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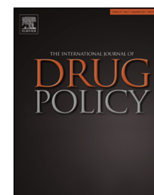

Research paper

Making change happen: A case study of the successful establishment of a peer-administered naloxone program in one Australian jurisdiction

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ABSTRACT

Analysis of how policy processes happen in real-world, contemporary settings is important for generating new and timely learning which can inform other drug policy issues. This paper describes and analyses the process leading to the successful establishment of Australia's first peer-administered naloxone program. Within a case study design, qualitative data were collected using semi-structured interviews with key individuals associated with the initiative ($n = 9$), and a collaborative approach to data analysis was undertaken. Central to policy development in this case was the formation of a committee structure to provide expert guidance and support. The collective, collaborative and relational features of this group are consistent with governing by network. The analysis demonstrates that the Committee served more than a merely consultative role. We posit that the Committee *constituted* the policy process of stakeholder engagement, communication strategy, program development, and implementation planning, which led to the enactment of the naloxone program. We describe and analyse the roles of actors involved, the goodwill and volunteerism which characterised the group's processes, the way the Committee was used as a strategic legitimising mechanism, the strategic framings used to garner support, emergent tensions and the evolving nature of the Committee. This case demonstrates how policy change can occur in the absence of strong political imperatives or ideological contestation, and the ways in which a collective process was used to achieve successful outcomes.

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Introduction

Multiple accounts have been put forward in the policy literature to conceptualise and explain the way policy gets made (for discussion see Colebatch, 1998; Nowlin, 2011; Ritter & Bammer, 2010; Ritter & Lancaster, 2013; Sabatier, 2007). Central in many of these accounts is an interest in the mechanisms by which policy change can occur, and the contribution of 'policy actors' to that change. Policy change may occur as a result of direct government action, through a process of consultation with stakeholders by government, or through community-led action involving networks of stakeholders, interest groups and citizens. While much has been written about the role of government as an authoritative decision maker and 'architect' of policy change, attention has turned to the significant role of non-government actors in affecting policy change. This is in many ways reflective of the changing notion of governance in today's society, conceptualising the role of government as 'steering' rather than 'rowing' (Osborne & Gaebler, 1992).

The notion of non-government or community-led policy change invokes several theoretical frames of relevance within the context of drug policy reform. The first of these is the 'ladder of participation'. Arnstein's (1969) seminal work conceptualises a typology to encourage dialogue about participation. Each of the eight 'rungs' in the ladder pattern relates to degrees of participation or control in policy activity, ranging from non-participation ('manipulation'), through 'consultation', 'partnership' and up to full 'citizen control' (see Arnstein, 1969, p. 217). This work has been expanded upon, to focus on the value of dynamic processes of involvement (Tritter & McCallum, 2006) and as the basis for the development of principles of 'multi-stakeholder participation' (Hemmati & Enayati, 2002). The multi-stakeholder participation approach aims to bring together the unique perspectives and expertise of relevant stakeholders, so as to generate communication and agreement which brings about change (Hemmati & Enayati, 2002). The notion of multi-stakeholder participation is also consistent with the theory

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of governing by network (Goldsmith & Eggers, 2004). The dated hierarchical 'command and control' models of government have been superseded by networked governance. Policy developments undertaken by government are now characterised by networks of partners. The advantages of governing by network include flexibility, speed, innovation and increased policy reach (Goldsmith & Eggers, 2004). The challenges are, however, noteworthy and include problems of communication, coordination and goal congruence (Goldsmith & Eggers, 2004). Hoppe (2010) also draws attention to the role of network management. In his analysis of policy processes he notes the importance of what he terms 'procedural instruments' (Hoppe, 2010, p. 197) to facilitate networks for both legitimacy and governability, and further considers the implications of this cooperative mode of governing for democracy. Hoppe (2010, p. 19) has argued for a responsive system of governance involving "better reflexive problem structuring through better institutional, interactive and deliberative designs for public debate and political choice".

The extent to which these notions of network governing and participatory processes are observed in Australian drug policy is the subject of this paper. Case studies offer a method for such an investigation allowing analysis of "a contemporary phenomenon in depth and within its real-life context" (Yin, 2009, p. 18). Previous case studies in the drug policy literature have demonstrated the value of this approach for examining policy processes (see Hughes, 2009; Kübler, 2001; Lancaster, Ritter, & Colebatch, 2014;Lenton, 2004; Monaghan, 2008; Small, Palepu, & Tyndall, 2006; Tieberghien, 2013; Uchtenhagen, 2010; Wälti & Kübler, 2003; Wälti, Kübler, & Papadopoulos, 2004).

The case study for examination in this paper is the recent successful establishment of Australia's first program to make naloxone available to potential opioid overdose witnesses. Naloxone (trade name, Narcan®) is a short-acting opioid antagonist, which temporarily reverses the effects of opioids and respiratory depression. It has been used for over 40 years by medical professionals, particularly in emergency medicine, and has been shown to be safe, reliable and effective (Dietze & Lenton, 2010). For more than two decades, researchers have argued that naloxone should be widely available to potential overdose witnesses, particularly people who inject drugs, to help prevent morbidity and mortality associated with opioid overdose (Darke & Hall, 1997; Lenton, Dietze, Degenhardt, Darke, & Butler, 2009; Strang, Darke, Hall, Farrell, & Ali, 1996; Strang & Farrell, 1992).

From the mid to late 1990s Australia experienced an increase in heroin supply, which was accompanied by greater prevalence of heroin use and a rapid escalation in incidence of heroin-related overdose deaths (Degenhardt, Day, Gilmour, & Hall, 2006). The rising number of heroin overdoses was of great public concern, with newspaper editors even publishing a 'heroin toll' alongside the road toll, under the heading 'stop the carnage' (Lancaster, Hughes, Spicer, Matthew-Simmons, & Dillon, 2011). In this critical context, policy makers, researchers and advocates sought strategies to respond to heroin-related overdoses. Increasing the availability of naloxone for administration by peers and families was one strategy considered at this time (Australian National Council on Drugs, 2001; Lenton & Hargreaves, 2000; Lenton, Stockwell, & Ali, 1997). The idea of peer-administered naloxone was raised by researchers in the academic literature and put forward by advocates at a range of drug strategy groups and consultation forums in Australia. However, Australian heroin markets changed suddenly at the end of 2000 (a change which has been the subject of extenstive analysis e.g. Degenhardt et al., 2006; Degenhardt, Reuter, Collins, & Hall, 2005; Dietze & Fitzgerald, 2002; Rouen et al., 2001; Weatherburn, Jones, Freeman, & Makkai, 2003). The associated sudden decline in heroin overdose incidence, and the lack of a perceived 'crisis', meant that discussion of an Australian trial of peer-administered naloxone waned. While peer-administered naloxone programs were not implemented anywhere in Australia in the decade following the sudden heroin shortage, programs were being considered and began to be rolled out internationally (see Enteen et al., 2010; Galea et al., 2006; Kim, Irwin, & Khoshnood, 2009; Maxwell, Bigg, Stanczykiewicz, & Carlberg-Racich, 2006; McAuley, Best, Taylor, Hunter, & Robertson, 2012; Piper et al., 2007, 2008; Seal et al., 2005; Strang, Bird, & Parmar, 2013; Strang et al., 2008, 1999; Tobin, Sherman, Beilenson, Welsh, & Latkin, 2009; Walley et al., 2013).

The case examined herein thus provides an example of how drug policy development occurs in a time of 'non-emergency' (that is, in the absence of an acute 'crisis' or heightened political and media concern, which is not to say that overdoses were not occurring). Since its establishment in December 2011, the program has provided naloxone on prescription and training in intramuscular naloxone administration for people who inject opioids (and their family and friends) within the context of a comprehensive overdose prevention and management education program. Particular priority populations were identified as the focus for the program including people exiting prison or treatment programs, and Aboriginal and Torres Strait Islander people. Recruitment and program delivery is led by the local peer-based drug user organisation. The program was funded for an initial two-year period, and is currently being evaluated.

Method

Within the single case study design (Yin, 2009), qualitative data were collected using semi-structured interviews with key individuals associated with the initiative (primarily members of a circumscribed group which shall be referred to as 'the Committee'). In total nine interviews were conducted (via telephone or in person), sampling participants from across the different professional organisations who contributed their expertise to the initiative. An open-ended and flexible approach was taken to the interview format, to explore key concepts with participants. Interviews ranged in length from 30 min to over 2 h, and were audio-recorded and transcribed verbatim. Participants were given the opportunity to review their transcripts for the purposes of verifying accuracy, correcting errors and providing clarifications. Preliminary data analysis was undertaken by the authors using an inductive, data-driven approach (Braun & Clarke, 2006). Qualitative data analysis techniques were used to identify, analyse and report patterns within the data (Braun & Clarke, 2006; Coffey & Atkinson, 1996). More fulsome analysis was then undertaken collaboratively. All participants were invited to attend a face-to-face meeting to discuss the data, review the authors' preliminary interpretation and generate new insights. To produce a dialogue between the participants and the authors, participants were provided with an outline of the preliminary themes and de-identified data extracts. Participants' reflections were later compared and contrasted with our initial analysis of the data so as to refine our interpretation. New concepts emerging from these discussions were noted. All participants were also invited to comment on an initial draft of this paper. As this case study documents a contemporary process which is still underway, anonymity has been protected by not disclosing specific details relating to the program under examination nor the names of the organisations involved.

Results

Central to policy development in this case, and the focus of this paper, was the formation of a Committee as a 'collective' structure: the collaborative and relational features of this group (who was involved, how they worked together, and what strategic actions

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