustain (or, at times, interfere with) a set of assumptions about knowledge and rationales for policy action. This, in turn, raises questions about how the evidence-based drug policy endeavour might be reconsidered and remade in other ways.

Key words

Evidence based policy, performativity, enactment, policy knowledge, science and technology studies, drug policy

Introduction

To date, the focus of much of evidence-based policy scholarship has been on finding ways to bridge the divide between two communities: 'policy decision-makers' and 'knowledge producers.' In the field of drug policy research where the rhetoric of evidence-based policy has been enthusiastically embraced, efforts have centred on the production of 'gold-star' evidence and increasing its uptake in policy and practice through 'research translation' activities (Lancaster, 2014). To overcome perceived barriers, some drug policy researchers have also been dedicated to analysing policy processes so as to better understand how evidence is utilised in this highly politicised domain, and develop more nuanced models which explain the contested relationship between evidence and policy decision-making (e.g. Monaghan, 2009). However, such pursuits are underpinned by a number of presuppositions. Firstly, it assumes that policy-relevant knowledge (or 'evidence') is fixed, stable and inherently valuable in policy (Lancaster, 2014); that it is "both discrete and isolatable" (Wood, Ferlie, & Fitzgerald, 1998). Secondly, the preoccupation in policy scholarship with "understanding how externally generated knowledge finds its way into policy" presumes that this thing we call 'evidence' sits *outside* of the policy process thus perpetuating the 'two communities' dichotomy (Freeman & Sturdy, 2014, p.3).

A number of researchers and theorists working across a range of policy domains and disciplines have sought to problematise the notion of knowledge as something prior and external to policy. For example, Jasanoff (2004) argues for the 'idiom of co-production' of knowledge and policy. From this perspective, policy and knowledge are not distinct, but rather co-constitutive. Jasanoff (2004, p.3) contends that "knowledge-making is incorporated into practices of state-making, or of governance more broadly [...] States, we may say, are made of knowledge, just as knowledge is constituted by states." In the realm of clinical practice, Wood et al. (1998, p.1737) draw on poststructuralist approaches to argue against seeing evidence and clinical practice as "diametrically opposed." Instead they see the boundaries between research and practice as "indeterminate" and the nature of evidence itself as "ambivalent" (Wood, et al., 1998, p.1737). Wood et al. (1998, p.1737) suggest there is a need to move towards models that incorporate evidence and clinical practice in "a more immanent relationship." Taking this theoretical perspective out of clinical practice and applying it to policy development in multi-agency settings, Green (2000, p.472) concludes that "such phenomena as 'knowledge,' 'evidence' and 'practice' are not natural or necessarily distinct,

but are constituted through local and contingent practices.” Evidence here is not seen to be a “distinct entity” but rather “ambivalent and negotiable”; it is practice which “constitutes that evidence” (Green, 2000, p.472). Analysing the concept of evidence-based medicine (EBM) and its accretion into public policy, Harrison and Checkland (2009, p.136) suggest that the notion of ‘evidence-based medicine’ (and by extension, I suggest, evidence-based policy) involves more than knowledge; “it also entails relationships between such knowledge, the technologies through which it is codified and disseminated (such as systematic reviews and the Cochrane websites) and practised (such as medical interventions) and the humans engaged in the EBM project.” From this perspective, “EBM might be seen as a network into which ideas, technologies and humans are ‘enrolled,’ but which has to be constantly sustained through continued ‘performance’ of their interrelationships” (Harrison & Checkland, 2009, p.137).

Each of these writers set forth a view which destabilises the notion of ‘evidence’ as a fixed and stable thing existing outside of or distinct from the policy process, and focus attention on interrelationship and practice. In doing so, many of these approaches invoke the language of ‘constitution,’ ‘performance’ or ‘enactment.’ While those working within the broad church of ‘social constructionism’ have long highlighted the constructed nature of knowledge claims about the world (Hacking, 1999), the notion of ‘enactment’ is somewhat different (Law, 2004). Teasing the two apart, Law (2004, p.158) argues that:

Construction usually implies that objects start without fixed identities but that these converge and so gradually become stabilised as singular in the course of practice, negotiation and/or controversy. Enactment does not necessarily imply convergence to singularity, but takes difference and multiplicity to be chronic conditions.

While ‘construction’ implies completeness, ‘enactment’ invokes an ongoing process of becoming. For Law (2004, p.56):

To talk of enactment, then, is to attend to the continuing practice of crafting. Enactment and practice never stop, and realities depend on their continued crafting [...] And if things seems solid, prior, independent, definite and single then perhaps this is because they are being enacted, and re-enacted, and re-enacted, in practices. Practices that continue. And practices that are also multiple.

Here, Law relies on the arguments developed by another science and technology studies (STS) scholar, Annemarie Mol (1999, 2002). As Mol (1999, p.77, emphasis original) argues, “[t]alking

about reality as *multiple* depends on another set of metaphors. Not those of perspective and construction, but rather those of intervention and performance. These suggest a reality that is *done* and *enacted* rather than observed."

Thus, the perspectives outlined above suggest that what we call 'evidence' is not stable and distinct but rather constituted in policy and practice. The arguments put forward by STS scholars extend this and suggest that these ongoing enactments of 'evidence' lead to ontological multiplicity. In the context of drug policy scholarship, the question then becomes: how do the practices of drug policy enact (and re-enact) 'evidence' and the 'evidence-based policy' paradigm?

Law and Singleton (2000) offer a way forward in this examination. In their paper *Performing Technology's Stories*, Law and Singleton examine the field of technoscience. They argue that *accounts* of technoscience, that is the 'stories' told within the field, do not simply offer descriptions but rather *perform* technoscience realities. That is, accounts (stories) told by people within the field enact technoscience in particular (and different) ways. A differing empirical account (story) is not necessarily wrong, it is "*a particular and located enactment or performance of technological knowledge and practice* that does equally particular kinds of work" (Law & Singleton, 2000, p.767, emphasis original). Different people working within the field "perform alternative and different understandings of the character of technological knowledge" (Law & Singleton, 2000, p.767). Law and Singleton draw on several empirical accounts in their analysis. They highlight the ways in which the telling of technoscience stories may frame technology, for example, around the notion of "project" (Law & Singleton, 2000, p.768). In doing so, stories do not simply describe a technological 'project.' More than this, a particular story acts to "breath [sic] life into a whole set of assumptions that we might think of as '*projectness*'" (Law & Singleton, 2000, p.768). This implies, for example:

that technologies (in part) evolve under centralised control; that they need to be managed; that if they are fragmented then this is likely to be a problem; that they involve coordinated puzzle-solving; that they benefit from a coordinated perspective; that they indeed move through stages, have chronology; that they may have setbacks that need to be overcome [and so forth]. (Law & Singleton, 2000, p.768)

Law and Singleton (2000, p.769) argue that in this way stories told by the field are not "innocent descriptions" of what 'is,' they make a difference and interfere, therefore it is imperative to "understand how this happens." Since some descriptions may interfere to either

“prop up” or alternatively “undermine” other performances, this task is “both analytical and political” (Law & Singleton, 2000, p.769).

In this paper, I take the work of Law and Singleton (2000) as a springboard for analysis. Through the lens of *performance*, this paper critically examines how ‘evidence’ and the ‘evidence-based policy’ paradigm are constituted in drug policy processes, enacted through the telling of policy stories. I argue that policy stories do not simply describe the drug policy process, but rather frame the notion of ‘evidence’ and ‘evidence-based policy’ in particular ways. Drawing on two Australian case studies and interviews with policy makers, advocates, researchers and clinicians involved in the establishment of harm reduction programs to extend distribution of injecting equipment through peer networks and make naloxone available for administration by overdose witnesses, I ask: what do participants’ accounts of drug policy perform? And what might this imply? Through this analysis of participants’ accounts, I argue that what we call ‘evidence’ is not fixed, but rather constituted by specific performances and practices. I suggest that these performances of the evidence-based drug policy paradigm are important, as they work to make and sustain (or, at times, interfere with) a set of assumptions about knowledge and rationales for policy action. This, in turn, raises questions about how the evidence-based drug policy endeavour might be reconsidered and remade in other ways.

Method

The analysis in this paper is based on two empirical case studies documenting Australian drug policy processes. The first case examined the processes leading to the establishment of two recently implemented programs to make naloxone available to potential overdose witnesses in Canberra, ACT and Sydney, NSW. Naloxone (trade name, Narcan®) is a short-acting opioid antagonist, which temporarily reverses the effects of opioids and respiratory depression. It has been used for over 40 years by medical professionals, particularly in emergency medicine, and has been shown to be safe, reliable and effective in these settings (Dietze & Lenton, 2010). For more than two decades, researchers have argued that naloxone should be widely available to potential overdose witnesses, particularly people who inject drugs, to help prevent morbidity and mortality associated with opioid overdose (Baca & Grant, 2005; Coffin & Sullivan, 2013; Darke & Hall, 1997; Kim, Irwin, & Khoshnood, 2009; Lenton, Dietze, Degenhardt, Darke, & Butler, 2009; Strang, Darke, Hall, Farrell, & Ali, 1996). Until recently, naloxone was not distributed for peer-administration anywhere in Australia despite the accumulated international descriptive and observational evidence. In December 2011, Australia’s first

overdose prevention and management program providing naloxone on prescription to potential overdose witnesses was launched in Canberra (ATODA, 2013). Soon after, in June 2012, Sydney's first naloxone program was established through the Kirketon Road Centre and the Langton Centre.

The second case examined the development of a pilot program to extend distribution of injecting equipment through peer networks (also called 'secondary supply' or 'peer-distribution') in Sydney, NSW. Multiple legislative and policy barriers restrict access to sterile injecting equipment because needle and syringe programs (NSPs) operate under a series of exemption laws (Australian Injecting & Illicit Drug Users League, 2010; Lancaster, Seear, & Treloar, 2015; Legal and Discrimination Working Party of MACBBVS, 2013; NSW Users and AIDS Association, 2009). In most Australian jurisdictions it is ordinarily illegal to distribute or to provide injecting equipment to another person unless designated by law as an 'authorised' category of persons. In recent years there have been calls from advocates and drug policy experts to remove legislative barriers to peer-distribution of sterile injecting equipment as a way of improving coverage, reducing equipment reuse and enhancing peer education activities (ANCD, 2013; Australian Injecting & Illicit Drug Users League, 2010; Legal and Discrimination Working Party of MACBBVS, 2013; NSW Users and AIDS Association, 2009). In NSW the legal provision and distribution of injecting equipment is made possible under exemptions outlined in section 19 of the Drug Misuse and Trafficking Regulation 2011, whereby the Director-General of the Department of Health may exempt 'authorised persons' to 'participate in an approved needle exchange program,' which until recently had been limited to approved authorised staff and workers of NGO and government services including NSPs and through pharmacies. In October 2013, NSW Ministry of Health implemented a pilot project with the NSW Users and AIDS Association (NUAA) for peer distribution of sterile injecting equipment (a commitment previously mentioned in the NSW HIV Strategy 2012-2015: NSW Ministry of Health, 2012). This pilot has been made possible not by amending legislation through parliament, but rather by the Director-General amending the regulation to extend 'authorised persons' to include clients of NUAA's NSP.

To inform the case studies, semi-structured in-depth interviews were conducted with individuals identified as key actors in the development of these programs. This included policy makers, advocates, researchers and clinicians who had contributed their expertise at various stages throughout the discussion and development of these harm reduction initiatives. In total

19 interviews were conducted for the naloxone case study (across both the NSW and ACT programs), and 10 interviews were conducted for the extended distribution of injecting equipment case study.¹ Interviews were on average one hour in length (ranging from 30 minutes to over 2 hours), and were conducted either by phone or in person. The interview guide focussed on eliciting participants’ perceptions of policy activity, the processes through which policy activity occurs, and the roles of multiple knowledges and ‘voices.’ Of particular relevance for the analysis of policy ‘stories’ in this paper, most participants were asked: “Tell me the story – from your perspective, how did the [naloxone program/extended distribution pilot] come to fruition?” Most participants offered lengthy narrative responses to this question. Participants were also asked about the knowledge or information they found compelling in thinking about the policy issue at hand. All interviews were audio-recorded and transcribed verbatim. Participants were given the opportunity to review their transcripts for the purposes of verifying accuracy, correcting errors and providing clarifications. Interview transcripts were organised and coded with the assistance of NVivo 10 data management software. The transcripts were analysed through a process of close reading, using the theory to guide the coding categories and identify kinds of ‘performances.’

In the following section I focus on one particular kind of ‘performance’ identified within this analysis: the enactment of the notion of evidence as ‘tool-like’, to be ‘used.’ I draw out the particular notions of the character of ‘evidence’ and ‘evidence-based policy’ which are enacted by participants’ accounts and, in turn, consider what these performances might imply (Law & Singleton, 2000). In doing so, I raise a set of related critical questions about the boundaries this performance places around what we might think of as ‘evidence-based policy’ and whether, at times, it might be practiced in ways that are counterproductive to its express aims (Race, 2011). I also suggest that framing ‘evidence’ around the notion of ‘usefulness’ may be seen as a kind of “coordinating mechanism” (Mol, 2002, p.117) and while this insistence on “virtual singularity” (Law, 2004, p.58) is in some ways productive it may also obscure the ways in which the evidence-based drug policy paradigm may be otherwise.

¹ The case studies necessarily involved small sampling frames, given their specific focus on particular policy development processes. Individuals were invited to participate due to their key roles or involvement in these processes. In some cases a small core group of individuals had led the process, and the memberships of these committees were publically accessible and well-known within the Australian drug policy field. As such, titles, sex and age of participants are not reported to protect anonymity.

Performatively constituting 'evidence' as a 'tool' for 'use'

They used the evidence that I had collected in the best way that they possibly could to put their policy position paper out there and then they used it in the way - I mean they are expert advocates so they know how to use research evidence in particular kinds of ways and they used my research evidence in the way that they knew would get them what they aimed for. (Interview 21; Researcher)

The idea that evidence is 'used' for policy making is almost incontrovertible. However, as Law and Singleton (2000) argue such accounts (no matter how ubiquitous) are not mere descriptions, they are *performances* which give life to a range of assumptions about how we might think about the interplay of evidence and policy and the 'evidence-based policy' paradigm. The account above performs a particular notion of the character of 'evidence': that evidence is a thing that is '*used*'; that it is 'tool-like.' But what might 'using' 'evidence' like a 'tool' imply? Firstly, a tool needs to be picked up and operated. Its purpose only becomes clear when it is manipulated by a craftsperson to fulfil a desired task. Thus, by performatively constituting evidence as a 'tool' for 'use,' this account gives credence to the adage that evidence 'does not speak for itself' but more than this, it constitutes the 'expert advocate' as having a particular symbiotic role to play within what we might imagine as the 'evidence-based policy' assemblage. The tool here only becomes relevant when it is used to achieve the result the craftsperson had in mind; when it is taken up by an advocate to "get them what they aimed for" (Interview 21; Researcher). Performing a particular notion of the character of evidence as being 'for use' (as 'tool-like') implies that evidence is only given meaning and purpose when it is taken up by particular actors for specific strategic purposes within the policy process.

This connects to another set of assumptions about the character of evidence which is given life through this account of drug policy. This account of 'evidence' as a 'tool' to be 'used' also suggests that evidence must be fit for purpose. One cannot hammer a nail with a screw driver. Thus by performatively constituting the thing we call evidence in this particular way, this account also invokes the notion of 'usefulness' which necessarily implies an assessment of quality, practicality, suitability and, perhaps most significantly, *instrumentality*. As one policy maker said:

I work with the researchers, with community based organisations, to get the evidence that's needed. And I know sometimes their evidence might be different to what I need. Because I have an understanding of how things work, and how decisions are made, and what sort of evidence will be considered, and the weighting of different evidence bases. So for me, it's presenting as strong a case as possible. (Interview 23; Policy maker)

By invoking the notion of 'usefulness' the character of 'evidence' performed here extends beyond the idea of 'evidence' as merely knowledge. 'Evidence' is useful when it is what is "needed," that is, when it fits a particular purpose. This implies and grants legitimacy to a "restricted understanding of 'knowledge' as (useful) 'information'" (Bacchi, 2009, p.240). Such assessments of 'usefulness' have a range of political effects. As Bacchi (2009, p.240) argues, beliefs about knowledge as having an instrumental purpose (as a "means to an end [...] rather than for its own sake") are a characteristic of advanced liberalism as a mode of governance. Bacchi (2009, pp.240, 251) argues that this rationalist and positivist paradigm "removes political and power dimensions from policy deliberation" and serves to sustain the "image of 'policy' as rational." But more than this, the notion that 'evidence' is 'useful' when it fits a particular purpose also carries with it the implication that the job for which this 'tool' will be 'used' is known and exists outside of the political process; a policy 'problem' "waiting to be 'solved' through 'relevant' 'evidence'" (Bacchi, 2009, p.253). In this way, it could be argued that accounts which performatively constitute 'evidence' as a 'tool' for 'use' bolster dominant (but nonetheless critiqued) accounts of policy activity as a rational process of authoritative decision making and obscure competing representations of policy problems thus perpetuating a policy world where 'problems' are treated as exogenous to policy processes.

By sustaining a view of 'evidence' as having an instrumental purpose, these accounts also imply that a particular kind of knowledge is superior, or more 'useful,' than another. The charge that 'evidence' be 'useful' potentially drives out more "contextual and interpretative forms of research" (Bacchi, 2009, p.253). As the same policy maker stated:

You can't make policy decisions based on interviews of ten people and these are the quotes that they provide. You know, you need to look at it from a population perspective, and epidemiology comes into it. Numbers do play a part of it. (Interview 23; Policy maker)

From the researcher's perspective, it was noted:

I think that they're seeking a certain kind of knowledge from this, they want a certain kind of evidence and it was just the kind of evidence that we just could not provide them because of the budget, because of the design of the [study], and the evidence that they wanted was not qualitative interview evidence, they want some key bits of what they might think of as hard data that they can take to their Director. (Interview 21; Researcher)

Such statements extend the account above, and highlight some of the many effects of enacting 'evidence' as a 'tool' for 'use.' When evidence is performatively constituted in this way it produces a world in which only particular forms of knowledge "will count as 'truth'" (Bacchi, 2009). An instrumentalist view of 'evidence' depoliticises the process of 'knowledge' construction, re-inscribes objectivist criteria for identifying 'knowledge,' and privileges some knowledges over others (Bacchi, 2009).

As Law and Singleton (2000, p.768) note, "in the abstract there is nothing wrong" with focussing on the notion of 'evidence' as a 'tool' for 'use,' but this is not an innocent description. It performs a particular notion which arguably suppresses the multiple other ways that 'evidence-based drug policy' might be imagined or enacted. For example, an account of 'evidence' as a 'tool' for 'use' (and its implied focus on instrumental knowledge) leaves little room for other voices and knowledges to be 'made as' evidence. If the character of the thing we call 'evidence' is performed as 'instrumental usefulness' in the telling of policy stories, and this (as I have shown above) carries with it a range of assumptions about what 'usefulness' entails, then this performance pushes aside the possibility that values and emotion, for example, may be valid knowledge(s) ('evidence') in policy processes. This limitation was expressed by a number of participants as they told their policy stories:

there were a number of older women, who were the family - the parents - of dead drug users who were responding [to a survey], [telling] their stories of their experience of overdose and how it had shaped their lives many years afterwards. Their kids had died when they were adults and they'd grown old and they were still – it was really moving, and the impact – *I don't know if this is a policy thing* – but the impact on individuals of losing loved ones, it can never be – it gets really hard to – *it's a really big thing, and it's really hard to capture that as a piece of evidence to inform policy*. We do trials, and we do the things that we've talked about. (Interview 16; Clinician, emphasis added)

The comment that this participant makes as an aside (“I don’t know if this is a policy thing”) reveals that while knowledge gleaned through lived experience could be powerful (that the character of the thing we call ‘evidence’ could be imagined and enacted otherwise), there is little room for this multiplicity. A policy maker similarly reflected:

you know, for all of the population level evidence that we have about what helps people avoid harms, the death of a person, and in particular the death of a young person, is a counterweight. Like it carries so much emotional weight that all of our rational evidence based policy in the world just doesn’t have. (Interview 26; Policy maker)

Performatively constituting the character of ‘evidence’ as ‘tool-like’ (as a thing for ‘use’) thus conceals a range of other, what Foucault (1980, p.82) calls, “subjugated knowledges.” As Bacchi (2009, p.36) explains, “these knowledges provide points of rupture to challenge conventional ‘knowledges.’” So while ‘evidence’ is enacted as a ‘tool’ for ‘use’ in drug policy stories, the comments offered by this clinician and policy maker provide insight into the ways in which the ‘evidence-based policy paradigm’ “*could be otherwise*” (Law & Singleton, 2000, p.769) and indeed *is already* being done otherwise (although these ‘other doings’ are difficult to recognise and obscured).

It is at this juncture that it is important to ask some different, but related, critical questions. How might framing ‘evidence’ around the notion of ‘usefulness’ be counterproductive? What happens when these performances of evidence-based policy “misfire” (Race, 2011, p.411)? While the purported aim of evidence-based policy may be to provide a rational basis for action, what happens when enactments “can be seen to participate in processes that undermine some of its express aims” (Race, 2011, p.411)? Could it be that this performance of ‘evidence’ as a ‘tool’ for ‘use’ becomes a barrier to action even when players are agreed that action is required, due to the boundaries it places around other possible rationales for action (that is, other ways of ‘knowing’ that action is required)? The two case studies examined here provide fertile ground for such examination. In both cases, there has been local and international debate about lack of ‘high level’ evidence. In neither case is evidence of effectiveness available in the form of randomised-controlled trials (RCTs) or systematic reviews. While observational studies exist, these studies do not conclusively satisfy the

question of 'what works' according to the 'hierarchy of evidence.'² However, both the availability of naloxone for administration by peers and peer distribution of injecting equipment potentially rest on human rights arguments, and the values-based understanding that people who inject drugs can and should play a role in enhancing their own health and the health of their community. In both cases a strategy has been implemented involving the 'piloting' and 'evaluation' of the intervention, to provide a rationale for action in each jurisdiction in the absence of existing 'high level' evidence. However, in telling their stories, for many participants there was an awkward fit between what was 'required' by the threshold of 'evidence-based policy' and the shared understanding between most actors that implementing these programs was simply 'common sense.' This perspective was strongly expressed by several clinicians in particular:

I had to come out fairly strongly and so I tried in the nicest possible way to say that now and then we just have to use common sense and do what's right. And that has been my catchcry I guess. That at a certain level, if it gets to the stage where evidence is being used as a barrier, we have to call that for what it is and just say look this is just crap and we need to just get on with it and don't be silly. (Interview 13; Clinician)

In some areas common sense can – must prevail. I don't see what the benefit of a high order, high level random controlled trial would achieve. (Interview 16; Clinician)

Sometimes I think we make it hard for ourselves at the altar of wanting to have evidence-based policy, letting it get in the way of doing things that just make obvious common sense. (Interview 28; Clinician)

It is in these accounts that it can be seen in very real, practical terms, the ways in which evidence-based policy storytelling "makes a difference" (Law & Singleton, 2000, p.769). From the accounts above, it can be seen that enactments of what is called 'evidence-based policy' do occasionally "misfire" (Race, 2011, p.411). These case studies demonstrate that sometimes the way in which 'evidence-based drug policy' has been performed actually constrains action. The possibility that things 'could be otherwise' becomes an extremely pertinent and political issue when the barriers produced by this particular performance are teased out. In the case studies outlined above, it is clear that at times the characterisation of the primacy of

² For discussion of the history of relevant concepts relating to the 'hierarchy of evidence' in medicine and its more recent accretion to public policy, see Harrison and Checkland (2009).

instrumental knowledge for policy and the paradigm of authoritative decision making are inadequate, and at times counterproductive. As the three clinicians expressed, there is little room for their expert clinical knowledge to come to bear (here, described by clinicians using the language of 'common sense') nor local knowledge, lived experience or arguments on the basis of justice or values. Therefore, we are left with a critical question: does the characterisation of evidence as 'useful,' as it is performed through the telling of policy stories, actually limit our capacity for action in drug policy processes at times when other knowledges suggest that action is not only viable but imperative?

There is another possibility which could be explored here, that of "virtual singularity" (Law, 2004, p.58). The seemingly incontrovertible idea of the 'usefulness' of 'evidence' in policy may be *productive* in that this "insistence on singularity" pushes multiplicity into invisibility, thus "avoiding the appearance and the experience of multiplicity" (Law, 2004, pp.65, 66). The accounts told by participants in these case studies are stories about the singularity of evidence-based drug policy, which in their telling hide "the unfolding and uncertain nature of practices in favour of apparently stable and separate objects" (Law, 2004, p.65). As participants give their different accounts of the drug policy process, they think they are describing the same thing. The idea that there is a single, useful thing we call 'evidence' or 'evidence-based policy' "makes it easier to create many different versions of [it] because it allows participants to assume that they are talking about (and making) a single [thing]" (Law, 2004, p.66). This means that participants can assume that they share a 'fixed' notion of what 'evidence' is and its usefulness. As one policy maker said of the practice of evidence-based policy:

we use evidence to talk things out. (Interview 23; Policy maker)

Here, 'evidence' becomes the agreed upon shared language, even though it may be many different things to many different people, enacted through many different practices. In this way, perhaps the insistence on singularity is "productive" (Law, 2004, p.66) insofar as it allows participants to invisibly craft many versions of a thing while simultaneously allowing them to assume that they are talking about the one thing. Perhaps it is enough for the evidence-based policy endeavour to imagine that we all co-ordinate our vision of evidence. It may be that it is this production of "visible singularity and invisible multiplicity" (Law, 2004, p.66) which creates room for different actors to think of 'evidence' (or 'evidence-based policy') as many different things while sharing a sense of a single idea and a language to 'talk things out.' It could be

argued that the word 'evidence' is a "coordinating mechanism" (Mol, 2002, p.117). The problem, as highlighted in the clinicians' comments above, is when the insistence on singularity conceals alternative knowledges and directs us away from other possible realities; when it obscures the ways in which the reality of 'evidence-based policy' might "in some measure *be made in other ways*" (Law, 2004, p.66; Law & Singleton, 2000).

Conclusion

This paper has pursued a mode of inquiry quite different to the dominant approaches within evidence-based policy scholarship which have hitherto sought to 'bridge the divide' between 'knowledge producers' and 'policy makers.' Following the perspective of policy scholars who have sought to destabilise the notion of 'knowledge' in policy, I have argued that what we call 'evidence' is not fixed prior to its expression in accounts of policy. Rather, 'evidence' and 'evidence-based policy' are *performatively constituted*.

The argument I have raised here is also slightly different from that of other drug policy scholars who have drawn attention to the limits of the science of addiction, and have sought to uncover the ways in which 'facts' are discursively produced (e.g. Thomson & Moore, 2014). Here, my focus has been not on how the 'truth' of 'addiction' or 'drugs' is enacted through scientific method but rather how the thing we call 'evidence' *itself* is performatively constituted in policy practice and the telling of policy stories. Accounts of policy constitute the character of what we call 'evidence' and its purpose in policy.

Participants' accounts "are not simply *describing*" (Law & Singleton, 2000, p.768) evidence-based drug policy making, but "performing a particular notion of the nature" of it. Following Law and Singleton (2000, p.768), I have argued that as participants "tell a story" about drug policy, they breathe life into a range of assumptions underpinning what we call 'evidence-based drug policy.' These accounts are not "innocent descriptions" (Law & Singleton, 2000, p.769) of evidence-based drug policy processes; they are located enactments or performances that in their telling constitute the thing we call evidence as a particular kind of thing (here, 'a tool for use'). In doing so, these performances imply that a particular kind of knowledge is more useful. Enacting 'usefulness' as the hallmark of evidence provides justifiable rationales, legitimacy, and protection to actors within the policy process. The enactment of 'evidence' as a 'tool' for 'use' is therefore important as it makes and sustains a set of assumptions about

knowledge, evidence, and rationales for policy action. These stories ‘prop up’ an idea of policy making as a rational process of authoritative choice.

As I noted earlier, much of this seems incontrovertible. However, seeing these accounts not merely as descriptions but rather as a particular kind of performance opens up the possibility to interrogate the ways in which this familiar ‘talk’ reproduces a range of troubling political assumptions which place limits around what gets to count as valid knowledge and which voices may be heard. And while these accounts may seem familiar that is only because ‘evidence’ is enacted in this way, in stories and practices, over and over again across the drug policy (and indeed the broader evidence-based policy) field. These accounts seem familiar “*because that is how they are performed*” (Law & Singleton, 2000, p.769). It is through enactment that a such reality is produced, but it depends upon a continued practice of crafting (Law, 2004). So if the notions of ‘evidence’ and ‘evidence-based policy’ seem solid, this is because they are being enacted as such. And we as researchers are complicit too.³ As researchers in the field we “mimic” in our writing the assumptions performed in these accounts, and have our own stories to tell which prop up (or interfere with) these other performances (Law & Singleton, 2000). Like in Law and Singleton’s (2000, p.769) study, the participants in my study gave me particular accounts when interviewed, to “set the record straight and contribute to what they thought of as the definitive story.”

Most importantly, what the lens of performance offers is a window through which we can see that things “*could be otherwise*” (Law & Singleton, 2000, p.769, emphasis original). Indeed, in the participants’ accounts analysed here, I have identified some ways in which ‘evidence-based policy’ *is already* being done otherwise. However these ‘other’ enactments (values, emotion, and common-sense) are obscured, perhaps by an insistence on singularity. The idea that things could be otherwise raises critical questions about how the evidence-based drug policy endeavour might be reconsidered. Here, I have argued that the thing we call ‘evidence’ does not sit objectively outside the policy process, but rather is constituted within it through

³ Indeed, as one anonymous reviewer astutely noted, I too am complicit here. For example, in describing the case studies in the methods section I relied on a form of empirical ‘evidence,’ citing papers which draw on qualitative and quantitative methods to support claims regarding naloxone’s effectiveness. This example illustrates the almost inevitable reliance at times on particular forms of ‘evidence’ in the research community, and is a reminder that such appeals always carry with them a range of political effects (for further discussion see Bacchi, 2009).

practices and the telling of policy stories. Thus, if the reality of what we call 'evidence' is enacted and not fixed prior to its expression in policy activity, then it can also be said that the reasons for enacting one version over another are political. Evidence and the evidence-based policy paradigm can be remade in other ways. Mol (1999) suggests that we can think of what is enacted and constituted as an *ontological politics*, which "suggests a link between the real, the conditions of possibility we live with, and the political." This means that we might "interfere, to make some realities realer, others less so" (Law, 2004, p.67). The question of how the evidence-based drug policy paradigm might be remade in other ways is a question which remains to be explored.

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Paper 6

Confidentiality, anonymity and power relations in elite interviewing: Conducting qualitative policy research in a politicised domain

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Preamble

This final paper is in many ways a postscript to the preceding papers. In Paper 6, I provide a methodological and reflexive account of the challenges associated with conducting qualitative interviews with 'elite' participants (such as policy makers, researchers and clinicians) in a highly politicised domain like drug policy. Drawing on my experiences of interviewing across the three case studies, I examine issues associated with anonymity and confidentiality produced through power relations between researcher and participant, and reflect on the practical and political implications for data collection, analysis and reporting of policy research.

While this paper is situated within the qualitative methods literature on interviewing, the issues raised are reminiscent of some of the theoretical concerns which have been explored throughout this thesis, in particular, the idea that subject positions are not fixed or stable. This paper challenges the idea that certain participants are 'in possession' of power, or are necessarily always already 'vulnerable.' As Foucault (1980, p.98) argued, "power must be analysed as something which circulates [...] It is never localised here or there, never in anybody's hands." Although I examine these notions through a different lens, the arguments contained within this paper mirror the underlying concerns of this thesis by problematising the taken-for-granted status of concepts such as 'sensitivity,' and suggesting that such concepts (along with subjectivities) ought to be seen as emergent and political.

This paper also offers a more in-depth account of data collection and data management processes (including recruitment, interview encounters, and data anonymisation) than is contained within the preceding papers due to the word limits associated with many journals, and is therefore an important accompaniment to the research undertaken during my candidature.

Abstract

While the methods used to study 'elites' are of particular relevance in policy research, to date there has been little examination of the particular challenges associated with 'elite' interviewing in this field. More specifically, the issues associated with interviewing 'elites' while conducting qualitative research in a contested policy domain, especially if policy processes are being studied as they play out in real time, remain underexplored. While the extant literature on 'elite' interviewing has begun to grapple with the notions of 'power' and 'vulnerability,' the question of how these notions might need to be rethought in the context of a politicised policy domain remains open for examination. This article provides a methodological and reflexive account of the challenges associated with conducting research in one highly contested policy domain, namely, drug policy. Drawing on examples from a study which examined Australian drug policy processes, this article examines issues associated with anonymity and confidentiality produced through power relations between researcher and participant, particularly as these play out in a contested policy domain. In doing so, this article critically reflects on the practical and political implications for data collection, analysis and reporting of policy research.

Key words

Interview, elites, policy research, anonymity, confidentiality, vulnerability, power

Introduction

In recent years, a small but growing body of research has documented the issues and dynamics associated with interviewing 'elite' participants in qualitative research (for example, Duke, 2002; Harvey, 2011; Hertz & Imber, 1995; Mikecz, 2012; Morris, 2009; Neal & McLaughlin, 2009; Smith, 2006; Stephens, 2007; Welch, Marschan-Piekkari, Penttinen, & Tahvanainen, 2002). The term 'elite' is not always defined within this literature, but is generally used to describe individuals or groups who ostensibly have closer proximity to power or particular professional expertise (Morris, 2009). A variety of challenges associated with researching elites have been documented in the literature, ranging from difficulties with gaining access to the suggestion that elite participants may seek to exert too much control over research and manipulate dissemination processes (for discussion see Smith, 2006; Welch, et al., 2002). In the context of policy research more specifically, it has been suggested that additional issues must be considered when the 'elite' participants in question also interact and operate within policy networks (Duke, 2002; Farquharson, 2005).

While the methods used to study 'elites' are of particular relevance in policy research, as much empirical research on policy making is based on interviews with individuals ordinarily regarded as 'powerful' or 'expert' including politicians and policy makers (Berry, 2002), to date there has been little examination of the particular challenges associated with 'elite' interviewing in this field. Although a growing literature has been dedicated to examining policy processes and the roles of individuals within policy networks, there have been few reflexive accounts analysing the ways in which this research is conducted and the challenges encountered by policy researchers (Duke, 2002). More specifically, the issues associated with interviewing 'elites' while conducting research in a contested policy domain, especially if policy processes are being studied as they play out in real time, remain underexplored. While the broader extant literature on 'elite' interviewing has begun to grapple with the notions of 'power' and 'vulnerability,' the question of how these notions might need to be rethought in the context of a politicised policy domain where professional, personal and political stakes are high, remains open for examination.

This article provides a methodological and reflexive account of the challenges associated with conducting research in one highly politicised and contested policy domain, namely, drug policy. I draw on examples from an empirical study which aimed to examine how policy knowledge ('evidence') is constituted and validated within drug policy processes, from a social

constructionist perspective (see Lancaster, 2014). The research involved an empirical multiple-case (or collective-case) study design (Stake, 1995; Yin, 2009) with multiple qualitative methods. The multiple-case study design compared the development of three contemporary drug policy issues in Australia: (i) the development of opioid overdose prevention and management strategy, with a particular focus on examining the processes leading to the establishment of two recently implemented programs to make naloxone¹ available to potential overdose witnesses in Canberra, ACT and Sydney, NSW; (ii) the development of approaches to extend distribution of injecting equipment through peer networks (also called 'secondary supply' or 'peer-distribution') in Sydney, NSW; and (iii) the development of 'recovery' approaches to drug policy and drug treatment provision. To inform the case studies, semi-structured in-depth interviews were conducted with individuals identified as key actors in these policy processes. This included policy makers,² advocates, researchers and clinicians who had contributed their expertise at various stages throughout the discussion and development of these drug policy issues. Interviews were on average one hour in length (ranging from 30 minutes to over 2 hours), and were conducted either by phone or in person. The interview guide focussed on eliciting participants' perceptions of policy activity, the processes through which policy activity occurs, and the roles of multiple knowledge(s) and 'voices.'

The strength of such qualitative methods for studying policy processes is that they can be used to "delve into parts of the policy process which quantitative methods cannot reach" which, importantly, offers a way "to explore innovation, originality, complexity, interactions, conflicts and contradictions" (Duke, 2002, p.42). However, I suggest that there are a number of challenges associated with delving into the complexity and contradictions of policy processes, particularly in a highly politicised policy domain like drug policy. Arguably, the choice to study policy processes as events unfold in real time amplifies some of these challenges. Nevertheless, for policy processes research, a commitment to collecting data as the policy process unfolds may be beneficial when the purpose of the research is to study dynamics, contestation and multiple perspectives, rather than trying to document an 'official' account of

¹ Naloxone (trade name, Narcan®) is a short-acting opioid antagonist, which temporarily reverses the effects of opioids and respiratory depression.

² The descriptor 'policy maker' requires some explanation. As Neal and McLaughlin (2009, p.691) note, policy processes are "by definition plural in nature in that they involve a range of actors and stakeholders, who function as a 'policy community.'" Acknowledging the multiplicity of 'makers' in the policy process, I use the descriptor 'policy maker' to refer to individuals who occupy professional public service or political positions, whose day to day role involves policy advice and planning.

events, as was my aim in this research. When people speak about the past, narratives have been established. When examining historical processes, particular accounts have already become accepted and authorised within the policy field. While these 'established' narratives are always in flux, and the meaning of historical events is never truly fixed, in examining contemporary policy processes these stories are only just emerging. It is possible to see the emergence of particular narratives over the course of a data collection period as the 'definitive narrative' has yet to be embedded. It is my contention that commitment to studying policy processes as they unfold in real time produces particular methodological and ethical challenges for collecting, analysing and reporting participants' accounts of policy processes.

In this paper I focus specifically on the issues associated with interviewing policy 'elites' that I encountered within this research. I examine the issues associated with anonymity and confidentiality produced through power relations between researcher and participant, particularly as these played out in a contested policy domain. I suggest that there is a need to reconceptualise notions of authority, sensitivity, vulnerability, and power not as fixed qualities inherent to the researcher or the participant, but rather as fluid and relational. In doing so, I also reflect on the practical and political implications for data collection, analysis and reporting findings of policy research, especially when policy processes are being studied as they play out in real time.

Interviewing policy 'elites'

It has been suggested that gaining access to 'elite' participants is sometimes challenging, as these individuals occupy positions where barriers can be produced to resist the scrutiny of research (Duke, 2002; Hertz & Imber, 1995; Mikecz, 2012). In her review of the literature, Morris (2009, p.213) noted that "the literature abounds with recommendations on how interviewers should behave in order to gain access." Some techniques include drawing attention to the researcher's own professional credentials, affiliations and standing, or using personal connections (Welch, et al., 2002). However, I concur with Ostrander's (1995, p.135) observation that the difficulties associated with gaining access and establishing rapport may have been "exaggerated" within the literature, while other (potentially more problematic) aspects of 'studying up' remain relatively underexplored.

Similar to the techniques described by Ostrander (1995), in my study I primarily gained access through activities which put me in touch with possible participants, such as attendance at

relevant conferences, meetings, public discussions and seminars. Through these activities I started to discuss my research with key individuals, and made my interest in the particular case studies known. In most of these settings, the presence of a researcher with an interest in the topic was not unusual (in this sense, I was a “natural participant”: Hunter, 1995, p.161). My previous research experience in the field, association with a well-known drug policy research team (the Drug Policy Modelling Program), and existing relationships with some participants assisted these interactions. This kind of “insiderness” is often regarded as advantageous at the beginning of a study (Labaree, 2002, p.104). In some instances, however, I contacted potential participants via email without having made any previous personal connection. In these approaches, I explicitly used my position as a researcher in a well-known research centre, the respected reputations of my supervisors and the ethical governance of the project as legitimising markers to ease access.

Conversations with key individuals within the policy sphere also provided a way to do ‘preparatory work’ before data collection began, enabling me to scope the field and better understand who the key actors were prior to interviews. These more casual discussions informed decisions about the appropriate order of interviews (although due to practical limitations, the order of interviews for each case study was largely dependent on participants’ availability). I was acutely aware in organising appointments and conducting interviews that “gaining access is not the same as establishing the trust required for getting useful data” (Ostrander, 1995, p.135) and that some relationships required careful management both before and after the interview, and within the interview encounter itself (issues which will be discussed in more detail below).

Most of the individuals I approached for interview were enthusiastic participants, pleased to lend their expertise, perspectives and time to the research. Any barriers to access I encountered were due to individuals’ work contexts. I found that an individual’s sense of autonomy in their role (that is, whether or not individuals felt their participation depended upon approval by their manager) was of particular relevance. The impact of work culture was especially pronounced in relation to interview encounters with policy makers working within government departments. When approaching multiple policy makers within the one department, I invariably became aware of a process of co-ordination between invited participants behind the scenes. Even though letters of invitation had been personally addressed to individuals (and not the department as a whole), I would invariably receive an

email or telephone call suggesting that I speak to a particular individual within that department:

After discussion with the team, we believe that it would be most appropriate for one person – namely me – to take part. (Correspondence with invited participant)

Even after I emphasised that I was interested in multiple perspectives and reflections on the policy process, access was consistently limited to a particular individual who had been designated as the most appropriate spokesperson:

I am still of the view that [another participant's] contribution suffices for us. (Correspondence with invited participant)

Usually this person occupied a more senior position. It was suggested that I would gain little from speaking to others within the department (an issue also encountered by Duke, 2002, in her study of policy networks).

I found that some policy makers were “practiced in fielding questions and more tightly bound to organisational policies” (Welch, et al., 2002, p.615). Similar to Duke's (2002, p.46) experiences, in some of the interviews with policy makers it became obvious to me that there was a tightly controlled “official line” being communicated about particular issues. The limitations of this ‘gate-keeping’ was avoided in one of my case studies by seeking out individuals who were no longer working within the department, but who had previously occupied key policy roles within the department at various stages of the policy processes under investigation. These individuals were knowledgeable and all still worked within the drug policy field in different capacities. Most importantly, they were able to participate freely as they were no longer working within the more tightly controlled departmental environment. In another case study, consultants and collaborators who worked closely with the department were able to offer this broader perspective.

The participants in my study were used to leading discussions and being authoritative speakers on the topics being discussed. Most of the participants I interviewed (including clinicians, advocates, policy makers and researchers) occupied senior roles within their organisations or acted in an advisory capacity in drug policy settings. Most participants had long histories and vast experience working in and around the alcohol and other drug field. Discussing the elite interview experience, Ostrander (1995, p.143) notes that elites are “used to being in charge, and they are used to having others defer to them. They are also used to being asked what they

think and having what they think matter in other people's lives." All participants in my study were articulate and knowledgeable, and spoke freely about the issues under investigation. In many cases, participants were eager to 'inform' me of their perspectives of the issues and processes, often with the intention of 'setting the record straight.'

Many of the participants had knowledge of the research process, through their own experience conducting research (as researchers, collaborators or funders) or through the way they used research output in their day-to-day roles. In this sense, my position as a 'PhD candidate' was also a familiar category (Stephens, 2007). Participants' familiarity with research was in many ways beneficial to the interview encounter, but in some cases participants' research experience generated barriers, for example when participants made assumptions about what they regarded as being of particular interest or relevance to my research or dictated the topic to be discussed (this has been documented in other studies as well: Stephens, 2007; Welch, et al., 2002). Some participants even engaged to the point of suggesting theoretical frameworks which I should use to interpret the data:

And if you were looking for a policy model to help understand this, it's an absolutely classic case where the stages model fits beautifully. (Interview)

When this occurred I gave latitude to the participant to pursue a deviation, then guided the interview back using the semi-structured interview schedule or prompts (Stephens, 2007).

In making these observations about interview method and engagement with 'elites,' it is important to note that the participants in my study were not a homogenous group, and nor did power dynamics between researcher and participant play out in any predictable or consistent way. Indeed, this is one of the major inadequacies of literature describing 'elite interviewing.' The designation of participants as 'elite' relies on structural notions of power which have been critiqued, and moreover may conceal differences within groups of participants and the ways in which research encounters depend on context (Smith, 2006). Much of the literature assumes that 'elite' participants will always occupy a more powerful position than the interviewer (Mikecz, 2012). My experience suggests that dynamics between the participant and interviewer can be fluid and context dependent. Although my position as a PhD student ordinarily may be regarded as being less powerful than that of a participant occupying a senior policy position, being from a well-known research centre and supervised by two highly respected and accomplished professors in the field (both of whom are recognised for their expertise in drug policy spheres in Australia and internationally) meant that

participants were aware that their knowledge and accounts could potentially be scrutinised by senior researchers. In some interviews, this possibly generated particular 'performances' from participants who wished to appear knowledgeable in front of a critical audience. Such dynamics confuse the notion of 'studying up.' While not wanting to minimise other researchers' experiences of power in the interview encounter, Neal and McLaughlin (2009) suggest that a linear conceptualisation of power may limit discussions in the methods literature. They argue that power has been "statically defined as residing in the explicit structural positions of either the researcher or the research participant rather than as an ambiguous, fluid, multi-directional dynamic, which can flow unevenly across and between different positions in the research relationship" (Neal & McLaughlin, 2009, p.695). The designation of a group of participants as 'elite' (and the assumptions about fixed and consistent power upon which this category relies) thus obscures notions of vulnerability or sensitivity.

The unsettling of power dynamics has been examined in other ways in the context of research with policy makers (Neal & McLaughlin, 2009). In these research encounters, participants were made vulnerable, despite their elite professional status, through emotional recall and retelling of their personal experience of the policy process. Other researchers have also noted the almost therapeutic effect that the presence of "an attentive and sympathetic listener" can have in interviews with elites (Welch, et al., 2002, p.622). I experienced this effect in several encounters with participants, who in reflecting on particular processes also took the opportunity to reflect more broadly on their frustrations with the drug policy field, and the personal toll associated with working in a politicised domain:

I was at [a conference] on Monday and I just said to [a colleague], 'You know what, I think I've been doing this for too long because I can't bear listening to these conversations anymore.' I can't. It's the same stuff, year in, year out, and we don't learn. We don't learn, and we allow this stuff to continue to happen. (Interview)

Neal and McLaughlin (2009, p.699) observe that as power is "entangled with emotionally difficult reflexive processes" it becomes "much looser, messier and multidirectional," challenging the idea that the power of elites is fixed and may be deployed consistently. They conclude that the category of 'elite' can be problematic, particularly in a highly politicised or publicised context (a conclusion of particular relevance in conducting policy research in a domain such as drug policy). Following Smith (2006), Neal and McLaughlin (2009, p.704)

suggest that the notion of “vulnerable elites” ought to be considered. This notion provides a way of understanding and accounting for the shifting and transient power held by these participants, the dynamics between researcher and participant, and also the professional vulnerabilities, political uncertainties and personal costs and experiences of participants in the policy processes.

Thus by applying a different lens, the idea that ‘elites’ are a homogenous group for research purposes with fixed and consistent power, is open to challenge. In my research, conceptualising power not as fixed, but rather as fluid, relational, negotiated and changeable was helpful for being responsive to changing vulnerabilities and power dynamics over time. This perspective also highlights that a one-size-fits-all approach to interviewing is not only unnecessary, but in some cases problematic. Flexibility and reflexivity were essential throughout the research process as the cases evolved in real time. Thus, rather than uncritically using the term ‘elite’ to describe a particular group of participants, I chose not to use this term in analysing data or later reporting research findings. Following Smith (2006), as an alternative I used the domains in which the participants do most of their work as descriptors (e.g. clinician, policy maker, researcher, advocate) as way of signalling the differing contexts of participants within the case, without making assumptions about who may be exerting what kinds of power.

Confidentiality, anonymity and ‘vulnerable elite’ participants

The negotiated and fluid nature of participants’ power and vulnerability became especially apparent in the post-interview analysis and reporting stages of the research. In this section, I discuss the particular challenges I encountered in conceptualising and operationalising the conventions of confidentiality and anonymity in the context of policy research in a highly politicised domain.

Respect for participants’ privacy and confidentiality is one of the key principles expressed in Australia’s National Statement on Ethical Conduct in Human Research (National Health and Medical Research Council, 2007). Concerns about confidentiality when researching ‘vulnerable groups’ including children, people who use drugs, people experiencing mental health problems or terminal illness, have been well documented. The concept of confidentiality is associated with anonymity, insofar as anonymity is one way to operationalise (or apply) confidentiality by ensuring that individuals cannot be identified (Wiles, Crow, Heath, & Charles, 2008). However,

“confidentiality is a complex process that involves more than merely disguising the identities of research participants or sites” (Tilley & Woodthorpe, 2011, p.198), and anonymising data does not necessarily comprehensively address all aspects of confidentiality.

It is important to note that the conventions of confidentiality and anonymity, as well as notions of vulnerability, harm and privacy which underpin them, are not static and have been both flexibly employed and critiqued within the qualitative methods literature (for discussion see Tilley & Woodthorpe, 2011; Vainio, 2013). One principal dilemma encountered by qualitative researchers is balancing the faithful reporting of findings with potentially exposing respondents' identities, or alternatively choosing to withhold information to reduce the risk of harm to participants, but in doing so possibly bring into question the accuracy of the study (Baez, 2002). Another dilemma has been less discussed:

If researchers see themselves as political activists as well as researchers [...] they have to reconcile their conflicting responsibilities as researchers/protectors and activists/exposers (Baez, 2002, p.36; for further discussion of these and other challenges see Tilley & Woodthorpe, 2011).

While not all qualitative researchers may identify as 'activists' per se, many would nonetheless recognise their role in enacting their object of study, co-constituting data in the interview process, and acknowledge that research is itself a political intervention. This dilemma is also relevant for researchers who, at the very least, hope that their work might 'make a difference.'

Like in Baez's (2002) study of the experiences of faculty members of racial minority backgrounds working at a predominantly white research university in the north-eastern United States, my ability to protect the confidentiality and anonymity of participants in my research was partially compromised by the specific nature of my inquiry. The case studies necessarily involved small sampling frames, given their specific focus on particular policy development processes. Individuals were invited to participate due to their key roles or involvement in these processes. In some cases a small core group of individuals had led the process, and the memberships of these committees were publically accessible and well-known within the Australian drug policy field. Although not all participants would be identifiable within the field or to the general public, it is possible they could be identifiable to other participants involved in the study (Allmark, et al., 2009).

I found that participants were often interested in knowing who else I had spoken to (Hunter, 1995). Given the small sampling frame, many participants also made assumptions about who else I would be interviewing, and suggested I speak to other individuals about particular issues which arose in the course of the interview:

and [another participant] I hope will discuss this. (Interview)

I would say that's something probably you'd need to discuss with [another participant]. (Interview)

In some cases, participants were fully aware of who else had been interviewed because participants' involvement had been openly discussed at committee meetings or within personal and professional networks (this has also been documented in other studies involving policy elites: Farquharson, 2005; Neal & McLaughlin, 2009). So as to maintain confidentiality and anonymity in accordance with the ethical governance of the study, I often gave vague responses to questions or assumptions about other participants' involvement in the study. At other times, I referred to 'others' without naming individuals to generate discussion about particular issues: "A few people I've spoken to as part of this study have been somewhat surprised at your position" (Interview). However, I was acutely aware at times of the awkwardness of this obfuscation (see also Duke, 2002; Farquharson, 2005).

Maintaining participants' confidentiality and anonymity was important due to ongoing partnerships and professional relationships between participants (indeed, the interconnectedness of many of the participants is a key finding of this research). Many of the participants knew each other and had long histories of working closely together, and continued to collaborate. In this context of close professional and personal networks, where a small number of individuals had been involved in particular processes and events, I was aware that anonymising data through the use of pseudonyms would not be sufficient to ensure that particular voices would not be recognised by others in the field (Neal & McLaughlin, 2009). When choosing techniques to anonymise data, Vainio (2013, p.693) suggests that researchers need to consider the ultimate goal of the research: "identifying information that is not relevant from the perspective of theory and research questions should be excluded when describing the participants." For the purposes of my research questions, roles or organisational affiliation (broadly described) and professional background and expertise were key analytic categories for considering how knowledge(s) and voice(s) come to bear on drug policy processes, but for the purposes of the study, questions of gender, age or ethnicity were not relevant and

therefore not reported. However, I was aware that at times even these professional descriptors may have been identifying. Then again, by not using individuals' roles or work titles as descriptors, or not identifying the particular case and instead engaging in cross-case comparison to broaden the sampling frame, I was also aware that substantial detail in reporting findings would be omitted.

In negotiating this dilemma, it is important to note that these participants (researchers, clinicians, experienced advocates and policy makers) are not ordinarily conceptualised as 'vulnerable' according to research conventions (nonetheless noting the imprecision with which the term 'vulnerable' is often used in the methods literature: Allmark, et al., 2009). However the disclosure of information and accounts provided by participants in some cases could potentially expose them to retaliation from others in the policy sphere, embarrassment, potential job loss, or compromise organisational partnerships, damage relationships and jeopardise delicately balanced politicised policy processes underway. While it could be argued that the 'vulnerabilities' experienced by these relatively affluent and educated participants may be less dire than that of a low-wage worker who may lose their job as a result of discussing their drug use (for example), arguably the consequences for my participants were equally concerning as the implications extended beyond the individual and to the very viability of programs, organisations and policies. Some participants were acutely aware of these sensitivities:

I would like to very much be as honest as I can, as will my memory allow me to be, but I'm cautious of the fact that this exists, it's still happening, all the players are still here and I guess I'm particularly mindful of [...] how we make sure that through this process there's not kind of unintended consequences for them. (Interview)

We might not be able to tell the full picture until ten years down the track or something and there can be a follow up. A secret release of what really happened when everybody gets new jobs or something. (Interview)

To overcome these sensitivities, some participants engaged in a kind of self-censoring, being careful with their expression to find a "politically correct way of saying it" (Interview).

While participants wanted to share their perspectives and knowledge with me, some participants emphasised when information should be used as 'background' only:

A lot of this just has to be background information for you because this is, in my opinion, how it worked. But the relationships and the background of that, if this was to go into print or something, these relationships would be ruined and I can't have that. But I'm happy to speak to you frankly about it. (Interview)

This dynamic in the interview encounter has also been experienced by other researchers studying policy networks (Duke, 2002).

As one practical way of reassuring participants and managing these sensitivities, participants were advised that they would be sent a copy of their transcript to review for the purposes of verifying accuracy, correcting errors or inaccuracies, and providing clarifications. This procedure has been adopted in similar studies (Wiles, Charles, Crow, & Heath, 2006; Wiles, et al., 2008). This approach was taken due to the professional, personal and political sensitivities involved in the case studies under examination and the specific sampling frame, which meant that anonymisation of the data would be challenging. The reminder that participants would be sent their transcript later often acted as a 'safety net' whereby participants felt they still had a degree of control over the data:

I'm glad that you've said that we'd have a chance to have a look at stuff before it comes out, and I feel uncomfortable about sort of just speaking openly about it [...] And I don't want this to be just raw, repeated raw without me actually having a look at the data, if you like. (Interview)

During the interview encounter, I sometimes reminded participants of the option to later see their transcript, if I sensed they required reassurance to be more expansive in their responses. This technique served as a way of maintaining trust at times when the conversation entered sensitive territory. When participants expressed concern, I also offered them the opportunity to 'flag' particular sections of their transcript as potentially sensitive for my information. This was either done later when participants reviewed their transcripts or verbally at the time of interview (as this participant did):

you're going to have to think about how you handle this (Interview)

I would like this not to be attributed to me – but... (Interview)

These sections were treated with care in analysis. Ultimately, where I was aware that participants could be readily identified, I chose not to disclose identifying information by

removing roles and association to particular cases, erring on the side of protecting participants from personal and professional harm and preserving their anonymity.

However, participants' positions of 'power' and 'vulnerability' in relation to me, the researcher, constantly shifted throughout the research process. Like Wiles et al. (2006), I found that some participants took the opportunity to exert a degree of control over 'their' data when reviewing their interview transcript. For example, some participants changed their expression, or deleted whole sections of the interview. Some participants asked how specific quotes might be used. One participant withdrew their interview data completely after the transcript had been sent, and requested a new interview. This situation was particularly challenging, as the decision to withdraw the data was also due to emerging concerns about the policy process (the policy situation had gained political sensitivity and garnered media attention between interview and transcript being received; another challenge associated with conducting policy research as processes play out in real time). This individual had also become aware of the depth of data I had collected (an awareness gleaned through discussions with other participants). The second interview with this participant was highly controlled, and it was clear that the participant had decided to place boundaries around what could or could not be discussed. By contrast, the first interview had been far more free-flowing and conversational, with the participant offering insights into the intricacies of their role and behind-closed-doors strategies. In these situations, somewhat paradoxically, it was in the expression of personal, professional or political vulnerability that participants exerted power within the research process (once again highlighting the complex, multifaceted and fluid nature of power and vulnerability).

Requests from participants to see how the data would be used were carefully negotiated to ensure that participants did not have 'control' over what could be reported (analysis and interpretations) while also respecting participants' concerns so as to maintain access and participants' ongoing consent (an issue also encountered by other researchers conducting interviews with elites, see: Ostrander, 1995, p.139). Moreover, the careful management of participants' concerns was not only important for maintaining access and trust throughout the study, but as many of the participants involved were influential figures within the drug policy field, it was essential that relationships be maintained for future research and collaborations. The use of a multiple case study design was crucially important to overcoming some of the issues associated with confidentiality and anonymity in reporting, and to allay participants'

concerns (which differed depending on their individual positions). While confidentiality and anonymity may be more difficult to protect within a case (given the small number of people involved in these policy processes) by using multiple cases, across jurisdictions, the study design offered more flexibility for analysis.

However, it must be acknowledged that cross-case analysis does obscure the specifics of any one particular case. In this sense, confidentiality and secrecy are “inextricably linked” (Baez, 2002, p.45). Obscuring the case, and supporting the right to secrecy as expressed within the convention of confidentiality, may work to protect individuals from harm but in doing so may also permit or contribute to other problematic practices (Baez, 2002). Paradoxically, it is sometimes these very secrets the researcher wants to disclose in the interests of answering key research questions (Baez, 2002). Respecting participants' concerns about the use of particular data, or choosing not to report sensitive issues, can maintain and perpetuate the very power relationships participants may fear or seek to uphold. These are key questions in policy processes research. As Baez (2002, p.52) notes, “hidden power arrangements are maintained by secrets – the secrets of those who might benefit from those arrangements and the secrets of those who might be victimized by them (because they fear retaliation).” Therefore, decisions to disclose or not to disclose potentially sensitive information in the research process should not be taken lightly by qualitative researchers, and decisions to keep ‘secrets’ at the request of participants must be acknowledged as balancing acts, and political choices. After all, “what is published influences the meaning that is created” (Morris, 2009, p.214).

Conclusion

When presenting research, we often focus on findings rather than illuminating research processes and practices (Duke, 2002). While reflexivity may be regarded as a “risky enterprise which may leave researchers exposed and vulnerable” (Duke, 2002, p.56), reflexive accounts of the research process are also essential for better understanding the dilemmas of research which are too often sanitised or lost in other methodological descriptions. For researchers engaged in the study of a highly politicised policy domain like drug policy, these dilemmas are not only methodologically complex but also fundamentally shape and constitute the data and research process as a whole.

The particularities of conducting policy research in a highly politicised domain, and the vulnerabilities of participants usually conceptualised as 'elite' within these spheres, have been underexplored in the qualitative methods literature. I suggest that this oversight is partly due to the limitations of the categories used to locate qualitative research inquiry in the methods literature (for example, the dichotomous perspectives of 'studying up' versus 'studying down'). The particular challenges encountered in my research indicate that these categories may fundamentally limit how we think about vulnerability and power, which has implications for both researchers and participants in the conduct of qualitative research. It profoundly shapes how researchers and participants regard 'sensitivity,' and how that sensitivity could most effectively and ethically be managed.

My experience conducting research in the drug policy domain suggests that 'sensitivity' is not an "unproblematic or commonsensical" concept but rather relational and emergent (Lee & Lee, 2012, p.46). While policy processes research may not fit the usual categories of 'sensitivity' to which ethics committees are attuned (such as traumatic events, violence, death or drug use), the vulnerabilities of participants in this study were at times significant due to the personal, professional and political issues in play. Such vulnerabilities could easily be overlooked by researchers entering the field, as they are masked by the apparent 'elite' power of the roles occupied by these individuals in policy networks. Moreover, in conducting research as policy processes play out in real time, what may be regarded by participants as sensitive at the time of interview, may or may not remain sensitive at later stages of analysis and reporting.

On the other hand, managing these sensitivities and participants' control over 'their' data is a balancing act. Researchers conducting research in policy networks have described the "trade off" (Farquharson, 2005, p.351) involved in guaranteeing confidentiality to participants and how this shapes both data collection and the way that research findings can be reported. By guaranteeing confidentiality to participants, participants are protected and may more confidently offer rich description and detailed accounts. However, the guarantee of confidentiality necessarily limits the ways that these accounts can be reported in this kind of contemporary policy research, given the necessarily confined sampling frame. Researchers must be aware that the decision not to disclose particular information is a political choice which may have implications for maintaining or perpetuating troubling power dynamics. This is a reminder that what makes any piece of research sensitive is highly contextual (Lee & Lee,

2012) and that negotiating such challenges requires constant re-evaluation and reflection within the research process, and further exploration within the qualitative methods literature.

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Conclusion

As I embarked on my Doctoral candidature, my aim was to raise new, critical questions about the ‘evidence-based drug policy’ endeavour. A substantial body of drug policy scholarship has drawn on policy theories to understand processes of contestation and policy change through an interpretivist lens. It was my view that by failing to problematise taken-for-granted concepts (like ‘problems’ or ‘evidence’) embedded within ‘evidence-based policy’ discourse, the capacity for interpretivist approaches to open up new spaces for conceptual and strategic intervention was limited. Rather than bemoaning the barriers to research uptake in this highly politicised policy domain, or analysing historical case studies and the roles of policy actors using well-worn theories, I sought novel lenses through which to consider these issues anew. By drawing on a range of critical perspectives (including Bacchi’s Foucauldian-influenced approach, social construction theory, poststructuralism, feminist theory, and arguments from the discipline of science and technology studies) and studying three contemporary case studies as they played out in real time, I sought to problematise the *premise* of the ‘evidence-based policy’ paradigm and, by interrogating underlying taken-for-granted assumptions, consider the *implications* and *effects* of this dominant mode of governance for drug policy.

Taking a novel approach and drawing on a range of critical perspectives, I was able to analyse ‘evidence-based drug policy’ as a *constructed* and hence *contestable* reality. By shifting the analytic focus towards the *productive techniques* and *constitutive effects* of both drug policies and ‘evidence-based policy’ discourse, my research revealed how policies constitute the ‘problems’ they purport to address (Paper 1) and the discursive, subjectification and lived effects that flow from particular problem representations (Paper 2); how knowledge (‘evidence’) is legitimised (Paper 3) and constituted by specific performances (Paper 5); and how political subjects (such as ‘consumers’) are enacted in material-discursive practices (Paper 4). The work done here to identify taken-for-granted assumptions, interrogate problematisations with a keen eye to their effects, and consider the ways in which drug policy ‘problems,’ ‘subjects’ and ‘objects’ might be *made otherwise* has been undertaken with a critical intent. Following Bacchi (2009), my goal in undertaking this research has been to identify and open up spaces for possible intervention, in order to reduce deleterious effects. If we, as a field, acknowledge these problematisations (and the politics and contingency involved in shaping their meaning), and are not comfortable with the implications and effects identified herein, then it is possible to contend that drug policy may need to be governed through a

different set of practices. It follows that we may well need to rethink the dogged pursuit of the hitherto tacitly accepted 'evidence-based drug policy' endeavour, as it is currently constituted.

My work has aimed to destabilise the largely unquestioned hegemonic status of 'evidence-based policy' discourse in the drug policy field by challenging three implicit assumptions. First, this research challenges the assumption that policy problems objectively exist 'out there' waiting to be 'solved' through the application of 'evidence.' By applying Bacchi's (2009) approach, I demonstrated the ways in which the 'problem of drugs' is constituted *within* policy and law, and the multiple material-discursive effects which flow from these problematisations. These findings contribute to a growing body of poststructuralist scholarship in the alcohol and other drugs field which continues to question the tacitly accepted status of 'drug problems,' including 'addiction' (e.g. Bacchi, 2015; Fraser & Moore, 2011a, 2011b; Fraser, Moore, & Keane, 2014; Keane, 2002, 2009; Keane, Moore, & Fraser, 2011; Lancaster, Hughes, Chalmers, & Ritter, 2012; Lancaster & Ritter, 2014; Pienaar & Savic, 2015; Seear & Fraser, 2014). Despite the quality of the work undertaken by these and other critical drug policy scholars, the notion of 'drug problems' (and their 'causes' and 'effects') remains thoroughly embedded in the broader alcohol and other drugs field. One need only scan a conference program or a journal's table of contents to see this. Too often, the desire to find 'what works' in the alcohol and other drugs field forecloses a range of prior questions about the 'problem' to be 'addressed' and how it might be understood.

As I noted in Paper 1, the proposition that policies *produce* the problems they purport to address may be particularly challenging in a field like drug policy, where researchers and practitioners genuinely spend a good deal of their time seeking to ameliorate or 'solve' what they regard as 'obvious' health and social problems. This proposition calls into question the (sometimes seemingly unshakable) realist presumptions which underpin much drug policy analysis. Nevertheless, I suggest that continuing to reveal the historically contingent and mutable assumptions that are used to rationalise 'evidence-based' policies and practices is imperative. What is perhaps most challenging is acknowledging the ways that our own assumptions, and the categories and concepts we often unquestionably deploy in the field, might actually serve to re-produce troubling conditions and sustain the status quo. As Rhodes and Moore (2001, pp.288-289) note, "conceptions of 'drug use,' 'addiction,' 'dependence' and 'problems' associated with drug use are in part socially constructed by the paradigms, methods and findings of research." Taking this suggestion one step further, as I demonstrated

in Papers 1 and 2, oft used concepts and categories such as ‘problematic substance use,’ ‘dependence’ and ‘addict’ are not only constructed but also *produce* (and re-produce) a range of deleterious discursive, subjectification and lived effects. When we can see the ways in which these concepts and categories reinscribe familiar marginalising stereotypes, close off other ways of thinking and doing, and materially affect people’s lives, these issues cannot be dismissed as mere matters of rhetoric or disciplinary difference. While I have examined these issues in relation to three case studies in this thesis, there are multiple domains within the broader alcohol and other drugs field which require similar interrogation. For example, how might opening up and questioning the conceptual premises which lodge within ‘alcohol-related violence’ destabilise this dominant shaping of the ‘problem,’ help reveal its silences and constitutive effects, and shift our understanding of this issue of concern? Continuing to interrogate these and other categories and concepts such as ‘drug users,’ ‘licit’ and ‘illicit’ drugs, ‘risk,’ ‘recovery’ and ‘harm reduction,’ will be an ongoing task for critical scholars in the field.

Secondly, this research challenges the presupposition that a particular kind of knowledge (‘evidence’) is inherently useful and superior for policy decision-making. Drawing on constructionist and poststructuralist ontologies and epistemologies, and the arguments put forward by science and technology studies scholars, in this research I destabilised the assumption that a particular kind of knowledge is always already ‘superior’ and, moreover, the assumption that the object of ‘evidence’ precedes policy practices. The thing we call ‘evidence’ is *enacted* and *legitimised* in drug policy processes. It is worth emphasising that this enactment takes place within the *specific practices* of an ‘evidence-based drug policy’ world (one where, as I have discussed above, ‘problems’ are treated as exogenous to policy processes, and moreover, as discussed in Paper 4, one which intersects with other practices like ‘consumer participation’). As I raised in the Introduction to this thesis, the ‘objective’ and ‘superior’ status of research ‘evidence’ is ground which has yet to be conceded by many who advocate for ‘evidence-based’ drug policy, despite the now extensively cited arguments put forward by science and technology studies scholars (e.g. Latour & Woolgar, 1979; Law, 2004; Law & Urry, 2004) and a growing body of research in the drugs field which has thrown light on these issues (e.g. Dwyer & Moore, 2013; Fraser, et al., 2014; Moore, 2011; Thomson & Moore, 2014; Vitellone, 2011, 2013). From one perspective, this might be simply explained away as an issue of disciplinary siloing within the drug policy field. Perhaps those working in intervention research or realist evaluation do not read the literature generated by critical drugs scholars, or

do not regard it as relevant to their work. Perhaps (as one senior researcher in the field suggested to me during my candidature) this critical work can be dismissed as merely ‘word play’ with little real-world application. In contrast to critical scholars working in the field, many advocates of ‘evidence-based’ drug policy put themselves forward as depoliticised, objective and rational brokers of ‘what works.’ The irony here is that ‘evidence-based policy’ (and its antecedent ‘evidence-based medicine’) is a social as much as a technical phenomenon, with a clear ideology and normative beliefs, and strategy in pursuit of its goals (Harrison & Checkland, 2009). It is a *political* enterprise.

Vitellone (2011, p.204) makes a key point here: what is at issue “is not a politics of method but method as politics” (that is, *ontological politics*). The arguments I have raised in this thesis move beyond the old ‘paradigm wars’ and the sometimes conflicting epistemological and ontological positions of qualitative and quantitative methodologies (see Bryman, 2008). Science and technology studies scholars argue that *all* research methods enact their objects of study. The significant question here, as Vitellone (2011, p.204, emphasis added) argues by drawing on the work of Law (2004) and Mol (1999, 2002), is “not what is the best method (or the worst) but ‘*which realities*’?” In this research I have sought to extend these ideas from discussion of method per se to ‘evidence-based policy’ itself. If the thing we call ‘evidence’ is enacted in the practices of policy making, then which realities of ‘evidence-based drug policy’ “do we want to help to make more real, and which less real? How do we want to interfere (because interfere we will, one way or another)?” (Law & Urry, 2004, p.404). We, as a field, could interfere in the realities of the ‘evidence-based drug policy’ world “to make a difference, to engage in an ontological politics, and to help shape new realities” (Law & Urry, 2004, p.404), but this requires different and novel modes of thinking and practice. But, as Jasanoff (2016, p.236) argues, all we need to realise new possibilities is one “baby step,” one radical and critical move that asks “Why is it so, and must it be?”

In suggesting that we engage in this interference, it is important to note that there is not necessarily one ‘better’ new reality that we (as a field) might all agree about. Multiplicity does not necessarily mean pluralism, or ‘choosing’ between alternative realities co-existing side by side (Mol, 1999). Realities may clash, but they also may *collaborate* or *depend* on each other in different contexts; to partition them off as if they were a ‘plurality of options’ is to “skip over the complex interconnections between them” (Mol, 1999, p.86). Thus, the interdependence and interconnections between different enactments makes ‘choosing’ an inapt term for

describing what needs to be done by us, in the field (Mol, 2002). Mol (2002, p.177, emphasis added) suggests that “for a long time, and in many places, science held (or continues to hold) the promise of *closure* through fact-finding.” So too, I argue, has the catch-cry of ‘what works.’ Mol (2002, p.177) suggests that one way of disrupting this “promise of closure” is to “call ‘what to do?’ a political question” so as to maintain openness and indeterminacy. From this perspective ‘what to do?’ or indeed ‘what works?’ is not given. By returning *politics* to this question, it cannot be closed; it is a matter of “trying, tinkering, struggling, failing, and trying again” (Mol, 2002, p.177). In Paper 5, I identified a number of ways in which ‘evidence-based policy’ is already being done otherwise, but noted that these ‘other’ enactments are being obscured by an insistence on singularity. Perhaps by thinking of what is enacted and constituted as an *ontological politics* (Law & Urry, 2004; Mol, 1999, 2002) we might, as a field, find spaces to ask new questions about how we might enact different realities and bring the ‘evidence-based drug policy’ endeavour into being in new ways. By returning *politics* (a term which “works to underline this active mode, this process of shaping, and the fact that its character is both open and contested”: Mol, 1999, p.75) to the ‘evidence-based drug policy’ endeavour, we will no doubt find tensions but also a multiplicity of ways of doing which have been silenced and closed off by the current (virtually singular) constitution of this dominant mode of governance.

Thus, acknowledging that the thing we call ‘evidence’ is not fixed, but rather constituted by specific performances and practices, raises a new set of questions for the ‘evidence-based drug policy’ endeavour. Borrowing from and reconfiguring Jasanoff’s (2013, p.16) discussion of democracy, one might say that if we take the object of ‘evidence’ to be “essentially contested,” then the focus of inquiry shifts from ‘how do we achieve this thing called “evidence-based drug policy”?’ to ‘what is this thing called “evidence-based drug policy” that we hope to achieve anyway?’ While my research has begun to explore this second question, there is more work to be done. My exploration of these issues has been delimited by the contextual and temporal boundaries generated by the three contemporary Australian drug policy case studies. The thing we call ‘evidence-based drug policy’ may be enacted differently in the accounts of practitioners, researchers and advocates working in a range of alcohol and other drug policy settings such as liquor licencing, compulsory drug treatment, street-level illicit drugs policing, drug interdiction, or school-based drug education. Understanding *how* this happens and *what* is performatively constituted in different locations and policy settings around the world will be essential to ongoing discussions as to how the ‘evidence-based drug

policy' endeavour might be reconsidered and remade. As I have argued, when we ask questions about the 'thing' we call 'evidence-based drug policy' it becomes possible to see that it may be not be one thing at all, but rather multiple; enacted differently in different times and places.

Fraser et al. (2014) have taken the exploration of this question in a different direction by following Woolgar's suggestion that we need to think not only of 'evidence' but of *evidencing*. This is a salient suggestion, they argue, "for a domain of discourse so fraught and constrained in its processes of authorisation" (Fraser, et al., 2014, p.236). Through my own research, I too have seen the salience of this suggestion. My research demonstrated the ways in which 'consumer representatives,' having been cast into a position of difference, invoked the language of the 'evidence-based policy' paradigm so as to be seen as legitimate (Paper 4), and how for decades the quest for 'scientific' knowledge in the form of a randomised-controlled trial hindered roll-out of peer-administered naloxone programs (Paper 3). I also queried how committees in the UK and Australia became involved in developing 'expert' consensus in an area with very little 'evidence' (Paper 1). The ways in which 'evidence-based policy' discourse and its prescribed modes of 'evidencing' silenced, delimited and delegitimised other knowledges and voices was demonstrated across all three case studies (Papers 3 and 4). These findings highlight the ways in which the drug policy field is so dependent on 'evidence-based policy' discourse that despite the evident fractious tensions (and, as Fraser et al. (2014, p.236) argue, "the epistemological (not to mention ontological) limitations of evidence as it is currently constituted") we continue to rely on taken-for-granted modes of evidencing.

It has been suggested that "the sciences must adopt new habits, become more 'polite' about other ways of seeing and enacting the world" (Fraser, et al., 2014, p.241). Latour (2013, pp.7, 11) has called for a "diplomatic" arrangement, which might "give more space to *other values* that are very commonly encountered but that did not necessarily find a comfortable slot for themselves within the framework offered by modernity" and, might I add, the framework offered by the instrumental rationalism of 'evidence-based policy.' In my research, I revealed the ways in which other ways of knowing and doing are *already co-habiting* in 'evidence-based drug policy' (for example, 'common sense' and knowledges gleaned through lived experience of drug use which have been kept in the margins). In opening up new spaces for thinking about 'evidence' and 'evidencing,' more work needs to be done to consider the ways in which some of these alternative knowledges might be brought to the fore, whilst also recognising that

these ‘other’ enactments, ‘other’ values, and ‘other’ ways of doing and knowing also require critical interrogation as to their implications and effects (Bacchi, 2009).

Through this research, I have revealed the contingent and emergent nature of ‘problems,’ ‘subjects’ and the object of ‘evidence’ itself. However, there is another route of inquiry to be explored in future research: that is, the enactment of the ‘object’ of an intervention. ‘Evidence-based’ policy and practice presupposes the existence of a stable intervention object. Also building on the work of science and technology studies scholars, Rhodes et al. (2016, p.17) have put forward an argument which fundamentally challenges this assumption, positing that “an intervention, and the knowledge which constitutes it, is *made locally*, through its processes of implementation.” This perspective destabilises the ‘evidence-based’ policy and practice paradigm by suggesting that the intervention object *itself* is (along with ‘problems,’ ‘subjects’ and the ‘object’ of ‘evidence’ as has been explored in this thesis) not prior, fixed and stable but rather *made in practices*. Extrapolating from the work of Latour and Woolgar (1979) and Law (2004), Rhodes et al. (2016, p.18) consider “the processes and practices through which ‘material’ interventions or substances (for instance, methadone) are turned into representations or meanings (that is, inscriptions) through the enactments of their implementation (of which scientific practices are a part).” In the first application of this ‘evidence-making intervention’ framework, Rhodes et al. (2016) take a case study of the implementation of methadone treatment in Kenya to explore how enactments of methadone promise *make multiple methadones*. Similar to the ways in which I have argued that policy processes are a site of constitution of the thing we call ‘evidence’ (as well as the constitution of ‘problems’ and political subjects), Rhodes et al. (2016) argue that the implementation process is a site of *intervention constitution*.

In many ways echoing the findings of my research, Rhodes et al. (2016, p.25) note that “there is always the tendency for those comfortable with sticking with a particular discourse of evidence-based intervention to discount alternative knowledges, scientific or otherwise, as less worthy or rationally persuasive, according to their own methods of assessment” and suggest that this “relates in large part to the (illusionary yet comforting) sense of certainty and determinacy enabled by the idea of stable objects of evidence-based intervention.” Thus, by destabilising another taken-for-granted assumption underpinning ‘evidence-based policy’ discourse (that is, that intervention objects are fixed and given) we can open up the possibility for rethinking implementation sciences. Because this approach opens up new ways of thinking

about interventions, knowledge, and implementation processes, it is then possible to trace the *becoming* of interventions in different times and places, and thus their potentially different effects (Rhodes, et al., 2016). Importantly, because this approach also points to the ways in which research is a key site for the making of interventions, and the ways in which scientific discourse interacts with other forms of knowledge to constitute the intervention object, this approach encourages reflexivity about how dominant scientific discourses make knowledge, and also gives weight to local experiences (Rhodes, et al., 2016). Thus, incorporating ‘evidence-making intervention’ approaches into implementation sciences would appear to be a promising route of inquiry, and perhaps a next step for further considering the questions I have raised within this thesis.

Third, and following on from the arguments set forth above, the findings of this research destabilise the presumed-to-be privileged status of both research evidence and researchers themselves. While I have examined the power-effects of ‘evidence-based policy’ discourse in the context of Australian drug policy processes specifically, the implications are much broader. Jasanoff (2013, p.16) argues that

what societies choose to protect, what authority they invoke, and what they challenge under the rubric of ‘science’ all relate in complex ways to the things they wish to protect, invoke or challenge under the rubric of ‘politics.’ Making sense of the politics of knowledge thus requires, in part, deeper reflection on the contested nature of contemporary democracy, most particularly those aspects of democratic governance that rationalise or naturalise the exercise of power.

The findings of this thesis demonstrate the ways in which ‘evidence-based policy’ discourse (a dominant mode of governance in contemporary democratic societies) rationalises and naturalises the exercise of power. By invoking the authority of ‘evidence-based policy,’ particular ‘rational’ and ‘objective’ voices were made as legitimate contributors to the policy process, while others were silenced and marginalised. If we value participation, then these constitutive power-effects should be unsettling. Jasanoff (2013) argues that understandings of politics, citizenship, expertise, and of science itself are divergent and at times nation-specific. Thus, while I have identified and interrogated the implications and effects of ‘evidence-based policy’ discourse in Australian drug policy processes at this particular point in history, analyses of policy processes in other times and places may yield different insights.

The research undertaken in this thesis has also highlighted the ways in which researchers become implicated in particular modes of governance (Bacchi, 2009). By reifying the ‘evidence-based policy’ paradigm, researchers play a role in sustaining the image of policy as a rational pursuit (that is, as a process of ‘authoritative choice’: Colebatch, 2010). As I noted in the Introduction to this thesis, ‘evidence’ has become part of the way an authoritative story of governance is articulated (which, as demonstrated in Paper 5, is in turn productive and constitutive). ‘Evidence-based policy’ discourse depoliticises both the processes of policy decision-making and the processes of producing research knowledge (Bacchi, 2009). In doing so, this discourse leaves little room for the kind of critical interrogation I think is required, if we are to assess and intervene against problematisations which produce deleterious consequences. Bacchi (2009, p.271) argues that the ‘evidence-based policy’ paradigm is difficult for researchers to resist, and that “there appears to be a pressing need to challenge the growing tendency in the research community to provide ‘evidence’ for *pre-defined* ‘problems’.” That is, we need to be alert to the inherent limitations of research conducted to address questions set by others (primarily those who control research funding). This is a deeply challenging and political argument for researchers working in an environment of rapidly shrinking research funding pools, and unprecedented low success rates in competitive grant schemes (which have traditionally funded investigator-driven research). More frequently, researchers are looking to government-commissioned projects to sustain a critical mass of research funding. For researchers working to ‘make a difference’ through policy research (like the research team of which I am a part), the question then becomes: how might we think about engaging with government funders whilst maintaining, as Bacchi (2009, pp.xvi, 271) and Deleuze (1994, p.158) put it, “a right to the problems?” The first step, following Bacchi’s (2009, p.242) approach, is to resist a narrow understanding of the kind of knowledge which may be relevant for policy, and resist the presumption that ‘problems’ (so often designated to be the *starting* place for research) are “clear-cut and uncontroversial.” Researchers “do not stand outside the knowledge-power nexus” (Bacchi, 2009, p.249). Research is itself a process of governing and constituting subjects and hence, must be recognised as a political practice with attendant power-effects.

Given our place as researchers located *within* these discourses and modes of rule, it is difficult to step back and reflect on them. It is for this reason that Bacchi’s (2009) approach explicitly encourages reflexivity and self-scrutiny. Throughout my candidature, I have sought to reflect on research as a *political practice* (Bacchi, 2012). The account given in Paper 6 formed part of

this reflection, however in light of the broader aims of this thesis the reflexive task is undoubtedly much greater. The methods, concepts and categories we routinely (and often unquestionably) deploy in research “are not a way of opening a window on the world, but a way of interfering with it” (Mol, 2002, p.155). Mol (2002) suggests that as researchers we should direct our energy towards trying to understand what we are *doing* when we observe, count, measure, evaluate, publish and speak. Here, I find myself tied in knots. While I have spent my candidature questioning, opening up and interrogating dominant modes of ‘evidencing,’ I have produced a thesis which has been presented in precisely these modes. Each of the papers contained herein has been presented as research requiring method; in the form of ‘rational’ and ‘authoritative’ empirically-based arguments, erasing the irrational and the mess. I have cited empirical qualitative and quantitative studies throughout the papers, and thus by working with a notion of ‘evidence’ I have rendered myself complicit. These are not observations I need to grapple with alone, as others have more eloquently tackled these questions before me. Law (2004, p.143) emphasises the performative nature of method, how it produces realities and, hence, is *creative*. From this perspective, through research it is possible to continually make “new signals and new resonances, new manifestations and new concealments,” none of which automatically fix or stay in place. The suggestion here, for us as researchers, is to find ways of working that “*apprehend* that multiplicity” (Law, 2004, p.152). We need to find other ways of working (new method) which set aside the dominant blinkered presumption of a prior, stable, observable, fixed, knowable and singular ‘real’ in favour of possible presences and gatherings, absences and relations; ways that “make and depict the world differently” (Law, 2004, p.148). In asking what alternative methods might look like in practice, Law emphasises that there is no single answer. Indeed, he suggests that the ability to pose the question is as significant as its potential answers. Debating process, symmetry, multiplicity, reflexivity, goods, imaginaries, materialities, indefiniteness and re-enchantment might open up a wider range of questions about method and inscription (Law, 2004).

While the pursuit of different kinds of “method assemblage” (Law, 2004, p.144) continues (and will remain an ongoing question in my own future research), in the meantime it is important “*politically to contest* the view that research produces disinterested, objective contributions to solving clearly observable societal problems” (Bacchi, 2012, p.150, emphasis original). By problematising the ‘evidence-based drug policy’ paradigm, I have aimed to do just that. By treating ‘evidence-based drug policy’ as a constructed and hence contestable reality, in this work I have destabilised its underlying premise. I have opened up and brought into question

the implicit assumptions that policy ‘problems’ are exogenous to ‘evidence-based policy’ processes, that ‘evidence’ is always already useful for policy-making and precedes policy practices, and the presumed-to-be privileged status of both research ‘evidence’ and researchers themselves. But is a turn to problematisation, accompanied by a commitment to opening up and questioning deleterious effects, really enough? As Bacchi (2012, p.151) asks, “is it enough to bring light to bear on the dynamics that produce realities that could be otherwise? Can these sorts of interventions produce change in the dynamics themselves?” Here, I return to the words of Judith Butler (1990, p.viii):

One might wonder what use ‘opening up possibilities’ finally is, but no one who has understood what it is to live in the social world as what is ‘impossible,’ illegible, unrealisable, unreal, and illegitimate is likely to pose that question.

Thus, the research I have undertaken is not merely a descriptive or theoretical exercise, nor critique for critique’s sake. It is a *conceptual strategic intervention* (Bacchi, 2012, p.151), which hopefully might make it possible to “shift the ground for our political imaginings” and “make it possible to create other realities.” Given the ways in which ‘evidence-based policy’ discourse limits the possibilities of what can be thought and said, shapes how people see themselves and their place in the world, materially impacts in people’s lives, and privileges some voices and ways of thinking and doing while silencing others, I suggest that this shift is both urgent and imperative. While shifting the ground might seem unlikely given the near hegemonic status of the ‘evidence-based policy’ paradigm in the drugs field, it is important to recall that “major shifts in thinking do occur” (Fraser, 2016, p.4). Indeed, through this research I have identified already present possibilities for reproblematisation and resistance.

Given the ways in which ‘evidence-based policy’ discourse (as a socially produced form of knowledge) delimits “what it is possible to think, write or speak about” (Bacchi, 2009, p.35) the ‘problems,’ ‘subjects’ and ‘objects’ which form the basis of drug policy deliberation, we must be attendant to its effects. The task before us is to continue to interrogate and challenge drug policies and modes of governance which produce or sustain deleterious effects. This should include ‘evidence-based drug policy’ discourse, as it is currently constituted. The question of how drug policy and ‘evidence’ may be *otherwise* enacted remains before us still.

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Appendix – Data collection methods

A qualitative multiple-case (or collective-case) study design (Flyvbjerg, 2011; Stake, 1995; Yin, 2009) was employed to examine three contemporary drug policy issues in Australia: (i) discussion of the notion of ‘recovery’ in drug policy and drug treatment provision at the national level; (ii) the development of approaches to extend distribution of injecting equipment through peer networks (also called ‘secondary supply’ or ‘peer distribution’) in Sydney, NSW; and (iii) processes leading to the establishment of two programs to make naloxone available to potential opioid overdose witnesses in Canberra, ACT and Sydney, NSW. The case studies were informed by a range of qualitative data including documentary sources, and semi-structured in-depth interviews (n=41) with policy makers, advocates, researchers, non-government organisation representatives, consumer representatives and clinicians closely involved in these policy processes. Participant observation was also undertaken. Background to the three cases has been described briefly in the Introduction to this thesis, and in detail in Papers 1, 2 and 3. Approaches to analysis are also included in each of the six papers. In this Appendix, I outline the data collection methods used in this research.

Case sampling

The three cases were selected on the basis that they were all prominent, keenly debated and contentious issues of concern in the Australian drug policy field at the time of the commencement of this research in 2013. Rather than selecting historical cases, my aim was to study contemporary policy processes as events unfolded in real time. As I discussed in Paper 6, a commitment to collecting data as the policy process unfolds may be beneficial when the purpose of the research is to study dynamics and contestation, rather than trying to document ‘official’ accounts of events (which are themselves, of course, always in flux and their meanings never truly fixed). In keeping with the theoretical concerns of the thesis, such an approach recognises (and aims to work with) emergence and contingency, not definite or well-tailored accounts (Law, 2004). In documenting and analysing these case studies, I have not assumed that there is one definite or independent reality, waiting to be discovered through my inquiry, but rather that the particular realities of these case studies are “*constructed* in networks of practices that include inscription devices and their contexts” (Law, 2004, p.22, emphasis original). That is, methods help produce and shape these case study realities, as well as

describing them. As a researcher, I am not a detached observer, but rather involved in co-constituting these case studies as objects of study.

The three cases shared some basic elements and similarities, but also varied across a range of dimensions to allow for breadth of analysis. The sample of cases spanned both treatment and harm reduction (two different and major domains of drug policy activity). The three cases also engaged with policy activity across multiple jurisdictions: the recovery case study was examined across international borders by comparing discourses in Australia and the UK; the naloxone case study examined policy development processes in two state and territory jurisdictions (the ACT and NSW); and the extended distribution of injecting equipment case study examined policy processes at the state and local level. Given the theoretical concerns of the thesis, the cases were also selected on the basis that multiple voices within the drug policy field (for example researchers, advocates, peak bodies and consumers) had made knowledge claims about these issues within drug policy settings and in the public domain. This allowed for examination of the historical and discursive context of the policy development process, as well as contemporary policy discussion. All three case studies shared concern about a particular kind of drug use, that is, what would ordinarily be referred to in the drug policy field as ‘problematic drug use’ (recognising here that the use of opioids and injecting as a route of administration may or may not be ‘problematic’ or associated with ‘harms’).

Data collection

Multiple methods of qualitative data collection were used, including documentary sources and semi-structured in-depth interviews. Participant observation was also undertaken alongside these data collection methods, in order to ‘scope the field’ and immerse myself in the unfolding policy discussions and social milieu. In the data collection process, consideration was given to: *policy activity* (problematisation, participation, policy knowledge, discourses); the *settings and processes* through which policy activity occurs (committees, inquiries, forums, conferences, symposia, public debate, media); and the roles of *multiple knowledges and ‘voices’* (consumer representatives, advocates, peak bodies and other non-government organisation representatives, clinicians, practitioners, researchers, bureaucrats).

In accordance with the National Statement on Ethical Conduct in Human Research (National Health and Medical Research Council, 2007), ethical approval was sought from the University of NSW Human Research Ethics Advisory Panel (HREA Approval Numbers: 9_12_002;

9_13_018; 9_14_008; HC15145) and NSW Ministry of Health (HREC Reference Number 14/029).

1) Documentary sources

A critical approach was taken to collecting and analysing documentary data, with each document being regarded as a communicative event. As Mason (2002, p.110) notes, documents are “constructed in particular contexts, by particular people, with particular purposes, and with consequences – intended and unintended.” Moreover, given the theoretical concerns of this thesis, ‘texts’ are productive and constitutive, and their selection for analysis must be recognised as an interpretive exercise (Bacchi, 2009). In this study, full consideration was given to the discursive context in which the document analysed was created and distributed; who created the document, the purposes for which the document was created, and the ways in which the document had been used or validated within policy discussion.

Sampling

A review of the academic and grey literature was conducted for each of the cases, to provide detailed context to each case. Public documents including reports, research papers, policies, position papers, press releases, media articles, inquiry transcripts, submissions and legislation were sourced online and via academic and parliamentary databases. These searches also helped to ‘scope the field’ under examination, and trace individuals and organisations who had been active in policy discussion surrounding the cases. These searches partially informed the selection of interview participants. Throughout the iterative data collection process, documents discussed by participants in interviews or mentioned within observed events were also collected. Finally, Google alerts were used to monitor evolving discussion of the policy issues under examination both in Australia and internationally throughout the duration of the study. Online discussions in drug policy e-lists such as ADCA Update and DrugScope (UK) were also monitored.

2) Interviews

Interviews are regarded as an essential case study data source (Yin, 2009) and have been widely used in drug policy research (e.g. Hughes, 2009; MacGregor, 2013; Monaghan, 2008; Ritter, 2009). Qualitative interviewing “begins with the assumption that the perspective of others is meaningful, knowable, and able to be made explicit” (Patton, 1990, p.278). The

“essence” of the interview is inter-subjective interaction (Minichiello, Aroni, & Hays, 2008, p.78). Consideration of the role of the researcher within this close interaction is important (Glesne, 2011b), and the establishment of rapport is essential (Patton, 1990).

Data collection instrument

A semi-structured interview guide was developed and adapted for each of the cases (see following Appendix). The interview guides focussed on eliciting participants’ perceptions and accounts of policy activity, the processes through which policy activity occurs, and the roles of multiple knowledges and ‘voices.’ Although the interview guide assisted me to direct conversation towards key topic areas, a flexible approach to interviewing was taken whereby probing and follow-up questions were used to uncover new insights (Minichiello, et al., 2008). As an interviewer, I played an active role in building conversation about a particular issue, responsively changing the wording or ordering of questions, and allowing for the emergence of individual perspectives (Patton, 1990). The interviews allowed for flexibility and sought a balance between consistent discussion of the topics outlined in the interview guide and pursuing the ‘elusive’ aspects of participants’ stories (Fraser & valentine, 2008).

Sampling and recruitment

Semi-structured in-depth interviews were conducted with individuals identified as being closely involved in policy processes related to the three case studies. Policy makers, advocates, researchers, non-government organisation representatives, consumer representatives and clinicians who had contributed their expertise at various stages throughout the discussion and development of these drug policy issues, or who had been closely involved in key committees or events (for example, the ANCD Recovery Roundtable and the Expanding Naloxone Availability in the ACT (ENAACT) Committee), were invited to participate. Participants were identified in several ways, for example through review of documentary materials (to identify committee memberships, authors of reports, or opinion writers on e-lists such as ADCA update), during participant observation, and in conversations with supervisors. Additionally, during interviews, participants would mention the names of other individuals who had been closely involved, or would suggest that I speak to particular people. Of all the individuals who were invited to participate, only three refused to participate. A further three participants initially agreed to participate, and then were unavailable despite efforts made to find a mutually agreeable interview time.

For each case, interviews were conducted with two groups of participants: primarily, individuals closely involved in policy discussion about the relevant drug policy issue within a specific jurisdiction; but also individuals who had been involved in discussion of these issues at a broader, national or international level but who may not have been involved in local-level discussions within a particular jurisdiction at the time. In total, 41 interviews were conducted: 19 for the naloxone case study; 12 for the recovery case study; and 10 for the extended distribution case study. The case studies necessarily involved small sampling frames, given their specific focus on particular policy development processes. Across the cases, 23 men and 14 women were interviewed (four participants – two men and two women – were interviewed across two of the cases, given their close involvement in different policy processes. In these situations, the two interviews were spaced out over several months, and I was careful to recognise the additional burden on the participant). Seven participants were consumer representatives, 5 were non-government organisation or peak body representatives, 11 were researchers¹, 7 were clinicians, 2 were advocates, and 5 were policy makers. These categories, of course, are limiting and do not take into account the multiple roles that these individuals occupy within the field, and are intended only as guiding descriptors. As discussed in Paper 6, more detailed description of the interview sample is not provided due to concerns about confidentiality and anonymity in this highly politicised policy domain, especially given the small number of individuals involved in discussion of each of these drug policy issues.

Participants were sent a letter via email inviting them to participate in the study, along with a Participant Information Statement and Consent form. No inducements were offered and participation was voluntary. Interviews were on average one hour in length (ranging from 30 minutes to over 2 hours), and were conducted either by phone or in person (generally in the participant's own office or workplace). Interviews were digitally audio-recorded and then transcribed verbatim by a professional transcribing service (Smart Docs). The transcripts were carefully reviewed against the original audio recording, checking for errors and omissions.

¹ It is important to note that my two supervisors were interviewed as participants in this research, due to their involvement in one of the case studies as policy processes unfolded. A number of strategies were employed to minimise any undue influence. All data were de-identified prior to analysis, and then coded and analysed by me alone. There was a significant time-lag between conducting the interviews, analysing the data and presenting my interpretation to supervisors. The papers which include analysis of these two interviews were either sole authored papers, or included a fourth author (Kate Seear). Across all of the papers, final interpretation of the data rested with me as lead author.

Participants were sent a copy of their transcript to review for the purposes of verifying accuracy, correcting errors or inaccuracies, and providing clarifications. This procedure has been adopted in similar studies (Wiles, Charles, Crow, & Heath, 2006; Wiles, Crow, Heath, & Charles, 2008). To maintain confidentiality and anonymity, all interviews were de-identified prior to analysis.

3) Participant observation

Concurrently, I also conducted participant observation in order to 'scope the field' and immerse myself within the case studies as policy discussion unfolded in real time throughout the data collection period. The purpose of participant observation was not to collect data per se, but rather served as background to the cases. In 2013 and 2014 I attended a variety of events around Australia where policy discussion about the three cases was taking place, including, for example, the Victorian Alcohol and Drug Association (VAADA) forum, the Australian National Council on Drugs (ANCD) consultation on drug and alcohol issues, the Network of Alcohol and other Drugs Association (NADA) 'Community (re)integration' forum, the NSW Users and AIDS Association (NUAA) 'Drug Policy and You' forum, and the Australian Injecting and Illicit Drug Users League (AIVL) National Needle and Syringe Program (NSP) consultation forum. Through these participant observation activities, I also identified interview participants and documentary data sources.

Participant observation is a method which involves simultaneously fulfilling the dual roles of 'actor' and 'researcher' in a particular social milieu (Guest, Namey, & Mitchell, 2013; Waddington, 2004). Within a case study design, participant observation provides an opportunity to perceive the case "from the view-point of someone 'inside' the case rather than external to it" (Yin, 2009, p.112). The role of the participant observer is to become immersed in the action and context of a setting so as to produce insights and contextual understanding about complex interactions (Glesne, 2011a; Guest, et al., 2013). What is learned about behaviours, perspectives, processes, routine actions, rules and norms within a setting is gained through both the researcher's observation and participation and, as such, the researcher's own experience in the setting is considered important (Waddington, 2004).

An observational guide was developed (see following Appendix). Attention was given to observing processes ("explicit and implicit rules, regulations, and rituals that describe how a program, institution, or group works") and talk ("what people say to each other") (Glesne, 2011a, p.90). Given that the settings observed (academic conferences, policy forums,

consultations etc.) were situations in which note-taking is normal and accepted practice, full running notes were written throughout the observational period. Further reflections and analytic notes were written up as soon as practicably possible after the event (immediately after leaving the setting, or later that day). Where informal conversations and interactions occurred (for example over lunch or following a meeting), mental and jotted notes were taken and completed later in the day (Glesne, 2011a).

Coding and data organisation

The foundational principles of thematic qualitative analysis (Braun & Clarke, 2006) were initially applied across the multiple data sources. The fundamental processes of data reduction, data organisation and interpretation embedded within this basic qualitative approach provided the necessary structure to analyse large volumes of data. Interview transcripts were coded and organised with the aid of NVivo 10 and NVivo 11 data management software.

Following a process of familiarisation with the multiple sources of data, initial codes were generated first within one case and then subsequently across cases. These initial codes were derived from the principal concerns which had framed data collection (that is, policy activity; the settings and processes through which policy activity occurs; and the roles of multiple knowledges and ‘voices’), the participants’ own accounts, and the theoretical concerns under examination (for example, discussion of ‘evidence’). Codes were then collated and categorised into potential themes, the themes reviewed, and then the identified themes defined and named (Braun & Clarke, 2006). This analytic process assisted the recognition and re-contextualisation of data by linking fragments of data to particular concepts, and establishing linkages (Coffey & Atkinson, 1996). This approach to identifying, analysing and reporting patterns in the data provided an organisational foundation on which to build theoretically-driven examination and apply the approaches to analysis described specifically within each of the individual papers. Thus, a reflexive and iterative approach was taken to coding and analysis, as the research process unfolded. Such approaches have been described elsewhere as ‘adaptive coding’ (Radcliffe & Stevens, 2008). These methods of coding and data organisation allowed me to produce patterns, and to “gather or ‘craft’ a reality from the ‘mess’ that is [my] object of study” (Fraser & valentine, 2008, p.31) in these policy cases.

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Appendix – Interview and participant observation guides

Recovery case study semi-structured interview topics

1. Tell me about your role and experience in the drug policy field.
2. In your own words, what is 'recovery'?
 - Where has this idea come from?
 - What do you think drives this idea?
3. What (knowledge or information) do you find compelling or important in thinking about 'recovery'?
 - How does it 'fit' with how you think about drug policy issues?
4. In recent years, the notion of 'recovery' has been debated in drug policy discussions both in Australia and internationally. Tell me the story from your perspective, how did 'recovery' emerge in Australian drug policy discussion?
 - Have you been involved in these discussions?
 - How did you come to be involved?
 - At what point did you come to be involved?
 - What was your interest in being involved?
 - What did you already know about recovery prior to these discussions/ How had you thought about recovery prior to these discussions?
 - (Were you involved in the ANCD roundtable event? Can you tell me about that experience?)
 - Can you tell me about a time when you have been involved in recovery policy debate?
5. In your opinion, who are the critical players involved in discussion of this issue?
 - Who has played a significant role? Why do you think they have been involved?
 - What qualities or knowledge did they bring to the process?
 - Who has been missing from these debates? Why have they been missing?
6. Thinking about a timeline of events, from your perspective what have been the critical moments with the 'recovery' agenda?
 - Have there been moments where traction was stymied?
7. Thinking more broadly, why do you think 'recovery' has emerged as a drug policy issue in Australia in recent times?
 - From your perspective, what has been the story in the last few years?

- Why now?
 - What factors are underlying the kind of discussions which are going on?
 - In your opinion, what is being missed or dismissed in these discussions?
 - In your opinion, why has discussion of recovery in Australia died down?
8. How do you think 'recovery' should be thought about in the Australian context?
- What effects do you see as potentially emerging?
 - In the future, how do you think recovery will be defended? Or disrupted and replaced?
9. What lessons do you think you have learned through being involved in this issue/these discussions?
10. Do you think there are lessons for drug policy in Australia which have emerged through the recent recovery discussion?
11. What do you perceive to be the ongoing challenges?
12. Do you have any further reflections?

Extended distribution case study semi-structured interview topics

1. Tell me about your role and experience in the drug policy field.
2. A pilot to extend distribution of injecting equipment through peer networks (also called 'secondary supply' or 'peer-distribution') has been developed and established in Sydney. Tell me the story from your perspective, how did the extended distribution pilot in Sydney come to fruition?
 - How did you come to be involved?
 - At what point in the process did you come to be involved?
 - What was your interest in being involved?
 - What did you already know about extended distribution prior to being involved in Sydney?
3. What knowledge or information did you find compelling in approaching the issue of extended distribution of injecting equipment at this time?
4. Who were the other players involved in the process?
 - In your opinion, who were the critical players?
 - Who played a significant role in shifting the agenda?
 - What qualities or knowledge did they bring to the process?
 - Who has been missing from these debates? Why?
5. Thinking about a timeline of events, from your perspective what were the critical points or moments of traction with the extended distribution issue in Sydney?
 - What were the critical points or moments where traction was stymied?
 - Would you say there was there a strategy used to effect change in Sydney? If so, what was the strategy?
6. Why was Sydney, and particularly inner-city Sydney, chosen as the setting for this program?
 - What was it about environmental context that you felt made it amenable to this initiative?
 - Were there particular political or social factors involved?
7. Overall, what do you think were the critical factors in rolling out the extended distribution pilot in Sydney?
8. Do you think that the approach to establishing the extended distribution pilot which was used in Sydney is replicable:
 - To other jurisdictions? Why or why not?

- To another drug policy issue? Why or why not?
9. What lessons do you think you have learned through this process?
- What parts of the roll-out didn't work?
 - What were the barriers to success?
 - Were there parts of the roll-out which you felt consumed time and energy but contributed little to the successful outcome?
 - Were there any surprising moments of traction or success?
10. Do you think there are lessons for drug policy in Australia which have emerged through the recent processes surrounding the extended distribution pilot?
11. What do you perceive to be the ongoing challenges?
12. Thinking more broadly, why do you think extended distribution of injecting equipment has emerged as a drug policy issue in Australia in recent times?
- From your perspective, what has been the story in the last few years?
 - Why now?
 - What factors are underlying the kind of discussions which are going on?
 - In your opinion, what is being missed or dismissed in these discussions?
13. Do you have any further reflections?

Naloxone case study semi-structured interview topics

A) Sydney, NSW and Canberra, ACT

1. Tell me about your role and experience in the drug policy field.
2. An expanded naloxone program has been developed and established in Sydney/Canberra. Tell me the story from your perspective, how did the expanded naloxone program in Sydney/Canberra come to fruition?
 - How did you come to be involved?
 - At what point in the process did you come to be involved?
 - What was your interest in being involved?
 - What did you already know about naloxone prior to being involved in Sydney/Canberra?
3. Was there a strategy used to effect change in Sydney/Canberra?
 - If so, what was the strategy?
4. Thinking about a timeline of events, from your perspective what were the critical points or moments of traction with the naloxone issue in Sydney/Canberra?
 - What were the critical points or moments where traction was stymied?
5. Who were the other players involved in the process?
 - In your opinion, who were the critical players?
 - What did they bring to the process?
6. Why was Sydney/Canberra, chosen as the setting for this program?
 - What was it about environmental context that you felt made it amenable to this initiative?
 - Were there particular political or social factors involved?
7. Overall, what do you think were the critical factors in establishing the expanded naloxone program in Sydney/Canberra?
8. Do you think that the strategy (or approach) which was executed in the Sydney/Canberra is replicable:
 - To other jurisdictions? Why or why not?
 - To another drug policy issue? Why or why not?
9. What lessons do you think you have learned through this process?
 - What parts of the strategy didn't work?
 - What were the barriers to success?

- Were there parts of the strategy which you felt consumed time and energy but contributed little to the successful outcome?
- Were there any surprising moments of traction or success?
- Do you think there are lessons for drug policy in Australia which have emerged through the recent processes surrounding naloxone?

10. What do you perceive to be the ongoing challenges?

11. Thinking more broadly, why do you think overdose prevention has emerged as a drug policy issue in Australia in recent times?

- From your perspective, what has been the story in the last 2 years?
- Why now?

12. In thinking about these issues, what information or evidence do you find compelling?

13. Do you have any further reflections?

B) 'Commentators'

1. Tell me about your role and experience in the drug policy field.

2. What is your interest overdose prevention and naloxone in particular?

3. From your perspective, how did naloxone emerge as a drug policy issue in Australia?

- From your perspective, what has been the story in the last 2 years?
- Why do you think the issue of naloxone has come to fruition?

4. In the last 2 years, expanded naloxone programs have been developed and established in Sydney and Canberra. Have you been involved in these processes or discussions about these programs?

- How did you come to be involved?
- What was your interest in being involved?

5. Why do you think the naloxone programs in Sydney and Canberra came to fruition?

- Why now?
- What were the critical factors in establishing the expanded naloxone programs in Sydney and in Canberra?

6. From your perspective what were the critical points or moments of traction?

- What were the critical points or moments where traction was stymied?

7. In your opinion, who were the key players involved in the process?

- Who played a significant role in shifting the agenda?
- What did they bring to the process?

8. What was it about environmental contexts of Sydney and Canberra that made these places amenable to this initiative at this time?
 - Were there particular political or social factors involved?
9. Do you think that the strategy which was executed in Sydney or Canberra is replicable:
 - To other jurisdictions? Why or why not?
 - To another drug policy issue? Why or why not?
10. Do you think there are lessons for drug policy in Australia which have emerged through the recent processes surrounding naloxone?
11. What do you perceive to be the ongoing challenges?
12. In thinking about these issues, what information or evidence do you find compelling?
13. Do you have any further reflections?

Participant observation guide

1. Type of event
2. Date, time and location of event
3. Purpose of the event
 - Was there a specific aim?
 - Why were the participants brought together?
4. People present
 - Individuals and their roles in the 'drug field'; representatives of organisations
 - Anything noteworthy about the mix of people present or absent?
5. Description of physical setting
 - Anything noteworthy about the space?
6. Description of event
 - What happened? What activities were undertaken and by whom?
 - Types of interactions (formal, informal, how did people interact)
 - What was said? (formal presentations, discussion time, informal conversations, illustrative 'vignettes')
 - What was the feeling of the event? (adversarial, combative, collaborative, relaxed, friendly)
7. Summary notes
8. Reflections
 - Analytic ideas and interpretations (key ideas; new ideas; reinforced ideas; contrary ideas; how do these observations connect to the broader conceptual framework of the project or other data collected)
 - Personal reflections about the event
 - Personal reflections on my role as 'participant observer' at this event
9. Methodological notes
 - Ethical and procedural issues to resolve
 - What worked; what needs to be refined
10. Reminders
 - Follow up

Appendix – List of other publications during candidature

Peer reviewed journal articles

1. **Lancaster**, K. (in press, accepted 3/8/2016). Rethinking recovery: a commentary on “Making the hard work of recovery more attractive for those with substance use disorders”. *Addiction*.
2. **Lancaster**, K., Ritter, A., Hughes, C., & Hoppe, R. (2016). A critical examination of the introduction of drug detection dogs for policing of illicit drugs in New South Wales, Australia using Kingdon's 'multiple streams' heuristic. *Evidence & Policy: A Journal of Research, Debate and Practice* (Advance online publication), DOI: 10.1332/174426416X14683497019265.
3. Chalmers, J., **Lancaster**, K., & Hughes, C. (2016) The stigmatisation of 'ice' and under-reporting of meth/amphetamine use in general population surveys: A case study from Australia. *International Journal of Drug Policy* (Advance online publication), DOI:10.1016/j.drugpo.2016.06.001.
4. **Lancaster**, K., Hughes, C., & Ritter, A. (2016) “Drug dogs unleashed”: An historical and political account of drug detection dogs for street-level policing of illicit drugs in New South Wales, Australia. *Australian and New Zealand Journal of Criminology* (Advance online publication), DOI: 10.1177/0004865816642826.
5. Chalmers, J., Ritter, A., Berends, L., & **Lancaster**, K. (2016) Following the money: mapping the sources and funding flows of alcohol and other drug treatment in Australia. *Drug and Alcohol Review*, 35(3), 255-262.
6. Ritter, A., Hull, P., Berends, L., Chalmers, J. & **Lancaster**, K. (2016) A conceptual schema for government purchasing arrangements for Australian alcohol and other drug treatment. *Addictive Behaviors*, 60, 228-234.
7. Berends, L., Chalmers, J., & **Lancaster**, K. (2015) Trust, agency, and control: Perspectives on methadone takeaway dosing in the context of the Victorian policy review. *Drug and Alcohol Review*, 34(5), 483-486.

8. **Lancaster**, K., Santana, L., Madden, A., & Ritter, A. (2015) Stigma and subjectivities: Examining the textured relationship between lived experience and opinions about drug policy among people who inject drugs. *Drugs: Education Prevention & Policy*, 22(3), 224-231.
9. **Lancaster**, K. (2014) Social construction and the evidence-based drug policy endeavour, *International Journal of Drug Policy*, 25(5), 948–951.
10. **Lancaster**, K. & Ritter, A. (2014) Making change happen: a case study of the successful establishment of a peer-administered naloxone program in one Australian jurisdiction, *International Journal of Drug Policy*, 25(5), 985–991.
11. **Lancaster**, K., Sutherland, R., & Ritter, A. (2014) Examining the opinions of people who use drugs towards drug policy in Australia, *Drugs: Education, Prevention, and Policy*, 21(2), 93-101.
12. **Lancaster**, K., Ritter, A., & Colebatch, H. (2014) Problems, policy and politics: making sense of Australia's 'ice epidemic', *Policy Studies*, 35(2), 147-171.
13. **Lancaster**, K., & Ritter, A. (2014) Examining the construction and representation of drugs as a policy problem in Australia's National Drug Strategy documents 1985 to 2010, *International Journal of Drug Policy*, 25(1), 81-87.
14. Ritter, A., & **Lancaster**, K. (2013) Illicit drugs, policing and the evidence-based policy paradigm, *Evidence & Policy: A Journal of Research, Debate and Practice*, 9(4), 457-472.
15. **Lancaster**, K. & Hughes, C.E. (2013) Buzzed, broke, but not busted: How young Australians perceive the consequences of using illicit drugs, *Youth Studies Australia*, 32(1), 19-28.
16. **Lancaster**, K., Ritter, A. & Stafford, J. (2013) Public opinion and drug policy in Australia: engaging the 'affected community', *Drug and Alcohol Review*, 32(1), 60-66.
17. Ritter, A., & **Lancaster**, K. (2013) Measuring research influence on drug policy: A case example of two epidemiological monitoring systems, *International Journal of Drug Policy*, 24(1), 30-37.

Book chapters

1. Ritter, A. & **Lancaster**, K. (2013) Policy models and influences on policy processes. Chapter 5 in Ritter, A., Hamilton, M. & King, T. (Eds.) *Drug Use in Australian Society* (pp. 99-132). South Melbourne: Oxford University Press.

Research reports

1. Ritter, A., Berends, L., Chalmers, J., Hull, P., **Lancaster**, K. & Gomez, M. (2014) *New Horizons: The review of alcohol and other drug treatment services in Australia*, Final report submitted to the Commonwealth Department of Health. Sydney: Drug Policy Modelling Program.
2. **Lancaster**, K., Ritter, A., & Matthew-Simmons, F. (2013) *Young people's opinions on alcohol and other drugs issues*, ANCD research paper no. 27., Canberra: Australian National Council on Drugs.

Other outputs

1. Ritter, A., **Lancaster**, K. & Barratt, M. (2016) Researcher engagement with people who use drugs. *Drug and Alcohol Research Connections*, April 2016.
2. Hughes, C., Ritter, A., Chalmers, J., **Lancaster**, K., Barratt, M. & Moxham-Hall, V. (2016). *Decriminalisation of drug use and possession in Australia – A briefing note*. Sydney: Drug Policy Modelling Program, NDARC, UNSW Australia.
3. Belackova, V., Ritter, A., Shanahan, M., Chalmers, J., Hughes, C. Barratt, M. & **Lancaster**, K. (2015). *Medicinal cannabis in Australia – Framing the regulatory options*. Sydney: Drug Policy Modelling Program, NDARC, UNSW Australia.

Appendix – List of presentations during candidature

1. **Lancaster, K.** (2016, August) Drug dogs unleashed: policy processes, politics and ‘evidence-based drug policy.’ Invited guest lecture at the School of Social Sciences, UNSW, 8 August, Sydney.
2. **Lancaster, K., Treloar, C. & Ritter, A.** (2016, May) “Naloxone works”: The politics of knowledge in ‘evidence-based’ drug policy. Paper presented at the International Society for the Study of Drug Policy Conference, 16-18 May, Sydney.
3. **Lancaster, K., Treloar, C. & Ritter, A.** (2016, April) “Naloxone works”: The politics of knowledge in ‘evidence-based’ drug policy. Paper presented at the National Drug and Alcohol Research Centre Seminar Series, 21 April, Sydney.
4. **Lancaster, K.** (2016, April) Examining the introduction of drug detection dogs for street-level policing of drugs in NSW. Invited guest lecture at the School of Public Health and Community Medicine, UNSW, 18 April, Sydney.
5. **Lancaster, K., Seear, K. & Treloar, C.** (2016, March) Laws prohibiting peer distribution of injecting equipment in Australia: A critical analysis of their effects. Paper presented at the Social Research Conference on HIV, Viral Hepatitis and Related Diseases, 1 April, Sydney.
6. **Lancaster, K., Ritter, A., Hughes, C. & Hoppe, R.** (2015, November) ‘An idea whose time has come?’ Examining the introduction of drug detection dogs for street-level policing of drugs in NSW. Paper presented at the National Drug and Alcohol Research Centre Seminar Series, 12 November, Sydney.
7. **Lancaster, K., Seear, K. & Treloar, C.** (2015, October) Laws prohibiting peer distribution of injecting equipment in Australia: A critical analysis of their effects. Paper presented at the Drug Policy Modelling Program Symposium, 15 October, Sydney.
8. **Lancaster, K.** (2015, October) Performing the evidence-based policy paradigm. Invited presentation at ‘Policy and making sense in (and of) governing’: Workshop on interpretation and policy, Sponsored by the APSA Research Group on Policy Studies, 1 October, Canberra.

9. **Lancaster, K.** (2015, September) "We know this": The constitution and validation of knowledge(s) in drug policy processes. Paper presented at the Contemporary Drug Problems Conference – Encountering alcohol and other drugs, 16-18 September, Lisbon, Portugal.
10. **Lancaster, K.** (2015, August) Laws prohibiting peer distribution of injecting equipment in Australia: A critical analysis of their effects. Paper presented at the 2nd UNSW Postgraduate Research Symposium: Where the marginal matters: Strengthening trans-disciplinary connections in postgraduate health research on sex, drugs and risk, 21 August, Sydney.
11. **Lancaster, K.** (2015, July) Laws prohibiting peer distribution of injecting equipment in Australia. Invited presentation at Roundtable: Public health and legislative amendments focussed on people who inject drugs and their families and friends, convened by the Alcohol Tobacco & Other Drug Association ACT, 3 July, Canberra.
12. **Lancaster, K.** (2015, May) 'Ice epidemic' then and now: problems, policy and politics, Invited guest lecture at the School of Public Health and Community Medicine, UNSW, 18 May, Sydney.
13. **Lancaster, K.** (2015, April) Contemporary case study research in a politicised domain: examining drug policy processes in Australia. Paper presented at the International Institute for Qualitative Methodology Qualitative Methods (QM) Conference, 28-30 April, Melbourne.
14. **Lancaster, K.** (2014, December) A cross-national comparison of the 'recovery' concept in British and Australian drug policy. Invited presentation at the Centre for Social Research in Health Seminar Series, 10 December, Sydney.
15. **Lancaster, K., Duke, K. & Ritter, A.** (2014, November) A cross-national comparison of the 'recovery' concept in British and Australian drug policy. Paper presented at the National Drug and Alcohol Research Centre Seminar Series, 20 November, Sydney.
16. **Lancaster, K., Duke, K. & Ritter, A.** (2014, November) Examining the construction and representation of 'recovery' in UK and Australian drug policy discussions. Paper presented at APSAD Conference, 9-12 November, Adelaide.

17. **Lancaster**, K., Ritter, A. & Matthew-Simmons, F. (2014, September) Young people's opinions about alcohol and other drug policy. Poster presented at the National Drug and Alcohol Research Centre Annual Symposium, 8 September, Sydney.
18. **Lancaster**, K. (2014, August) Social construction and the evidence-based drug policy endeavour. Paper presented at the Inaugural Postgraduate Research Symposium, Where the marginal matters: Strengthening trans-disciplinary connections in postgraduate health research on sex, drugs and risk, 29 August, Sydney.
19. **Lancaster**, K., Ritter, A., Santana, L. & Madden, A. (2013, December) Public opinion and drug policy: engaging the 'affected community'. Paper presented at the 11th Dangerous Consumptions Colloquium, 12-13 December, Sydney.
20. **Lancaster**, K. (2013, October) Examining the opinions of people who use drugs towards drug policy in Australia. Invited presentation at the NSW Users and AIDS Association 'Drug Policy and You' Symposium, 16 October, Sydney.
21. **Lancaster**, K. (2013, August). Examining the construction and representation of drugs as a policy problem in Australia's National Drug Strategy documents, 1985-2010. Paper presented at the National Drug and Alcohol Research Centre Seminar Series, 8 August, Sydney.