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EXPERTS, EXPERTISE AND DRUG POLICYMAKING

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Abstract: Over the past two decades, policymakers have been encouraged to develop evidence-based policies in collaboration with experts. Drug policy is unique since it has an established inbuilt mechanism for soliciting expertise via the Advisory Council for the Misuse of Drugs (ACMD). Increasingly alternative mechanisms have been used. Based upon detailed analysis of two case studies of drug policymaking using alternative methods to solicit expertise, we argue that the framing of the policy problem, the mechanisms used to involve experts and the type of evidence actively sought, have continued to marginalise the involvement of the drug user in policymaking.

Keywords: drug policy; evidence; experts; expertise; policymaking

Over the past two decades, policymakers have been encouraged to develop evidence-based policies in collaboration with experts. In the field of UK drugs policy,[1] expertise has been formally embedded in the decision-making apparatus since the passing of the Misuse of Drugs Act 1971 (MDA 1971), but long before this the findings of learned committees influenced the direction of policy. The Rolleston Committee in 1921 and the Brain Committee in 1961 provide noteworthy examples (Barton 2011). The MDA 1971, established the Advisory Council on the Misuse of Drugs (ACMD) whose initial remit was to consider any matter relating to drug dependence or the misuse of drugs. Since its inception, ministers have been obliged to consult the ACMD before making regulations under the MDA 1971 and prior to laying orders before

parliament, but do not have to act on its advice (Taylor 2016, p.130). While working relations between government and its drug policy experts have always been fractious, in the past decade there have been high-profile clashes, most notably in relation to drug classification.

A significant feature of recent drug policymaking is the use of alternative mechanisms to the ACMD to solicit expert advice to inform policy. Whether this is a consequence of the awkward relationship between government and the ACMD, a response to new challenges in the drugs field such as the rapid rise of novel psychoactive substances (NPS), or shifts in the way in which drug policy has been framed (see Monaghan 2012), is a source of debate. Here we consider whether these alternative mechanisms have changed the policy landscape to the extent that it has been 'opened up' to new voices, including those of former and current drug users who can potentially bring different types of experientially-derived evidence to the policy process, resulting in improved drug policy through understanding the breadth and depth of experiences, knowledges and beliefs surrounding drug use (see Ritter, Lancaster and Diprose 2018).

In this article, we concentrate on 'high-level' policy development stemming from central government recognising that expertise is but one influence on policy development, that policymaking is not simply top-down, and that there is often a disconnect between 'high-level' policy and practice on the ground. The first section offers a theoretical overview of the nature of expertise and policymaking. We then reflect specifically upon the role of the ACMD in informing drug policy. Following on from this we introduce two case studies to illustrate different mechanisms used by the government to solicit expertise in relation to drug policy. The first relates to the establishment of a bespoke expert panel to conduct the New Psychoactive Substances (NPS) Review. The second – the Black Review – utilised a wider range of mechanisms, including a public call for evidence and round tables with experts, to explore how best to improve employment outcomes for drug users. We argue that despite the

use of new mechanisms, there is evidence of more continuity than change with a heavy reliance on similar types of evidence to the past and relatively little opportunity for experts-by-experience, and especially drug users, to shape the policy agenda.

A Brief Theoretical Overview: Experts, Expertise and Policymaking

There is an extensive literature on defining expertise, much of which is discipline specific. Cognitive scientists tend to view expertise as a tangible good and an individual trait. For example, Ericsson (2006) argues that expertise is manifest in 'the characteristics, skills and knowledge that distinguish experts from novices and less experienced people' (p.3). Experts are identified by their own ability rather than by social markers such as credentials or attribution (Salthouse 1991, pp.286–7). Researchers in this tradition have also identified experts by particular measures summarised by Shanteau et al. (2002) as: number of years' experience; formal recognition of skills through certification; behaviours (for example, confidence, perception, communication skills); abilities (for example, to tell the difference between similar cases within their field of knowledge or to make judgments in a consistent manner); and knowledge within a particular topic area.

Sociological understandings of experts (vis-à-vis non-experts) are more relational, and regard expertise as contextual and attributed in specific situations. Criteria and standards of expertise are relative and the attribution of expert status is variable and dependent on the audience (Mieg 2006, pp.745–6; Nowotny, Scott and Gibbons 2001, pp.215–6). Consequently, an expert can be someone who is 'regarded or addressed as such by someone else' (Mieg 2006, p.743), and expertise becomes less of a measurable attribute of individuals and more the display of knowledge and authority in a particular context. For Bourdieu (1975, pp.19–26) expertise is closely aligned with science. The nature of scientific authority encompasses both 'technical capacity and social power'. Technical capacity is akin to individual aptitude, but 'scientific competence' relies on social capital or a 'socially recognised capacity to speak and act

legitimately (i.e. in an authorised and authoritative way) in scientific matters' (Bourdieu 1975, p.19). For Elias (1982), being recognised as an authority is linked to defining or establishing the 'means of orientation' of an issue. In other words, it is about establishing the symbols and concepts that are used to explain the social world.

Applying these relational ideas to the drugs field, we can begin to understand how expertise has been constructed over time and how certain kinds of knowledge, and consequently, certain kinds of experts, become dominant and others marginalised. In the 19th Century, the medical profession claimed that drug use should be viewed as an addiction which could be treated; yet as drug use become more widespread in the 20th Century it came to be understood in terms of moral deviance and then as criminogenic (Berridge 2013; Stevens 2011a). More recently, notions of moral failing have re-emerged but this time in the context of the apparent failure of dependent drug users to fulfil their citizenship duties through lack of engagement in paid work (Wincup and Monaghan 2016). Portraying drug users in these stigmatising ways arguably detracts from the legitimacy and authority of their accounts, and coupled with their lack of social and cultural capital, they have become excluded from policymaking (Duke and Thom 2014).

Claiming the means of orientation is akin to 'framing'. Framing considers the way that policy discussions are brought to bear and the shape that they take. As Rochefort and Cobb (1994, p.5) note, often policy discussions can be characterised by technical knowledge and thus become infiltrated by technical experts, or they can be discussed with recourse to societal values, and expertise is democratised. In the drugs field, it is the purveyor of technical language who most frequently addresses the policy community. The distinction between 'experiential' and 'technical' expertise becomes more pronounced as technical experts engage in 'boundary work', actively differentiating their work from non-scientific accounts (Gieryn 1983). As a result, drug users and, to a lesser extent, professionals working in the drugs field with 'hands-

on' experience, find it difficult to influence policy directly. Their voices are often prominent in qualitative research studies but they are mediated through the technical language and framing of the researcher and lack the credibility and authority of research evidence perceived to be more objective and scientific (Jasanoff 2003, pp.395–7).

The primacy of technical expertise over user opinion was visible in Stevens's (2011b) ethnographic account of policymaking in a central government department. He highlights the complexity of the evidence and policy relationship showing how the volume of research can be unwieldy and, therefore, policymakers adapt evidence into suitable policy narratives that frequently support a pre-exisiting stance. This 'cherry picking' approach highlights how it is not simply the case that that technical expertise stemming from supposedly more rigorous research designs – like randomised controlled trial studies – are the 'gold standard' for policymakers while experiential knowledge lies at the bottom (Nutley, Powell and Davies 2013), but it does reinforce the marginality of user opinion in policy, which is seen as being decidedly 'unscientific'.

While scientific evidence is privileged, it represents only one (often minor) consideration in the decision-making process (Pawson 2006; Sanderson 2009; Weiss 1979):

> When policymakers want to know 'what works' they refer to what is feasible politically at least as much as the 'technical feasibility' and effectiveness of a policy solution. When they use 'knowledge', it includes their own knowledge of the policymaking system, as well as the 'practical wisdom' of their advisers and colleagues, the professional and 'hands on' knowledge of practitioners, and the insights of service users. (Cairney 2016, p.23)

The broader appreciation of evidence in policy cited by Cairney creates the possibility that those with expertise developed via experience can influence policymaking. Nowotny (2003) refers to this as a 'pluralisation of expertise' with experience becoming a valid, often vital,

source of authoritative knowledge that can usefully complement scientific knowledge (see also Collins and Evans 2008). Empirical studies have documented, for instance, cases of activists developing knowledge through interaction with a scientific community and presenting this alongside their experiential expertise to extend the knowledge that is considered relevant to scientific and policy debates on that topic (see, for example, Epstein (1995) on AIDS). Experiential expertise can also include knowledge that is gained through living or working within a particular community, termed as either 'local' (Corburn 2007) or 'lay' (Wynne 1996) knowledge.

Overall, the notion of experiential expertise suggests particular and contextual, rather than abstract and generalisable, knowledge, based on either direct experience or in-depth, long-term observation of an issue and policy and practice responses to it (see Wicker 2017). The value of experiential expertise in debates on the causes of social problems and the impacts of policy and practice has been highlighted elsewhere, for instance, pharmaceutical regulation (Meijer, Boon and Moors 2013), mental health (Fox 2008), and health and social care more broadly (Glasby and Beresford 2006). In such accounts, the knowledge of experts-by-experience presents a complementary perspective to certified professional expertise that can contribute to understanding and addressing practical problems.

We will explore shortly, via two case studies, whether experts-by-experience have influenced recent developments in drug policy. Before we do this we explore how expertise is embedded in drug policymaking.

The Role of the ACMD in Drug Policymaking: An Ideal-type

The MDA 1971 is the primary piece of legislation controlling substances in the UK. It created Britain's first legal advisory body on illicit drugs, the ACMD. The ACMD currently comprises 24 experts who are appointed by the Secretary of State for up to three years. Members come from a wide range of backgrounds. Their expert status derives from their professional practice

as academics and practitioners. The work of the main committee is supported by three subcommittees, currently focused on recovery, NPS and technical (that is, drug classification) matters. In addition, there are working groups looking at specific topics at any given time.

Expertise is, therefore, embedded into the drug policy system but the system is premised on a linear or sequential model of research use (Weiss 1979) where a (drug) problem is identified, expertise is harnessed or generated, and the government responds accordingly. The path from evidence to policy is rarely this straightforward (see, for example, Lindblom 1959; Weiss 1979) and drug policy provides a good example with recent intense disagreements between the government and their advisors over the positioning of cannabis and ecstasy in the 1971 MDA classification system. Over the past ten years, the ACMD has suggested that ecstasy be downgraded from class A to B and that cannabis be classified as class C. In both instances, the government acted against this advice. In 2009 this culminated in the dismissal of Professor David Nutt as the Chair of ACMD (Drake and Walters 2015; Monaghan 2011). A more recent example of the difficulties of using evidence in drug policy relates to a report from the ACMD on ways of reducing opioid-related deaths in the UK (Advisory Council on the Misuse of Drugs 2016). This recommended introducing drug consumption rooms, maintaining methadone maintenance treatment of optimal dosage and duration, and reintroducing heroin-assisted treatment for those for whom opioid substitution therapy is deemed to be not working. A brief response was published seven months later, which made it explicit that the government had no plans to fund drug consumption rooms but local authorities could determine whether to introduce them (BBC 2017).

In the remainder of this article, we argue that a current direction of drugs policy has been to move away from the unique position of relying solely on the ACMD to consider other ways in which expertise can be embedded into the system. We use two case studies to consider

whether these have afforded new opportunities for alternative forms of expertise to come to the fore.

Case Study One: New Psychoactive Substances (NPS) Review

In the UK, NPS – or legal highs as they were known – hit the headlines in early 2009 when mephedrone, a synthetic stimulant, continued to grow in popularity across Europe. By the time the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and Europol issued their first report (EMCDDA 2014) over 250 NPS were being monitored. The latest data from the EMCDDA reveals that the pace of development has begun to slow since 2014 (EMCDDA 2016).

Frequently labelled as 'research chemicals' or 'plant food', NPS were originally sold over the Internet or in 'head' shops. To circumvent law enforcement, many of the products (or their ingredients) were constantly tweaked and rebranded by manufacturers, which complicated efforts to identify substances and decisions over control. Some 'new' substances were found to contain ingredients that are illegal to possess under the MDA 1971. A central policy response was deemed unavoidable when mephedrone was (wrongly) implicated in the deaths of two teenagers in Lincolnshire, UK (BBC 2010). Clause 152/Schedule 17 of the Police Reform and Social Responsibility Bill 2015 proposed that the Home Secretary would have the power to invoke a temporary class drug order (TCDO). A TCDO is a holding classification under the MDA 1971 for substances yet to be classified. TCDOs prohibit the importation, exportation, production, supply but not possession, of such substances. Substances should remain in the temporary class for up to twelve months allowing the ACMD to gather evidence to assess whether their prohibition should become permanent. This requires the ACMD to undergo an assessment of their medical and social harms. The introduction of TCDOs was intended to build some flexibility into the MDA 1971 and to give law enforcement agencies the chance to be more proactive in responding to the rapidly changing NPS market.

TCDOs provided the platform for the Psychoactive Substances Act 2016. Since its enactment in May 2016, the Psychoactive Substances Act has existed in parallel to TCDOs. From the Bill stage, the Psychoactive Substances Act was beset with controversy and has been described as being 'legally flawed', 'scientifically problematic', and 'potentially harmful' (Stevens et al. 2015, p.1167).

The development of the Psychoactive Substances Act was significant in the way expertise was solicited. In December 2013, the Home Office appointed an expert panel to consider the options for the most efficacious way to regulate NPS. The panel members were drawn from a range of areas including enforcement agencies and prosecuting authorities; local authorities; medical and social science experts; forensic science experts; and academia. This panel was independent of ACMD although there was an overlap in membership. Other experts and interested parties, including those from government departments, devolved administrations, international administrations and experts in the fields of education, prevention and treatment, were invited to provide the panel with evidence and support during their deliberations. The terms of reference were:

> To look at how the UK's legislative response can be enhanced beyond the Misuse of Drugs Act 1971 to ensure that law enforcement agencies have the best available powers, sending out the clearest possible message that the trade in these substances is reckless and that these substances can be dangerous to health, even fatal ... The review Panel have been asked to analyse the problem we are seeking to address and consider:
>
> - the nature of the New Psychoactive Substances market;
> - the effectiveness and issues of the UK's current legislative and operational response;
> - identify legislative options for enhancing this approach;
> - consider the opportunities and risks of each of these approaches, informed by international and other evidence; and

- make a clear recommendation for an effective and sustainable UK- wide legislative response to New Psychoactive Substances. (New Psychoactive Substances Review Expert Panel 2014, p.4, italics added)

These terms of reference are significant. Stating that the legislative response 'can be enhanced beyond' the MDA 1971 had major implications for how the government viewed the technical capacity of the ACMD, tacitly ruling out, or at least demoting, recommendations previously given by the ACMD (Advisory Council on the Misuse of Drugs 2011) on the control of NPS. These recommendations included:

a) Expediting the processes of updating the MDA to keep apace of the changing drug markets.
b) Using a variety of the US Analogue Act 1986 whereby new drugs could be controlled due to their chemical similarities.
c) Deploying existing medicines regulation (for example, Medicines Act 1968) to place the burden of proof for safety on the suppliers of new substances by ensuring 'beyond reasonable doubt that the product being sold is not for human consumption and is safe for its intended use'.
d) Using Consumer Protection and Product Safety legislation and regulations to control the trade in NPS. (Advisory Council on the Misuse of Drugs 2011)

The second key phrase in the terms of reference was 'to ensure law enforcement agencies have the best available powers'. While law enforcement is not restricted to criminal law, framing the issue in this way sent out a clear signal about the Home Office's vision of regulation. This was reinforced by the composition of the independent panel which was skewed towards enforcement and prosecution expertise, buttressed by Local Government Association (LGA) support (see Table 1). The LGA strongly supported the move by the government to ban the

distribution, sale and supply of NPS in the UK through development of the Psychoactive Substances Bill (Local Government Association 2014).

>>>>>>>>>>>Table 1 about here<<<<<<<<<<

The panel had a neatly delineated set of guiding principles. It was tasked with coming up with solutions consistent with the key strands of the 2010 Drug Strategy (HM Government 2010) to reduce demand, reduce supply and help individuals to recover from their dependence on substances. In addition, the panel was encouraged to think about harm-reduction strategies and ways to tackle the NPS market, maintaining effective control mechanisms as well as developing the evidence base to inform future policy responses. The panel met six times over the six months from the start of 2014, with its meetings facilitated by the Home Office Drugs and Alcohol Unit and supported by officials from the Home Office Policing Analysis Unit, Department of Health and Public Health England (Home Office 2014).

In terms of expertise, the panel considered national and international evidence on NPS and invited expert witness presentations from countries which had established responses to NPS. Subgroups were also appointed to consider specific issues around interventions and treatment, prevention and education, and information and communications. Experts from broader networks were invited onto the subgroups. Written evidence was also supplied to the panel from parliamentary and non-parliamentary groups. The core business was to consider the range of potential policy responses, summarised by Reuter and Pardo (2017) in Table 2.

>>>>>>>>>>>Table 2 about here<<<<<<<<<<

There are clear crossovers here between this range of options and those suggested by the ACMD (Advisory Council on the Misuse of Drugs 2011). However, the terms of reference of the expert panel and its composition meant that realistically the only option was likely to be blanket prohibition. It can be deduced that there was initially some potential for the government

to try something different in terms of the regulation of NPS but that tensions within the Home Office between Norman Lamb, the Liberal Democrat Minister with responsibility for drugs, and Theresa May, the Conservative Home Secretary, played a part in the final deliberations. On leaving his ministerial post, Lamb described the blanket ban as 'ridiculous' (IB Times 2015). Ultimately, despite pursing a different mechanism to incorporate evidence into policy, the NPS expert panel performed much the same function as the ACMD, relying on similar kinds of evidence and similar ways of appropriating it.

Case Study Two: The Black Review

Over the past decade, drug policy in the UK, and in a number of other jurisdictions (for example, the US, New Zealand, and Australia) has become closely intertwined with welfare reform. As part of a broader agenda to tackle welfare dependency and worklesssness, there have been repeated attempts to introduce bespoke interventions for the estimated 267,000 drug users described as problematic due to their use of opiates and/or crack cocaine while claiming social security benefits (Hay and Bauld 2008). Provisions were included in the Welfare Reform Act 2009 but repealed by the Conservative-Liberal Democrat Coalition Government in 2012, although similar proposals periodically re-emerged in ministerial speeches throughout their term which ended in 2015 (see Wincup and Monaghan 2016). The main focus of attention was on the estimated 100,000 drug users estimated to be dependent on drugs and social security benefits and perceived to be making little effort to address their problematic substance use or enhance their employability (Department for Work and Pensions 2008). A recurrent theme was the use of a scrounger narrative, pitching the 'hard-working taxpayer' against the 'irresponsible' and 'undeserving' drug user who was blamed for their drug dependency and worklessness (Wincup and Monaghan 2016). This was used to justify proposals to introduce tailored conditionality within the social security system, linking payment of State benefits to

specific actions to enhance their employability, with financial sanctions for those perceived as unwilling to address their drug dependency.

In February 2015, the Prime Minister, David Cameron, asked Dame Carol Black, an expert advisor on health and work (HM Government 2015), to look at whether it would be appropriate to withhold social security benefits from individuals with alcohol, drug or weight-related problems who refuse to undertake treatment. Once again, the familiar narrative about fairness to the hardworking taxpayer if dependence on social security went unchallenged, was deployed. The review later became a manifesto commitment (see The Conservative Party 2015), and was formally established by the newly-elected Conservative Government in July 2015 as an independent review into the impact on employment outcomes of drug or alcohol addiction, and obesity (Department for Work and Pensions 2015). While located within one government department, the Department for Work and Pensions (DWP), a cross-government steering group was established with representatives from the Department of Health, the Ministry of Justice and other groups from the criminal justice system (HM Government 2015). Although the review had a broader remit, namely 'to consider how best to support those suffering from long-term yet treatable conditions back into work or to remain in work' (Department for Work and Pensions 2015, p.4), media attention quickly picked up on the renewed attention to whether social security benefits should be removed from those who refuse treatment (see, for example, BBC 2015; Wintour 2015).

It is worth reflecting upon how drug addiction was framed within the context of the review. In contrast to alcohol dependence and obesity, no definition of drug addiction appeared in the glossary of key terms but all were described as potentially treatable conditions. Arguably this was a less bold definition than that used to announce the review, and the inclusion of the word 'potentially' is significant. Nonetheless, it still underestimates the challenges of abstaining from drug use. Drug careers are often lengthy and rarely reach their end point after

one period of treatment (Best et al. 2008). The review was focused on looking for evidence-based solutions to an identified problem. There was little opportunity to consider how the problem had been identified and framed yet these, as Ritter (2015) argues, have a significant influence on the options considered.

Independent reviews are often recommended as an example of good policymaking (see, for example, UK Drug Policy Commission 2012). As Hallsworth and Rutter (2011) note: 'too often policy is developed behind closed doors through an unproductively adversarial departmental process' (p.28), although there is growing interest in deliberative democratic approaches which engage in public representatives in policymaking (see Ritter, Lancaster and Diprose 2018). They go on to suggest that there are advantages to depoliticising the analytic phase so that it becomes less disputed and ministers can focus on considering policy options once this has been completed. In this instance, the notion of independence is a source of some debate. The Chair had previously led reviews on sickness absence (Black 2008; Black and Frost 2011) and had also served as an advisor to the Department of Health and Department for Work and Pensions to the New Labour (1997–2010) and Coalition Governments (2010–2015). Dame Black noted in the published review (Department for Work and Pensions 2016a) that she was 'asked to consider and offer practical solutions for them, consistent with the government's direction of travel' (p.5), again questioning whether she was afforded sufficient scope to be truly independent.

The independent review promised to consult widely with a wide range of health and addiction experts (Department for Work and Pensions 2015). The main component of the review was a call for evidence. A 14-page document was published by the DWP at the start of the review process which lasted approximately six weeks over the summer of 2015. Its main purpose was to outline the review's terms of reference and invite individuals and organisations to respond to the review. The call for evidence was structured around eleven questions

(Department for Work and Pensions 2016a, pp.10–11). They were wide-ranging but for the most part converged around three themes: seeking to understand the experiences of current and former drug users in their interactions with employers, employment support, health care, and the benefits system; mapping existing service provision for this group; and searching for evidence on 'what works' (from the UK and elsewhere) to enhance employment outcomes for them. There were also more specific questions covering the impact on children and families; the implications (including legal and ethical) of linking benefit entitlement to take-up of appropriate treatment of support; and identification of, and support for, groups most 'at risk' of experiencing addiction or obesity. Consequently, the call invited individuals or organisations to supply a range of evidence, including 'formally evaluated programmes both in GB [Great Britain] and internationally' (Department for Work and Pensions 2016a, p.10), locally-produced monitoring data, and professional opinion. The review also stated that it would 'particularly welcome evidence from individuals who have suffered from addiction or obesity and who have returned to work, on what worked for them' (p.10). Implicit in this, is that the experiences of those who had not been able to secure paid employment was not required. The call received over 120 responses (Department for Work and Pensions 2016a). The majority of respondents included individuals and organisations with expertise acquired through either research and/or professional experience from the public, private, and voluntary sectors. Ten per cent of all responses took the form of personal testimonies from people with lived experience of drug or alcohol dependency or obesity.

The call for evidence was also accompanied by a range of other mechanisms to solicit different forms of expertise. Round-table events were held with experts. As Ritter (2015) observes, these are commonly used in drug policy and aim to bring together small groups of people with multiple perspectives. They are highly interactive with discussion mediated by a neutral facilitator. Chatham House rules are often applied to provide a safe place to share

scientific and professional knowledge without the risk of public disclosure. A 'scrutiny group' was also established comprised of 20 experts. Only their names are listed in the final independent review report which could imply that they were invited as individual experts rather than representatives of their organisation. An Internet search revealed that they were from a wide range of backgrounds (for example, academic, clinical, public health, and business) spanning the public, private and voluntary sectors. No detail was provided on how this group, or those invited to the round tables, were selected. In addition, the review refers, albeit vaguely, to talking to stakeholders from the treatment sector and local authorities. A small-scale qualitative research project was commissioned (Aznar, MacGregor and Porter 2017) based upon interviews with 21 current and previous claimants with a history of substance use (defined only in terms of drug and alcohol use) and interviews with five 'addiction treatment' staff. This seems to replicate a far more expansive government-funded study, albeit focused on drug use (Bauld et al. 2010), which is not referenced in the research report. There was no reference to consultation with the ACMD or inclusion of an ACMD member on the scrutiny group, although the published review does make reference to the work of the ACMD Recovery Committee. Responses by the ACMD to consultations are published online and there is no evidence of a formal ACMD response.

The evidence-based policy paradigm to which governments attach great importance, at least at the level of rhetoric, strives for a technical-rational approach to policymaking. In so doing it privileges certain forms of evidence, and the published review contains many examples of such forms of evidence including academic research, statistical analysis of administrative data, and cost-benefit analyses. At the same time, the review adopted a more deliberative approach through engaging with those who had experientially-based expertise. This produced evidence of a very different nature from the objective, formal and aggregated evidence referred to above. The different mechanisms used by the review produced very different kinds of

evidence but there was no recognition of the challenges of working with such varied forms. As Ritter, Lancaster and Diprose (2018) observe, expert knowledge is the key driver in evidence-based policy and this leads to a lack of clarity over how alternative knowledges are valued when more deliberative approaches are used.

The review process was protracted, and the outcome of the review was not published until December 2016 (Department for Work and Pensions 2016a). The press release which launched the report stated that: 'the government will now carefully consider the findings of the review before responding in due course' (Department for Work and Pensions 2016b). To date, no official response has been published, although the most recent drug strategy (HM Government 2017) noted that some of the recommendations were responded to in Improving Lives: Helping Workless Families (Department for Work and Pensions 2017). Discussion of the recommendations of the Black Review is beyond the scope of this article but it is worth noting the lack of support for what the media highlighted to be the main purpose of the review, namely to make access to social security payments for drug users conditional upon accessing drug treatment.

Discussion

Drug policy is an interesting case for exploring the relationship between expertise, evidence and policy. At the level of rhetoric there is a firm commitment to evidence-based policy, and an in-built mechanism for soliciting evidence. In the foreword to the latest drug strategy, the Home Secretary talks of extensive engagement 'with key partners in the drugs field, including health and justice practitioners, commissioners, academics and service users, as well as our independent experts, the Advisory Council on the Misuse of Drugs' (HM Government 2017, p.2). Although the 2017 Drug Strategy proclaims that the advice of the ACMD is fundamental to informing its approach, the traditional mechanism of soliciting evidence via the ACMD now sits alongside other approaches which have emerged in this highly politicised field. The

different mechanisms of expertise utilisation pursued by the NPS expert panel and by the Black Review afforded an opportunity for new forms of expertise to make significant impacts upon policy. However, as we have demonstrated, government decision makers tend to fall back on tried-and-tested approaches which produce politically feasible evidence. This was particularly apparent in relation to our first case study which suggests that a review was commissioned to support a blanket ban. It is less explicit in relation to our second case study, particularly given that quasi-compulsory treatment for drug users in receipt of social security was not supported, but the recommendations were largely in keeping with the emphasis placed in drug policy on the importance of paid work for recovery (see Monaghan and Wincup 2013).

Given the normative debates which surround drug policy it is debatable whether it could, or even should, be a matter of technocratic decision making. We identified, through our two case studies, the continued neglect of experts-by-experience. In this respect, drug policy lags behind areas of the other policies (noted earlier in the article) which have actively sought to include this group in policymaking. As a 'wicked problem', there are competing views on drug use and the most appropriate responses to it. Incorporating conflicting views into policymaking can be productive; for example, through challenging taken-for-granted assumptions about drugs and drug use (see Ritter, Lancaster and Diprose 2018). Whether greater inclusion of drug users would lead to different outcomes is not clear, since there are few studies of drug users' perspectives relating specifically to policy and practice. One exception is Neale's (1998) study of methadone treatment in Scotland, which found consistency of views between service users and service providers over the relative benefits and harms associated with methadone maintenance treatment. Regardless of whether drug users might offer differing views, there is a moral and ethical obligation to include the voices of those most directly affected by policy change but their inclusion needs to have positive effects for all

involved rather than be an attempt by policymakers to add legitimacy to policy processes with little impact on outcomes.

As our case studies demonstrate, neither the NPS nor the Black Review provided sufficient opportunity for experts-by-experience to influence significantly the policymaking process.

We suggest that the first step to meaningful engagement of experts-by-experience in the policymaking process is to reflect critically on the different ways in which they might be marginalised in the policymaking process and how they might be overcome. Our case studies suggest two areas of particular concern. The first concern relates to how particular problems – and therefore solutions – are framed, which has beome a significant area of focus for drug policy analysis in recent years (Lancaster 2014). Our first case study represented the emergence of NPS as a problem in need of a legislative response. Arguably, this limited the scope to engage with current users of NPS. Potentially there was scope to do so since the review also covered education, prevention, and treatment, but there is no evidence in the published report that this took place. Our second case study provided more scope for engaging drug users through framing drug use as a barrier to employment rather than a criminal act. However, while the Black Review did consult with drug users it actively sought the experiences of those with a successful story to tell, denying a voice to those who had not been able to secure employment or had chosen to prioritise other aspects of their lives; for example, re-establishing relationships with children. The second concern relates to the type of evidence which experts-by-experience can bring. Case studies of other high-level policy discussions have documented the marginalisation of experiential knowledge and have detailed attempts by other experts to undermine its credibility, branding them as 'anecdotal' (Kent 2003; Suryanarayanan and Kleinman 2013). This suggests the need for guidance for policymakers to be trained on how to

utilise experiential knowledge so that the inclusion of drug users moves beyond a tokenistic approach, and that participatory processes do not marginalise drug users further.

There are some recent examples of practices which try to ensure drug users' voices get heard and are influential. The first relates to enhancing the level of support provided to experts-by-experience. For example, Serentity Café – a recovery project based in Edinburgh – has trained steering group members on how policymaking and the political process works to empower them to cope with large groups of professionals, deal with direct challenge from them, and become active and effective members of policy fora at local and national levels (Campbell et al. 2011). This represents one example of the recovery movement bringing together drug users, contributing collective experiences of recovery to policy formulation, and often providing a challenge to professional expertise (Beckwith, Bliuc and Best 2016). This mirrors developments in other fields, such as mental health and disability, where there is greater evidence of social activism and user involvement (Branfield and Beresford 2006), particularly in terms of improving service delivery. The second relates to the promotion of co-production models of research. This collaborative approach to the research process involves producing evidence with drug users rather than about them through working in partnership with drug users at all stages of the research process (Campbell and Vanderhoven 2016). For Harper and Speed (2012) individual narratives can be powerful when they are linked together to reveal collective lived experiences, which demonstrate the connections between individual lives and wider social, political and economic struggles. A co-production model can facilitate this and produce practical and policy-relevant research. It might also enhance the credibility of drug users' expertise allowing it to play a more central role in policymaking and avoid being dismissed as anecdotal. There are examples of this type of work in the UK (see, for example, the work of the Scottish Drugs Forum) and it is being actively promoted in major journals in the drug field (see Neale et al. 2017).

Conclusion

In the highly controversial arena of drug policymaking, there is less precedent, or even demand as our first case study illustrates, for the voice of drug users to be heard. Attempts at moving towards more participatory forms of policymaking are often limited in practice and can be somewhat tokenistic. Despite good intentions, experts-by-experience have not become an integral and active part of the drug policymaking process, and often achieve little influence over the direction and details of policy. Powerful professional constituencies retain their central positions, resulting in little substantive changes to the terms of debate. In the UK (more specifically English context) clinical and law enforcement perspectives coupled with particular policy framings, currently in terms of abstinence and recovery, present considerable challenges to promoting the meaningful inclusion of experts-by-experience in policymaking, particularly current drug users. While we have offered some suggestions for promoting the meaningful inclusion of experts-by-experience in policymaking, history suggests that we should exercise some caution here, not least because drug policymaking tends to favour the politically feasible over the technically possible. Failing to appreciate the invariably political nature of drug policymaking hampers the development of effective policies.

Note

[1] We use the term UK as the legal framework related to drugs is reserved to the UK government. However, it should be noted that the UK devolved administrations have their own strategic approaches. Additionally, some of the policy areas related to drugs have been devolved.

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TABLE 1

NPS Expert Panel Members

Expertise	Panel Member	Position
Enforcement	Commander Simon Bray	National Policing Lead for New Psychoactive Substances/Advisory Council on the Misuse of Drugs Member
	Gordon Meldrum (Represented by Laurence Gibbons)	Director for Organised Crime, National Crime Agency
	Carole Upshall	UK Border Force Director – National Customs and Border Force South Region
Local Authorities	Mark Norris	Senior Policy Advisor, Local Government Association
Forensics	Dr Jeff Adams	Office of the Forensic Science Regulator
Prosecution	Ian Elkins	Senior Strategy and Policy Advisor to the Crown Prosecution Service
Medical Science	Professor Les Iversen	Professor of Pharmacology/Chair of the Advisory Council on the Misuse of Drugs
	Dr Owen Boden-Jones	Consultant in Addiction Psychiatry
Social Sciences/Academia	Professor Fiona Measham	Professor of Criminology/Advisory Council on the Misuse of Drugs Member
International	Paul Griffiths	Scientific Director, European Monitoring Centre for Drugs and Drugs Addiciton
Education/Prevention	Andrew Brown	Director of Policy, Influence and Engagement, Drugscope
	Harry Shapiro	Director of Communications and Engagement, Drugscope

(Source: New Psychoactive Substances Review Expert Panel 2014.)

TABLE 2

Possible Policy Responses to NPS

Approach	Definition	Examples
Analogue approach	Control based on chemical similarity or intended psychoactive effects to substances already controlled by law	United States Federal Analogue Act
Neurochemical approach	Control different groupings of substances regardless of chemical variation that have a specific neuropharmacological effect on brain	Cannabimimetic agents under the United States Synthetic Drug Abuse Prevention Act
General prohibition	Prohibit supply, import and export of any psychoactive substance that is not exempted	Irish Psychoactive Substances Act
Full regulatory approach	Through detailed regulations, permit and regulate sale of limited class of NPS that are proven to be of low risk	New Zealand Psychoactive Substances Act
Restricted availability approach	Restrict NPS to limited points of sale, labeling, age, etc. until harms are established	New Zealand Class D substances under Misuse of Drugs Act

NPS = New psychoactive substances.

(Source: Reuter and Pardo 2017.)