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Research Paper

Evidence-based policymaking: Lessons from the Chilean Substance Use Treatment Policy

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ABSTRACT

Background: Evidence-based policymaking is a guiding paradigm of substance use treatment (SUT) policy, that seeks to prioritise scientific criteria over other concerns (e.g., economic, political) when addressing policy decisions. We provide a comprehensive analysis of the context and mechanisms that enable and constrain evidence to improve the Chilean SUT policy and draw some lessons that might be useful to other contexts, particularly low and middle-income countries.

Methods: This study relied on an interpretive case study design based on the principles of realist evaluation. We included interviews (N≈17) with international, national, regional, and local policymakers and experts, as well as technical and clinical teams from private and public care SUT providers in Chile.

Results: Complex sets of institutional realities and notions of 'evidence' shared by actors - between other elements- guide the SUT policy decisions and shape the specific type of evidence considered relevant. Evidence is understood in Chile in narrow terms, and national non-experimental research is often overlooked. This limits the possibility of studying other research questions that could contribute to improving and informing SUT policy.

Conclusions: In contexts where addiction research resources are limited, it appears necessary to re-frame the notion of "evidence", to consider relevant national non-experimental knowledge to strengthen SUT policy and achieve its goals. Indeed, this study is an example of how methodological approaches, such as case analysis, can provide a powerful heuristic alternative contribution to the local and global mental health debate.

Background

The worldwide burden of substance use disorders calls for adequate policies and interventions to tackle this issue. The evidence-based policymaking (EBPM) paradigm that emerged from high-income countries has permeated the policy process of low and middle-income countries (LMIC) for decades, but with varying levels of implementation (Bergmark & Karlsson, 2020; Rawson et al., 2015; Klingemann, 2020). EBPM constitutes an important shift in modern political processes, proposing that policy, understood as larger-scale decisions on the delivery and management of public services, should be informed by evidence (Oliver et al., 2014). It assumes that (i) evidence will enable a more efficient and effective means of achieving social goals;(ii) '*good*' evidence is required to do so, which is determined from a '*hierarchy*' of scientific evidence that places experimental trials on the top in terms of methodological quality, and non-experimental methods (i.e., case studies) on the bottom, due to their higher risk-of-bias in the research process; and finally (iii) that science should trump ideology when addressing policy issues (Cairney, 2022; Parkhurst & Abeysinghe, 2016). However, it has been documented that EBPM assumptions are rarely met in practice, and effectiveness is only one criterion of complex policymaking processes (Lancaster, 2014; Parkhurst & Abeysinghe, 2016). Since the health sector has championed the EBPM approach, first through evidence-based medicine (EBM), it is unsurprising that substance use treatment (SUT) is one such policy, even though the definition of evidence is rarely articulated in this field.

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In recent decades, many countries have made increasing efforts to make SUT systems more effective, controllable, and standardised (Klingemann, 2020; Storbjörk & Stenius, 2019); Latin America is not an exception, although public policy efforts in this area are still incipient (Marin-Navarrete et al., 2018). Recent reviews have pointed to a North-South divide[1] for substance use and responses to drug problems, claiming a knowledge and information gap in most LMICs (Klingemann, 2020). While research from high-income countries (e.g., United States, United Kingdom, Australia) have significantly contributed to knowledge on addiction and its treatment, evidence from the Latin American context is largely unknown.

Using results from other regions, particularly high-income countries, can be misleading. First, because the context, populations, and specific nature of substance use disorders are different, along with the fact that such treatments are designed to the country-specific epidemiologic context (e.g., harm reduction, emphasis on detoxification, etc.) (Castro et al., 2021; Rawson et al., 2015). Second, because if only 'good' or top-level international evidence is being considered, it may overlook that public health policy decisions usually involve competing sets of concerns beyond intervention effectiveness, including, for instance, organisational strategic goals, resource capacity, and the interpretations of the individuals involved (Bennett & Holloway, 2010; Parkhurst & Abeysinghe, 2016). That is why a critical perspective of EBPM has pointed out that different research questions require different types of evidence, indicating that a more fertile focus for policymaking may be the *appropriateness* of evidence required, which implies the examination of the policy goals and concerns, and the generalisability of pieces of evidence imported from other contexts (Cairney, 2022; Parkhurst & Abeysinghe, 2016). Different research questions come from alternative approaches, such as realist evaluation (RE). This method has been developed in response to the acknowledgment that informing complex interventions and systems demands deeper insights into implementation contexts and mechanisms that trigger specific policy outcomes (Pawson & Tilley, 1997; Wong et al., 2016).

The Chilean SUT policy is an interesting case study since it is one of Latin America's oldest and most developed (Marin-Navarrete et al., 2018). Chile has one of the highest rates of alcohol use per capita in the Americas, with a 61% prevalence in the last year in the adult population (Peña et al., 2021; SENDA, 2018). It is followed by marijuana, with a last-year prevalence of 14.5%, placing Chile as the second country in the Americas with the highest prevalence of marijuana in the general population, over Canada, the United States (14% both) and just behind Jamaica (15.5%) (CICAD, 2019). National studies also pointed to 1% and 0.4% of the adult population having used cocaine hydrochloride and cocaine paste in the last year, respectively. However, this may still be underestimated because of methodological limitations in covering disadvantaged populations (DIPRES, 2020).

To address this problem, the Chilean government—through the National Service of Drug and Alcohol Use (SENDA) and the Ministry of Health— funds SUT for people with public health insurance (~80% of the population), in addition to treatment for adolescents under the Explicit Health Guarantees (GES) law and the brief intervention and referral to treatment programs implemented in primary care. SENDA funds around 30,000 treatments each year; two-thirds correspond to treatment for the adult population, and the rest for adolescents in contact with the criminal system. These treatments are provided by public (coverage ~71%) and private (~29%) centres that are required to follow technical protocols for quality assurance (e.g., infrastructure, treatment team composition). SUT considers ambulatory (~85%) and residential (~15%) treatment settings, as well as treatment tailored for specific subgroups, such as gender-specific or justice-involved populations. As part of the technical development of treatment programs, a national-level system was implemented to centralise individual-level data from treatment programs in 2010. The data infrastructure in Chile is pioneering in the region and is the basis for producing local evidence.

Despite long-term efforts and significant economic investment in SUT, there is still limited evidence to inform SUT policy in Chile; moreover, barriers to filling the knowledge gap and the type of evidence required have not been documented. Clarifying these elements is key to elaborate local responses to strengthen SUT policy in contexts where resources are scarce, such as LMICs. Following a critical view, an exclusive gaze on 'good' evidence ignores other issues such as equity in SUT access, human rights practices, and obstacles in the implementation process that are also relevant to improving this policy. This provides an opportunity to address two key questions: (1) How is evidence enabled and constrained by the context and mechanisms of the Chilean SUT Policy?; (2) What kind of evidence informs and might inform the Chilean SUT policy?

Our study aims to comprehensively analyse the challenges of generating and implementing EBPM on SUT in the Chilean socio-cultural, epidemiologic, and political context, and draw some lessons that might be useful to other LMICs.

Chilean SUT policy overview

The Chilean SUT policy is relatively recent. One of its founding milestones was the creation of the National Council for the Control of Narcotics (CONACE) in 1990. CONACE was a public agency within the Ministry of Home Affairs and Public Security (MHAPS) responsible for advising the president of Chile on the prevention, control, production, and illicit trafficking of narcotics. This agency initially covered only illicit drugs. It was the first Chilean public institution to strengthen and finance part of the drug treatment initiatives that already existed but depended on NGOs or civil society groups, with varying levels of specialisation and no regulation.

The transformation of CONACE into the current National Drug and Alcohol Service (SENDA) in 2011 shaped the next milestone. SENDA is also housed in the MHAPS but moved from an advisory body to a Public Service: a decentralised administrative body with greater autonomy and budget. By law, SENDA is responsible for developing and implementing drug and alcohol prevention, SUT policy, and national drug and alcohol strategies (Law 20,502, 2011). Thus, SUTs financed by SENDA were no longer limited to illicit drugs but also included alcohol. This allowed the emergence of an integrated treatment approach across substances.

It must be noted that the Ministry of Health, the health authority, and a higher-level institution than SENDA, also provides an important part of the SUT programs in Chile. Part of the role of the Ministry of Health under the law is the formulation, implementation, and evaluation of the National Mental Health and Psychiatry Plan (2000), which includes providing SUT.

Methods

Ethics statement

This study protocol was conducted in the context of Fondecyt Grant 1191282, which was reviewed and approved by the Institution Review Board at Universidad Mayor, Chile. Interview transcripts were de-identified.

Study design

We used an interpretive case study design based on the principles of RE (Pawson & Tilley 1997). This approach has been widely used in the study of Latin American health programs (Quintans et al., 2020) because

[1] This is an imprecise distinction, since rather than being based on a geographic delimitation, it refers more to a difference between high-income countries (such as the United States and Canada) and middle- and low-income countries, such as Venezuela, Colombia, Mexico and other countries of Central America (strictly located in the Northern Hemisphere). However, it is used because it is conceptually useful.

Table 1
Participant's characteristics.

Link with SUT policy	
National expert (academic, researcher)	2
International expert (academic, researcher)	2
SENDA member (quality manager, technical supervisor, policymakers, and bureaucrats)	5
Ministry of Health member (manager, supervisor, policymakers, and bureaucrats)	4
Private providers (owners, managers, street-level professionals)	2
Public providers (owners, managers, street-level professionals)	2
Location/Geographic Zone	
Outside of Chile (Mexico, United States, United Kingdom)	3
Santiago Metropolitan Region	10
Outside Santiago metropolitan region (Northern and Southern Chile)	4

it facilitates describing how programs work while accounting for the intermingled relationship between context, mechanisms, and outcomes (Wong et al., 2016). Due to the COVID-19 pandemic, we conducted semi-structured online interviews (N=17) with international, national, and regional/local policymakers and experts, as well as technical and clinical teams from private and public care providers of publicly funded SUT in Chile. Finally, we included documents, regulations, and reports mentioned by our interviewees to enrich and triangulate our analysis.

Sampling strategy

We used purposive sampling by mapping key actors and institutions as an initial step, followed by a snowball sampling strategy. Above all, we seek to represent the different actors involved in the SUT policy.

Data handling and analyses

Interviews (n = 17) were conducted, transcribed, analysed in Spanish, and then translated to English. Transcripts were imported into the MaxQDA software (version 12) for systematic coding. To maintain confidentiality, participants were invited by email, without intermediate contact (e.g., boss or colleague), thus assuring that nobody in their organisations could identify them. To guarantee anonymity, once participants were interviewed, the same researcher oversaw saving audio archives and transcripts in an anonymised way (e.g., deidentifying the files stored). Finally, descriptors in Table 1 were double-checked to avoid deductive disclosure of participants' identities.

A three-stage analysis was developed. In the first stage, deductive codes based on the following interview topics were settled: (i) Development of a national SUT Policy; (ii) SENDA/Ministry of Health tension; (iii) Public/private treatment differences; (iv) Funding and (v) Evidence notions. In the second stage, inductive codes were created based on the emergent topics proposed by the interviewers, which were generally linked to enabling or constraining elements, such as (i) The supervising role of SENDA, or (ii) bidding system issues. As a result of the previous stages, 41 codes were generated, transcripts were coded line-by-line, and coded data was exported from MaxQDA into Microsoft Excel documents and analysed thematically.

In the third stage, a more abstract analysis followed the principles of RE, a theory-driven approach to assessing complex social interventions (Pawson & Tilley 1997). The RE approach recognises the importance of context and the implementation process to understand outcomes, addressing the questions of what works, for whom, how, and under what circumstances. The goal of RE is not to answer: 'Is SUT Policy in Chile evidence-based?', but to explore (a) 'How is evidence enabled and constrained by the context and mechanisms of the SUT Policy' and (b) 'What kind of evidence informs and might inform the Chilean SUT policy?'. Findings were then mapped onto one of the three core RE concepts: (i) context; (ii) mechanisms; and (iii) outcomes. As distinctions between these concepts are often unclear in the RE literature, we defined them as: (i) context— organisational setting and external constraints, including resources, prevailing policies, and technologies that influenced the implementation of an evidence-based SUT policy; (ii) mechanisms—The ways actors (policymakers, experts and care providers) involved in the SUT policy implementation interpret and use evidence; and (iii) outcomes— to what extent do evidence findings have informed SUT policy improvement and what kind of evidence might inform SUT policy. Thus, RE scheme is not used here in a standardised way (Wong et al., 2016), but as an ad hoc tool to organise and analyse our findings. The first two concepts (i, ii) are useful to approach the first research question (a) since they allow a better understanding of the nature of SUT as a complex health system in the specific Chilean reality. Meanwhile, the third concept (iii) enables exploring the second research question (b), by providing insights on how to address the knowledge gap to inform SUT.

Findings

This section is organised as follows. First, we develop an analysis of how the context has enabled and constrained evidence to inform SUT policy. Contextual elements such as the institutional framework and its fragmentation, or the funding structure appear relevant to understanding the emergence and gap of knowledge in Chile. Secondly, we analyse mechanisms that facilitate and prevent an evidence-based Chilean SUT policy. Here the notions of 'evidence' between actors, reflections around the fidelity-adaptability dilemma, and the competition logic triggered by the bidding system emerge as important clues. At last, we offer insights on the type of evidence informing and that might inform the Chilean SUT according to the actors. Specifically, we discuss the tensions raised by considering only 'good' evidence, and barriers to producing local evidence.

Context

Main institutional framework

The main institutional framework -currently embodied in SENDA- of SUT policy constitutes a trade-off for the emergence of an EBPM. On the one hand, SENDA has facilitated the emergence and improvement of an EBPM of SUT in Chile by injecting resources and having it as part of its institutional strategic aims. That is why the interviewees have pointed SENDA as a decisive factor behind the fact that, in less than 30 years, Chile has become a regional benchmark in SUT:

> "Chile is the most developed country in Latin America in terms of treatment, the only country that can boast that it has a national treatment system in all its 16 regions, from primary care to residential care (…) Chile has the largest regional treatment system, the largest financing, the largest State responsibility for treatment in Latin America. In the rest of the region, treatment is mainly based on NGOs" (International expert).

On the other hand, the position of SENDA within the MHAPS is associated with several difficulties, both symbolic and practical. As the United Nations has recommended that Latin American countries install drug agencies at the highest political level, the position of SENDA in the public security arena is no exception in the region, according to the interviewees. In terms of the symbolic contradictions, even the early shift made by SENDA in passing from a public security to a public health perspective of the substance use problem, the fact that SENDA respond to security goals instead of evidence-based practices (EBP), is an actual worry:

> "I think as long as treatment continues to be in SENDA (instead of Ministry of Health) the same thing will continue to happen because the Minister of Home Affairs' priorities are different. They are not focused on what we are talking about, on what the evidence says in terms of health" (private sector representative).

Other interviewees linked the position of SENDA to a punitive treatment approach that was initially installed, characterised by drug use stigmatisation and abstinence-based practices, which has slowly shifted to a health approach that favours EBP. Others pointed out a more practical issue: SENDA, its authorities, and the National Drug Strategies are especially dependent on changes in government. Although historically, most of the staff of drug treatment in SENDA remained, political changes have affected SUT policy in terms of the budget that sustains it, and its emphasis on quality:

> "The Treatment Unit had wide backing from their authority, and quality had a 'pivotal' role (…) But since 2018 onwards that design was blurred and quality is no longer the axis of the design and quality managers still exist, but they do not have the support they had before" (Ministry of Health Representative).

An important element worth noticing is that even when quality and EBP have been a concern in the SENDA approach of SUT, the experts clearly indicated that it is still a low public investment in research and evaluation of public policies on this matter in Chile.

Institutional fragmentation of SUT

The fact that both SENDA and the Ministry of Health provide SUT is an element that should be highlighted as part of the complexities of the Chilean scenario since it implies a problem of service duplication and fragmentation and a challenge for integrating treatment into the continuum of care. Interviewees emphasised practical problems for coordination between both institutions, since each of them have established different implementations of SUT, including different criteria for financing, supervision, and technical support:

> "People always said that 'SENDA was more demanding than the Ministry of Health because the quality managers were there'. The problem is that they are only concerned about 'their' patients, not those financed by the Ministry of Health. That is wrong…the idea was that all users have the same service, regardless of which public agency finances their treatment" (Ministry of Health representative).

The quote above illustrates how different Government institutions provide SUT affects its implementation and the possibilities to consistently implement an EBPM of SUT across institutional boundaries. The fact of multiple financing sources and the unequal resources offered by each institution directly impact the service quality provided and, thus, the adoption of EBP. Despite efforts at inter-institutional coordination, the Ministry of Health and SENDA do not share the same quality of care standards. Moreover, as literature on drug policies has shown in other contexts, the evidence that is considered relevant often depends on institutional agendas (Lancaster, 2014). Then, the institutional fragmentation of Chilean SUT also implies a tension between the emphasis given to different types of evidence (e.g., security vs. public health) by the different institutions involved in SUT policy.

Technical supervision of SUT

As an enabling factor, interviewees highlighted the work by SENDA on disseminating EBP from high-income countries at the national level through guidelines, quality protocols and supervision of SUT provision. Those EBP include motivational interviewing, cognitive-behavioural therapy, harm reduction approach, and treatment specialisation according to subpopulations' needs (e.g., women, young people, and offenders).

> "SENDA has been working to incorporate a standardisation of core treatment elements. For example, leaving behind the therapeutic community model, which was the traditional model (…)There were some practices that not only had no evidence, but some could even violate human rights" (SENDA Representative).

Chilean concerns about moving towards standardisation and mandatory control of treatment providers coincide with a broader international trend of implementing the methods of New Public Management, also observed in Anglophone democracies and some Nordic countries (Klingeman, 2020; Storbjörk & Stenius, 2019; Pierre & Peters, 2017). It should be noted that in Chile, along with the quality goal, the idea of incorporating EBP was introduced early. Already in the National Drug Strategy 2009-2018 developed by CONACE (in 2009), the principle that treatment interventions should be based on evidence was explicit. However, it is SENDA that makes concrete efforts to make it real.

According to the interviewees, the monitoring work performed by SENDA through technical supervisors (in charge of the administrative compliance of agreements with clinical centres) and quality managers (clinical advisors to staff) is key to ensuring EBP. This is mainly because when evidence-based interventions are applied beyond the context of a research project, difficulties in translation may arise. Some strategies, such as having clinical champions (the role of quality managers) and training teams by staff, are increasingly used in health contexts worldwide. Their effectiveness in aiding the implementation and adoption of such practices has been documented (Condon et al., 2008; Wood et al., 2020). Indeed, the interviewees consider that SENDA has had greater technical expertise in terms of support and training than the Ministry of Health has had in SUT and mental health in general, along with other Government agencies:

> "I see that the treatment technologies that we use are light years ahead compared to the Ministry of Health, I mean that we demand more things, we supervise more things, we install new methodologies based on evidence" (SENDA Quality Manager).

Even so, other interviewees recognised both institutions' efforts to build collaboration capacity. Instances such as joint consultancies and supervision between SENDA and the Ministry of Health have contributed to effectively implementing the continuum of care in several country regions.

Funding structure

Treatment funding structure is a critical element in treatment program delivery and thus, for the actual implementation of EBP. The funding structure is different for public or private actors providing treatment. The financing mechanism for public agents is based on resources transferred from SENDA to the regional Health Services, which administratively depend on the Ministry of Health. To provide SUTs, public centres financed by SENDA must carry out this work; moreover, they also must provide other health services. According to the data obtained in this study, SENDA does not have the attribution to "mark" the transferred resources or monitor public health service expenditures, which means that SENDA funding for SUT can be used for other purposes or other health priorities, given the high demand in the Chilean public health system. This helps explain why many of those interviewed said that the quality of SUT (the size of services provided, staff turnover, and the possibility of implementing evidence-based practices) is weakened in the public system. Interviewees persistently pointed out staff turnover

as one of the main contextual elements that hinder the installation of EBP in the public treatment provision context. Interviewees argue that private treatments generally work better than the public, because private centres and teams are focused exclusively on SUT provision.

Accountability is central when the administration responsible for treatment provision is separated from care providers (Storbjörk & Stenius, 2019). In Chile, accountability is regulated by law, inspections, and detailed contracts. Contracts between private providers and SENDA thus seek to ensure elements that cannot be required for public providers, such as EBP and team stability. However, private providers' independence risks fragmenting care and impeding coordination. The financial structure that supports private providers also has its complexities, subject to the Procurement Law (Law 19,886, 2003), which sets out rules and principles for the procurement of services required for the adequate performance of State functions. However, its guidelines do not conform to the characteristics of health service procurement.

"The only available legal framework is the Procurement Law, even when it does not meet the requirements of clinical service. Hopefully, at some point there will be another legal framework or another format that allows for greater sustainability, that effectively allows a scenario in which the technical, clinical, and quality factors of the programs have greater weight when choosing a provider" (SENDA representative).

In this sense, and despite the so-called "bidding system" seeking accountability, it is also widely recognised as a barrier for several reasons. First, the better technical offer at the lowest price evaluation becomes a bureaucratic process focused on administrative requirements rather than content. In doing so, the selection process does not properly capture technical and quality factors. This finding resonates with studies on similar SUT systems, which show that the tendency to monitor quality through exclusively quantitative outcomes can incentivise providers to be concerned with immediate, measurable statistics of interventions rather than focusing on longer-term treatment outcomes (Storbjörk & Stenius, 2019).

Information system

The SENDA information system is another relevant contextual factor for installing evidence-based policy. It allows a pioneering data infrastructure compared to other regional and national agencies and SUT systems. This information system is much more specific than the Ministry of Health, providing ample information on users' profiles, treatment trajectories, drug use, and service details. Also, it is the basis of the SENDA SUT monitoring system, allowing for statistical reports on treatment outcomes at the national and regional levels, including indicators such as waiting time, length of stay, drop-outs, and others. According to the interviewees, few countries have public institutions that generate annual statistical reports on treatment outcomes, and Chile is the only country in Latin America.

Despite its comparative advantage over the rest of the region, Chilean data infrastructure has several flaws that explain some current barriers to local evidence emergence. This is mainly because no unified system contains information on all users who receive SUT, regardless of the public provider (SENDA or the Ministry of Health). This fact could introduce biases in the information obtained on treatment. Some interviewees stated that treatment teams differentiate users funded by SENDA from those funded by the Ministry of Health in the information system. According to some actors, this is because SENDA is stricter with providers in terms of monitoring, so many of them prefer to enter users "*with a more complex profile*" (e.g., because of their lower adherence) into the Ministry of Health information system.

The fact that SENDA has its own information system also challenges the proper integration of SUT into the care continuum. For example, the information on SUTs is unavailable for health professionals outside SENDA's network (e.g., the primary care sector). Additionally, interviewees pointed out that, despite the potential of the SENDA information system for monitoring local initiatives and their improvement, few centres use it. This shows that actors may understand the SENDA information system as an administrative tool to control SUT operations and not as a source that allows technical monitoring and the generation of local evidence.

Mechanisms

Notions of 'evidence'

EBPM has become part of the discourse of Chilean state agents. The new National Drug Strategy 2021- 2030 (SENDA, 2021) defined one of its guiding principles as "*to be based on international and national scientific evidence*" (p. 37), making explicit that such evidence must be of "*sufficient quality*" (p. 37). Thus, from the Chilean institutional framework, the kind of evidence that is promoted and supposed to inform SUT policy is "good" evidence, the one on the top of the *hierarchy* of scientific evidence (Cairney, 2022; Parkhurst & Abeysinghe, 2016; Oliver et al., 2014).

Even though national evidence is considered in the mentioned guiding principles, an important part of the Chilean actors involved in SUT seem to understand "evidence" as a product that must be imported, since the international EBP appears as a clear set of knowledge and as a cost-effective plan, given that it is perceived unfeasible to generate local evidence:

> "I don't know if we are in conditions to wait for the teams to generate evidence. Today it is clear that the practices that have evidence are the motivational strategy, the cognitive-behavioural, etc. I do not expect them to generate evidence, but to implement it" (Expert).

Some other interviewees added that the lack of local evidence might result from high standard effectiveness studies expectations (i.e., from randomised controlled trials or RCT) that collide with a context where that is not viable, considering the lack of resources, time constraints, and political agendas. As a result, SUT policy is starting to be seen by some actors as stagnant and rigid entailed in performance management and day-to-day policymaking, rather than being focused on developing, testing, and piloting new knowledge on responsive approaches to emerging Chilean SUT-related needs. These needs may not necessarily be conducted to study via RCT, since the 'good' evidence to guide clinical interventions is not the same as the 'good' evidence to guide policy decisions on SUT (Parkhurst & Abeysinghe, 2016).

Fidelity-adaptability dilemma

From the teams' point of view, 'evidence' imported from abroad hides a one-size-fits-all assumption. Some practitioners problematised "cognitive-behavioural theory" as a structured practice that sometimes fails in recognising and incorporating the context in which SUT are provided, especially when users are homeless and do not adjust to the agenda planning requirement. Similar cultural differences are valid within Chile, where there are important sub-national differences and heterogeneous capacities to translate imported evidence. Cultural sensitivity and the lack of evidence-based treatment programs raise the dilemma between the fidelity-adaptability of EBP when implemented in the "real world". Interviewees also agree that evidence has been imported for many years to Chile without any studies of how it is being implemented. The EBP implementation fidelity level is unknown, and a theoretical-practical gap is suggested, given the heterogeneity in treatment implementation:

> "People come up with a project that might seem excellent because everything holds up on paper. They can tell 'we are oriented to harm reduction'. (...) But then you are in the field and you realise that the team is not harm-reduction oriented, but abstinence oriented. (...) In the end, you find inconsistencies in the smaller practices, in the micro-skills" (supervisor, Ministry of Health).

In fact, for some interviewees, a cross-cutting factor in public and private centres, is teams' resistance to incorporating evidence into practice. Some experts propose that the resistance comes from inadequate

professional formation: "*in Chile, you have to work with a mass of clinicians with a formation that goes in the opposite direction of what the international evidence says*" (Expert). This coincides with what has been identified in the European context, where actors' resistance to change is pointed out as one of the causes impeding the evolution and adaptation of SUT policy (Klingemann, 2020). Although policy transfer discussion is not the focus of this study, it emerged as one of the main concerns among actors, and it is relevant as it may guide the kind of evidence that is needed in the Chilean context.

Competition logic and EBP

The bidding system at the basis of the Chilean private SUT provision promotes competition among private agents rather than collaboration, which could impede the dissemination of best practices and the EBP installation, according to some interviewees and the literature (Spoth et al., 2013; Storbjörk & Stenius, 2019). The Chilean bidding system has difficulty establishing short-term agreements (2 years), which implies that teams must reapply when agreements end. Thus, the logic of competition installed on teams seems to weaken continuity of care and health system interconnectivity, as some conceptualise it as the antithesis of coordination (Storbjörk & Stenius, 2019). It has also been shown that despite how highly detailed a contract and performance criteria can be, the "mistrust-based contract logic" at the base of systems can make providers limited to perform what the contract determines, but unwilling to go the extra mile (Pierre & Peters, 2017) which could mean not being receptive to what the evidence says. The mere fact that when teams are not awarded the bid, they lose their jobs, and users must be referred to new centres (meaning that many of them drop out of treatment) is contrary to EBP. Thus, the Chilean experience shows that SUT policy 'marketisation' may hinder the effective use of EBP, as has been identified in several Western countries, including Europe and Nordic countries (Storbjörk & Stenius, 2019).

Outcomes

The exposition of the context and mechanisms made so far gives some clues about the kind of evidence that informs and might inform the SUT Chilean policy. As has been anticipated, 'good' evidence is informing the Chilean SUT policy, an understanding that assumes the use of foreign evidence and reduces the prospect for the generation of evidence locally since the rigorous methodological expectations collide with the Chilean possibilities. To elaborate on this point, it might be illustrative that the only study of Chilean SUT effectiveness to date was funded by the Chilean Budget Office (DIPRES, 2020) and even when it had an unprecedented budget for the country (about 200,000 USD) it presented several methodological limitations (small sample size, short follow-up) that positioned it far from the top-level scientific evidence.

More importantly, the same study met several resistances from SENDA, for considering the weak outcomes of SUT that it found, failing to acknowledge important indicators of patients' recovery process given the chronic (and non-linear) nature of addiction. This tension is relevant because it clarifies the limitations of an exclusive focus on "good" evidence. Firstly, SENDA reaction is aligned with literature warnings about how EBP hierarchies rank evidence of intervention effect on a specified and limited number of outcomes, which may serve the needs and realities of clinical medicine, but not necessarily public policy (Parkhurst & Abeysinghe, 2016). Secondly, an exclusive focus on SUT effectiveness may unexpectedly cause public institutions—such as SENDA—to avoid outcomes evaluations (that may have political and economic consequences on its budget), which in turn, may inhibit the generation of local evidence.

That is why for some implementers, the institutional emphasis on EBPM is nothing more than an empty discourse far from an accurate reflection of the complexity of the process of 'producing' local evidence and 'importing' a practice, elements considered crucial in public health decision-making (Oliver & de Vocht, 2017). Researchers in other contexts have also noted that the evidence-based paradigm has become accepted and disseminated as a *trademark* even when it is not well understood, and there is no interest in how that evidence is produced and applied in practice (Bergmark & Karlsson, 2020; Cairney, 2022). In line with this argument, some interviewees raised the need to legitimise the knowledge emerging from the Chilean experience beyond locally collected quantitative data, which provides insights on the question to what kind of evidence might inform SUT policy:

> "Whoever you talk to nowadays in the State tells you 'we have to generate evidence', 'evidence-based treatment' ... and it's a nice slogan, but I would say that here there is a challenge as a country. We believe that evidence can be bought (…) But I am convinced that adaptation is sometimes possible and sometimes just isn't possible and while we realise that the truth is that we are losing enormous resources and valuable Chilean experiences" (Private sector representative).

Besides local best practices, other evidence not currently considered to inform SUT policy is the one provided by users' opinions, also known as "people-centred evidence" (Bergmark & Karlsson, 2020). Although SENDA has made efforts to incorporate user satisfaction surveys, it is an initiative that depends on teams' will, and is not applied at the national level. Moreover, currently applied surveys are conducted by the same staff, and since anonymity is not strictly granted, the data may not be reliable.

In sum, when thinking about what kind of evidence might inform SUT, a comprehensive definition of "evidence" seems more appropriate to the Chilean context, which implies broader indicators of recovery to test treatment outcomes, legitimise Chilean best practices, and incorporate the view of users on SUT. These elements challenge the common tendency to understand the evidence as universal, generalisable, and sanctioned. Instead, it seeks to incorporate the experiences, needs, and preferences of individuals, families, and treatment teams as valid sources of information to improve SUT systems and policies as well as a much cheaper alternative to traditional strategies, such as outcomes evaluations (Bergmark & Karlsson, 2020; Greenhalgh et al., 2009; WHO, 2015).

Discussion

The Chilean SUT policy is oriented by the EBPM paradigm, which seeks to prioritise scientific criteria over other considerations (e.g., social, economic, political). Several perspectives, such as philosophy of science, sociology of knowledge, and political science have shown the limitations of this paradigm by questioning not just evidence as the only source for policymaking, but also the notion of 'evidence' itself (Lancaster, 2014; Parkhurst & Abeysinghe, 2016). The analytical tools provided by RE allowed us to examine how 'context' and 'mechanisms' shape policy 'outcomes', and by doing so we gained insights into the kind of evidence that best serves to improve Chilean SUT policy.

Our findings give some lessons around how evidence is enabled and constrained by the Chilean context and mechanisms, making it clear that complex sets of institutional realities and the notions of 'evidence' shared by actors —between other elements—are guiding the SUT policy decisions and at the same time, shaping and selecting the specific evidence that is considered as relevant. This fact should not be interpreted as a Chilean SUT policy failure; instead, it illustrates the limitations of the "*myth of EBPM*" (Cairney, 2022) that assumes a decision-making process is purely rational or science-driven and that only a single kind of evidence ('good' evidence) should inform policy. Additionally, our critical examination of the context, mechanisms involved in the use and generation of evidence on the Chilean SUT is valuable to identify the best possible evidence, of various forms and around different issues, that is required to achieve the SUT policy goals.

Regarding the Chilean SUT context, the analysis showed that elements of institutional and organisational framework, as well as the technical supervision, funding structure, and information system, constrain and shape the possibilities of moving toward an evidence-based SUT. The implications of mainly locating this policy within an agency (SENDA) that reports to the Ministry of Home Affairs and Public Security, as occurs in other Latin American countries, are paradoxical. Even when it raises concerns about the prevalence of a security approach to treatment over a health approach that enables EBP, the fact is that it has allowed a resource injection and technical expertise that would not have occurred if SUT had been maintained as just another mental health program in Chile.

However, there are still multiple coordination challenges between SENDA and the Ministry of Health. Among all, this institutional fragmentation results in inequities in treatment provision quality and a lack of a unified information system that allows for generating robust and local evidence, partly because of differences in institutional agendas (Lancaster, 2014). Poor coordination of care across organisational boundaries, as well as the fragmentation and duplication of functions, are a leading cause of quality failure in health services not only in Chile but globally (Greenhalgh et al., 2009). Even so, we must recognise that this Chilean institutional structure has managed to leave behind treatment intervention models that might threaten patients' rights, to integrate international EBP and standards, which today are understood as the minimum floor of Chilean SUT.

What is considered 'evidence' is rarely articulated, and this work presents some insights. Our analysis of mechanisms suggests that 'evidence' is understood in Chile in narrow terms, as 'good' evidence. It hides a gold standard expectation (e.g., RCTs) in national research that clouds other methodological possibilities and research questions that would contribute significantly to improving and informing SUT policy. Policy and decision-makers discourse may often dismiss evidence on the fidelity with which EBP are implemented and how they are adapted to users' specific needs in the different Chilean territories, or users' opinions. Several studies have shown that even the "best scientific evidence" does not have a smooth, uncontested flow into practice (Bergmark & Karlsson, 2020; Björk, 2016; Greenhalgh et al., 2009). Additionally, the mistrust-based contract logic as an effect of the bidding system on the SUT policy base, overemphasises the focus on outcomes and disregards attention to the EBPs (Storbjörk & Stenius, 2019).

When analysing the outcomes, our findings point to the necessity of generating local evidence as a valuable insight that might inform SUT policy, which implies overcoming the installed practice of merely transferring evidence from abroad. Some literature problematises the goal of knowledge "transfer" (not "exchange") from the North to the South, indicating that Northern research threatens to undermine the legitimacy of whatever evidence is produced outside of its limits (Bergmark & Karlsson, 2020; Björk, 2016). The "universal" evidence-based formula is assumed to improve SUT response, but national and subnational barriers, socio-cultural and political traits, as well as the reasons for the current lack of evidence illustrated in the Chilean case, are valuable for LMICs, as they are under-researched (Bartlett et al., 2014; Klingemann, 2020).

Conclusions

Our findings warn about the limitations of embracing the "*myth of EBPM*" (Cairney, 2022). Improving a health policy as Chilean SUT, requires additional types of evidence (not just 'good' evidence or evidence of intervention effect) that consider the different elements and research questions- related to context and mechanisms beyond outcomes-that are *appropriate* to strengthen the policy and achieve its goals (Parkhurst & Abeysinghe, 2016). Moreover, decision-makers in contexts of limited recourses may need to re-frame the notion of "evidence" imported from abroad, to consider learnings and findings from a broader range of scientific strategies (quantitative and qualitative) that contribute to improving complex systems, such as SUT. This also allows for the emergence and legitimisation of evidence from the South, distinct from the predominant epidemiological, institutional context, and mechanisms of the North (Bergmark & Karlsson, 2020).

The prior does not mean that scientific rigour or the hierarchies of evidence have no relevance in the policymaking of SUT. Rigour and quality should always remain important, but methodological quality standards may derive from the appropriate sciences that generate such evidence (Parkhurst & Abeysinghe, 2016). For instance, if a user's opinion survey is considered important for decision-making, an assessment of statistical power, reliability, and external validity is expected.

This study exemplifies how methodological approaches such as case analysis can provide a powerful heuristic alternative contributing to the global mental health debate, specifically to questions about universality versus cultural specificity of evidence, the fidelity-adaptability dilemma (Bartlett et al., 2014), as well as the rivalry between the medicalisation and criminalisation approaches to drug use (Björk, 2016). However, it is imperative to perform further "South" research to think about the kind of evidence on SUT needed to fill the knowledge gap from new and more diverse findings.

Ethics approval

This study protocol was conducted in the context of Fondecyt Grant 1191282, which was reviewed and ethically approved by the Institution Review Board at Universidad Mayor, Chile.

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Declarations of Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

CRediT authorship contribution statement

Mariel Mateo Pinones: Conceptualization, Formal analysis, Methodology, Writing – original draft. **Andrés González-Santa Cruz:** Writing – original draft. **Rodrigo Portilla Huidobro:** Writing – review & editing. **Alvaro Castillo-Carniglia:** Funding acquisition, Conceptualization, Methodology, Writing – review & editing.

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