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Drug policy constellations: a Habermasian approach for understanding English drug policy

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Abstract

Background: It is increasingly accepted that a view of policy as a rational process of fitting evidence-based means to rationally justified ends is inadequate for understanding the actual processes of drug policy making. We aim to provide a better description and explanation of recent English drug policy decisions.

Method: We develop the policy constellation concept from the work of Habermas, in dialogue with data from two contemporary debates in English policy; on decriminalisation of drug possession and on recovery in drug treatment. We collect data on these debates through long-term participant observation, stakeholder interviews (n = 15) and documentary analysis.

Results: We show the importance of social asymmetries in power in enabling structurally advantaged groups to achieve the institutionalisation of their moral preferences as well as the reproduction of their social and economic power through the deployment of policies that reflect their material interests and normative beliefs. The most influential actors in English drug policy come together in a ‘medico-penal constellation’, in which the aims and practices of public health and social control overlap. Formal decriminalisation of possession has not occurred, despite the efforts of members of a challenging constellation which supports it. Recovery was put forward as the aim of drug treatment by members of a more powerfully connected constellation. It has been absorbed into the practice of ‘recovery-oriented’ drug treatment in a way that maintains the power of public health professionals to determine the form of treatment.

Conclusion: Actors who share interests and norms come together in policy constellations. Strategic action within and between constellations creates policies that may not take the form that was intended by any individual actor. These policies do not result from purely rational deliberation, but are produced through ‘systematically distorted communication’. They enable the most structurally favoured actors to institutionalise their own normative preferences and structural positions.

Keywords: policy constellations; English drug policy; decriminalisation; recovery; critical theory

Introduction: power, morality, complexity and policy constellations

To understand drug policy, we need to develop explanatory theories of how drug policy decisions are produced (Burris, 2016; Ritter, Livingston, Chalmers, Berends, & Reuter, 2016; Stevens, 2011a). The policy studies literature has moved beyond thinking about policy in terms of sequences of rationally developed 'stages' (Cairney, 2012; Hill, 2009; Ritter & Bammer, 2010). Several authors have explored the inadequacy of the concept of rationally justified, 'evidence-based policy' for explaining drug policy decisions (e.g. Lancaster, 2014; Maccoun, 2010; Monaghan, 2008; Stevens, 2011b; Valentine, 2009). They draw our attention to the influence of power on the use of reason and evidence. The exercise of rational deliberation is also influenced by normative commitments to certain forms of morality (Haidt, 2012; Knill, 2014; Zampini, 2016).

The works of Jürgen Habermas relates directly to this interplay between rationality, normativity and power (Flynn, 2004; Habermas, 1984, 1986, 2006). This article uses his ideas to describe and explain particular decisions in English drug policy. In doing so, it introduces a new concept to the field of drug policy studies: the 'policy constellation'. This can take account of structurally distributed power differences and normative preferences in the production of continuity and change in English drug policy.

The concept of the policy constellation builds on Habermas' (1986, p. 241) idea that we can explain the outcome of legal processes 'in terms of interest and power constellations'. Habermas notes that public debates about legal provisions always rest on normative principles. Principles are multiple, and may come into conflict. As such, they undergo 'discursive testing' (1986: 227). On the basis of his theory of communicative action, Habermas (2002) proposes that rational communication is 'systematically distorted' by strategic, purposive action. In distorting such rational deliberation, structurally favoured social actors can deploy their 'social power' (Habermas, 2006: 418). So laws which reflect moral principles held by more powerful people will prevail, even if they would not be justified through purely deliberative, rational communication. He argues that 'the legitimacy of legality cannot be explained in terms of some independent rationality which, as it were, inhabits the form of law in a

morally neutral manner' (Habermas, 1986: 228), as some advocates of rational, evidence-based policy would demand. Rather, he argues, 'in the clash of value preferences incapable of further rationalization, the strongest interest will happen to be the one actually implemented' (Habermas, 1986: 241). So values that reflect existing socio-economic and ideological power asymmetries and that coincide with dominant interests will heavily influence the development of laws and other forms of social regulation (e.g. drug policy).

For Habermas, such values do not flow through impersonal, all-pervasive discourses of power, as suggested by some Foucauldian analysts (Schmidt, 1996). Rather, they can be attributed to human actors who occupy specified positions in the social structure and who engage in strategic action in pursuit of their goals. In these terms, a policy constellation is a set of social actors (individuals within organisations) who come together in deploying various forms of socially structured power to pursue the institutionalisation in policy of shared moral preferences and material interests. Constellations are not stable groups with fixed rules or memberships. They are made up of fluid sets of actors who gravitate towards each other on the basis of shared interests and norms. Their actions are not necessarily directed or coordinated. Rather, actors in a constellation tend to align their actions through creating connections of mutual recognition and support. They do so in contest and collaboration with the members of other constellations, who have different interests and norms (although there may be overlap between the memberships, interests and norms of some policy constellations).

Constellations are not actors in themselves. Rather, the connections between actors that constitute the constellation serve to amplify the influence of each individual actor. The degree of amplification will depend on the power of other actors in the same constellation. Some constellations are made up of people who have relatively powerful positions in the social structure. In Gamson's (1975) terms, they are 'insiders'. They can use various mechanisms – including 'opportunity hoarding' and other strategies described by Tilly (1998) as creating 'durable inequalities' – to reproduce their own positions and power. These resources and mechanisms are not available to challenging 'outsiders' who 'lack the basic prerequisite of membership - routine access to decisions that affect them' (Gamson, 1975: 140).

This is an approach that enables understanding of the ‘messy’ business of policy-making by acknowledging the variety of axes along which social actors align or divide, including ‘epistemological, disciplinary and political’ boundaries (Smith & Joyce, 2012: 70) as well as professional, normative, economic and socio-demographic divisions in the ‘complex world’ of drug policy making (MacGregor, 2017: 12). In England, cleavages between insiders and outsiders often appear along lines of class, race, gender and age. The most powerful positions in state and other institutions are disproportionately held by privately educated, middle or upper class, middle-aged or older, white British men (Andrews & Ashworth, 2013; Kirby, 2016; Knights & Richards, 2003; Rampen, 2017; Sampson, 2005; Social Mobility Commission, 2017). Their power rests not only on their abilities in rational, deliberative communication, but on the resources of power, money and connections that they have by virtue of their positions in the social structure. This is what Habermas (2006:418) calls ‘social power’. They engage in policy discussions that have the outward appearance of an ‘ideal speech situation’ (Habermas, 1984; Neale, Nettleton, & Pickering, 2011) in which consensus is reached through rational deliberation. But they are able to distort such deliberations through strategic action (Habermas, 2002; Stevens, 2011b) by deploying political, economic and media power (Habermas, 2006).

These privileged actors have heavy influence on what kinds of evidence will be produced, disseminated and given the status of authoritative, legitimate knowledge (Hall, 1993; Blomkamp, 2014; Elgert, 2014). They have the capacity to shape policies that reflect their interests and norms. But – as noted by both Gamson (1975) and Habermas (1986) - there is not a homogeneous ‘ruling class’ that can simply direct policy. There are multiple constellations of interest and power in and around the state. Actors with competing interests and preferences have a diverse range of structural positions. It is from communicative and strategic action between these individuals that constellations and then policy decisions emerge. Their actions are influenced by – and go on to influence in future – the structural positions that these actors hold (Colebatch, 2009; Giddens, 1984). Policy constellations operate in a complex policy system in which path dependency, feedback mechanisms and unintended outcomes are to be expected (Cairney, 2012). Focusing on how people work in policy constellations enables us to

incorporate the roles of both agency and structure in describing and explaining the policy decisions that produce these outcomes.

We will fill out our description of English drug policy constellations – of their membership, beliefs, and their types of strategic action – in dialogue with empirical data. These data will come from close examination of two decisions in the English drug policy process: the non-implementation of formal decriminalisation of drug possession; and the turn to ‘recovery’ in drug treatment. In studying these debates, we observed the work of several organisations. As an aid to readers, we provide introductory information about these organisations in an appendix. In the text, these organisations are marked with an asterisk when they are first mentioned.

In both debates, we observe the substantial influence of social actors who share moral and policy preferences that have been characterised by Berridge (2013) as constituting a ‘medico-penal framework’. She observes the development of this framework over the 20th century history of English drug policy. Through this framework, she describes the overlap of medical and penal professionals and ideas in creating English drug policy. Here, we suggest that there still is, at the core of English drug policy making, a ‘medico-penal policy constellation’. Members of this constellation are able to assert their shared interests and preferences, despite continuing challenges from ideas and actors in other policy constellations.

Notes on method, data, ethics and terminology

We focus on England, rather than the UK more broadly. While the Misuse of Drugs Act 1971 applies across the UK, each of its four countries has its own drug strategy and treatment systems. These have diverged over time, especially since 2008 (Lloyd, 2009). The two chosen policy debates - on decriminalisation and recovery - have engaged the interest of a wide range of actors within and around the drug policy process. They offer good opportunities to observe how it works, especially as they provide a contrast in exemplifying continuity (the continued criminalisation of drug possession) and change (the shift to recovery in drug treatment).

Habermas' work on normativity has been criticised for focusing on procedures of normative contestation, rather than on the substantive content of normative preferences (Boudin, 2013; Sayer, 2011). To address this, we use the empirical work of Haidt and his colleagues, who have shown that people with conservative political orientations tend to hold normative beliefs that focus on purity/sanctity, social conformity and respect for authority (Graham, Haidt, & Nosek, 2009).¹ We also note that these normative beliefs are congruent with upholding the legitimacy and reproducing the structurally favoured positions of social groups who have the power to define what is 'pure', who is conforming, and who holds authority. We understand individuals' beliefs as driven by normative and moral preferences, as well as by political and economic self-interest. Policy is as much about the promotion of normative values as it is about the allocation of resources (Barton & Johns, 2013; Easton, 1953; Hill, 2009).

We employed three methods of data collection: long-term participant observation; qualitative interviews; and documentary analysis. Both authors have been active in English policy debates over a period that is longer than is usual for short-term, time-limited, ethnographic studies. Alex Stevens has worked in the field of drug policy since 1991, including a stint working in a policy unit at the highest levels of the civil service (Stevens, 2011b). He has been a member of the UK Advisory Council on the Misuse of Drugs* (ACMD) since 2014.² Giulia Zampini worked with Transform Drug Policy Foundation* in 2009/10, and the Bristol Drugs Project in 2010/11. This deep immersion in the world of English drug policy has enabled the authors to develop a rich, ethnographic understanding of the social world of English drug policy in which we have participated. It gives us a particular viewpoint of this social world. We have, for example, worked more closely with civil servants and drug policy reform organisations than with the police or conservative think tanks. A different view of English drug policy

¹ This is not to say that we accept Haidt's evolutionary psychological explanation for these moral preferences. The sociological analysis of overlapping preferences in England for moral purity and its imposition on the community at large has deep sociological roots (MacKinnon, 1993; Weber, 1920)

² The views expressed in this article do not reflect those of the ACMD. No specific information or data that is available to members of the ACMD but not the public is used in this article.

constellations might emerge from such different viewpoints (Hammersley & Atkinson, 2007).

The analysis is supplemented by data from qualitative interviews, which were carried out as part of a PhD project by Zampini (2016) on the use of evidence in drug and prostitution policy in the UK and Australia. Interviewees (n=15 in UK drug policy) were selected on the basis of their involvement in drug policy making. They belong to different and at times overlapping categories, including politicians, civil servants, researchers, advocates and knowledge-brokers. Some interviewees had more than one role, as noted next to their quotes. Their personal characteristics reflected the dominance of white, middle-class, middle-aged men in English drug policy discussions. Thirteen of them were men. The youngest interviewee was in his late 30s. All were of white ethnicity. None has publicly identified themselves as a user of illicit drugs. The absence of publicly self-declared active drug users from our sample reflects the exclusion of active drug users from influential positions in English drug policy debates. The interviews focused on the use of evidence in policy, opening the door to broad discussion of policy debates, of which decriminalisation and recovery were prominent features.

The article also draws on analysis of documents that have been published in the field of English drug policy since 2000. Documents are the 'primary medium' of policy work (Budd, Charles, & Paton, 2006:1). Analysis of their production, content and deployment can provide useful insights into the social world in which they circulate (Prior, 2003). Selection of the documents that are analysed and cited here was informed by the participant observation and the interviews. The cited documents are those that seemed – to us, our interviewees and other researchers (e.g. Lancaster, Duke, & Ritter, 2015; MacGregor, 2017) – to be particularly interesting for the ways that they were constructed and used (or, in some cases, not used).

Our analysis of these data involved reading, re-reading, coding and re-coding field notes, interview transcripts and documents with the aim of identifying how the observed actions and discourses work in connecting together the themes that they contain. In this way, our analysis is similar to the 'argumentative analysis' proposed by Thompson

(1990) for the study of forms of symbolic communication which support or challenge inequalities in power. Thompson argues that this puts into practice Habermasian concepts by making visible the common elements in this communication, and how they are organised into arguments that include or exclude certain people and ideas.

Permission was given for the interviews by the ethics committee of the University of Kent. No ethical approval was sought for the long-term participant observation that informs this article. It would not be practical to seek ethical approval for every observation of action in the field over a period of decades. Nor would it be ethical to refuse to use this information for the purposes of developing knowledge in the field, simply because there has been no formal review of the processes of information gathering. We attempt to minimise the possibility of harm to people whose activities we have observed by not compromising their anonymity; any information given in this article that identifies individuals is already in the public domain.

For this article, we are happy to adopt the definition given by both Jenkins (1978: 15) and Hill (2009: 15) of policy as ‘a set of interrelated decisions... concerning the selection of goals and the means of achieving them within a specified situation’. We focus on policy decisions as outcomes of processes of ‘structured interaction’ (Colebatch, 2009) that are not just written in documents, but enacted in practice (Houborg & Bjerge, 2017). By ‘drug’, we refer to those substances that are controlled under the UN Single Convention on Narcotic Drugs and its successor conventions (Bewley-Taylor, 2012). We do not attempt evaluation of the impact of these policy decisions on drug use, harms and benefits in this article. Rather, we are interested in the processes and actions which shape these decisions.

Policy constellations in the decriminalisation debate

In her historical work, Berridge (2013) describes the development of the ‘medico-penal framework’, which brought together medical and law enforcement professionals around the idea that legal coercion was needed in order to protect public health from the dangers of drugs. Challenges to this viewpoint, which emanated in the 1960s from the

‘welfare branch of the alternative society’ (e.g. organisations such as Release* and the Soma Research Association* [Mold, 2006]), were not effective in ending the criminalisation of possession. The Misuse of Drugs Act 1971 (MDA) still includes possession as a criminal offence, despite ongoing criticisms and challenges. Professionals from both medical and law enforcement institutions have continued to support this stance. This includes people who are concerned with both individual and public health, such as doctors, psychiatrists and civil servants in the Department of Health. However, the more powerful supporters of criminalisation have come from the institutions that focus on social control; Home Office ministers and civil servants, as well as the police. In contrast, the principal targets of criminalisation have always been people who could be constructed as ‘outsiders’ to the mainstream of English society (Mills, 2013). The burdens of criminalisation – in the form of arrests, penal sanctions and criminal records – continue to fall most heavily on young people of black and minority ethnic origin (Stevens, 2011c), who are also largely excluded from drug policy discussions and decision-making.

In 2000, the MDA was examined by an expert group brought together by the Police Foundation*, with Ruth Runciman³ in the chair (Independent Inquiry into the Misuse of Drugs Act 1971, 2000). Among other things, it recommended that cannabis be moved out of class B of the MDA. There followed a well-documented “cannabis kerfuffle” (Lloyd, 2008; Monaghan, 2008; Shiner, 2015; Stevens, 2011c). As Home Secretary, David Blunkett moved the drug down to class C. In 2009, his successor Jacqui Smith moved it back to class B. This latter reclassification reflected the conservative views of the Centre for Social Justice* (Gyngell, 2007) more closely than the reforms proposed by the Police Foundation, or the recommendations of the ACMD (2002, 2005, 2008). Further attempts to change the government’s mind (e.g. by the UK Drug Policy Commission* [UKDPC], again chaired by Ruth Runciman) have had little impact. In 2017, the law on cannabis possession is the same as was enacted in 1971. The MDA still formally criminalises the possessors of a wide range of psychoactive substances. It is still being justified on the basis that criminalisation sends powerful signals to potential users. This is a common thread in political discussion of cannabis, from the time when

³ Runciman had been a prominent member of the ACMD, as well as being involved with other bodies concerned with public health.

James Callaghan was Home Secretary in the late 1960s (Oakley, 2012), through the New Labour era (Stevens, 2017) to the present position of the Home Office (see below). Such justification rests on the normative role of the law to express certain moral principles (Habermas, 1986); in this case, norms of purity/sanctity, and of respect for authority (Haidt, 2012). The burdens of enforcing these norms still fall most heavily on relatively powerless social groups.

As suggested above, despite the continuity of the MDA, there is active contestation about criminalisation. There have been a series of individuals and organisations involved in efforts to reduce or eliminate the criminalisation of drug users. These groups have been as diverse in their membership and institutional aims as the Soma Research Association of the 1960s, the Police Foundation in 2000, Transform and the Beckley Foundation* from the 2000s onwards and – more recently – the UKDPC, Volteface* and both the Faculty* and the Royal Society of Public Health* (2016), with Release being the only organisation to maintain this position from the 1960s onwards. These organisations have frequently worked alongside each other in arguing for reform; acting to encourage debate and to disseminate evidence on the harms of existing policies and the benefits of possible alternatives (e.g. Rolles, 2009; Rolles et al., 2016; Rosmarin & Eastwood, 2012; UKDPC, 2012). However, the actions of this constellation have not resulted in its members' desired policy change.

The opponents of decriminalisation have repeatedly succeeded in preventing change to the law. These include a wide range of actors, both within and outside the state, but it is generally perceived within the field (as noted by several of our interviewees) that the Home Office is the most powerful supporter of the criminalising *status quo*. It is to the Home Office that journalists turn for quotes on any new decriminalising initiative. They are repeatedly given the same line:

Drugs are illegal where there is scientific and medical evidence that they are harmful to health and society. We must prevent drug use in our communities and help dependent individuals to recover, while ensuring our drugs laws are enforced. (Home Office, cited by Connolly, 2016)

The same Home Office position has been stated many times in response to reforming initiatives and political challenges (BBC, 2016a, 2016b; The Guardian, 2016; Home Office, 2013).

Occasionally, cracks appear in the Home Office position. Under the Conservative/Liberal Democrat coalition government of 2010-2015, the junior minister responsible for drug policy was a Liberal Democrat. In 2014, the job was held by Norman Baker.⁴ He commissioned a report that compared the content and effects of drug policy in several countries (Home Office, 2014). The report was not supportive of the usual Home Office line that it is necessary to enforce the laws on possession in order to reduce the harms of drugs. It found no link between the severity of law enforcement in a country and its levels of drug use and related harm. After resigning from his post, Baker reported that publication of this report had been 'blocked' by 'Conservative colleagues', including then Home Secretary Theresa May. He also claimed that draft versions of the report included recommendations in favour of a 'Portuguese model' of decriminalisation, but that these were removed before publication (BBC, 2014). In the end, the power of the Home Secretary prevailed; a clear example of strategic, purposive action that excluded certain ideas from the public argument, and so distorted rational deliberation.

In contrast to the constellation of actors that support decriminalisation, the Home Office – and the Home Secretary in particular – stand in a hierarchical position of power in relation to other agencies. The Home Office controls the funding of police services and sets the policy environment within which they work. Within the UK government, the Home Office take the formal lead in drug policy coordination, so its acquiescence – at least – is required for any other central government policy on drugs. As one interviewee put it:

The Home Secretary has a huge influence [...] the priority that they give to drugs, their attitude to evidence; their general perspective on how the drugs issue should be managed is very influential. And the junior ministers [...] they do influence as

⁴ The Liberal Democrats are persuaded that decriminalisation is the way forward, and have adopted this as an official party line, contrary to both the Conservative and Labour parties. It is also relevant to note that Liberal Democrats have rarely been part of government, and more often part of the opposition. They are thus more frequently 'outsiders' to the government executive.

well because they also have to make the case to the Home Secretary [...] although the Home Secretary undoubtedly is the final arbiter of what goes on (Researcher/ Knowledge Broker/ Civil Servant 13)

Civil servants take their lead from ministers in 'making policy happen' (Maybin, 2015: 288). If the Home Secretary wishes to make or refuse a change in English drug policy, she has the constitutional authority and the political power to do so; in other words, government matters (Zampini, 2014). MacGregor (2016) calls this 'the rather obvious but crucial importance of political power'. It is important to remember that political power is itself structured through inequalities of class, race, gender and age (McLellan, 1995). The Home Office is led by individuals who have benefited from social inequality. In contrast to supporters of decriminalisation, they have the power to make policy through powerful orders rather than complex and contingent negotiation and persuasion. These decisions then reinforce the power of the Home Office and its leaders.

Nevertheless, for their decisions to be agreed and implemented, Home Office ministers need to ensure that they have legitimacy among those in subordinate organisations and external agencies. So there is some room for negotiation and contestation. And there is some space for divergent practices to emerge. For example, both Durham and Bristol police services have set up schemes that divert drug possession offenders away from the criminal justice system. The charity The Loop* set up multi-agency safety testing of drugs at some dance music festivals in England in the summers of 2016 and 2017, with the support of local health and police services. However, these are examples of localised change in a national picture within which a dominant policy constellation – centred around the Home Office – has successfully prevented substantial policy change that has been advocated by a longstanding but fluid constellation of challengers and outsiders. The normative preference of members of the dominant constellation for moral purity and respect for authority coincides with their material interests in maintaining their access to power and resources. The burdens of continuing criminalisation fall largely upon young people and members of ethnic minorities who do not share these normative preferences or material interests.

Policy constellations around recovery in drug treatment

Another interesting strand of English drug policy is the debate over how to treat people who have become dependent on drugs, and especially heroin. This too has a long history, dating back at least to the discussions over the treatment of heroin addiction that engaged the Rolleston committee in 1926 (Berridge, 1999). More recently, the debate has expressed itself in the conflict between ‘harm reductionists’ and ‘abstentionists’ over the relative roles of opioid substitution therapy (OST) and recovery in specialist drug treatment (Ashton, 2008; Berridge, 2012; Hickman, Vickerman, Robertson, Macleod, & Strang, 2011; Lancaster et al., 2015; Monaghan & Yeomans, 2015; Roy & Buchanan, 2016; Stevens, 2011d).

The immediate backdrop to this revived antagonism was the substantial expansion in OST under the Labour government of 1997 to 2010. By the year 2006/7, there were over 200,000 people in ‘structured drug treatment’, with 74 per cent of them receiving OST. The BBC reported that a very small portion (less than 4 per cent) was leaving treatment ‘free of drugs’ (Easton, 2008).

the NTA [National Treatment Agency] presented some treatment figures that Mark Easton from the BBC pulled apart [...] the government got a roasting in the papers [...] it opened up a whole big hoo-ha in the sector about abstinence versus harm reduction, and that rumbled on until you had the current Tory bit of the coalition in shadow, and Ian Duncan Smith in particular, looking at the Centre for Social Justice, linked into welfare reform (Knowledge Broker 12)*

This fed into debates that had already been escalating about what the aim of treatment should be: to protect people’s health; to prevent offending; or to help people recover by fulfilling their wishes to become abstinent (Best, 2009; McKeganey, Morris, Neale, & Robertson, 2004). The UK and Scottish drug strategies that were published in 2008 emphasised the need to support such recovery (Lloyd, 2009). In England, the push for recovery accelerated after the election of the coalition government in 2010, as could be seen in the national drug strategy published that year (Stevens, 2011d) and in think tank reports such as the Centre for Policy Studies’ *Breaking the Habit* (Gyngell, 2011).

In 2012, an ‘inter-ministerial’ report called *Putting Full Recovery First* was published (Inter-Ministerial Group on Drugs, 2012). As argument, this ‘recovery roadmap’ sought to include a morally pure vision of abstinent recovery – and to exclude OST – as the dominant form of drug treatment. It stated that drug treatment agencies would be paid only for delivering such ‘full recovery’. This was defined as abstinence from all illicit and substitute drugs. This was a direct contrast to the UKDPC’s earlier (2008) attempt to create a ‘consensus’ definition of recovery, which included controlled use of drugs. The inter-ministerial document promised that the government would ‘maximise access to abstinence-based’ treatment by reducing the amount of time that people would be prescribed methadone. It envisaged a prominent role in the management of drug treatment for ‘strategic recovery champions’; people who had succeeded in recovering from drug addiction themselves and could thus lead other drug users along the steps to sobriety.

In this policy document, the triumph of recovery and of the conservative morality expressed through the abstinent purity/sanctity sentiment held by many of its advocates (Haidt, Graham, & Joseph, 2009) was complete. The move to recovery was seen in the field as a specifically moral endeavour. As one interviewee put it,

by critiquing maintenance prescribing, they tick moral boxes for the authoritarian and religious right (Civil Servant 9).

In the debate around recovery, we see the activity of several prominent ‘policy entrepreneurs’, including social conservatives associated with the Centres for Social Policy and Social Justice. They, in contrast to actors who support decriminalisation, were able to have a greater influence on policy. One of our interviewees echoed Kingdon’s (1995) notion of the need for policy windows to be exploited by policy entrepreneurs:

a window opens [...] you have to be ready to go in there. Sometimes I think those of the research fraternity and community are not responsive enough, are not ready enough to be able to utilize those windows. (Knowledge Broker 10)

The contrasting examples of the decriminalisation and recovery debates suggests that the ability to be responsive and ready to exploit policy windows will depend on an actor's position within a constellation of connections, interests and resources. Some will find it easier than others to identify and take up such opportunities. Both the Centre for Policy Studies and the Centre for Social Justice promoted funding recovery instead of harm reduction. The former has been influential on Conservative party policy since the Thatcher era. The latter was founded by Iain Duncan Smith in 2004 after he was deposed as leader of the Conservative opposition. It developed several of the ideas that he later took into government as a minister. Kathy Gyngell (2007, 2011) wrote reports on drug policy for both think tanks. Senior staff members became close advisers to government ministers from 2010. For example, Philippa Stroud was a co-founder of the Centre for Social Justice. She became a special adviser to both the Secretary of State for Work and Pensions (Iain Duncan Smith) and the Prime Minister (David Cameron) on social justice. She was ennobled in 2015 and returned to running the Centre for Social Justice. Christian Guy also served as both an adviser to David Cameron and Chief Executive of the Centre for Social Justice. Their work was informed by advocates for recovery in the field of drug treatment, including Noreen Oliver and the Recovery Group UK* (Duke, Herring, Thickett, & Thom, 2013). They also have close contacts with senior media figures. In the words of one interviewee,

that's a strong strand of Tory thinking that coalesced around the Centre for Social Justice. (Civil Servant 9)

The board of the Centre for Policy Studies includes both Fraser Nelson, editor of *The Spectator* magazine, and the Viscountess Rothermere, widow of the proprietor of the *Daily Mail*. These are both highly influential conservative organs in the UK; the former among the Westminster-based political world, and the latter with a mass audience of newspaper and online readers. They bring what Habermas (2006) calls 'media power' into play by enabling some policy actors to gain differential access to political power through the media.

While the constellation of actors favouring recovery was more powerful than that favouring decriminalisation, it also faced opposition from another constellation that is

well established within English drug policy. This consisted of experts, academics and officials in and around the National Treatment Agency* (NTA) and the Department of Health (including the ACMD and the UKDPC) that had – between them – developed the prevailing approach to drug treatment. They were able to maintain its emphasis on ‘evidence-based’ treatment, including OST. The national drug strategy of 2010 included an emphasis on recovery, but also recognition that OST – and even heroin-assisted treatment – have a legitimate and valuable role in the drug treatment system. The efforts of members of this medically focused constellation are visible through the various reports they have produced in response to governmental requests to review the evidence on how drug treatment can contribute to recovery (ACMD, 2012a, 2015; Recovery Orientated Drug Treatment Expert Group, 2012). Other reports from expert groups have also endorsed the continuing value of harm reduction services, especially in the light of increases in opioid-related deaths over recent years (ACMD, 2012b, 2016; SDF, 2016). In accord with their recommendations that the medical intervention of OST should remain a central component of drug treatment, the inter-ministerial report on ‘full recovery’ was never fully implemented. The number of people in OST did not rapidly decline (PHE, 2015). Residential, abstinence-based services did not see a boost in income or referrals (Drugscope, 2015). There have been reports of changes within drug treatment services, with a shift away from harm reduction towards the achievement of ‘drug-free exits’ from treatment (Dennis, 2016; Floodgate, 2016). And funding for all forms of drug treatment has been cut (ACMD, 2016). But OST continues to be the predominant treatment modality for people who have problems with heroin (Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group, 2017; Independent Expert Working Group, 2016). Recovery has been absorbed into pre-existing treatment practices, through the hybrid concept of ‘recovery-oriented’ OST (Recovery Orientated Drug Treatment Expert Group, 2012). In relabelling OST as recovery-oriented, some professionals have been able to keep their positions of influence over drug treatment policy. They have absorbed the challenge of recovery into existing practices in ways that maintain their positions of influence and reflect their belief in the role of medical intervention to support public health.

Our interviewees focused on the actions of civil servants, academics and politicians in their accounts of how drug policy decisions are made, with close to no references to the

role of drug users themselves. This triangulates well with our observation of their relative absence from influential drug policy discussions, and their presence in drug policy documents as objects, rather than creators or authors of policy. It also fits well with the theoretical assumption that access to influential discussions tends to be limited to people who share structurally favoured social positions and norms. People who themselves have problems with drugs continue to be excluded - as Lancaster (2016) also notes - from direct participation in drug policy debates. They have little influence on the development of drug treatment policy. Rapid increases in deaths among this group have not, so far, led to substantial changes to the recovery-oriented treatment approach. The people who suffer problems and deaths from drug use come disproportionately from socio-economically deprived, working class areas in the deindustrialised parts of the UK (ACMD, 2016; Pearson, 1987). They are outsiders because of both their disadvantaged structural positions, and also their participation in normatively stigmatised, scapegoated patterns of consumption.

Some people and connections are more powerful than others. They use this power as 'active participants in the shaping of the negotiated order of which they are part' (Degeling & Colebatch, 1984). The relative power they bring to policy debates is highly influenced by the structural positions of these actors, and the structured nature of the connections between them. Connections that work for one area of policy (e.g. the Centres for Policy Studies and Social Justice's connections to the Conservative Party for economic and social policy) are more likely to also work for others (e.g. the shift to recovery in drug policy). People who have advantages of class, race, gender and age are much more likely to occupy such positions and to have such connections. So while policy entrepreneurship and the availability of 'policy windows' (Kingdon, 1995) are important in the description of English drug policy, we also need to pay attention to structured action within and between constellations of people who share similar values and interests across policy areas.

In the debate on recovery, we see a messy process of unintended compromises between influential people who may have different 'core beliefs' (Sabatier and Jenkins-Smith, 1993). For example, there may be competition between the 'moral foundations' (Graham et al., 2009) of 'care' and 'sanctity'. But even with some conflict in underlying

beliefs, a policy outcome can emerge (e.g. recovery oriented OST) that incorporates beliefs held by powerful actors on both sides of the debate and also satisfies their material interest by maintaining their access to power and resources.

Discussion: English drug policy constellations and the explanation of policy decisions

While pluralist accounts of policy-making focus on self-interestedly rational competition and exchange between interest groups, the focus of the Habermasian approach is on communicatively rational deliberation, and its distortion through strategic action and 'social power'. In both of the debates we describe, we observe the operation of policy constellations whose members bring different structural positions, various material interests, and diverging moral preferences into drug policy discussions. The concepts of decriminalisation and recovery both have normative as well as material aspects. Both involved a challenge to the *status quo* of policy. The challenge of recovery had a greater impact than that of decriminalisation. This does not appear to be because the evidence for a shift to 'full' recovery is stronger than that for the decriminalisation of drug possession. Rather, the constellation that supported recovery included more structurally favoured people, who had more direct access to the most influential actors. In both cases, the resulting policy decisions enable these actors to maintain their positions of relative power.

These analyses show us that English drug policy-making involves negotiation between actors who are connected in a distinguishable policy community, as suggested by some pluralist approaches (Kingdon, 1984; Rhodes, 1990; Sabatier & Jenkins-Smith, 1993). However, we argue that we need to pay more attention to the role of socially structured imbalances of power of the type that Habermas describes if we are to understand the outcomes of these processes of normative and discursive contestation. But our argument is not just that power is unequally distributed, and so the policy game is rigged in favour of some groups over others. It is also a feature of the Habermasian approach to focus on the way in which actors enter into communicative processes that have the appearance of rational deliberation (e.g. policy arguments, use of research papers, expert committees). But the deliberative potential of these communicative

processes is systematically short-circuited through the strategic deployment of socially structured power to exclude some people and ideas from the policy debate.

Communication within and between constellations is socially structured. The ability of actors to join and have influence within policy constellations is conditioned by the level of social power they possess (Habermas, 2006: 418). Habermas sees this as a form of power 'that depends on the status one occupies in a stratified society'. In England, that stratification includes dimensions of class, race, gender and age. Social power includes 'economic power' but also the advantages (or disadvantages) conferred by different levels of 'cultural capital' (Ibid). Some groups in society are differentially excluded from high social status, from wealth and economic capital, and from socially validated forms of cultural capital. This includes members of black and minority ethnic groups. They are disproportionately targeted by drug law enforcement (Eastwood, Shiner, & Bear, 2013; Stevens, 2011c), and are also under-represented in groups that take drug policy decisions. Similarly, women disproportionately lack social power and also face specific harms from drug policies (Malinowska-Sempruch & Rychkova, 2016). Despite the presence of some women at the highest levels of government, they are still under-represented among senior civil servants and in Parliament. The 2010 drug strategy paid little attention to the gendered nature of drug-related harms (Wincup, 2016). People under 25 are the most likely to be users of legally controlled substances (Lader, 2015), but they are rarely given any voice at all in drug policy debates. The people who are most likely to die through drug use or be imprisoned for drug offences are from the working class (ACMD, 1998, 2016). But working class accents are only rarely heard in drug policy discussions within Whitehall. Rather, the people who have the most severe problems with drugs have been denigrated as an 'underclass' (Monaghan & Yeomans, 2016) of 'high harm causing users' (PMSU, 2007). These structured inequalities influence who will become – in Gamson's (1975) terms – an 'insider' or 'outsider' of the policy discussion. As Habermas (2006: 421) argues, 'social deprivation and cultural exclusion' are major blockages to the inclusion of some people, their interests and their preferences in policy deliberation.

The cumulative effect of these intersecting axes of inequality is exemplified by the authors of this article. Stevens is a white British, privately educated man in his 50s. He is

regularly invited to discuss drug policy with politicians and civil servants. Such invitations are not extended to Zampini, who is a foreign-born, state-educated woman in her early 30s.

These structural features are not external to the policy network (as Compston [2009] suggests), but central to how it emerges and operates. Actors with different levels of social power have different degrees of connection, access and influence. The political and financial mass of the Home Office and the police services it funds gives them weight in policy debates that much smaller organisations, like Transform and UKDPC, have been unable to match. But some small organisations, like the Centres for Policy Studies and for Social Justice, are able to amplify their influence through political affinities and close, socially structured connections to more powerful actors.

Members of these constellations do not need to rely on 'coordinated activity', which Sabatier (1988) includes as a defining feature of 'advocacy coalitions'. We take coordinated activity to imply that there is some centrally organised planning of joint actions towards agreed policy decisions. We did not observe such coordinated activity in the two policy debates covered in this article. Rather, we see collaboration within policy constellations as a form of 'structuration' (Giddens, 1984) of social action. As Colebatch (2009) suggests, policy actors do not always need to jointly plan their actions towards a shared goal. When they share structural positions, normative preferences and material interests, independent actions taken on their own initiative will tend to work towards the institutionalisation of the same policy decisions. They will also tend to create connections of mutual recognition and support, and so will create policy constellations.

Successes in such strategic action will feed forward to shape the opportunities for these and other actors to influence future decisions. This process can reproduce longstanding inequalities in access and power, without the need for active coordination to consolidate favoured positions or exclude challenging groups and ideas.

Insert Figure 1 (illustration of English drug policy constellations) about here

Given the development of policy constellations over time, their nature as patterns of connections which may appear different from different standpoints, and the difficulty of showing deep, structural patterns in two dimensions, we hesitate to provide a fixed, two-dimensional representation of English drug policy constellations. But visualisation may help explain their operation. Figure 1 illustrates English drug policy constellations as they have worked in recent debates over decriminalisation and recovery. The cast of characters displayed spans Habermas' (2006: 416) list of 'actors who make their appearance on the virtual stage of an established public sphere': politicians; journalists; lobbyists; advocates; experts; and moral entrepreneurs. The diagram shows that these actors can be grouped together given their relative commitment to moral foundations on a spectrum between liberal and conservative positions (Graham et al., 2009). Those on the right of the diagram support policies in line with the moral foundations of loyalty, respect for authority, and purity/sanctity (Haidt, 2012). In this sense, such moral foundations are related with a belief in social control; a deep core belief of the type that Sabatier and Jenkins-Smith (1993) describe in the Advocacy Coalition Framework.⁵ Those on the left of the diagram are more likely to support policies that are in line with the moral foundations of liberty/oppression and care/harm. Liberty is salient for people who value individual freedom over obedience to authority. Care is salient for people who value compassion (or even love [Burris, 2004]) for the vulnerable and the avoidance of cruelty. Both these foundations tend to accompany the 'liberal' rather than 'conservative' position in empirical studies of the moral foundations framework (Iyer, Koleva, Graham, Ditto, & Haidt, 2012; Nilsson & Erlandsson, 2015). Care can be seen as a moral foundation for a core belief in the value of public health interventions.

At the centre of the diagram, there are powerful actors whose policy preferences tend to focus either on public health measures (such as OST) or social control measures (such as criminalisation of drug possession). The former group includes officials within the Department of Health and the NTA/Public Health England*, many members of the ACMD and several commissioners of the UKDPC. The latter group includes Home Office ministers and civil servants, as well as many (but not all) representatives of policing.

⁵ The relationship between moral foundations and deep core beliefs is further discussed by Clara Musto's thesis (*forthcoming*) on the political process leading to the legal regulation of cannabis in Uruguay.

The individuals within these influential organisations tend to come from groups that are favoured by structural inequalities and so have high levels of social power, being predominantly male, middle-aged and middle class. They are insiders. They have established senior positions within public and state-sanctioned institutions (e.g. police services, government departments, universities). They can be expected to act in ways that favour the interests of their social groups.

There is no necessary contradiction between public health and social control (Lupton, 1995; Stevens, 2011c). Measures taken to protect health often include state interventions to limit individual freedom. The overlap between policies for public health and social control enables cooperation between agencies that are committed to the 'medico-penal framework' that Berridge (2013) identifies. These actors are brought together in Figure 1 in the 'medico-penal constellation'. It is between these actors that the most important negotiations take place for English drug policy decisions.

Other actors, who are not themselves members of this central constellation, seek to influence it when they want to change English drug policy. On the side of social conservatism, we have observed actions by the Centre for Policy Studies and the Centre for Social Justice, with significant support in the media, to move drug policy in a more conservative direction. On the more liberal wing, Transform and Release (among others) continue to campaign to institutionalise greater respect for the individual liberties and rights of people who use drugs. These actors are outsiders to the medico-penal constellation. On both sides of the diagram, they tend to be somewhat more socially diverse than the 'medico-penal constellation'. The constellation that favours abstinence includes privileged right-wing think tank staff, but also some working class former drug users who are in recovery, and their family members. The constellation that favours liberalisation includes some younger people and some active drug users, as well as middle-aged, apparently sober professionals.

In trying to create influence, actors outside the medico-penal constellation create connections with politicians. Some advocates of abstinent recovery have created links (through the Centre for Social Justice) to the Conservative Party. Transform and Release

have succeeded in creating links with the Liberal Democrats (Rolles et al., 2016), but such links became less powerful after the party left government in 2015.

All the actors in these constellations take account of the broad contexts within which they work. They operate within the framework of international law (as laid out in the UN drug conventions), and under the influence of other countries. An example is the effective pressure that the USA placed on the UK government in 1990 to restrict the OST and harm reduction services provided in the north-west of England by Dr John Marks (Dean, 1995; Shiner, 2013). More recently, we have seen attempts, by the Liberal Democrats, public health bodies and other actors, to import the Portuguese model of decriminalisation (Jones, 2017; Royal Society of Public Health, 2016). The arrows in Figure 1 run in both directions because English drug policy actors also seek to influence international law and other countries.

Actors in English drug policy constellations must also win legitimacy and support from the media and the various publics whose opinions are considered by policy decision makers. This includes members of relevant professional groups, as well as the general public. The compliance of actors such as doctors and police officers is necessary in order to implement drug policy decisions (Houborg & Bjerge, 2017). Each of the actors listed in Figure 1 has staff or colleagues responsible for press relations. Some actors have closer connections to journalists than others, as exemplified by the presence of right wing media figures on the board of the Centre for Policy Studies. Again, the arrows run in both directions as drug policy actors must respond to the agenda of the media, as well as trying to set it.

On this diagram, we would place ourselves as being in the intersection between concerns for public health and individual freedom. We have personal connections with organisations named in both these sections of Figure 1. A different view of policy processes could emerge from different viewpoints. For example, one group of researchers (Lancaster et al., 2015) saw the UKDPC's 'consensus definition' of recovery as an attempt to 'responsibilise' drug users for their own recovery by emphasising their choices over drug use, in line with neo-liberal ideas on individual responsibility for social welfare. We rather see the UKDPC document as a form of strategic action. It

defended the practice of OST from the challenge it faced from the socially conservative policy constellation by including OST within recovery. In doing so, it defended the interests and normative positions of actors on the medical side of the constellation. This was partially successful in repelling the threat to collective provision of health care to people who use drugs, in that publicly funded OST has not (yet) suffered the massively diminished fate intended for it by the Centre for Policy Studies. It is interesting that the UKDPC presented its definition as a 'consensus', thereby implying that it was the result of deliberative communication, not strategic action. It is through such processes of negotiation and contestation within and between policy constellations that policy decisions are produced.

Conclusion: towards a critical theory of English drug policy outcomes

This article uses the Habermasian concept of the policy constellation to provide both a description and an explanation of two recent aspects of English drug policy; the non-implementation of decriminalisation; and the absorption of recovery into drug treatment policy.

The description focuses on the relative inclusion and exclusion of certain actors and ideas from the process of decision-making. This process is based on patterns of shared or conflicting material interests, overlapping or divergent moral preferences, and diverse structural positions. We have described these structured interactions as creating policy constellations of power and interest through which individual actors attempt to influence policy. The most influential is the medico-penal constellation, in which preferences for care and public health overlap with norms of authority and social control. Actors and organisations in the medico-penal constellation are able to influence policy both by engaging in rational, communicative action, and by systematically distorting such communication through strategic deployment of their power. Less powerful, but connected constellations include people who are more concerned with norms of social conservatism or individual liberty. As Habermas (1986) predicted, it is the norms held by the most powerful social actors which have been most influential in producing policy decisions.

So the explanatory element of the analysis comes through the incorporation of both material interests and normative preferences, and of both individual agency and structured positions, in our understanding of which decisions are most likely to emerge from English drug policy processes. The high level of overall continuity observed in English drug policy can be explained by the continuing predominance of a constellation of actors whose social positions and power remain stable, even as the individual participants change. English drug policy is largely made by middle or upper class, middle-aged or older, white British professionals in the early 21st century, as it were in the early 20th. They deploy their social power through collective but relatively uncoordinated action in policy constellations. Their action ensures that English drug policy continues to reflect their material interests and normative preferences, although not in a way that any individual actor might have intended, and certainly not in a form that would result from disinterested, purely rational, communicative or 'evidence-based' deliberation.

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