



Research paper

Exchanging expertise and constructing boundaries: The development of a transnational knowledge network around heroin-assisted treatment



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ABSTRACT

Over the last 20 years, supervised injectable and inhalable heroin prescribing has been developed, tested and in some cases introduced as a second line treatment for limited groups of entrenched heroin users in a number of European countries and Canada. Based on documentary analyses and eleven key informant interviews, this paper investigates the growth of 'expertise' and the sharing of knowledge between scientific stakeholders from different countries involved in researching and developing this area of treatment. Drawing on Stone's concept of the 'knowledge network' (Stone, 2013) and Gieryn's theory of 'boundary-work' (Gieryn, 1983), the analysis demonstrates the collective power of this group of scientists in producing a particular form of knowledge and expertise which has accrued and been exchanged over time. It also illustrates the ways in which this type of science has gained credibility and authority and become legitimised, reinforced and reproduced by those who employ it in both scientific and political debates. Boundaries were constructed by the knowledge network between different types of professions/disciplines, different forms of science and between the production of science and its consumption by non-scientists. The uniformity of the knowledge network in terms of their professional and disciplinary backgrounds, methodological expertise and ideological perspectives has meant that alternative forms of knowledge and perspectives have been neglected. This limits the nature and scope of the scientific evidence on which to base policy and practice decisions impacting on the work of policy makers and practitioners as well as the experiences of those in treatment who are most affected by this research and policy development.

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Introduction

In the last 20 years, supervised injectable (SIH) and inhalable heroin prescribing has been developed, tested and in some cases implemented for limited groups of entrenched heroin users as a second-line treatment in a number of European countries and in Canada. This form of prescribing differs from that under the old 'British system' where the heroin prescription was taken away from the clinic setting and injected in an unsupervised context (Strang, Groshkova, & Metrebian, 2012). The new developments in supervised heroin prescribing have been based on over two decades of intensive research, mainly in form of randomised controlled trials (RCTs), to test its effectiveness on a range of outcome measures. These began with the Swiss studies from

1994 to 1996 (Perneger, Giner, del Rio, & Mino, 1998; Rehm et al., 2001), followed by the Dutch trials from 1998 to 2002 (Blanken et al., 2010; van den Brink et al., 2003), the German trial from 2003 to 2005 (Haasen et al., 2007), the Spanish trial from 2003 to 2006 (March, Oviedo-Joekes, Perea-Milla, Carrasco, & PEPSA Team, 2006), the British trial from 2005 to 2008 (Strang et al., 2010), the Canadian trial from 2005 to 2008 (Oviedo-Joekes et al., 2009), and more recently the Belgian trial from 2011 to 2013 (Demaret et al., 2015). The evidence and expertise in this area have accumulated with each successive trial and demonstrated that heroin-assisted treatment (HAT) is more effective than oral methadone in reducing street heroin use, physical and mental health problems and criminal behaviour for methadone refractory heroin users (Strang et al., 2012). Based on this international evidence, the Danish National Board of Health concluded that there was no need to launch their own trials of supervised injectable heroin (National Board of Health, 2008). From March 2009, HAT was permitted in Denmark and the first clinic opened in Copenhagen in

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2010. Denmark, Germany, the Netherlands and Switzerland have approved supervised heroin-assisted treatment as a second-line treatment and SIH clinics have been integrated into local treatment services.

Heroin-assisted treatment has been politically controversial in all of the countries that have conducted trials. It has been described by Khan, Khazaal, Thorens, Zullino, and Uchtenhagen (2014: 200) as 'one of the most controversial practices in clinical medicine despite its documented effectiveness'. This relates to the stigma associated with heroin as the perceived 'hardest drug' and the related stigmatisation and marginalisation of those who use it. It also is linked to paradox of treating those who are dependent on heroin with the very drug of dependency – heroin. Although HAT attracts much political attention, only a small proportion of heroin users receive such treatment. For example, in countries where HAT has been integrated into the treatment system, it accounts for between 5 and 8% of those enrolled in substitution treatment (Strang et al., 2012). Several researchers have outlined the multiple challenges, barriers and restrictions involved in designing and conducting RCT research in this area, particularly in relation to negotiating the tensions between the demands of science and politics (Gartry, Oviedo-Joekes, Laliberte, & Schecter, 2009; Small, Drucker, & Editorial for Harm Reduction Journal, 2006; Trujols & Iraurgi, 2009; Wodak, Ritter, & Watson, 2002). Against this challenging backdrop in each country, the scientists conducting the trials have relied on their epistemic authority and scientific integrity to counter the political challenges to the research and implementation of HAT. Science and scientists have played increasingly important roles in the acceptance and growth of HAT.

Drawing on Stone's concept of the 'knowledge network' (Stone, 2013) and Gieryn's theory of boundary-work (Gieryn, 1983), this paper explores the development of the transnational network of scientists involved in the development of HAT across Europe and internationally, the ways in which the expertise and knowledge in this area has been constructed, exchanged, mobilized and transferred between key actors in the different countries and how the scientists have engaged in different forms of boundary-work to demarcate their expertise and knowledge from other forms. The paper begins by examining the concepts of knowledge networks and epistemic communities, followed by a description of the research design and methodology employed in the study. It then explores the ways in which expertise, ideology and interests were defined within the knowledge network around HAT, how this knowledge and expertise has been exchanged and transferred inside and outside the network and the ways in which the scientists have engaged in 'boundary-work' to demarcate 'science' from 'non-scientific activities'.

Knowledge networks, epistemic communities and boundary-work

The existing literature exploring the ways in which scientific evidence has been developed and invoked in the debates around heroin-assisted treatment has focused mainly on national case studies, for example in Denmark (Houborg, 2012; Jepson, 2001) and in the Netherlands (Dehue, 2002) and the mapping of the network of HAT researchers through co-authorship analyses (Houborg & Munksgaard Anderson, 2015). Research attention has not been directed towards the *group* of scientists from the various countries involved in the trials and their *collective* roles in the production, exchange and translation of this knowledge and expertise. Such analysis is important for understanding which forms of knowledge and expertise are defined as legitimate and credible and become reinforced over time through the mobilisation and transfer of scientific results and practices between scientists and other actors. This paper draws on concepts and

theories from both the fields of global governance and the sociology of scientific knowledge. In order to explain the networking activities of the group of scientists involved in the development of heroin-assisted treatment transnationally, Stone's concept of the knowledge network will be employed (Stone, 2013). Gieryn's theory of boundary-work (Gieryn, 1983, 1999) will be applied to illuminate the social processes involved in the development and mapping of the science around HAT by the knowledge network.

Knowledge networks are not necessarily policy-focused, but they are engaged in advancing science around a specific topic or issue and concerned with "'codified' forms of knowledge produced by recognised intellectuals in the form of research and analysis" (Stone, 2003: 8). They produce, exchange and translate knowledge across national boundaries. Knowledge networks can take different shapes over time and many are not permanent entities. Inclusion in networks depends on 'official recognition of expert authority as well as more subtle and informal processes of validating scholarly and scientific credibility' (Stone, 2002: 2). The expertise, scientific knowledge, professional experience and credentials of the actors in knowledge networks give them epistemic authority and credibility to inform policy and practice. The temporal aspect of the knowledge-policy interface is important as the influence of knowledge networks and knowledge actors may shift over time. As Stone (2012: 3) argues, influence rests in the aggregate contributions of wider networks of researchers who develop knowledge and evidence over time, rather than resting on individual contributions of lone scholars. This paper will explore how the knowledge network around HAT developed, the ways in which their knowledge and expertise was constructed and diffused between the different countries and how the aggregate contributions of the knowledge network built up over time and influenced the development of policy and practice.

The emergence of epistemic communities has become increasingly important within drugs policy-making at the European level (Elvins, 2003). Epistemic communities are actor based, so attention is focused on the source of ideas and the development of supranational 'expert' networks in particular policy and practice domains. These communities aim to attain an authoritative voice in issue areas, generate 'multistakeholder dialogue' and build consensus – with resultant implications for policy and practice at national level. Haas (1992: 3) defines an epistemic community in the following way: "a network of professionals with recognized expertise and competence in a particular domain and an authoritative claim to policy-relevant knowledge within that domain or issue-area." Epistemic communities normally include professionals from a range of disciplines and backgrounds, but they must have shared normative and principled beliefs, causal beliefs, notions of validity and a common policy enterprise (Haas, 1992: 3).

As Demortain (2011) argues, Haas' conceptualisation is compelling because it offers three layers of explanation. First, the authority of science underpins the framework. The influence of scientists is dependent on them embodying scientific method, prestige and authority. Where uncertainty surrounds policy problems (e.g. drugs), epistemic communities provide knowledge to compensate for this uncertainty. Second, the notion of 'community' is important because it increases co-ordination between policy makers and scientists. Third, the involvement of professionals enhances the codification and authority of specialised expert knowledge. Scientists within epistemic communities act as 'experts' in the policy world. Politicians and bureaucrats may turn to experts and their ideas at particular junctures. However, the influence of experts only materialises when there is a connection between these two worlds (i.e. the scientific world and the policy world). In this perspective, the production of scientific knowledge is viewed as external or separate to politics and policy-making processes.

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