The Politics of Partnership: The Role of Non-Government Organisations in Australian Drug Policy

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Abstract

The concepts of ‘partnership working’ and ‘intersectoral collaboration’ have become increasingly central to contemporary policy discourse on drugs and crime in Western liberal states, and the non-government sector now plays an integral role in the drug policy systems of many countries. Governments have actively sought to partner with non-government organisations in addressing drug problems and formulating effective drug policy. There has, however, been little empirical investigation of non-government policy work and their relationships with the bureaucratic state in the drugs field. This thesis responds to this gap by providing an account of the development of the idea of government/non-government ‘partnerships’ in the Australian drugs field, and presents new data on the broader role of non-government organisations in drug policy.

Informed by governmentality and critical policy studies literature, this thesis adopts a qualitative approach that engages with three major sources of data: 1) Primary governmental documents including national and state and territory drug policy documents; 2) semi-structured interviews with 19 representatives from Australian non-government organisations; and 3) documents produced by non-government organisations.

A genealogy traces the historical, political and social context of the emergence of ‘partnerships’ discourse in Australian drug policy at the national level. The findings suggest that whilst there has long been an association between governments and the non-government sector in this area, the rise of neoliberal political rationalities of government from the 1980s provided the conditions for the proliferation of ‘partnerships’ rhetoric in Australian drug policy.

This historical work provides a foundation for a thematic analysis of contemporary policy documents and interviews with key informants involved in the non-government drug and alcohol sector. The results of this analysis demonstrate the differential effects of neoliberal rationalities
of ‘governing at a distance’ on the Australian drugs field. On the one hand, neoliberal economic frames have enabled the growth of non-government organisations’ activities in service delivery whilst concerns with efficiency, accountability and cost-savings have presented particular challenges for non-government organisations. Quality improvement initiatives have also had a major impact on the drugs field through workforce development and accreditation programs, consumer engagement models and the idea of ‘evidence-based policy’. Neoliberal governance frames have provided a rhetorical space for non-government organisations’ political participation, particularly through the emphasis on partnerships in drug policy.

The realisation of the ideal of partnerships is complicated by the politics of the drugs field. Government/non-government sector partnerships have presented opportunities for non-government organisations to participate in and contribute to governance instruments such as consultation processes and stakeholder reference groups and committees. This has seen a move towards more collaborative approaches to policy-making, as opposed to critical public advocacy. Despite these practices, participants in this study generally reflected the idea that ‘partnerships’ in the policy process remained more of a theory, or goal, than a reality of the current political environment. Government actions have acted to undermine representation of the non-government sector in national drug policy discourse. Changes to governance forums at the national level, along with the defunding of the national peak body representing the alcohol and other drug sector, have limited the capacity of the non-government alcohol and other drug sector to contribute to national drug policy debate. The research argues that the politics of the drugs field shape inclusion and exclusion in policy processes, and result in gaps between the policy goal of ‘partnership’ and what is actually implemented.

A focused analysis of recovery policy in the Australian context provides further qualitative detail on how non-government organisations contribute to and shape drug policy. It explores the way international policy ideas about ‘new recovery’ were negotiated in the Australian context,
highlighting the importance of historical, political and social contingencies in shaping the process of policy learning. Non-government organisations contributed to the translation of recovery policy in the Australian context by negotiating some of its more controversial elements — namely the tensions between abstinence and harm reduction — to fit with the overarching policy framework of harm minimisation.

This thesis contributes to new knowledge by providing qualitative insight into the role of non-government organisations in the drugs field, their relationships with governments and others in this policy field, and the factors that both facilitate and constrain their ability to contribute to drug policy across Australian jurisdictions.
Statement of Originality

This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

_____________________________
Natalie Thomas
### Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADCA</td>
<td>Alcohol and other Drugs Council of Australia</td>
</tr>
<tr>
<td>ADF</td>
<td>Alcohol &amp; Drug Foundation</td>
</tr>
<tr>
<td>AFADD</td>
<td>Australian Foundation on Alcoholism and Drug Dependence (later ADCA)</td>
</tr>
<tr>
<td>ATODA</td>
<td>Alcohol, Tobacco and Other Drug Association of the ACT</td>
</tr>
<tr>
<td>AIVL</td>
<td>Australian Injecting and Illicit Drug Users League</td>
</tr>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>ANACAD</td>
<td>Australian National Advisory Council on Alcohol and Drugs</td>
</tr>
<tr>
<td>ANCD</td>
<td>Australian National Council on Drugs</td>
</tr>
<tr>
<td>AOD</td>
<td>Alcohol and other Drugs</td>
</tr>
<tr>
<td>ATDC</td>
<td>Alcohol Tobacco and other Drug Council Tasmania Inc</td>
</tr>
<tr>
<td>BBV</td>
<td>Blood-borne Virus</td>
</tr>
<tr>
<td>FRATADD</td>
<td>Foundation for Research and Treatment of Alcoholism and Drug Dependence of New South Wales</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>IGCD</td>
<td>Intergovernmental Committee on Drugs</td>
</tr>
<tr>
<td>MCDS</td>
<td>Ministerial Council on Drugs</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Government Organisation</td>
</tr>
<tr>
<td>NTCOSS</td>
<td>Northern Territory Council of Social Service</td>
</tr>
<tr>
<td>NDS</td>
<td>National Drug Strategy</td>
</tr>
<tr>
<td>QNADA</td>
<td>Queensland Network of Alcohol and Other Drug Agencies</td>
</tr>
<tr>
<td>SANDAS</td>
<td>South Australian Network of Drug and Alcohol Services</td>
</tr>
<tr>
<td>TC</td>
<td>Therapeutic Community</td>
</tr>
<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>VAADA</td>
<td>Victorian Alcohol &amp; Drug Association</td>
</tr>
<tr>
<td>VFADD</td>
<td>Victorian Foundation for Alcoholism and Drug Dependence</td>
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WANADA Western Australian Network of Alcohol and other Drug Agencies
WHO World Health Organisation
Acknowledgements

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Chapter 1: Introduction

The manufacture, distribution and consumption of illicit drugs is a worldwide phenomenon associated with a seemingly endless array of problems — homelessness, crime, mental health problems, bloodborne viruses and other health problems, to name just a few. Issues related to the distribution, sale and consumption of illicit drugs are represented as problems requiring increasingly complex, co-ordinated and multilateral policy responses (Ritter & Berends, 2016). Owing to this complexity, ‘partnership working’ and ‘stakeholder consultation’ are now mandatory features of most drug policy-making processes (Roberts, 2014). A diverse range of actors are now involved as stakeholders in contemporary drug policy-making processes, including medical experts, law enforcement, academics, non-government organisations, service providers and people who use drugs (Edwards & Galla, 2014; MacGregor, Singleton, & Trautmann, 2014; Rhodes, 1996; Roberts, 2014; Zampini, 2014).

Accordingly, the role of particular stakeholders in the policy process has received considerable empirical and theoretical attention within recent drug policy literature. The contemporary drug policy literature is now replete with examples exploring the themes of governance, partnerships and stakeholder dynamics (Edwards & Galla, 2014; MacGregor et al., 2014; Rhodes, 1996; Roberts, 2014; Zampini, 2014). This thesis considers the role of one particular stakeholder group in the drug policy process: the non-government, not-for-profit sector.

The political significance of the non-government sector has increased as governments have sought engagement and ‘partnership’ with the non-government sector in the delivery of health and welfare services — including drug treatment and intervention services — and in the formulation of effective policy (Alcock, 2010; Goddard, 2006; Head, 2007, 2011; Hughes, Lodge, & Ritter, 2010; Keevers, Treleaven, & Sykes, 2008; Mold & Berridge, 2008; Mold & Berridge, 2010; Ritter, Lancaster, Grech, & Reuter, 2011). This promotion of partnerships between the state and non-government sector in the drugs field has not occurred in a vacuum — partnership working can be linked with wider trends observed in Western states towards models of ‘community engagement’, collaboration, and
participatory mechanisms in contemporary policy environments (Keever et al., 2008). There is now a growing empirical and theoretical literature documenting and analysing these trends in criminal justice and drugs policy towards the mobilisation of non-state actors to accomplish policy aims and goals (Hellman, Berridge, Duke, & Mold, 2015; Mold & Berridge, 2008; Mold & Berridge, 2010; Thom et al., 2011; Thom, Herring, Bayley, Waller, & Berridge, 2013b). This thesis seeks to understand the role of the non-government sector in Australian drug policy against this broader trend towards ‘decentred’ governance. In this chapter, I introduce the major lines of investigation considered in this thesis and provide important background information for understanding the analysis presented in the chapters ahead. The following section frames the historical and political context of the non-government sector’s role in Australian society, and the Australian drug policy environment in particular.

**Historical and Political Context**

In Australia, non-government organisations have played an important role in providing charity and social services since white settlement. Hudson (2009) observes that “early colonists and their wives brought with them middle class notions of charity and experience of charitable organisations in Great Britain” (p. 2). Religious organisations in particular were significant in the early years of the colony (Camilleri & Winkworth, 2005; Hudson, 2009). These organisations offered charitable relief to the poor, and provided for the social welfare, health and recreation of the colony (Camilleri & Winkworth, 2005; Hudson, 2009). In the early stages of the colony, the bureaucratic state was not well developed. Lyons (2001) observes that in the 19th Century, rather than providing welfare services directly, the state encouraged and supported the formation of non-profit organisations to provide services for the poor and the sick. Governments financially supported these organisations, often subsidising them on a dollar-for-dollar basis — or higher than this — into the 20th Century (Lyons, 2001). Government subsidising of non-profit organisations continued with the Liberal-Country Party government, in office from 1949 until 1972 (Lyons, 2001).
The 1970s marked a high water point in terms of Australian social services (Harris & McDonald, 2000). At the federal level, the then incumbent Whitlam Labor Government (1972 to 1975) increased state funding for a range of social services (Harris & McDonald, 2000). It encouraged the formation of new non-profit, community-based organisations, and provided them with government funding to deliver an array of social services, including services for older people, children, and homeless people (Lyons, 2001). This period saw the expansion of community service non-government sector organisations. State and territory governments also began funding these organisations. The expansion of government funding for community service non-profits continued into the 1980s and early ‘90s, albeit at a reduced rate. The Hawke-Keating federal Labor government (1983-1996), influenced by neoliberal and managerial ideas, used the non-profit sector to deliver government mandated social policy initiatives (Crane, 2003; Lyons, 1998, 2001); including for example, welfare to work programs (Wright, Marston, & McDonald, 2011). Between the 1990s and 2010s, successive Australian governments have embraced these techniques of neoliberal government.

Discourses of ‘collaboration’, ‘networks’ and ‘partnerships’ are hallmarks of neoliberal policy (Keevers et al., 2008). In Australia, these ideas have guided government thinking for the past three decades or so. Throughout the 1980s and 1990s — the era of the Hawke-Keating Labor governments — principles of managerialism and rationalisation influenced the Australian government to use models of competition and collaboration in their service delivery systems (Wanna, 2008, p. 6). This saw the introduction of wide-spread contracting, funding, and purchase-provider systems to manage service delivery (Wanna, 2008). Increasingly, collaboration has involved more complicated and active forms of relationships, both across government at all levels (e.g. ‘whole-of-government’ discourse), and between governments and non-state actors including businesses, communities, and the non-government sector. This is often referred to as governments delivering services in ‘partnership’ with the non-government sector or private sector (Carey & Riley, 2012). This thesis argues that the role of non-government organisations in contemporary Australian drug policy has been shaped by these wider trends towards forms of ‘advanced liberal’ government.
Australian Drug Policy Environment

Australia has a federal system of government whereby power is divided between the Commonwealth Government — also called the Federal or national government — and the six state governments of Queensland, Victoria, New South Wales, Western Australia, South Australia and Tasmania. The Commonwealth of Australia was formed in 1901 when the British Parliament passed the Commonwealth of Australia Act 1900, under which the former colonies of Australia were united as states in a federation. Clause 9 of the Act is the Australian Constitution. The Constitution sets out the rules for the relations between the different levels of government, and outlines the powers ascribed to the Commonwealth Government and the state governments. The powers of the Commonwealth Government are laid out in the Australian Constitution. The Commonwealth Government is responsible for national affairs, with its key areas of responsibility pertaining to: defence and foreign affairs; economic and fiscal matters; immigration; as well as social services and pensions (Ryder, 2008). State governments have powers over state matters, including education, health, police and criminal justice, and community services (Ryder, 2008). The Commonwealth or federal government is also involved in matters relating to education and health, mainly through the provision of funding to state and territory governments (Ryder, 2008). For a detailed explanation of how Australia’s federal system of government influences drug policy, see Ryder (2008). In what follows, I provide a brief outline of the Australian drug policy environment as context for the current study.

Considering that Australia has one of the highest rates of consumption of illegal drugs in the world (United Nations Office on Drugs and Crime, 2015), drug policy is an important area of government and non-government action. Since the 1980s, drug policy in Australia has been guided by the National Drug Strategy, introduced as the National Campaign Against Drug Abuse (NCADA) by the Hawke government in 1985. The state and territory governments are also required to develop and implement their own drug strategies, however the national policy framework — in the form of the National Drug Strategy — provides overall guidance. Harm minimisation has been the overarching framework of Australian drug policy since 1985 (Ritter et al., 2011). While the interpretation of the term ‘harm
minimisation’ has been somewhat fluid across manifestations of the national drug strategies, the underlying idea of minimising harms caused by drug use has been retained. In the most recent National Drug Strategy 2010-2015, harm minimisation incorporates the ‘three pillars’ of supply reduction, demand reduction, and harm reduction:

- demand reduction to prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the misuse of alcohol and the use of tobacco and other drugs in the community; and support people to recover from dependence and reintegrate with the community;
- supply reduction to prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and control, manage and/or regulate the availability of legal drugs; and
- harm reduction to reduce the adverse health, social and economic consequences of the use of alcohol, tobacco and other drugs (Ministerial Council on Drug Strategy, 2011, p. ii).

To tackle these three key areas, national drug policy has focused on co-operation across all levels of government, across government agencies, and across sectors.Whilst the states and territories of Australia must develop their own drug policy frameworks, they must be in line with the National Drug Strategy and the framework of harm minimisation.

Drug interventions can take many and varied forms (Ritter & McDonald, 2008). Responses to drugs occur at different levels, including the global, national, state, and local level (Ritter & McDonald, 2008). Since the introduction of the international drug control system during the early 20th Century, the laws, instruments and actors involved in the regulation of illicit drugs have proliferated. Interventions can usefully be divided into four areas: law enforcement, prevention, treatment, and harm reduction (Ritter & McDonald, 2008). Law enforcement responses most closely correspond to the harm minimisation pillar of ‘supply reduction’, and includes responses such as international treaties, prohibition, border interdiction and customs control, and policing practices such as crackdowns and raids. Prevention and treatment correspond to the ‘demand reduction’ pillar of harm minimisation. Prevention interventions include mass media campaigns, school-based drug education programs, drug action teams (DATs), and
other drug education programs (Ritter & McDonald, 2008). Treatment includes pharmacotherapy, brief interventions, withdrawal management and detoxification, counselling, therapeutic communities and residential rehabilitation, case management, and peer-based recovery and self-help groups such as Narcotics Anonymous. Harm reduction services include needle and syringe programs, peer-led information programs (such as safer injecting education), overdose prevention programs, blood-borne virus education and supervised injecting facilities (Ritter & McDonald, 2008).

The non-government sector plays an important role in Australian drug policy, particularly in the delivery of drug and alcohol services and interventions that come under the banners of ‘demand reduction’ and ‘harm reduction’. A large proportion of alcohol and other drug (AOD) services are provided by the non-government sector. Recent surveys indicate that nationally, responsibility for the delivery of drug treatment and intervention services is almost equally shared between the government and the non-government sectors (Australian Institute of Health and Welfare, 2012, 2014; Roche & Pidd, 2010). Non-government sector organisations involved in the drug and alcohol sector in Australia perform and administer a diverse array of functions, activities and services — some are involved in advocacy, support, counselling services, prevention, harm reduction services, therapeutic communities and other drug treatment. Organisations often perform a combination of these activities.

**Drug Policy Partnerships**

Since the 1980s, Australian drug policy has been explicitly based upon a partnership approach (Ritter et al., 2011), requiring coordination and cooperation across government agencies, and across government and non-government sectors. As such, policy partnerships are intended to extend not just between different government agencies, but also across the public, private and non-government sectors. In this context, the non-government sector is an important partner in informing policy under the National Drug Strategy, at least at the level of rhetoric (Ritter et al., 2011).

Within Australian drug policy, this idea of partnerships signifies an emphasis on co-operative networks in which the non-government sector represents one component within a broader alliance of multiple
stakeholders, including the research community, the state, international regulatory bodies, as well as the general public more broadly (Ritter et al., 2011). The use of the partnership approach in this context also implies that the non-government sector has a role to play in drug policy as well, not just in service delivery. Indeed, the non-government sector’s important role in service provision may, at least theoretically, provide them with a greater level of input into the policy process (Casey, 2004; Ritter et al., 2011). However, scholarly research on government/non-government relations indicates that the situation may be decidedly more complicated than this. Service delivery partnerships and contracts have the potential to undermine non-government sector organisations (NGOs) genuine political participation both indirectly — through marginalising advocacy organisations and activities — and directly, through active moves by the state to prevent or control non-government sector advocacy and political participation (Casey & Dalton, 2003, 2006).

To complicate matters further, the views of stakeholders are not homogenous — non-government sector organisations approach drug treatment and policy from a variety of discursive, functional and philosophical positions. To give just a basic example of the diversity of positions from which non-government sector organisations might approach drug policy, there are abstinence-oriented organisations, drug user and peer-support organisations, and harm reduction-oriented organisations (Ritter et al., 2011). This indicates a fundamental tension around what the goals of drug policy should be. It is against this setting that the current study seeks to investigate the notion of government/non-government partnerships and non-government sector engagement with drug policy.

While the role of non-government sector organisations and drug policy advocacy groups in influencing and shaping Australian drug policy has been acknowledged (Hughes, 2009; McDonald, Bammer, & Breen, 2005; Ritter et al., 2011), little work has been done on systematically investigating, mapping or theorising their engagement with drug policy. To date, there are also few studies that investigate how government/non-government relations shape non-government sector engagement with drug policy. This research aims to address these gaps in the literature by providing a critical analysis of non-government sector advocacy and policy work in the drug policy field.
Research Purpose and Research Questions

The overall aim of this research is to document and analyse the role of non-government organisations in the Australian drug policy field and their relationships with government. The idea of ‘partnerships’ between governments and NGOs is now pervasive in drug policy rhetoric at the national and state/territory levels; therefore a key objective of this study is to chart the historical development and contemporary dynamics of ‘partnerships’ in the drug policy field, and the implications of ‘partnerships’ for non-government participation in the policy process. A central goal of this thesis is to highlight how the contemporary role of NGOs in drug policy is contingent on power relations that have been shaped by the historical development of varying problematisations of both the drugs and political fields. In line with this broad purpose, this research seeks to:

1. Chart the relations between government and the non-government sector in the Australian drug policy field.
2. Describe the broad historical, social and political conditions that shape NGOs’ contemporary role in drug policy governance.
3. Understand the different dynamics of government/non-government ‘partnerships’ in the drug policy space and their implications for NGOs’ role in policy.
4. Describe, compare and analyse how NGOs have engaged with drug policy.

To accomplish the broad objectives outlined above, the thesis pursues the following four research questions:

1. What are the key historical, social, and political conditions that have shaped government/non-government relations and the development of ‘partnerships’ in the drug policy field?
2. What are the contemporary conditions shaping the role and work of NGOs in the Australian AOD field?
3. What is the relationship between the rhetoric of government/non-government ‘partnerships’ and the experiences of NGO representatives in drug policy processes?
4. How have NGOs engaged with, and attempted to shape, drug policy?

To answer my research questions, I employed a diverse range of qualitative research methods. The methods used in this study included:

1. Document analysis of primary and secondary sources.
2. Policy analysis, including an analysis of national drug policy documents and state and territory drug policy documents.
3. Semi-structured interviews with 19 representatives drawn from 19 different Australian NGOs.
4. A focused analysis that examines the ways that NGOs engage with and respond to drug policy issues.

The combination of these methods pushed me to examine the problem of government/non-government ‘partnerships’ in the drug policy space from multiple perspectives, allowing for a more comprehensive understanding of the different facets of NGOs’ role in drug policy.

**Research Approach**

This research provides in-depth, qualitative information on the role of the non-government sector in the Australian AOD field and their relations with the state. The thesis offers a critical policy analysis of ‘partnerships’ between the government and the non-government sector in the Australian AOD field. As such, the research is positioned in the field of critical policy studies (Fischer, Torgenson, Durnova, & Orsini, 2015; Orsini & Smith, 2006; Taylor, 2006; Yanow, 2007). Critical policy studies is a broad field, but at its essence it involves the application of critical theory to studying policy and the rejection of positivist or objectivist approaches to policy analysis (Fischer et al., 2015; Orsini & Smith, 2006). Where traditional approaches to policy analysis might ask ‘are government/non-government partnerships effective?’, or ‘how can we evaluate partnerships?’, a critical approach to policy analysis directs us towards questions of meaning and representation (Fischer et al., 2015; Orsini & Smith, 2006; Taylor, 2006; Yanow, 2000, 2007). So whilst traditional approaches to policy analysis treat policy-
making as a process of rational, objective decision-making, critical policy analysis seeks to bring ‘politics’ and power relations back into the analysis. For critical policy analysts, the policy process is characterised by politics, power relations and struggles over meaning. As such, critical policy studies provides an appropriate approach because I am interested here in the representations, meanings and ‘politics’ of government/non-government ‘partnerships’ in policy and in practice.

In this study, I borrow from some of Foucault’s (1991a) tools for analysis, in particular the idea of governmentality, as a lens through which to critically analyse the meanings and power relations underlying the role of NGOs in drug policy. To clarify, this is not a post-structural, post-modern or Foucauldian analysis. Rather, the analysis presented in this study draws most heavily on the way governmentality has been conceived and extended in the social policy and criminological literature — particularly in the criminological work of Garland (1997, 2001, 2014) and Stenson in developing an ‘empirical’ or ‘realist’ governmentality (Lippert & Stenson, 2010; Stenson, 2008). The thesis is situated broadly in the criminological and drug policy literature that takes a critical approach to the study of drugs and crime policy through applying and extending the idea of governmentality.

In a basic sense, Foucault used the term ‘governmentality’ to refer to rationalities of government (Gordon, 1991). Traditional contemporary understandings of the term ‘government’ take the formal administration of ‘the state’ by a governing body as paramount. In the governmentality literature, however, the meaning of the term ‘government’ is described broadly as “the conduct of conduct” (Gordon, 1991, p. 2). Building on this wider understanding of government, Foucault used the term governmentality to refer to a specific way of thinking about government that emerged in the 18th Century. In his lecture entitled Governmentality, Foucault argued that this governmentality is a “very specific albeit complex form of power, which has as its target population, as its principal form of

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1 Dean (2009) provides an explanation of the sense in which Foucault uses this term: “Government is any more or less calculated and rational activity, undertaken by a multiplicity of authorities and agencies, employing a variety of techniques and forms of knowledge, that seeks to shape conduct by working through the desires, aspirations, interests and beliefs of various actors, for definite but shifting ends and with a diverse set of relatively unpredictable consequences, effects and outcomes” (p. 18).
knowledge political economy, and its essential technical means apparatuses of security” (Foucault, 1991a, p. 102). Governmentality scholars have subsequently developed the term by referring to the general meaning of “mentalities of government” (Miller & Rose, 1990, p. 8) or more simply “how we think about government” (Dean, 2009, p. 24). This understanding allows for a wider lens through which to view “the art of government” (Foucault, 1991a, p. 87), directing our attention not just to the rationalities and practices of the state but also to those of non-state actors (Rose, O'Malley, & Valverde, 2006). This understanding extends to the ways in which government seeks to act on “practices of the self”, or the practices of government “that try to shape, sculpt, mobilize and work through the choices, desires, aspirations, needs, wants and lifestyles of individuals and groups” (Dean, 2009, p. 20). In doing so, a governmentality perspective pays attention to the “multiplicity of power relations” (Dean, 2009, p. 8) within modern societies.

Governmentality is concerned with problematisations, and the rationalities, strategies, technologies, and programs of government; how problems and solutions are constituted through discourse, how programs work, and their unintended effects. Governmentality scholars view problematisation as the foundation of modern government (Rose & Miller, 1992). Problematisation in this sense refers to “how governing (broadly conceived) involves problematizing, shaping issues as ‘problems’” (Bacchi, 2015, p. 3). As Bacchi (2015) notes, the use of the term problematisation also signals a critical intent. The contemporary drug policy literature has seen a recent turn to Bacchi’s ‘What’s the Problem Represented to Be?’ approach as a frame for conducting critical analyses of problem representations in drug-related policy (Lancaster, Duke, & Ritter, 2015; Lancaster & Ritter, 2014a; Lancaster, Ritter, & Colebatch, 2014; Moore, Fraser, Torronen, & Tinghog, 2015). The current study does not employ Bacchi’s (2009) methodology directly, but this research can be seen as broadly complementary to the critical drug policy studies literature that uses Bacchi’s (2009) method as a platform for critical analysis of problematisations in the drugs field (Lancaster et al., 2015; Lancaster & Ritter, 2014a; Lancaster et al., 2014; Moore et al., 2015). This critical drug policy literature sees policy not as an objective process of problem definition and resolution but as a problematising activity (Lancaster et al., 2015; Lancaster & Ritter, 2014a; Lancaster et al., 2014). Rather than using Bacchi’s (2009) methodology, this thesis uses
the idea of governmentality as a tool for analysing problematisations in the drugs field, and how these problematisations have shaped meanings of government/non-government partnerships. As an analytic tool for critical policy analysis in the current study, governmentality provides a framework for analysing the interplay of political rationalities, power/knowledge and expertise in policy processes, as well as the historical, social, and culturally contingent nature of policy (Fischer et al., 2015; Lövbrand & Stripple, 2015; McKee, 2009; Shore & Wright, 1997).

**Research Contribution**

This study contributes to drug policy research on governance and stakeholder dynamics by highlighting the role of one set of key stakeholders: non-government organisations. The thesis contributes to the drug policy literature on both an empirical level and a theoretical one, through a detailed qualitative study of the role of NGOs in drug policy. The empirical contribution of the thesis lies in the qualitative documentation of both the historical and contemporary role of NGOs in drug policy, and the presentation of new data relating to their role in policy. The thesis analyses the conditions of possibility for partnerships between governments and NGOs in the drug policy space, by tracing the development of partnership rhetoric in drug policy. It examines some of the empirical realities of NGOs’ role in the drug policy space including some of the challenges of the relationship between NGOs and government in this policy area. Additionally, the thesis makes an original contribution to knowledge by exploring how NGOs engage with drug policy issues through a focused analysis of ‘New Recovery’ in the Australian context. It links empirical, qualitative detail on the role of NGOs in drug policy with broader theoretical analysis about policy and modern government.

**Scope of the Research**

This thesis concentrates mainly on illicit drugs policy; however because the development of illicit drugs policy has been so entwined with the development of thought and policy on alcohol, alcohol policy is referenced briefly at times as is alcohol and other drug (AOD) policy. In the Australian context, the recognition of the problems caused by alcohol has been a key concern in many activities in the drugs
field, with a range of policy targeting both alcohol and illegal drugs (Drew, 2014). The NGOs engaged in advocacy on drugs issues often comment across a broad range of areas, including alcohol policy. This thesis does not provide an exhaustive review of the policy terrain in each state and territory or even policy at the federal level, nor is it a review of all policy activities and projects engaged in by the non-government sector. Rather, it is analytical in its approach, drawing out some key moments and themes in drug policy (Dean, 2002). At times it takes a broad-brush approach because it is necessary to the overall aim of the thesis. It is beyond the scope of this thesis to comment on the merits or otherwise of prohibition policy, although this will be touched on throughout because it has without doubt been an issue shaping and influencing the work of the sector.

**Defining Key Terms**

Before I outline the structure of the thesis, I want to first outline some key terms used throughout this work. Non-government organisations are known by many different names, including third sector organisations, voluntary sector organisations, non-profit organisations, and community-based organisations. Australian organisations do not generally use the term ‘voluntary organisations’ or ‘third sector organisations’ — which appears to be the preferred term in the UK literature — to describe themselves. Indeed, when I embarked on this research study I struggled with choosing the right terminology for this thesis, having first chosen the term ‘third sector organisation’, and then the term ‘voluntary sector’. After reflection, I have chosen non-government organisations here because that is generally how these organisations describe themselves in Australia. Non-profit is also a popular term in Australia.

Like many fields, there is debate about how to define the term ‘non-government organisation’. It is not my intention to engage with this debate, as it is necessary to start somewhere; instead this thesis adopts a purposefully broad definition of non-government organisation (NGO) as “any non-profit-making, non-violent, organized group of people who are not seeking governmental office” (Willetts, 1996, p. 5). This is in line with the definition in the *Dictionary of non-profit terms and concepts* by Smith,
Stebbins, and Dover (2006), which defines a non-government organisations as a “non-profit group, particularly a non-profit organization or association whose classification emphasizes the nongovernmental character of nonprofits” (p. 154). I use the term advocacy in this thesis to refer to “…action taken to further the interests of particular groups and, more directly, politically focussed activity that has the expressed goal of influencing public policy” (Dalton & Lyons, 2005, p. 61).

Similarly, the use of the term ‘policy work’ in this study specifically refers to policy-related activities. Throughout this thesis, I refer to ‘peak bodies’, which are “non-government organisation[s] whose membership consists of smaller organisations of allied interests” (Melville & Perkins, 2003, p. 5); peak bodies provide representation for their membership on key issues. Similarly, I use the term ‘non-profit action’ to refer to action by formal or informal groups to pursue a non-profit goal. The broad framing of activity by NGOs as ‘non-profit action’ allows me to capture some of the diverse forms of organised non-governmental activity around drugs, including voluntary groups, self-help groups, drug user groups, religious organisations, peak bodies, service organisations, and prevention and education organisations.

There will be sections where the language in this thesis changes to reflect how particular issues have been referred to historically, particularly where quotations are used from historical sources. For example, the non-profit, non-government sector is referred to by various names in various sources, and where possible the original terminology has been retained; changes in language used to describe key objects are an important part of this study. Similarly, whilst the majority of this thesis will use person-centred language and will conform to the recommendations about language outlined by the International Society of Addiction Journal Editors (2015) regarding the avoidance of stigmatising language (such as drug abuse, abuser, misuse, or addict), owing to the historical development of the drugs field and changes in language, terms that may contradict these recommendations may appear throughout this thesis.
Chapter Outline

This thesis is presented in eight chapters. This chapter has outlined the research problem, the purpose of the study, and the research questions and will outline the structure of the study. Chapter 2 situates my study within the broader literature on governance and policy studies, drug policy and NGOs. It also introduces the theoretical framework guiding the study using ideas from governmentality studies, network governance and the drug policy literature. Chapter 3 describes the methodology, research design and methods used in this research. It further explains how governmentality and the critical policy studies literature informed the methodological approach of the study.

Chapters 4 through 7 present the results of my research. Chapter 4 presents the ‘conditions of possibility’ for the emergence of the contemporary discourse of ‘partnerships’ in the Australian drugs policy field. It traces the development of partnership rhetoric in national drug policy, outlining the key historical, social and political dynamics that have shaped government/non-government relations in this field. In essence it presents a genealogy of government/non-government ‘partnerships’, and explores relationships between NGOs and governments in Australian drug policy at the national level.

Chapter 5 builds on the work done in Chapter 4 by documenting the ways that neoliberal rationalities have shaped the conditions impacting on NGOs’ role in the Australian drugs field. It presents an analysis of some of the major problematisations, discourses and practices in the contemporary field through a discussion of four major discourses — economic, scientific, instrumental and communicative — that have shaped the way the problem has been thought about and responded to. The chapter highlights some of the effects of funding regimes on NGOs in the AOD sector, and links some of the efforts to promote quality improvement in the sector with advanced liberal governmentality and ‘governing at a distance’. The chapter establishes that contemporary governments at the state and territory level and the national level have etched out a place for NGOs through a communicative discourse that situates the role of NGOs in drug policy governance in terms of ‘partnerships’.
Chapter 6 problematises the communicative discourse of ‘partnerships’ by investigating some of the key dynamics impacting on NGOs participation in the drug policy space, based on an analysis of the views of representatives from NGOs. The chapter is broken into a discussion of three broad areas. The first explores some of the justifications for and potential contributions of NGOs in drug policy processes. The second section explores some of the realities and tensions shaping the policy role of NGOs, including a discussion of drug policy politics, NGOs relationships with the bureaucratic state, and opportunities for NGOs in the policy process. The chapter then explores a number of challenges to the policy role of NGOs, including power differentials, the problem of tokenism and changes to forums for the representation of NGOs in drug policy processes. Overall, it considers partnership policy in practice, and the gaps between the policy intention of partnership and relationships in practice.

Chapter 7 provides a focused analysis of New Recovery in the Australian context to further investigate the different dynamics of how NGOs contribute to drug policy. The chapter draws on the ideas of ‘policy transfer’ and ‘policy translation’ to frame the analysis. It explores the international context of ‘new recovery’, the degree of policy transfer, and the influence of NGOs in the policy transfer process. Ultimately, the chapter highlights the political nature of the process and how NGOs contributed to the negotiation and translation of policy ideas in the domestic policy context.

In Chapter 8, I bring the major themes from chapters 4, 5, 6, and 7 together and discuss them in relation to the broader literature on drugs, policy, politics and governance. I outline how I have addressed my research questions and discuss the broader implications of my study.

The thesis argues that the rise of neoliberal techniques of government has provided challenges and opportunities for NGOs in the Australian drug policy system. The discourse of ‘partnerships’ has opened up the rhetorical space for the recognition of NGOs as legitimate actors in policy processes, and governance instruments in the drugs field have encouraged the inclusion of non-government actors in policy processes. Political factors, however, have presented numerous challenges to the realisation of government/non-government ‘partnerships’ at the policy level. The popularisation of neoliberal
techniques of governing has led to discourses and practices that both facilitate and constrain the political activity of NGOs in the drug policy space, which this thesis explores.
Chapter 2: Literature Review and Theoretical Framework

This chapter sketches the conceptual grounding of the thesis and situates the research in the broader literature on non-government organisations and drugs policy. This thesis is interdisciplinary and so draws on a number of different literatures. It does not have one ‘theoretical centre’, but is influenced primarily by the following areas of scholarship: governmentality and governance studies — in particular, the way these concepts have been developed in the criminological literature — critical policy studies, literature on non-government organisations and scholarship on crime control, drugs regulation and policy. The chapter begins with a discussion of government and policy-making in contemporary Western states, where I seek to outline the potential relevance of ideas from the governmentality studies, governance, and critical policy studies literature to understanding the contemporary role of NGOs in drug policy. Second, the key themes from the literature on government-non-government relations are discussed, paying particular attention to power relations between the sectors. The third part of this chapter focuses on the drugs policy literature and develops a framework for understanding how drugs are constituted and addressed as ‘policy problems’ and how different types of non-government organisations have developed in the Australian drug and alcohol field. In the fourth section, I pay attention to how drug policy problems are targeted through partnerships, the involvement of different stakeholders in the policy process and non-government advocacy. The chapter concludes with a summary of the major themes and omissions in the literature, and outlines the areas that will be addressed in this study.

Government, Governance and Policy in Contemporary Western States

Over the last several decades, a substantial amount of research has addressed changing approaches to government, governance and policy-making in Western liberal democracies. The ascendancy of neoliberalism has received significant attention in the literature analysing these social changes. The idea of ‘neoliberalism’ is central to the conceptual framework of this thesis. The concept of ‘neoliberalism’, is not well-defined in the literature, and it can take many forms (Mudge, 2008). Mudge (2008) argues
that neoliberalism has three ‘faces’: intellectual, bureaucratic and political. The intellectual basis of neoliberalism is most apparent in one key principle of neoliberal thought: “the superiority of individualized, market-based competition over other modes of organization” (Mudge, 2008, p. 707). Its bureaucratic form consists of the policies implemented by neoliberal governments, including but not limited to privatisation of public assets, market deregulation or depoliticisation, and liberalising economic policies targeted at opening markets to multiple service providers (Mudge, 2008). Neoliberalism as politics extends beyond mere left-right party distinctions (Mudge, 2008). Although neoliberalism is generally associated with the political ‘right’, governments from both the ‘left’ and the ‘right’ have pursued neoliberal policies (Mudge, 2008). Significantly, neoliberal politics and policies have been associated with the push for a minimalist welfare state. Whilst under welfare liberalism — a term used in the governmentality literature — the state is seen as responsible for providing for the health and well-being of its citizens through strategies such as pensions, under neoliberalism the role of the state is instead to facilitate the ‘free-market’, which is seen as capable for providing for the health and wellbeing of citizens. In this way, neoliberalism focuses on individual responsibility and discouraging reliance on the state and welfare provision (Seddon, 2010).

This is not to suggest that we have witnessed a “wholesale paradigm shift” (Seddon, 2007a, p. 337) from welfare liberalism to neoliberalism, to the point where our social, political and economic systems now rest firmly on a basis of pure neoliberal rationality. Indeed, O’Malley (1999b, 2002) rightly warns us not to use ‘neoliberalism’ as an all-encompassing explanatory framework. Instead, following Valverde (1998), we might see the contemporary situation as the operation of numerous hybrid logics, a “piling up of rationalities of governance on top of one another, rather than a shift from one to another” (p. 177). While the welfare state has been reconfigured under the influence of neoliberal ideas, there certainly has not been a wholesale retrenchment of welfare as suggested by some authors but rather a reorienting of welfare as incentive structures to achieve particular styles of neoliberal subjectivity — i.e. enterprising subjects. Spending on health and welfare spending has actually grown over this ‘neoliberal’ period (Fenna & Tapper, 2012).
The rise of a “partnering state” (Larner & Butler, 2005, p. 82) under neoliberal policy has received considerable empirical and theoretical attention not only within criminology, but more broadly in a range of diverse disciplinary fields (Gray, 2013; Larner & Butler, 2005; Stenson & Edwards, 2000; Zimmer, 2010). In analysing the decline of the welfare state and the concomitant rise of ‘neoliberal’ or ‘advanced liberal’ political rationalities, the narrative across this literature largely implies that while government departments still play a role in the delivery of many services, there has been a devolution of responsibility for service delivery onto the community or non-government sector (as well as for-profit companies). This literature also highlights the shift in governments’ role from direct service delivery (or “rowing”, using Osborne & Gaebler’s (1992) nautical analogy) to “steering” or regulating contracts and developing policy (Crawford, 2006). These trends all point to a reshaping of welfare and public service systems in liberal democracies and a change in the underlying relationships between the ‘state’ and civil society. There are, however, a diverse range of approaches to the study of these developments, including the network governance literature and the governmentality literature. Taken together as a conceptual framework for the thesis, these literatures encourage a step away from traditionally state-centred models of analysis, to consider how a range of actors and agencies beyond the state are involved in processes of contemporary governing in the ‘post-welfare’ age (Bevir, 2011; Bevir & Rhodes, 2006; Colebatch, 2009, 2014; Crawford, 2006; Rhodes, 1996; Rose & Miller, 1992).

Sociologies of governance theorists have observed that contemporary governance is achieved not just through the state alone but through complex networks of actors (Rhodes, 1996, 1997). The pioneer of this perspective, Rod Rhodes (1996, 1997, 2007), explains that the British Thatcher governments’ (1979-1990) attempts to marketise the delivery of public and welfare services resulted in the fragmentation of public service systems and the creation of new networks for the delivery of services. For ‘network governance’ scholars, the defining feature of this new style of governing is the “spread of networks” (Rhodes, 2007, p. 1245). This entailed a shift from government to governance through “self-organizing, interorganizational networks” (Rhodes, 1997, p. 53).2 Rhodes (1997) suggests that

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2 For extended discussions of the different meanings and utility of the term governance, see Colebatch (2009, 2014); Rhodes (1996); Torfing and Sørensen (2014).
“governance blurs the distinction between state and civil society” (p. 57). More than ever, the practical implementation — as well as design in some cases — of policy comes down to third parties (businesses, NGOs) who are contracted to deliver services (Rhodes, 1996, 1997; Shergold, 2008). As a consequence, there now exists a range of interdependencies and extensive policy networks involved in governance processes (Eggers, 2008; Rhodes, 1996, 1997; Shergold, 2008; Wanna, 2008). Shergold (2008) further argues that networks of policy influence are broadening: the provision of policy advice is no longer purely the domain of state officials, with a range of actors including advocacy organisations and ‘think tanks’ now increasingly involved in policy advice.

The sociology of governance literature gains its strength from this capacity to “move beyond state-centric analyses to include a focus on the processes of governance, to highlight the power of non-state actors, and to identify and theorize about the changing forms and institutionalization of political authority” (Sending & Newman, 2006, pp. 651-652). It is limited, however, in its conception of power. Earlier versions of the theory implied that these networks entailed the “hollowing out” (Rhodes, 1994, p. 138) of the state or a transference of power from the state to non-state actors. Although there are definite parallels between the ‘sociology of governance’ literature and the governmentality literature, several governmentality scholars (Rose, 1999; Sending & Newman, 2006) take pains to point out the distinction between the ‘sociology of governance’ and the governmentality approach. These scholars argue that the sociology of governance framework meets with several limitations: first, while it focuses on processes of governance, it lacks the analytic tools to actually study these processes (Rose, 1999; Sending & Newman, 2006); second, research from this perspective has a limited conceptualisation of power, where the increase in power of non-state actors is seen as ‘depleting’ the power of the state (Rose, 1999; Sending & Newman, 2006); and third, while the governance literature supposedly gains its strengths from its ability to highlight the power of non-state actors, its analytical framework is still tied to separation of state and civil society, furthering a preoccupation with the idea and power of the state and the “triad of sovereignty, authority and legitimacy” (Lemke, 2007; Sending & Newman, 2006, 3

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3 Both investigate the changing role of the state, and acknowledge the involvement of a multitude of different actors in ‘governing’. 
Another problem with this literature is its tendency to discuss governance as “institutions and structures alone” (McKee, 2008, p. 185), thus neglecting the role of agendas, ideas and political rationalities in shaping modern governance.

Rationalist accounts that understand neoliberalism as a policy agenda tend to explain neoliberalism as a logical response to the failure of welfare systems under the pressures of the globalised economy and new financial systems (Larner, 2000). The role of government is in improving economic efficiency and increasing states competitiveness in terms of international financial markets. To achieve this ‘policy agenda’, neoliberalism draws on ideas from managerialism and new public management. Major strategies flowing from these ideas include de-regulation, privatisation and market provision of public services (Harvey, 2007; Meagher & Goodwin, 2015; Pollitt, 2003). The rationalist perspective emphasises the agency of key actors such as think-tanks, politicians and policy-makers in advancing this agenda as if it constitutes a “coherent program of things to be done” (Teeple, 2000, p. 169 as cited in Larner, 2000). As Larner (2000) observes, however, the problem with this perspective is that it ignores the popularity and spread of neoliberal ideas across both social democratic and conservative political parties, and the spread of neoliberal ideas around choice and consumption in shaping individual subjectivities. Similarly, the Neo-Marxist literature’s treatment of neoliberalism as ideology falls short because of a lack of attention to the link between the macro context of political economic shifts and micro processes of self-governance and subject formation (Larner, 2000).

**Government at a Distance and Responsibilisation**

The solution to these problems, then is to understand neoliberalism as a form of governmentality that “is both a political discourse about the nature of rule and a set of practices that facilitate the governing of individuals from a distance” (Larner, 2000, p. 6). Mudge (2008) provides a useful working definition of neoliberalism that is consistent with governmentality: “an ideological system that holds the ‘market’ sacred, born within the ‘human’ or social sciences and refined in a network of Anglo-American-centric knowledge producers, expressed in different ways within the institutions of the postwar nation-state and
their political fields” (p. 706). Neoliberalism has been described as stemming from critiques of welfare liberalism centred on the all-encompassing power of the ‘welfare’ state, undue interference from authorities and experts in the lives of citizens⁴ and the inability of the state to successfully provide for social wellbeing (Rose, 1999). Where the ideals of welfare liberalism advocate a far more ‘social’ and interventionist form of government, neoliberalism seeks to address these concerns through a return to classic liberal ideals of minimalist government, the free subject and reliance on market relationships for providing for the social order. The governmental role is to create the ‘environmental’ conditions, through ‘market governance’ techniques such as budgets, audits, and standards, so that ‘the market’, and individuals, are autonomised and responsibilised, and able to regulate themselves (Larner, 2000; Rose et al., 2006). This combined emphasis on market models and the inculcation of individual choice means that, whilst neoliberal governmentality advocates a minimalist bureaucratic state, the actual reach of mechanisms of governance are intensified and extended (Larner, 2000).

In “governing at a distance”, neoliberal forms of government operate through a complex assembly of measures that seek to “link the conduct of individuals and organizations to political objectives” (Miller & Rose, 1990, p. 1). In this way, modern government is “not ‘objectifying’ but ‘subjectifying’” (Garland, 1997, p. 175), seeking to construct a free and active subject who is able to exercise action and make responsible choices in line with the broad targets of governing agencies. Key to this linking of government objectives with individual and group action is the deployment of technologies of the self.⁵ Here, programmes of government encourage subjects towards forms of ethical self-formation that are consistent with the ideal neoliberal subject: a calculating choice-maker and consumer (O'Malley, 1999a; Seddon, 2010). Action at a distance is achieved by encouraging individuals to conform to this ideal neoliberal subjectivity: “individuals are increasingly ‘responsibilized’ and empowered in order that they

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⁴ The disciplinary knowledges of the social sciences (sociology, social psychology, criminology) were instrumental in welfare liberalism, having significant impact on understandings and responses to problems such as addiction, crime and mental illness (Bayer, 1978; Bull, 2002, 2008). These issues were transformed into distinctly social issues, and therefore the domain of the state, working through experts.

⁵ This formation of self-governing subjects is one of the sites where ‘political technologies’ intersect with ‘technologies of the self’, where technologies of the self refer to “processes of self-guidance and the ways in which subjects relate to themselves as ethical beings” (Lemke, 2007, p. 49).
can be governed through their choices as citizen-consumers” (Seddon, 2010, p. 21). Through strategies of responsibilisation, individuals are encouraged to constitute themselves as subjects who are able to make choices consistent with governmental objectives.

Non-state actors and agencies play a central role in the functioning of neoliberal technologies of government by providing individuals with the tools to constitute themselves as neoliberal subjects. In effecting “governing at a distance”, neoliberal forms of rule rely on political power beyond the state:

…political forces can only seek to operationalize their programmes of government by influencing, allying with or co-opting resources that they do not directly control — banks, financial institutions, enterprises, trade unions, professions, bureaucracies, families, individuals (Rose & Miller, 1992, p. 198).

Strategies of responsibilisation are pivotal to the tying of governmental objectives with the actions of these non-state and civil society actors. Garland’s (1996) work on crime control in contemporary society is instructive here. In his descriptive analysis of contemporary strategies of crime control, Garland (1996) noted that modern governments face a predicament in crime control: consistently high crime rates in modernity, and an increasing recognition of the limitations of state criminal justice agencies abilities to respond to crime. He argued that governments have responded to this predicament with both strategies of adaptation (responsibilisation, defining deviance down, and redefining organisational success) and punitive strategies of denial, resulting in a volatile and contradictory policy environment. Garland (1996) argues that governments have increasingly relied on responsibilisation as an adaptive strategy to cope with the limitations of state criminal justice agencies — what he calls the “limits of the sovereign state” — and their inability to respond to crime alone. Examples of the operation of responsibilisation strategies can be found in the establishment of Neighbourhood Watch and local crime prevention programs (Garland, 1996). Non-state actors and agencies such as crime prevention experts and others are central to responsibilisation strategies, serving to provide advice to citizens and government agencies, providing instruction on how they can prevent or control crime. The responsibility for crime control is thus diffused across a range of actors who can persuade citizens to act appropriately. Garland (2001) links these responsibilisation strategies with governmentality and
strategies that seek to ‘govern at a distance’: “The state’s new strategy is not to command and control but rather to persuade and align, to organize, to ensure that other actors play their part” (p. 126). He observes that responsibilisation strategies imply a recognition that the state alone cannot be responsible for the maintenance of social order, and that the institutions of civil society represent a powerful site through which to encourage social processes of order and social control.

Policy, Government/Non-Government Relations, and Advocacy

Although the non-government sector has long played an important role in public welfare, under neoliberalism the way the state positions and funds these organisations has changed (Hancock, 2006; Murphy, 2011). As outlined above, NGOs are increasingly used as a key tool of governance — this is evident in their growing importance in service delivery and policy processes. Contemporary governments increasingly seek to devolve responsibility for service delivery onto the non-government and for-profit sectors, and diverse service sectors have seen the rise of various forms of public-private partnerships (Goodwin & Phillips, 2015; Meagher & Goodwin, 2015). Partnerships can serve a whole range of purposes in public service delivery and policy (Newman, 2001). These can be broadly divided into economic outcomes, program outcomes, and policy outcomes. Partnerships can: reduce costs associated with policy and service delivery through co-ordination and integration, and increase access to financial resources through joint ventures of partners; provide a more holistic approach to public service delivery by improving co-ordination and links between different types of service providers; and contribute to better policy outcomes through the development of new, innovative and effective policy approaches by bringing together a range of stakeholders with different areas of expertise and ways to contribute (Newman, 2001, p. 109). Theoretically, the push towards partnerships and the ‘mixed economy of welfare’ affords non-government sector organisations greater legitimacy in terms of input into welfare and social policy (Casey, 2004; Goodwin & Phillips, 2015; Phillips & Goodwin, 2013). There is a diverse and ever-growing body of literature that focuses on the shifts in government-non-government relations and the increased political significance of NGOs in contemporary society. Here I
review the literature that seeks to understand the changing role of NGOs in contemporary policy-making environments and highlight some of the issues associated with NGO advocacy.

**Views of the Policy Process**

The broad range of theories that offer explanations of the policy-making process makes providing a simple definition of policy, let alone conceptualising policy-making processes, no easy task. Broadly speaking, policy is a plan of action to address a problem; or following Foucault, an attempt at “action on the action of others” (Foucault, 1982, p. 219). Policy is a complex social phenomenon grounded in the historical, cultural, economic and social context in which it is created. It takes many forms, manifesting as documents (written texts), in language, and also in practices and measures taken in the name of specific institutions (Shore & Wright, 1997). In the following chapter, which outlines the methodology adopted in this thesis, I engage further with the critical policy studies literature regarding the nature of policy.

Here I want to simply draw attention to the fact that there are a range of theories that attempt to describe and explain the policy-making process. Colebatch (2002) identifies the following three approaches as the most prominent views of policy: policy as authoritative choice; policy as structured interaction; and policy as social construction. Authoritative choice views policy as the outcome of the decision-making of state or government actors, as “authorised decision-makers” (Colebatch, 2006a, p. 7). This is a rationalist approach to policy analysis, where actors are viewed as engaged in a process of rational decision-making about policy issues. One prominent view of the policy process is the policy cycle model, which conceptualises policy formulation as a rational progression of stages: problem or issue identification, policy analysis, policy instrument development, consultation, building coordination, decision-making, policy implementation and policy evaluation (Althaus, Bridgman, & Davis, 2012). Although this thesis does not subscribe to the model as an explanatory one, the language used in the model provides a useful framework for understanding some of the different elements of the process, and indicates the kind of language used to describe these practices in the contemporary policy field. As
Ritter and Bammer (2010) note, however, this model “de-emphasises the politics, players and political processes within policy-making” (p. 354). Rationalist accounts of the policy process have been criticised for the neglect of power dynamics and inattention to the active process of problem construction, and the lack of attention to the broader range of actors involved in policy advisory systems including interest groups, NGOs, the media and private industry groups. Accordingly, other perspectives on policy have tried to address the role of ideas and stakeholders in the process; for example the advocacy coalition framework developed by Paul Sabatier (Sabatier, 1988; Weible, Sabatier, & McQueen, 2009) is a complex model of public policy-making process which includes attention to multiple actors in the process, the role of policy beliefs and coalitions, and agenda-setting in the policy process.

Contemporary policy advisory systems are complex, and any approach to policy analysis needs to be able to account for this. Policy-makers take advice from multiple sources, both internal and external to the government (Craft & Howlett, 2013). As outlined in the network governance and governmentality literature, external actors and agencies have come to take a greater role in policy under advanced liberalism (Bevir, 2011; Bevir & Rhodes, 2001; Bevir, Rhodes, & Weller, 2003). The view of policy as ‘social construction addresses problems with the rational model of policy-making. This research is aligned with a social constructionist view of the policy process (Colebatch, 2006a), which “recognises that the world of policy is populated by a range of players with distinct concerns, and that policy-making is the intersection of these diverse agendas, not a collective attempt to accomplish some known goal” (Colebatch, 2006b, p. 1). As Colebatch (2006) notes, critical and interpretive approaches to policy view the work of policy concerned with the “construction of meaning” (p. 9): “policy work encompasses the processes of problematisation, the organisation of expertise and the devising of ‘technologies of government’” (p. 9). This is compatible with the use of governmentality as an analytic tool.

At an instrumental level, there are a number of formal and informal channels through which governments engage the non-government sector and external stakeholders in seeking policy advice, including: seeking submissions to government inquiries, formal and informal consultation processes,
and stakeholder forums. For example, the most recent National Drug Strategy was released after an extensive consultation process, and a number of non-government sector organisations made submissions during this process (Department of Health, 2015b). Of course, there are other modes of political participation where advice is not solicited by governments, for example through actions such as speaking with the media, developing policy positions, and developing petitions and other materials (Keen, 2006).

**Non-Government Political Participation**

But why would governments seek to involve NGOs in policy processes? There is a broad literature that discusses the function of NGO political participation in liberal democratic societies. Across this scholarship, non-government sector advocacy and policy work is theorised as contributing to a healthy democratic process (in terms of representing ‘community’ interests); fostering ‘good governance’ and contributing to public debate around policy; providing a voice for the disadvantaged, marginalised or vulnerable in society; and contributing to a strong civil society (Almog-Bar & Schmid, 2013; Maddison & Denniss, 2005; Phillips, 2006; Phillips & Goodwin, 2013; Putnam, 1995). Non-government advocacy work is also theorised to mobilise social capital in ways that impact on public issues (Phillips, 2006; Putnam, 1995). These arguments generally draw at the least on a pluralistic model of democracy encouraging many voices in the policy process (Maddison & Denniss, 2005; Phillips & Goodwin, 2013). Indeed, in Western states at least, there seems to be near universal agreement that non-government sector political participation is a necessary and desirable objective for a properly functioning democracy.⁶

Issues of voice, representation, legitimacy and accountability are central to understanding power dynamics in the policy-process in liberal democracies. Maddison and Denniss (2005) point out that under the pluralistic model, NGOs advocacy activities are thought to balance the “democratic deficit”

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⁶ NGOs also play an important role in non-democratic and developing countries, however the relations of power in these societies are different (Fowler, 2000). It is not within the scope of this thesis to consider issues for NGOs participation in non-democratic societies.
in liberal representative democracy. Hindess (2002) argues that the “democratic deficit” is actually an inherent part of representative democracy because it “places the work of government in the hands of representatives and unelected public servants, representative government is not in the hands of the people themselves” (p. 32). The non-government sector is thought to function as a ‘mediator’ between civil society and government (Almog-Bar & Schmid, 2013). This kind of idea is particularly prevalent in ‘Third Way’ discourse, which can be conceptualised as a variant of neoliberalism, where there is an emphasis on renewed democratic and social participation by the public, where NGOs are given an important role in facilitating and mediating this participation (Barraket, 2008; Pierson & Castles, 2002; Reddel, 2004; Rose, 2000). As Hindess (2002) noted, for most people in a representative democracy their direct political participation is essentially limited to elections, and for an active minority “it is channelled through a range of competing parties, movements and pressure groups” (p. 34). NGOs in this sense provide a means of channelling public participation in the policy process, presenting a way of “both transmitting and containing popular pressures on government” (Hindess, 2002, p. 34).

Under a pluralist model of democracy, the non-government sector has an important role acting as a “voice” of the community (Melville, 2001; Onyx, 2001). As Jenny Onyx (2001) writes, the idea of NGOs as ‘voice’ has several elements, beyond the capacity to advocate and engage with policy: as a ‘voice’ of civil society, the sector represents the diversity of voices in civil society, articulates the needs of the community, mobilises social capital to respond to those needs and develops innovative responses to those needs. The non-government sector is argued to represent the diversity of civil society and to articulate the needs of the community in public debates around policy, giving voice to those who are not ordinarily represented in policy processes by advocating on behalf of marginalised, disadvantaged or vulnerable groups (Almog-Bar & Schmid, 2013; Carson, 2001; Maddison & Denniss, 2005; Melville, 2001). This function of the sector has actively been encouraged by various (largely Labor) governments, beginning in particular with the Whitlam government that actively sought to strengthen ‘weak voices’ by actively funding peak bodies to represent marginalised groups in policy processes (Sawer & Laycock, 2009). Peak bodies are important facilitators of NGOs’ role in policy (Hancock, 2006;
Melville & Perkins, 2003). Melville and Perkins (2003) recommend the following definition of a peak body:

A ‘peak body’ is a non-government organisation whose membership consists of smaller organisations of allied interests. The peak body thus offers a strong voice for the specific community sector in the areas of lobbying government, community education and information sharing between member groups and interested parties (p. ix).

As Hancock (2006) observes, governments have encouraged peak bodies because they are a more efficient way of communicating with the non-government sector, or the sector that the peak body represents. Rather than dealing with a great number of organisations, government can instead communicate with a smaller number of representative peak bodies, who they communicate this information to their member organisations (Melville & Perkins, 2003). Hancock (2006) notes the more anti-democratic effects of government funding for peak bodies, in terms of governments retaining decisions about which groups are recognised as peak bodies, determining their level of funding, and problems around politicians using this power to stifle ‘dissenting voices’ (Maddison, Denniss, & Hamilton, 2004).

At an instrumental level, non-government policy work and advocacy activities can take many forms, including but not limited to: communicating with government and other agencies, commenting on policy, writing submissions, participating in consultation processes, national summits, roundtable discussions and other activities. Organisations employ a range of strategies in their advocacy activity (Onyx et al., 2010), including “generating support in the electorate or market place, invoking a moral argument, putting forward a research-based case for or against a particular policy proposal, and/or demonstrating that the public interest is best served by a particular course of action” (p. 45). Other strategies include generating public support for a cause or raising public awareness, and engaging directly with government officials to generate relationships (Onyx et al., 2010).

The literature generally makes a distinction between advocacy activity that is “radical” versus “institutional” in character, although most studies acknowledge that organisations’ activities often fall
somewhere in between the two (Onyx et al., 2010). Radical activist tactics might include public protests, while institutional tactics include more formal approaches to advocacy such as providing submissions on government policy, or participating in government committees or enquiries (Onyx et al., 2010). Onyx et al. (2010) investigated the advocacy activities of 24 organisations in the community services and environment fields in NSW and QLD. The authors found that the organisations were more likely to undertake institutional as opposed to radical advocacy action, but that the NGOs also engaged in emerging forms of advocacy, such as forming coalitions, that could not be classified as institutional or radical (Onyx et al., 2010). The authors observe that respondents emphasised the importance of forming relationships with government as an advocacy tactic (Onyx et al., 2010). Almog-Bar and Schmid (2013) note that recent years have seen an increase in the usage of “insider, institutional, and less aggressive tactics” by NGOs (p.11), tactics which Onyx et al. (2010) describe as “advocacy with gloves on” (p. 43). They discuss several factors which may have contributed to this situation, including the growing interdependency between NGOs and government and increased collaboration on program design and implementation (Almog-Bar & Schmid, 2013). Additionally, ‘insider’ tactics, as opposed to confrontational tactics, may prove more conducive to establishing relationships of influence with government agencies and officials (Almog-Bar & Schmid, 2013).

**Relations between NGOs and Governments: A Focus on Power**

As noted in the introduction, in the Australian context, non-profit and private providers have long had an important role in social service provision – and the state has funded them to deliver these services (Keen, 2006). With the rise of neoliberal logics of government, however, we have seen a growth in the contracting out of these services. As Meagher and Goodwin (2015) note, although there is diversity in policy instruments across jurisdictions, “the direction of change overall is clear – market organisations and market logics are playing an increasing role” (p. 1). This means that public services are increasingly contracted out to non-profit and private companies rather than delivered in the public sector, and competitive funding models and performance monitoring have become popular techniques involved in
funding and managing public services delivered in the non-government sector (Meagher & Goodwin, 2015).

Government policies encouraging marketisation and competition have worked to shape the non-government sector (Carmel & Harlock, 2008). It has been theorised that competition and contracting regimes have forced the sector to become more ‘business-like’, with a range of positive and negative effects (Maier, Meyer, & Steinbireithner, 2014). In terms of positive effects, government funding can act to legitimise the role and services of non-government sector organisations (Melville, 2001) and provides NGOs with essential resources to deliver programs and services. A large number of NGOs are now dependent on state-based funding sources to support their service provision (Lyons, 2001). The increased role for NGOs in service provision can also serve to legitimise their position as ‘experts’ in policy processes (Onyx et al., 2010). Furthermore, the demands of contracting regimes, and the competition between organisations, have had the effect of ‘professionalising’ the non-government sector (Carey, Braunack-Mayer, & Barraket, 2009). Villadsen (2009) however, cautions against locating the source of these organisational changes within any one sector (government, private, or the non-government sector) or type of organisation — rather he sees these trends as part of broader transformations affecting all sectors.

There are other, more ambivalent effects of government funding and neoliberalism for the non-government sector. These centre around threats to the independence of NGOs, and the erosion of their social missions (Carmel & Harlock, 2008; Considine, 2003; Goodwin & Phillips, 2015; Helminen, 2016). Carmel and Harlock (2008) argue that the emphasis on partnership, procurement and performance in the UK has resulted in “the attempted normalisation of VCOs [voluntary and community sector organisations] as market-responsive, generic service providers, disembedded from their social and political contexts and demuned of ethical or moral content and purpose” (p. 155). Scholars such as Najam (2000) and Smyth (2008) have warned about isomorphism, where non-government sector organisations take on the ‘image’ or characteristics of state agencies. Considine (2003) argued that the increased competition associated with neoliberalism and marketisation erodes the distinctive role of
non-profits. The co-optation of non-government organisations by government is another concern, whereby NGOs delivering state-funded services come to act as a kind of “shadow state” (Carey & Ayton, 2013; Wolch, 1990). NGOs’ important role in service provision, while potentially lending them a “stronger voice at the policy table” (Ritter et al., 2011, p. 40), may in fact be a double-edged sword — the mixed economy of welfare service provision has resulted in a co-optation of the non-government sector by government whereby the non-government sector functions as a kind of extension of the state by delivering “the political and ideological goals of the government” (Van Gramberg & Bassett, 2005, p. 10). The problem here is that community members may be less likely to support “shadow state” organisations, thus undermining the ability of the non-government sector to mobilise social capital on issues of shared concern and compromising the social and political functions of NGOs in democratic societies.

Funding and contracts can be used as a means of controlling non-government sector activities and political participation (Melville, 1999, 2001). Contractual stipulations against advocacy can hamper NGO’s ability to provide a ‘counter-voice’ at the policy table, considering the risk it poses to their current contracts or their ability to gain further funding. Short term funding and the threat of defunding can impact on how NGOs operate in the policy space; for example, they may self-censor or minimise dissenting voices to avoid jeopardising future funding opportunities. Maddison et al. (2004), and Melville (1999, 2001) describe how this occurred in Australia at the national policy level during the term of the Howard Government (1996–2007). During the Howard years the government actively sought to “silence dissenting opinions” (Maddison et al., 2004, p. 15), by implementing ‘gag-clauses’ on thousands of contracts with NGOs. Melville (1999, 2001) suggested that during this time, the threat of defunding was used to influence non-government sector advocacy activity, resulting in “a significant reduction of funding and de-funding of certain groups seen as critical of government policy or non-mainstream and self-interested” (Melville, 2001, p. 90). During this time, the government mobilised public choice theory to “de-legitimise the standing of NGOs in public policy processes” (Maddison & Denniss, 2005, p. 382). Public choice theory is a popular perspective that applies the ideas of rational choice theory to politics: in particular, the idea that people act in their own self-interests (Maddison &
Denniss, 2005, p. 382). Drawing on public choice theory, government representatives argued that NGOs were not representative of those they claimed to represent (i.e. their clients or the marginalised), but were instead representing their own interests as “the welfare industry” (Maddison & Denniss, 2005, p. 328).

In fact, the degree to which non-government sector organisations are actually able to contribute to policy-making has been debated in the literature. Indeed, as Casey (2004) observes, “effectiveness in the policy process is difficult to define and even harder to evaluate” (p. 242). In practical terms, there are a number of constraints on the ability of NGOs to contribute in meaningful ways to policy. According to Casey and Dalton (2006), constraints on NGOs advocacy include: lack of untied funds; funding shifts to business models and competition; fragmentation and lack of cooperation; government control of advocacy through contracts; and lack of a sense of efficacy in the new policy-making environment.

Although the inclusion of the non-government sector in the policy process has been presented as a kind of democratisation of policy-making processes in some cases, social policy researchers have commented on the power relations that this involves, particularly where NGOs receive funding from the state (Phillips & Goodwin, 2013). Phillips and Goodwin (2013) investigated human service NGOs and their role in knowledge production for social policy – specifically, their production of knowledge for use in policy through policy research activities. The authors highlight the tensions involved in the entry of human service NGOs into policy research, particularly in terms of the power relations around which organisations are funded to produce research, how these organisations produce research, and how this then influences policy processes. Phillips and Goodwin (2013) note that although organisations are non-profit and their policy activities are often motivated by the desire to represent the marginalised or the interests of the ‘common good’, the production of policy research can take on a kind of economic motivation “in the context of competitive state funding… as [it] become[s] part of the way in which organizations ‘win contracts’” (p. 581). These authors argue that, despite one of the rationales for NGOs’ policy role being the representation of the interests of the marginalised in policy processes, the
privileging of certain interests or organisations based on their policy knowledge production has the potential to actually exclude “welfare subjects” from policy processes (Phillips & Goodwin, 2013).

Evidently, there are a range of different perspectives on government-non-government relationships in the literature. Villadsen (2011) helpfully identifies three dominant approaches to the study of the role of non-government sector: the ‘competitive paradigm’, the ‘co-operative paradigm’ and the ‘critical paradigm’. First, under the competitive paradigm, state-non-government sector relations are characterised as competitive, with the state posing a potential risk to the independence and autonomy of NGOs (Villadsen, 2011). Some literature under this paradigm tends to ‘romanticise’ NGOs, pitting the ‘flexible’, ‘warm’ and ‘informal’ approach of the non-government sector against the ‘cold’ and ‘inflexible’ approach of the state (Villadsen, 2011). This paradigm is characterised by its suspicious or critical stance towards state involvement in the non-government sector (Villadsen, 2011). Second, the ‘co-operative paradigm’ sees the relationship between the non-government sector and the state as one of co-operation and collaboration, in which the traditional divisions between state and civil society are not so clear as previously thought (Villadsen, 2011). This approach acknowledges the complexity of state-non-government sector relations, but does not pose this complexity in terms of risk; instead, the language of this approach emphasises the potential benefits of ‘partnerships’, ‘networks’ and ‘co-production’ (Villadsen, 2011). Finally, authors under the critical paradigm display a suspicion about the purported benevolent contributions of the non-government sector. The critique here is “that philanthropy constructs its own necessity and gains support from the very thing that it claims to be trying to end, that is, marginality and poverty, and it does so by representing these as natural facts” (Villadsen, 2011, p. 1060). While all of these paradigms have valuable contributions to make to our understanding of the non-government sector, they tend to do so from extreme positions or simplistic characterisations of power-relations, thus limiting their potential to capture the complexity involved in voluntary action in the drug policy field. Although the mainstream literature on NGOs offers some valuable insights into state-non-government sector relations, Villadsen (2011) argues that it largely rests on simplistic characterisations of power-relations, thus limiting its potential to capture the complexity involved in voluntary action in the drug policy field.
Governmentality scholars studying the non-government sector highlight the complexity of power relations between the State and non-government sector. Sending & Neumann (2006) dispute the claim found within the global governance literature that the involvement of NGOs in carrying out global governance functions reflects the transference of power from the state to non-state actors. They argue instead that it represents a changing rationality of government in which civil society is constituted as both an object and a subject of government. In this way, non-state actors become a fundamental feature of how power, in this case government, operates in late modern society (Sending & Newman, 2006).

Carey (2008) also considers the relations between the non-government sector and the state. She argues that the position of non-government sector organisations in relation to governmentality is complex, with organisations simultaneously resisting, perpetuating and being regulated by the state (Carey, 2008). For example, in the case of compacts — a popular strategy used by governments to regulate the relationship between the state and the non-government sector — the state is specifically acting on non-government sector organisations to mobilise the resources of the sector in its own governance and the governance of others (Fyfe, 2005). NGOs themselves work to shape subjectivities, both of their staff and volunteers and their clients (Ilcan & Basok, 2004; Villadsen, 2007; Villadsen, 2011).

**Drugs Policy and Non-Government Organisations**

Changes to the welfare state and the rise of new modes of governance have had profound effects across western states in diverse arenas, drug policy being one of them. Keeping this in mind, this section outlines the main themes evident in the anthropological, sociological and criminological literature examining contemporary drugs discourse and policy. This work is used to position a number of related trends that have shaped the broader landscape of drugs policy, including: changes in popular and expert discourses on drug use and addiction, and a ‘reconfiguring’ of the subject of drug policy; a shift in focus away from ‘addicts’ and individualising policy to a population management approach (Bunton, 1998, 2001), along with a concomitant emphasis on risk and risk reduction and the expansion of interventions for ‘problem drug users’. Here I focus on outlining how drugs have been constituted as a ‘policy
problem’ — to borrow Carol Bacchi’s (2009) terminology — before turning to a more focused analysis of how non-government organisations have been involved in drug policy historically and contemporarily.

Drugs as a ‘Policy Problem’

If policy-making is to be considered more a process of active problem construction and representation than objective identification, then the different ways that drugs and drug use are constructed and represented as ‘problems’ shape conceivable and actionable drug policy responses (Bacchi, 2009; Lancaster, 2014; Lancaster & Ritter, 2014a; Lancaster et al., 2014). The way that we think about drugs (and indeed other policy problems) is shaped by historical, social and economic contexts. Indeed, scholars of governmentality have shown how thinking about drugs has undergone several shifts across the past two centuries. In particular, they have analysed how drug problems have been constituted in relation to axes of power/knowledge and political rationalities.

The problematisation of drug use has historically been intimately bound up with the problematisation of alcohol use (Levine, 1978). In his seminal work on the ‘discovery’ of the modern concept of addiction, Harry Levine (1978), argues that ‘addiction’, as it exists in its current modern form, did not exist before the 18th Century. He argues that the “invention of addiction” can best be seen “not as an independent medical or scientific discovery but as a transformation in social thought grounded in fundamental changes in social life — in the structure of society” (Levine, 1978, pp. 165-166). Levine (1978) observes that, consistent with classical liberalism, this shift in ideological and structural features emphasised individual freedom, necessitating a shift in social control to the individual level: “social order depended upon self-control” (Levine, 1978, p. 163). Over time, however, individuals incapable of exercising this kind of self-control and responsible freedom — in other words, the socially deviant

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7 It is not within the scope of this review to provide a comprehensive history of the problematisations of drug use or the development of drug control systems. There are far more detailed analyses of this elsewhere (see for example Carney (1980); Manderson (1993); there are also more comprehensive deconstructions of ‘addiction’, and histories of drug control elsewhere (see (Berridge & Edwards, 1981; Bull, 1996, 2002, 2008; Keane, 2002; Manderson, 1993; Seddon, 2010). Rather, the point here is to sketch some of the main trends and outline the relevance for non-government organisations.
— came to be viewed in a new way, through the lens of science and medicine. The identification of drugs and alcohol as a ‘social problem’ and the rise of the idea of ‘addiction’ can be traced back to the end of the 18th Century, coinciding with the rise of classical liberalism, and the rise in influence of ‘Enlightenment ideas’, and faith in reason and science (Bull, 1996, 2008; Levine, 1978; O'Malley, 2004). Towards the end of the late 19th Century, ideas of classical liberalism started to give way to the ideas of social welfare liberalism, having great social ramifications extending into conceptions of addiction and appropriate interventions (Seddon, 2010). The emerging disciplinary knowledges of the human sciences — psychology, sociology, criminology — shaped understandings of human behaviour during this period (Garland, 1985). With the rise of expertise in the human sciences, ‘addicts’ came to be seen as ‘defective’ and in need of control and correction, an idea fitting with the rationalities of welfare liberalism (Seddon, 2010).

The early to mid-20th Century saw the introduction of an international system of drug control premised on the regulation and criminalisation of a range of substances (Carstairs, 2005). The period of the 1960s-1980s saw the heavy criminalisation of a range of substances and the consolidation of the international system of drug control (Carstairs, 2005; Manderson, 1993). As such, drug use came to be viewed as a criminal matter and interventions directed towards the use of the penal welfare complex characteristic of the approach to drug use under welfare liberalism (Seddon, 2007b). The focus was on the normalisation of the ‘addict’ through treatment and expert intervention, based on knowledges from the positivist social and medical sciences (Seddon, 2007a). While it has been diversified and expanded over time, this system based on legal regulation and criminalisation remains in place in the current period and has served as a framework shaping both state and non-state activity around drugs.8

Where interventions under welfare liberalism focused on correcting and controlling the ‘individual’, under neoliberalism, however, the calculation and mitigation of risk has become a key feature of neoliberal governance more broadly and in the drugs field (Bunton, 1998, 2001). In drugs policy, the

8 There is a huge range of critical scholarship on the development of drug control (Berridge & Edwards, 1981; Bull, 2008), and it is not within the scope of this review to discuss any of that in detail here.
neoliberal concern to constitute a subject who is a ‘calculating choice-maker’, able to identify and respond to risk, is expressed most apparently in harm minimisation and harm reduction approaches (Bunton, 2001; Moore & Fraser, 2006; O’Malley, 1999a). As such, these policies still have an individualising effect as people who use drugs are encouraged to take individual responsibility for their health and wellbeing (Bunton, 2001). During the mid-1980s, public health concerns around injecting drug use and AIDS saw a shift in drug policy across many Western states towards the greater incorporation of what are now known as ‘harm reduction’ policies, programs and techniques — such as needle and syringe exchanges, safe injecting rooms and so on (Roe, 2005; Tammi, 2004; Tammi & Hurme, 2007). ^9 Susan Shaw (2012) observes that traditionally, drug problems have often been conceived as either criminal justice or medical problems in policy, but harm reduction has been presented as a third alternative that promises a pragmatic response to drug use focused on maintaining the health of the person who uses drugs in the face of the reality of drug ‘addiction’ “as a chronic condition of relapse and recovery” (p. 153). Instead of trying to change the ‘addictive’ behaviour of the person, the focus in harm reduction is on managing the health risks associated with drug use.

Bunton (1998, 2001) argues that there has been a shift from a focus on the ‘addict’ to a population management approach, involving a devolution of the responsibility from the state to the individual. O’Malley (1999a) draws on a governmentality framework to show how the drug using subject in Australian harm minimisation discourse is constructed as a ‘responsible’ user, a choice-maker capable of their own self-government in terms of managing the risks of their own drug use. This does not mean that risk-management is solely the domain of the individual however. As Zajdow (2004) argues, in fact, harm reduction techniques still privilege ‘expert’ discourses and knowledge, particularly in the form of public health and epidemiology, in identifying and responding to risk. In Chapter 5, I engage further with these debates about harm minimisation and drug policy under neoliberalism. In the section that

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^9 It would be remiss to state that these types of intervention were entirely ‘new’— they existed, in some form or another, before the mid-1980s (Roe, 2005). For example, doctors in the UK prescribed opium as a ‘substitution therapy’ for addicts early in the 20th Century (Berridge & Edwards, 1981), and opioid substitution in the form of methadone has been available since the 1960s in the US, Australia and Europe (although arguably this type of early intervention was rooted in the disease model of addiction).
follows, I focus on some of the synergies in the development of ideas about drugs and forms of non-profit action.

**Historical and Contemporary Forms of Non-Profit Action on Drugs**

The historical development of responses to drug use is bound up with the history of non-profit action and advocacy in the drugs field. In this section, I briefly outline the history and forms of organisations that make up the non-government drug and alcohol sector in Australia, in order to provide a foundation for the discussions in later chapters, and to serve as a road map for understanding some of the different forms of non-government organisations in the drugs field in Australia. Overall, the major point I wish to highlight is that there are quite a range of organisations, discourses and practices that make up the non-government drug and alcohol field.

**Temperance and moral regulation**

The first major organised form of non-profit action on drugs (broadly interpreted) in modern times can be traced to the emergence of the temperance movement in the United States (US) in the late 18th Century. This movement was primarily aimed at reducing the consumption of alcohol in society. The movement strengthened during the early 19th Century, and “by 1836, civic temperance organizations…claimed over 1.5 million members in over 8,000 auxiliaries — or about one out of every five free adults” (Schrad, 2010, p. 257). The ideas of the temperance movement soon spread to England, and then the colonies, also taking hold in Australia.\(^\text{10}\)

Temperance organisations were involved in a range of activities aimed at the regulation of liquor and other substances (including opium) (Berridge & Edwards, 1981; Levine, 1984; Windschuttle, 1979). During the late 19th and early 20th Centuries, temperance organisations played an important role in the push towards the medical treatment of inebriety, formulating arguments against the penal sanctions that characterised responses to habitual drunkards at the time (Garton, 1987). They drew heavily on the

\(^{10}\) There is a wealth of information about the activities of the temperance societies (Harrison, 1994; Schrad, 2010; Tyrrell, 1983) and it is not my intention to re-tread any of that ground here.
disease model of addiction, as first outlined by Benjamin Rush (Levine, 1978). While there was a push for the medical treatment of inebriety, the temperance movement was also pushing for greater state regulation of the liquor trade. Having found “appeals to individual conscience and willpower inadequate” (Lewis, 1988, p. 393), the Temperance movement were increasingly seeking action from the state in the form of legal restrictions on the sale of liquor. In the US, of course, the temperance movement were successful in agitating for prohibition of the liquor trade (Levine, 1978). In Australia, temperance was unsuccessful in relation to outright prohibition but found some success in this regard in terms of regulation, in that some states introduced restricted trading hours for hotel bars in the early 20th Century. School-based drug and alcohol education owes much to the legacy of the Temperance movement. Temperance organisations in America, such as the International Order of Good Templars (IOGT) and the WTCU were extremely vocal in advocating for temperance lessons in schools (Mammino, 1993). Towards the end of the 19th Century, most states in Australia introduced temperance lessons into schools (Mammino, 1993; Tyrrell, 1983). The Queensland Temperance League (now DrugARM) was also important in school-based temperance lessons in Queensland (Mammino, 1993). In spite of this, the temperance movement had an increasingly uneasy relationship with the general public. After the Second World War, there was a reaction against temperance, and the movement came to be associated with authoritarian ‘wowserism’ in popular discourse (Pixley, 1991; Room, 2014).

The temperance movement had effect through appealing to moral arguments, acting to shape public and medical understandings of addiction and inebriety and how best to deal with these problems (Harding, 1986; Levine, 1978, 1991; Yeomans, 2011). Temperance supporters adopted a view of addiction as a disease with a moral basis, advocating total abstinence as the only treatment: a view which has a continuing impact on conceptions of addiction (Levine, 1978). Levine (1978) observed that in the US, the Temperance Society considered addiction both a disease, and a sin, indicating a moral and religious basis to their arguments (Levine, 1978). Berridge (1979) suggested that “the earlier ‘moral’ view of

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11 Lewis (1988) notes that hours of opening still remained long during the 19th Century. Greater restriction was achieved in the early 20th Century with the six o’clock closing of hotel bars in South Australia, NSW, Victoria and Tasmania; Western Australia introduced nine p.m. closing, and Queensland introduced eight p.m. closing later in 1923.
addiction retained a place in disease theory, and owed much to the pressure of the temperance and anti-opium campaigns” (p. 68). Yeomans (2011) adds that although it had negligible impact on drinking behaviour, the influence of the British temperance movement resides in its advancement of the project of moral regulation which has encouraged the adoption of governance focused on the individual behavioural solutions.

**Self-help groups: Recovering the self**

The legacy of temperance can be seen with the rise of self-help groups during the middle of the 20th Century, as ‘problem drug users’ and alcoholics were encouraged to look within themselves and work on themselves through practices of the self (Valverde, 1998; Valverde & White-Mair, 1999). The ideas of recovery and addiction as a ‘disease’ began to be reconstituted in the late 1930s as a new movement of self-help emerged (Lewis, 1988). While the temperance movement had shifted their focus towards the legal regulation of alcohol, the disease model had a continuing legacy in the ‘Inebriates Acts’ implemented in various states (for example, the Inebriates Institutions Act enacted in 1896 in Queensland) where it served as a chief rationale for treating inebriates (Lewis, 1988). By the post-war period, however, the Inebriates legislation had “largely fallen into disuse” (Lewis, 1988, p. 396), and the influence of the temperance movement was on the decline.

12 The form of Alcoholics Anonymous was shaped considerably by the reaction against temperance (Ali, Miller, & Cormack, 1992; Valverde & White-Mair, 1999). It was founded just after the temperance movement had suffered a defeat in the repeal of prohibition in America in 1933, and thus the founders of AA sought to distance themselves from temperance (Valverde, 1998; Valverde & White-Mair, 1999). The founders of AA shunned the

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12 The inter-war period witnessed the emergence of self-help groups with the formation of Alcoholics Anonymous (AA) in 1935 in America. The first Australian AA group was started post-war in late 1944-1945 in Sydney; it spread relatively quickly with groups formed in Victoria and Western Australia, and Adelaide in Brisbane in 1947, followed by Hobart in 1949 and a group in the Northern Territory in 1955 (Wilson, 1988). The AA model was relatively popular from 1945-1970, with the number of groups per population in Australia being on par with, or even exceeding, that of the US (Leach & Norris, 1977, as cited in Levine, 1993, p. 13).

13 Lewis (1988) notes that the public facilities for the treatment of inebriety were of questionable therapeutic value, and the failure to find an effectual ‘cure’ for inebriety encouraged a feeling of pessimism. The success rates for treatment were disappointing, and the state had essentially failed to provide suitable special institutions for inebriates (Lewis, 1988). The language surrounding it also began to change, as the term ‘alcoholism’ came to replace inebriety in the 1920s and 1930s (Valverde, 1997).
public demonstrations and political tactics favoured by temperance, “especially debates about liquor/alcohol legislation” (Valverde & White-Mair, 1999, p. 396) instead preferring anonymity.

While AA relied on the disease model of alcoholism, this conception was different to the earlier temperance one. Perhaps owing to the repeal of prohibition and the political unacceptability of criticising alcohol itself at the time (Room, 1992), where temperance found the problem ‘in drink itself’, AA located the problem in ‘the person’ (Ali et al., 1992; Levine, 1978). The disease of alcoholism was confined to a particular minority of drinkers, and alcoholics’ reactions to alcohol were to be distinguished from those of non-alcoholics (Valverde & White-Mair, 1999). Rather than promote the prohibition or regulation of alcohol itself as temperance did, AA promoted techniques of self-governance, where abstinence is to be gained for alcoholics through the techniques of the self as contained in the ‘Twelve Steps’. The twelve steps provide a guide for AA members to work through during their ‘recovery journey’ (Valverde & White-Mair, 1999).

With public, medical and academic support the idea emerged that the AA model and the twelve-step approach could be adapted for the treatment of other conditions. Narcotics Anonymous (NA) was formed in the US in 1953 for the treatment of narcotics addictions (Toumbourou & Hamilton, 2003); however it was during the 1960s and 1970s — when the self-help movement experienced growth across a range of new areas, including the addictions — that the NA model expanded (Mold & Berridge, 2010), and meetings began happening in Australia during this period (Narcotics Anonymous World Services, 2014).

For groups stemming from the twelve-step AA model, addiction is conceived of as a life-long, incurable, and progressive disease marked by loss of control (Valverde, 1998). Alcoholism and addiction are seen as a loss of self-control, however as one of the first steps, participants are encouraged to acknowledge their powerlessness over their ‘drug problem’, and through the emotional support of a self-help group effect a kind of ‘personal transformation’ (Zajdow, 2001), hinged on adopting the
identity of the ‘recovering addict’ (Keane, 2000). This new identity was formed through working the twelve steps and through participation in the group process. Although groups based on the twelve-step model have traditionally been supported by medical professionals and academics, and have sought to build co-operative relationships with them, at the same time it has challenged ‘professional control’ of addictions by privileging individual and group experimental knowledge over professional and medical knowledge (Ali et al., 1992; Valverde, 1998; Valverde & White-Mair, 1999; Zajdow, 2004).

The modern landscape of self-help groups is quite diverse. Most recently, newer ‘recovery-focused’ self-help and mutual aid groups, not based on the twelve-step model, have emerged. SMART (Self-Management and Recovery Training) groups are secular, and ultimately based on ‘scientific knowledge’ and principles of ‘evidence-based treatment’ (Allwood & White, 2014). SMART Recovery groups began in the United States in 1994, and developed in Australia largely beginning in New South Wales in the 2000s (Allwood & White, 2014). Since then, the number of SMART Recovery Groups

14 Recovery is an ever ongoing process of self-governance, and in ensuring the avoidance of ‘relapse’ the process also thus involves discipline and self-monitoring (Keane, 2000).
15 Particular techniques, including abstinence, confession and storytelling are involved in this process of identity formation (Lyons, 2005; Rafałovich, 1999).
16 The first Australian AA groups were encouraged by medical professionals (Alcoholics Anonymous, 1995).
17 As Humphreys (2004) notes, “self-help organisations are complex and varied – in some ways looking like paraprofessional treatments, in other ways looking like community-based organizations, and in still other ways like social movements” (p. 12). The term ‘self-help’ can be misleading, in that most ‘self-help’ groups are focused around group processes and mutual aid rather than individualistic ‘self-help’ (Humphreys, 2004). Although they approach the problem of ‘addiction’ from different assumptions and practices, modern self-help groups tend to have the following features in common: members share a problem or status, self-directed leadership, valuation of experiential knowledge, norms of reciprocal helping, voluntary association, and inclusion of some personal-change goals (Humphreys, 2004, pp. 13-17).
18 The history of ‘rational’ recovery groups began somewhat earlier with the publication of The Small Book by Jack Trimpey in 1988. Trimpey was a social worker who had personal experience with overcoming an alcohol addiction, and he founded a non-profit organisation called the ‘Rational Recovery Self Help Network’ as well as a for-profit corporation to provide addiction services (Humphreys, 2004). The Rational Recovery (RR) Self Help network was explicitly started as an alternative to twelve-step groups, with its literature having a “near-evangelical anti-AA rhetoric” (Humphreys, 2004, p. 84). In 1994 the RR Self-Help network split from RR’s for-profit ventures following disagreements with Trimpey and changed its name to SMART Recovery. SMART stands for “Self-Management and Recovery Training”.
19 In 2003 St Vincent’s Hospital in Sydney piloted a SMART Recovery group as an alternative or adjunct to twelve-step groups (Allwood & White, 2014). The hospital received a $250,000 grant from AER to hire two coordinators which allowed the launch of 38 SMART Recovery groups over NSW over 2004-2006 (Allwood & White, 2014). In 2004, SMART Recovery was also adopted as a program within the New South Wales correctional system, and later also used in the Tasmanian correctional system (Allwood & White, 2014). In 2007 SMART was
has grown greatly, with groups being offered across a range of government and non-government settings (Allwood & White, 2014). Although SMART Recovery groups do use the word ‘addiction’, they do not subscribe to or reject the disease model; instead their position on the nature of addiction appears to be fluid: “we are committed to a greater understanding of this extremely complex psychological and social problem” (SMART Recovery Australia, 2015 para. 17). Experiential knowledge is also valued as “lived experience” (SMART Recovery Australia, 2014, p. 4). Furthermore, unlike AA and NA, SMART Recovery is not opposed to political activity: policy advocacy is included in its strategic plan (SMART Recovery Australia, 2014).

**Therapeutic community movement: Extending self-help**

Along with the rise of a range of consumer, user, patient and self-help movements (Mold & Berridge, 2010), the 1960s to 1970s saw the popularisation of ‘therapeutic communities’: a particular style of treatment, which had its roots both as an offshoot of the AA/NA self-help movement, and in the mental health/psychiatric arena (Mold & Berridge, 2010). Therapeutic communities largely developed along two tracks: the ‘democratic model’ as developed within psychiatry, and the ‘concept-based’ therapeutic community (TC) focused on treating drug and alcohol addiction (Mold & Berridge, 2010; Raimo, 2001). The first ‘concept-based’ TC emerged in North America in 1958 when Charles Dederich established Syanon in California (Kooymman, 2001). The Syanon model was rigid and based on a hierarchical structure, rejecting professional help and demanding that residents retain lifelong membership without reintegrating into the outside community. Later therapeutic communities, such as Daytop and Phoenix House, took a less rigid approach and served as the ‘prototypical’ therapeutic

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20 ‘Democratic’ therapeutic communities were developed by psychiatrists for the treatment of personality disorders and sometimes other mental health issues (Raimo, 2001). These developed in the context of a range of social changes, including the rise of consumer movements, the de-institutionalisation of the mentally ill, and the anti-psychiatry movement (Mold & Berridge, 2010). ‘Democratic’ therapeutic communities changed the balance of power in the therapeutic relationship as ‘patients’ became actors in their own treatment in their own right (Raimo, 2001)20. Therapeutic communities for addiction, or ‘concept-based’ therapeutic communities were pre-dated by these psychiatric therapeutic communities. Ascertaining the influence of these democratic therapeutic communities on the first ‘concept-based communities’, however, is not straightforward (De Leon, 2001).

21 For a more detailed discussion of the history of Syanon, see for example Kooyman (2001); Mold and Berridge (2010).
communities, inspiring similar “drug-free TCs” throughout the United States and internationally (Mold & Berridge, 2010).

These therapeutic communities embraced the self-help and mutual aid approach, having residents involved in their own treatment, but also allowed professionals (e.g. psychiatrists) to be involved in the program (Lloyd & O’Callaghan, 2001). They had in common the insistence on a drug-free environment (abstinence), and the idea that participation in the group or community promoted personal change (Lloyd & O’Callaghan, 2001). Structured group programs were important, as was the idea of completing the activities of daily living (e.g. cooking, work etc.) and working with the others in the community. They were hierarchical and employed a structured confrontational style (Lloyd & O’Callaghan, 2001).

These North American hierarchical models of therapeutic communities influenced the first TCs established in Australia. The first Australian concept-based therapeutic community, We Help Ourselves (WHOS), was established in 1972 in South Australia as a self-help group, and evolved into a traditional therapeutic community based on the US model in 1974 (Lloyd & O’Callaghan, 2001; WHOS, 2015). A number of other TCs were founded during the 1970s-1980s, including Odyssey House in Campbelltown NSW, a different Odyssey House in Victoria in 1979, and the Buttery in New South Wales in 1972, and Karralika TC in 1978 in the ACT. Most of these TCs have had some involvement and staff from professional backgrounds (e.g. psychiatrists, social workers and psychologists), but also employ ex-’addicts’ (Lloyd & O’Callaghan, 2001).

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22 Mold and Berridge (2010) note that Phoenix House in London, founded in 1969, combined both the American style ‘concept-based’ model and the democratic model of TC. Also note that it is significant that all the TCs established in Britain during the 1960s and 70s were founded by psychiatrists. The ‘addicts’ were allowed a place in treatment but this “was tightly managed by the professionals involved with the program” (p. 38).

23 It is not within the scope of this thesis to present a detailed history of these organisations in Australia or internationally. For more information see (De Leon, 2001; Kooyman, 2001; Lloyd & O’Callaghan, 2001; Mold & Berridge, 2010; Raimo, 2001).

24 Odyssey House was founded in Campbelltown, NSW by Walter McGrath in 1977, after his son died from an overdose. He received a small grant from the NSW Health department and travelled to a number of TCs worldwide to find the ‘best model’ of TC, and imported the US style model from Odyssey House. (Lloyd & O’Callaghan, 2001). An Odyssey House was also established in Victoria in 1979. These initial programs were based on the American ‘hierarchical confrontational’ model. The Buttery, another important TC, was founded as a program for ‘itinerant youths’ during the 1970s and operated as a Christian community caring for young people between 1972-1977 (Lloyd & O’Callaghan, 2001). It evolved into a more traditional TC during the late 1970s (Lloyd & O’Callaghan, 2001).
These therapeutic communities largely developed in isolation from each other until 1986 (Pitts, 2009) when a peak body, the Australian Therapeutic Communities Association (ATCA) was established.25 Most of the TCs set up during the pioneering days continue to operate today — in fact most have grown their programs and opened more TCs — and are influential in the peak body (Kooyman, 2001). ATCA has been important in providing a collective voice for therapeutic communities, and for maintaining and improving standards of treatment (Lloyd & O’Callaghan, 2001), promoting evaluation and research on TCs in Australia and for improving quality of service (Gowing, Cooke, Biven, & Watts, 2002).

Like self-help groups and AA, therapeutic communities draw on a discourse of ‘recovery’. Techniques of the self are to be facilitated through the group format, ‘social learning’ and through life education and programs of work, where individuals are to cultivate a new recovering identity, and gain life skills to prepare for life ‘on the outside’ (Wilton & Deverteuil, 2006). Ideas around ‘recovery’ have largely been linked with AA and therapeutic communities, but have also come to be associated with the drug and alcohol treatment field as a whole.

**Religious and faith-based organisations**

Beginning with their involvement in the temperance movement, faith-based and religious organisations have played an important role in the drug and alcohol field. They have a strong history of service provision in Australia, including working with people who use alcohol and other drugs (Howe & Howe, 2012). Lewis (1988) noted the early involvement of the Methodist Missions and the Salvation Army in the rehabilitation of alcoholics towards the end of the 20th Century (Garton, 1987). He indicates that the Central Methodist Mission in Melbourne employed ‘drug cures’ in its treatment of inebriates, thus illustrating the influence of medical ideas on philanthropic activity (Lewis, 1988). The Salvation Army operated several inebriates’ asylums in a number of states, including Victoria, New South Wales and Victoria (Garton, 1987; Lewis, 1988). In the Salvation Army’s inebriate homes, the main treatment was

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25 See Pitts (2009) for a more detailed history of the formation of ATCA.
religious pastoralism (Valverde, 1998). Another important organisation with a religious background is Teen Challenge, which was founded in 1958 in the United States under the Assemblies of God grouping of churches, and provides residential treatment for teenagers with drug and alcohol problems (Glenn, 2000). Teen Challenge today has an international reach, and there are several organisations operating in Australia providing faith-based, long-term residential treatment, although some also deliver short seminars and information services (Glenn, 2000). Their programs are explicitly faith-based and focus on abstinence. Teen Challenge is premised on the idea that ‘addiction’ is a spiritual and moral problem (Glenn, 2000), and thus treatment involves a strong emphasis on cultivating the spirituality of participants through structured programs.

Today, religious and faith-based organisations are involved in a diverse range of activities, and there is quite a range of approaches and views within religious and faith-based organisations. Survey research has found that religious affiliation does not necessarily influence service delivery, although religious organisations were slightly more likely to use a twelve-step model as part of their treatment program (McIlwraith, Kinner, & Najman, 2011). The most common modality offered by AOD treatment agencies is based on Cognitive Behavioural Therapy (CBT), and this holds irrespective of agencies status as religious or secular (McIlwraith et al., 2011). McIlwraith et al. (2011) theorise that because of government funding requirements, most AOD organisations — including religious organisations — have had to adapt their service delivery to ‘best practice’ approaches, such as CBT. Furthermore, not all organisations take a ‘conservative’ approach to drug interventions and policies; although such measures have been a point of contention for faith-based organisations, a range of these organisations have incorporated harm reduction principles into their repertoire or advocate for their extension (Rowe, 2013). For example, the Salvation Army runs the Health Information Exchange Program, which

26 McIlwraith et al. (2011) collected data on organisations rankings of the importance of the following treatment goals and activity orientations: Cognitive behaviour; therapeutic community; psychodynamic; medical; family; rehabilitation; dual diagnosis; twelve-step (McIlwraith et al., 2011).
includes a needle and syringe program and the Sydney Medically Supervised Injecting Centre in Kings Cross is managed by UnitingCare NSW.ACT (Rowe, 2013).27

Drug and alcohol foundations and peak bodies

The techniques associated with AA and twelve-step groups have had a huge effect on the drugs field, with lasting impact. AA and self-help groups helped popularise the ‘disease model’ of alcoholism, which facilitated the resurgence of interest in the special treatment of alcohol and drug dependence and facilitated the emergence of specialist drug and alcohol bodies. During the late 1950s and 1960s a number of drug and alcohol foundations were established in Australia (Lewis, 1988; Rankin, 2003). The first of the foundations was the Foundation for Research and Treatment of Alcoholism and Drug Dependence of New South Wales (FRATADD) (later known as the Alcohol and Drug Foundation NSW) (1956). The Victorian Foundation on Alcoholism and Drug Dependence was formed in 1959, and the South Australian Foundation on Alcoholism and Drug Dependence (SAFADD) in 1963. By the 1970s, the other states also had foundations that fulfilled a similar role to FRATADD, VFADD and SAFADD (Drew, 1985).28 These foundations assumed an important role not only in treatment and rehabilitation, but also advocacy, information and education around drug and alcohol issues (Lewis, 1988; Rankin, 2003). The Victorian foundation — now known as the Alcohol and Drug Foundation (ADF) — and the QLD foundation — known as Alcohol & Drug Foundation Queensland (ADFQ) — have continued to play important roles in the Australian AOD sector. Foundations played important roles in drug policy developments during the 1970s and 1980s, to be discussed in greater detail in Chapter 4.

27 St Vincent’s hospital in Sydney has been the site of a range of harm reduction measures, thanks to the advocacy of its Director of Drug Services, Alex Wodak. Due to its proximity Kings Cross, and Oxford Street, well-known for injecting drug use, it was one of the first hospitals to experience and respond to the initial ‘outbreak’ of HIV/AIDS during the early-mid 1980s. It opened the first needle and syringe exchange program in 1986 (Rowe, 2013).

28 The Tasmanian Foundation on Alcoholism and Drug Dependence (1975), the Australian Capital Territory Foundation on Alcoholism and Drug Dependence (1977), the Alcohol and Drug Problems Association of Queensland (1974), and the Northern Territory Foundation on Alcoholism and Drug Dependence (1976) (Drew, 1985)
In 1966, a federal body was formed that was to turn into the national peak body representing the non-government drug and alcohol sector. It was formed in the ACT originally under the name ‘Foundation for Research and Treatment of Alcoholism of Australia’, reflecting this initial concern with alcoholism (Stolz, 1978). Soon after, it changed its name to the Australian Foundation on Alcoholism and Drug Dependence (AFADD) (Stolz, 1978). The original constituents of AFADD were the state foundations FRATADD, VFADD and SAFADD. The national peak body has gone through multiple name changes since this time but was most recently as the Alcohol and other Drugs Council of Australia (ADCA). It served as the peak body representing the non-government AOD sector until recently, when it was defunded by the Abbott Government in 2012, to be discussed in more detail in the chapters that follow.

A number of state-based peak bodies have also emerged since the 1970s to represent non-government alcohol and other drug organisations in their states (Rankin, 2003; Seaborn & McBridge, 1978). There are peak bodies for drug and alcohol in each state and territory in Australia. They include, for example, the Network of Alcohol and other Drug Agencies (NADA) in NSW; the Tasmanian peak body, the Alcohol, Tobacco and other Drugs Council Tasmania formed in 2001; the South Australian Network of Drug and Alcohol Services (SANDAS) established in 2004; and the Queensland peak body, the Queensland Network of Alcohol and other Drug Agencies (QNADA) formed in 2007. These organisations represent drug and alcohol organisations in these states and territories and facilitate the voice of the sector in policy processes.

**Harm reduction and drug user organisations**

During the mid-1980s, mounting evidence demonstrating a link between injecting drug use and the transmission of blood-borne viruses (BBV) including HIV/AIDS spurred the mobilisation of collective action to try and address rising infection rates. It was during this time that harm reduction took root as a rationale for the development of a ‘social movement’, and strategies of harm reduction were mainstreamed and codified in governmental policy in Europe and Australia (Roe, 2005; Tammi, 2004; Tammi & Hurme, 2007). The ‘harm reduction movement’, however, is not a unified movement (Tammi, 2004). Using a constructionist framework, Tammi (2004) examines the meanings of harm reduction to different interpretive communities. She identifies three epistemic “fractions” (Tammi,
of harm reduction: a professional new public health fraction; a mutual-help and identity movement fraction of drug users; and a globally oriented fraction. These different fractions all approach harm reduction differently, with differing priorities regarding the risk of harm, as well as drug users (Tammi, 2004).

The role of NGOs in the promotion of harm reduction techniques has long been recognised, and there is a great deal of literature on the topic of harm reduction. Drug user organisations (DUOs), specifically, were influential in the implementation of harm reduction measures such as needle and syringe exchange programs (Crofts & Herkt, 1995; Lucas, 2011; Madden & Wodak, 2014; Mold & Berridge, 2008). In 2012, the national drug user organisations, the Australian Injecting and Illicit Drug Users League (2012a) released their own report on drug user organisations advocacy activities. The report explores experiences of drug user organisations with drug policy processes, including the aspects of their policy activity, their methods, and the outcomes of these methods. The authors note that some of the “most visible” activities of DUOs have actually been in a harm reduction and public health context rather than on drug use per se (Australian Injecting and Illicit Drug Users League, 2012a). Governments have funded their activities particularly in the area of blood-borne virus prevention and harm reduction (e.g. peer education and BBV prevention, hepatitis C treatment). Another important area of non-profit activity in harm reduction is what is referred to as the ‘party-drug scene’. Programs like RaveSafe or DanceSafe involved groups of volunteers from the rave or dance scene providing harm reduction services at raves or dance parties. It is only relatively recently that DUOs have been involved in drug treatment policy settings (Australian Injecting and Illicit Drug Users League, 2012a).

Although there have been peak drug user organisations for a number of years, as well as organisations providing leadership on harm reduction (e.g. Anex/Penington Institute), there has not been a peak harm reduction organisation. In 2015 Harm Reduction Australia was formed as a national organisation “for individuals committed to reducing the health, social and economic harms potentially associated with drug use” (Harm Reduction Australia, 2015a, para. 1). It aims to represent the views of its members in relation to drug policy issues.
Other organisations

There are other organisations that work with and provide specialist information and advocacy services for particular populations, for example multicultural populations or youths. There are now a range of non-government organisations involved in drug and alcohol service provision for Aboriginal people, some controlled by Aboriginal people themselves and some not. Criminologists have noted, in particular, the differential effect of particular laws — such as public intoxication laws — on Aboriginal Australians, over-criminalisation and their over-representation in the criminal justice (D’Abbs, 2012; McNamara & Quilter, 2015). Today, there is only one peak body representing Aboriginal organisations specifically in drug and alcohol matters. The Aboriginal Drug and Alcohol Council (SA) (ADAC) was established in 1993 “as a direct result of the Royal Commission into Aboriginal deaths in Custody” (Aboriginal Drug and Alcohol Council (SA)Inc, 2016). There are no other state peak bodies representing Aboriginal drug and alcohol services, and no national peak body. There is a national peak body representing Aboriginal Community Controlled Health Services (ACCHS): the National Aboriginal Community Controlled Health Organisation (NACCHO) was formed in 1974 as a peak body to represent these organisations nationally on Aboriginal health and wellbeing (NACCHO, 2016). Other organisations play a leadership role in the area, for example the Aboriginal Alcohol and Drug Service in Western Australia (Aboriginal Alcohol and Drug Service Inc (AADS), 2016).

Types of NGOs in the Australian Drugs Field

In summary, there are a range of other non-profit organisations involved in the drug alcohol sector in Australia and they approach drugs from a variety of positions. Organisations engage in a variety of practices including treatment, prevention, information provision, harm reduction, policy advocacy and representation, or some mixture of these activities. While not a perfect typology or categorisation, in Table 1 below I have outlined non-profit activity in a range of areas. These are not necessarily distinct categories and there is likely to be significant overlap between them, as well as significant differences in approaches between organisations.

29 The decommissioning of the National Indigenous Drug and Alcohol Committee will be discussed in the coming chapters (particularly Chapters 6 & 7).
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There has been a proliferation of types of non-profit action in the drugs field, as well as types of organisations involved in the area. Although NGOs have often enjoyed support and funding from government organisations, and NGOs and governments have long had some kind of relationship with government in the drugs field, but changes in political thought has resulted in changes in the forms of government/non-government relations in the drugs and crime field. As governments have actively sought to partner with non-government organisations, their forms and functions have shifted, and their relationships with governments have undergone transitions as well. The section below explores these developments in more detail.

**Drug Policy Partnerships, Governance and Stakeholders**

Through responsibilisation, modern government seeks to manage social problems such as crime and drug use not only through direct action but by encouraging action on the part of non-state agencies, organisations and individuals (Garland, 1996). Garland’s (1996) work provides a useful frame for analysing drug policy here. As he argues, NGOs and intersectoral partnerships are a key tool of governance here as the bureaucratic state seeks to devolve responsibility for crime and drug problems (Garland, 1996). Experts, in this case the non-government sector, are implicated in responsibilisation, serving to provide advice to citizens and government agencies, providing instruction on how they can reduce, prevent, manage or address drug use. The responsibility for drug policy is thus diffused across a range of actors who can persuade citizens to act appropriately. At the same time, however, Garland (1996) notes that where responsibilisation strategies work, it “leaves the centralised state machine with an extended capacity for influence and action” (p. 454).

As (1996); Garland (2001), O’Malley (1999b, 2008) and others have pointed out, the domain of crime control has witnessed a complex of hybrid, seemingly contradictory developments as the state tries to deny sole responsibility for the management of crime and social problems, encouraging communities to take shared responsibility for responding to these problems, yet at the same time tightening control over this area (Crawford, 1999a; Garland, 1996). In partnering government agencies, communities and
organisations in the name of crime control, there is a diffusion of responsibility for crime control, and a redistribution of risk (and blame) for programmatic failure (Crawford, 1999a; Garland, 1997; Mythen, Walklate, & Kemshall, 2012; Rose, 1999). Here, I focus on outlining the issues related to these policy responses to drugs, and the role of stakeholders and partnerships in drug policy with particular reference to the non-government sector.

The trends that Garland (1996, 2001) describes are evident in the domain of drugs and crime policy and practice, where government agencies have actively sought to partner with non-government organisations (NGOs) (Duke & Thom, 2014; Macgregor, 1998; MacGregor et al., 2014; Macgregor & Thickett, 2011; Mold, 2012; Mold & Berridge, 2010; Ritter et al., 2011). Intersectoral partnerships are now a commonplace strategy pursued by governments to both formulate drug policies and deliver essential programs and services (Thom et al., 2013b). In line with this trend, the ideas of partnership working and networked governance are of increasing interest to drug policy researchers (Duke & Thom, 2014; Lancaster & Ritter, 2014b; Thom, Duke, Frank, & Bjerge, 2013a). The literature published in this area since I began this study in 2012 has increased substantially. Recognising the involvement of a diverse range of actors in contemporary drug policy and service systems, drug policy scholars have been concerned to document and analyse the influence of these different stakeholders in particular policy areas (Duke & Thom, 2014; MacGregor et al., 2014; O’Gorman, Quigley, Zobel, & Moore, 2014; Singleton & Rubin, 2014; Wälti & Kübler, 2003; Wälti, Kübler, & Papadopoulous, 2004; Zampini, 2014). This work charts the complex relationships between forms of governance expertise, knowledge, evidence, politics and ideology in the drug policy arena. There is a diverse range of approaches to the study of drug policy and role of stakeholders, including Kingdon’s ‘multiple streams’ framework (Lancaster et al., 2014), the advocacy coalition framework (Kübler, 2001), as well as historical (Mold, 2004a, 2004b; Mold, 2012; Mold & Berridge, 2007; Mold & Berridge, 2008; Mold & Berridge, 2010) and mixed methods (Hellman et al., 2015; O’Gorman et al., 2014).

One emerging area of literature looks at governance and power relations in the drugs field. Recent work from the UK and the EU — especially stemming from the *Addictions and Lifestyles in Contemporary*
Europe-Reframing Addictions Project (ALICE-RAP) — has highlighted the role played by different stakeholders in contemporary drug policy governance processes and in the framing of the concept of addiction (Frank, Bjerge, Duke, Klein, & Stothard, 2015; Hellman et al., 2015; Thom et al., 2015; Thom et al., 2013a). Berends, Ritter, and Chalmers (2015) recently described the operation of collaborative governance in the reform of Western Australia’s AOD sector, observing that the stakeholders they interviewed reported positive relationships and that these facilitated the reform of the sector. Some of the contextual factors that facilitated the reform included increased funding for services, and the development of a partnership approach, characterised by a shared agenda and capacity for joint action (Berends et al., 2015). Wälti et al. (2004) provide an analysis of Swiss drug policy from a governance perspective, by investigating governance-induced problems of democracy in particular. They conclude that some of the deliberative and participatory criticisms of governance, while relevant, may not be entirely justified, noting that “the governance structures typical of drug policy are designed to be accessible to a wide range of private organizations and voluntary associations” (Wälti et al., 2004, p. 74). They, however, argue that governance structures contain some inherent biases that might exclude certain actors in some cases: “Thus, those directly concerned with drug policies, such as the addicts themselves, their families, as well as the neighbors affected by drug-related facilities are only occasionally present” (Wälti et al., 2004, p. 74). This is a theme that has been echoed in much of the work on stakeholder processes: the exclusion of the affected community themselves, people who use drugs, is a continuing theme (Frank et al., 2015; Hellman et al., 2015; Thom et al., 2015; Thom et al., 2013a).

Work from the UK describes the forms of partnerships in the drugs field as well as the shortcomings associated with partnership working (Macgregor & Thickett, 2011; Thom et al., 2013b). In their work on partnerships to address alcohol related harm, Betsy Thom and colleagues identified several themes including: consensus and tension around members’ relationships to each other and interactions; differences in professional cultures (e.g. medicine, law enforcement, social work etc.); differences in resources and allocating resources; and power imbalances between organisations involved in the partnerships (Thom et al., 2011; Thom et al., 2013b). A later article emphasises some of the problems
stemming from the incompatibility between requirements of collaboration and tensions between different institutional and professional cultures (health, social care and criminal justice for instance) (Thom et al., 2013b).

Whilst the rhetoric of governance and partnership is difficult to argue against, the actual operationalisation of these ideas is far from simple. The model of ‘good governance’ is an example here. ‘Good governance’ seeks to ensure that power is exercised fairly, stakeholders are afforded an appropriate voice, and that processes are accountable, transparent, open and fair. Homel and Homel (2012) define some of the main principles of good governance as: legitimacy and voice — that those in positions of power acquire and exercise that power legitimately, and that an appropriate voice is accorded to stakeholders; direction/strategic vision by those in power to guide action; performance — institutions and frameworks should be responsive to the interests of stakeholders; accountability of those in positions of power, transparency and openness; and fairness to ensure conformity to rules of law and equity (p. 441). Whilst these are good guidelines to work towards, the reality of some policy problems — ‘wicked problems’, like drug policy (Ritter & Berends, 2016) — means that there can be difficulty attaining consensus amongst stakeholders. In their study of the idea of ‘good governance’ in drug policy, Singleton and Rubin (2014) noted that stakeholders considered the good governance framework to be idealistic although “difficult to disagree with” (p. 940); the authors concluded that frameworks such as ‘good governance’ should not act as prescriptions, but rather as “heuristics that help provide insights and open-up thinking about potential solutions” (p. 940). The practical effect of governance and partnership working on policy outcomes is not clear. Thom et al. (2013b) point out that although partnerships are now a well-established strategy in drug and alcohol policy, whether or not they actually ‘work’ in practice or not is less well established.

Another concern about government/non-government partnerships in areas such as crime control and drug policy — where the state has so typically retained such a strong hold over policy development and regulation — is that NGOs will become extensions of the state and further the reach of state power through the criminal justice system (Tomczak, 2015). There is a growing literature on the role of
‘voluntary organisations’ in criminal justice — sometimes termed the ‘penal voluntary sector’ — that examines the role of voluntary organisations in working with prisoners, as well as in crime control and prevention programs (Corcoran, 2010; Corcoran & Fox, 2012; Mills, 2015; Mills, Meek, & Gojkovic, 2011; Mythen et al., 2012; Tomczak, 2013, 2015). This area of literature looks at the unique issues confronting voluntary organisations that work with offenders. The hybrid partnerships — where NGOs work with public and private organisations in a range of partnership models — that have become such a key feature of contemporary criminal justice presents a challenge to NGO independence, where ‘the fundamental values of the voluntary sector and its critical voice may be threatened’ (Hucklesby & Corcoran, 2016, p. 6) and co-opted in the name of state interests.

Research indicates that government control of the work of organisations through service delivery contracts has been a problem in the alcohol and other drug sector in the Australian context. In a report prepared for the Australian National Council on Drugs on NGOs in the Australian AOD field, Spooner and Dadich (2009) noted that interview respondents expressed concerns “about government constraints on the independence of NGOs to advocate for their communities, and about the ability of NGOs to influence government policy, although the evidence was mixed” (Spooner & Dadich, 2009, p. xvi). In a later publication, Spooner and Dadich (2010) noted that peak bodies had been weakened through funding conditions and contractual requirements — this demonstrates how public authorities impose contractual constraints on the use of government monies for public criticism of government policy. Spooner and Dadich (2010) also indicate that government policies encouraging marketisation have had an effect on the drug and alcohol sector, with NGO representatives raising concerns with competitive tendering processes (Spooner & Dadich, 2010).

It would be remiss, however, to present these trends as evidence of progressive state co-optation of the community and non-government sector. As suggested by the governmentality and other literature, the relations of power between the government and the non-government sector in the drugs and crime field are more complicated than simple co-optation. There is evidence of this from historical research on non-profit action in the drugs field. Alex Mold and Virginia Berridge have published a series of articles
and a book examining different facets of the history of ‘voluntary action’ around illegal drugs, using the topic as a case study for analysing broader issues around the changing relationship between the ‘state’, voluntary organisations and civil society (Mold, 2004a, 2004b, 2005; Mold, 2012; Mold & Berridge, 2007; Mold & Berridge, 2008; Mold & Berridge, 2010). In their book on voluntary action on drugs, Mold and Berridge (2010) identify that there has been a persistent rhetoric of partnership with the non-government sector since the 1960s; however, there have been major changes in the way the state relates to these organisations. Government funding of organisations has affected change in the drugs field, but they note “there has not been a neat, linear progression from pure voluntarism in the 1960s to ‘para-statal’ organisations or state incorporation today” (Mold & Berridge, 2010, p. 169). They observe that the relationship between the state and NGOs has often been a reciprocal one, pointing in particular to the role of NGOs in responding to the HIV/AIDS epidemic and the government funding of organisations “as they were believed to be more innovative and effective than statutory organisations” (Mold & Berridge, 2010, p. 169). Mold and Berridge (2010) argue that independent voluntary action on illegal drugs — such as lobbying for changes to drugs policy and the provision of new forms of service provision — has been a feature of the period they examined (1960s-2000s). Overall, they concluded that organisations have shown themselves to be flexible and adaptable, responding to changes in drug use and policy as well as wider social and economic trends (Mold & Berridge, 2010), thus challenging the neat narrative of ‘co-optation’.

**Advocacy in the Contemporary Drugs Field: Themes from the Literature**

Drugs policy, like many policy areas, is full of contestation, opportunities for innovation and opportunities for reform. Critical work in the drugs field has identified different ‘coalitions’ or groups of stakeholders that advocate for particular policy options. In a review of themes and trends in Australian drug policy, Ritter et al. (2011) highlight the importance of third sector organisations in Australian drug policy, and organisations’ heterogeneous approaches to advocacy. They identified two broad advocacy groups in Australian drug policy: conservative advocacy groups that promote abstinence oriented strategies and prohibitionist strategies, and those associated with harm reduction or
‘progressive’ approaches. Conservative or ‘prohibitionist’ organisations focus on ‘abstinence’ and achieving the goal of a ‘drug-free’ society through law enforcement, prevention and demand reduction (Mendes, 2007). There are a range of non-profit organisations that support prohibitionist and abstinence-based policies, including the Festival of Light, the Drug Advisory Council of Australia and Drug Free Australia (Mendes, 2007).30 Drug law reform organisations, or ‘progressive’ organisations are concerned with changing ‘unjust’ drug prohibitionist laws with an emphasis on advocating for the promotion of rational drug policy through harm minimisation (Australian Drug Law Reform, 2015). Example organisations include the Australian Drug Law Reform Foundation (ADLRF) established in 1993 and Family and Friends for Drug Law Reform.31 The influence of conservative versus progressive organisations has been commented on by Australian authors (Brook & Stringer, 2005; Ritter et al., 2011). Ritter et al. (2011) observed a shift in the key actors in drug policy ‘debates’ towards the inclusion of more conservative advocacy groups during the term of the Australian Prime Minister John Howard (1996-2007). Mendes (2007) similarly highlighted the influence of what he termed ‘prohibition groups’ in the Australian context during that time (Mendes, 2007).

The presence of similar coalitions has been noted in international jurisdictions. Kübler (2001) used the advocacy coalition framework to understand the change in Swiss drug policy from a focus on abstinence to harm reduction. The advocacy coalition framework views the “policy process as a competition between coalitions of actors who advocate beliefs about policy problems and solutions” (Kübler, 2001, p. 624). Specifically, he identifies two competing coalitions, the abstinence coalition and the harm reduction coalition, and one minor coalition, the quality of life coalition. A recent study by O’Gorman et al. (2014) investigated the drugs policy advocacy community in Europe. These researchers conducted an internet search for organisations meeting specific selection criteria. They identified 218 advocacy

31 Australian Drug Law Reform Foundation (ADLRF) is a non-profit organisation established in 1993 to “encourage a more rational, tolerant and humanitarian approach to the problems created by drugs and drug use in Australia” (Australian Drug Law Reform, 2015, para. 1). FFDLR takes an ‘activist’ role, and, amongst other things, advocates the ‘search for better drug policies based on evidence’ (McConnell & McConnell, 2015, p. 31). They highlight the harms caused by prohibition, and advocate the “removal of criminal sanctions for personal use of currently illegal drugs” (p. 31).
organisations based in the EU, including ‘civil society associations’ or voluntary associations, NGOs, and 'large-scale alliances and coalitions’, operating at different levels including locally, nationally and across Europe. Their study identified three major types of advocacy groups: professional advocacy groups including professional groups advocating on behalf of their clients or representing specific groups (35%); peer or self-advocacy organisations such as self-organised drug user groups and family support groups (17%); and public drug policy advocacy organisations that represent the interests or rights of particular groups or the general public (O'Gorman et al., 2014). O'Gorman et al. (2014) also identified two major areas of policy work: one focused on professional practice issues and service provision, and the other focused on changing or maintaining drug control legislation. They note that there are two opposing trends in the development of voluntary action around illegal drugs: “one moving towards abstinence and tougher measures on drugs, and the other moving towards abstinence and towards liberalisation and the establishment of drug use as a human ‘right’” (O'Gorman et al., 2014, p. 178).

Non-government organisations have even been recognised as important stakeholders in the international drug policy system (Carstairs, 2005). The United Nations Office of Drugs and Crime (UNODC) cooperates with non-government organisations and encourages their participation in its activities, recognising the “need to promote strong partnerships with civil society organisations” (United Nations Office on Drugs and Crime, 2016, p. para. 1). Non-government organisations, however, “cannot vote or contribute to debates; rather they seek to influence the views of national representatives” (Room & Reuter, 2012, p. 85). Consequently, whilst they hold an important symbolic role they have less capability to directly influence decision-making in the international system. Non-government organisations are important stakeholders in the domestic drug policy systems of many countries, including the US, the United Kingdom (UK), and areas of Europe (Macgregor & Thickett, 2011; Mold & Berridge, 2010; Narayanan, Vicknasingam, & Robson, 2011; O'Gorman et al., 2014; Thom et al., 2015).
The literature on drug user organisations highlights the important but often problematic and ambiguous role that these organisations play in policy processes (Australian Injecting and Illicit Drug Users League, 2012a; Crofts & Herkt, 1995; Lucas, 2011; Madden & Wodak, 2014; Mold & Berridge, 2008). Lucas (2011) draws on a governmentality approach to investigate partnerships involving people who use illicit drugs, and whether rhetoric matches the experience of people who use drugs. He argues that, “with a few exceptions, the concept of partnerships involving people who use illicit drugs is little more than a rhetorical tool used by neoliberal forms of government” (Lucas, 2011, p. ii). He lists the following as key factors that impede the success of ‘partnerships’: the impact of a morally conservative dominant discourse of prohibition; the political nature of what counts as ‘evidence’ in policy development and service delivery planning processes; and a lack of institutional support for genuine partnerships with people who use illicit drugs from governments, policy makers and service providers (Lucas, 2011, p. ii). Similarly, in their historical work tracing voluntary action on drugs since the 1960s in Britain, Mold and Berridge (2010) show that although governments outwardly encouraged the role of voluntary associations in drug policy, there have been a number of practical constraints limiting the role of drug users in particular in effecting policy change. In particular, they highlight the tensions between public health and criminal justice in British drug policy and how this affects the status of people who use drugs in services, particularly where those people have been coerced into treatment services by the criminal justice system under threat of sanction (Mold & Berridge, 2008).

There is a diverse literature discussing advocacy and its role in the genesis of changes in the drugs field. NGOs have played important roles in advocating for drug policy changes in international jurisdictions in developing countries (Baldwin, 2013). In particular, there is work demonstrating the roles that NGOs have had in encouraging the adoption of harm reduction measures to address HIV/AIDS and other BBVs. Across this work, NGOs have been documented as performing important advocacy activities including engaging the support of local academics and medical staff; educating partners on harm

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32 His methodology involved both the analysis of policy documents, and interviews with “members of the ‘drug policy community’, including policy-makers, service providers and members of peer-based advocacy organisations” (Lucas, 2011, p. ii).
reduction; and implementing harm reduction programmes (Aaraj & Jreij Abou Chrouch, 2016; Baldwin, 2013; Narayanan et al., 2011).

NGOs have played a role in drug policy changes in Australia. Case studies in the Australian context have highlighted the role played by non-government actors and agencies in particular cases of policy change, such as the introduction of diversion programs and naloxone overdose programs (Hughes, 2009; Lancaster & Ritter, 2014b). Caitlin Hughes’ (2009) study of the Illicit Drugs Diversion Initiative (IDDI) highlighted the significant role that non-government sector organisations had in the development of this policy. She argued that persuasive non-government sector advocacy was a key driving force in the move towards the IDDI. Specifically, the Alcohol and Other Drug Council of Australia (ADCA) (the peak non-government organisation for drug and alcohol in Australia) played a lead role in advocacy for diversion. She observed that advocacy was facilitated by prior changes to the governance arrangements allowing experts from the non-government sector to access and provide advice directly through the Prime Minister’s Office (Hughes, 2009).

Another growing advocacy movement, which has been discussed in the recent literature on drug policy, is the ‘New Recovery Movement’. This will be the focus of a focused analysis in Chapter 8. The new recovery advocacy movement was developed in the US in the late 1990s (Humphreys & Lembke, 2014; White, 2007). In terms of the historical context, White (2007) explains that growing dissatisfaction with the detachment of traditional addiction treatment from the community during the 1970s, 80s and 90s, and “shifts in broad cultural attitudes and social policies set the stage for a new politicised coalition of recovering people and their families and visionary addiction treatment professionals” (White, 2007, p. 696). According to White (2007) the core values and ideas of the movement centre on personal recovery as a platform for advocacy, the importance of ‘authentic, grassroots representation’ in drugs policy, recovery leadership, and the value of cultural diversity. The core strategies of the new recovery advocacy movement centre around: building strong local recovery advocacy organisations; advocating for meaningful representation in policy processes for people in recovery and their family members; educating the public, policy makers and service providers on recovery; creating recovery support
centres that deliver non-clinical, peer-based recovery support services; and supporting research that illuminates effective strategies and the processes of long-term recovery (White, 2007, pp. 700-701).

**Conclusion**

The aim of this chapter was to provide the conceptual grounding of the thesis and situate the current study in the broader literature on non-government organisations and drugs policy. The review of the literature outlined in this chapter has established a number of issues that provide important impetus for the current study. There is a broad narrative about the changing role of NGOs in contemporary welfare states: that they have an increased role in service provision as well as an increased role in policy processes (Goodwin & Phillips, 2015; Phillips & Goodwin, 2013). Modern liberal-democratic governments seek to form partnerships with NGOs and non-state agencies for the delivery of services and policy-making (Hancock, 2006). This thesis seeks to understand these trends in the particular context of the Australian drug and alcohol field, using the idea of governmentality as an analytic tool.

In the academic literature, and indeed within policy, the role of the non-government sector has largely been defined in relation to the state: as apart from the state, as an arm of the state, and sometimes against the state (Carey, 2008). Governmentality provides a conceptual framework that does not locate the reasons or source of power within people, institutions, or any one place, but rather views power from a relational perspective (Foucault, 1991a). Power is exercised, not held (Foucault, 1980); although it should be noted that this view of power does not discount the possibility for relations of domination. The relations between the state and the non-government sector in the drug field are complex as NGOs can simultaneously resist, perpetuate and be regulated by the state (Carey, 2008). Thus, Foucault’s idea of governmentality (Foucault, 1991a), and the way it has been extended in the criminological and ‘post-Foucauldian’ literature through the ideas of government at a distance and responsibilisation (Garland, 1997, 2001; Rose, 1996, 1999; Rose & Miller, 1992; Rose et al., 2006), provide this thesis with the conceptual tools to conduct a critical policy analysis of NGOs’ role in policy and the idea of ‘partnerships’ between governments and NGOs.
While the wider literature on non-government organisations (Goodwin & Phillips, 2015; Phillips & Goodwin, 2013) offers an indication of the types of issues that might be encountered by NGOs in the drugs field, it does not address the particular sector-level dynamics that shape NGOs’ role and influence in this particular policy domain. The regulation of drugs has a particular history — drug use is a criminalised behaviour, and drug policy options often operate at the intersection of justice, health and welfare. There are a number of particular understandings of drug use and policy approaches within the drugs field, and different interests expressed in the drug policy process (Lancaster, 2014; Lancaster et al., 2015; Lancaster et al., 2014). The kinds of discourses and ideas raised in this chapter — for example ideas around abstinence, recovery and the nature of the relationship between humans and drugs — resurface and permeate contemporary debates around drugs and policy options. Particular ‘movements’ and organisations differ in their conceptualisation of the nature of the problem of ‘drugs’ (i.e. whether it is a disease, a ‘moral failing’, a sin, a public health issue, a quality of life issue and so on) (Brook & Stringer, 2005; O’Gorman et al., 2014), and the legitimate goals of drug policy that address it. Informed by a critical policy studies framework, these are the kinds of struggles over meaning that will be explored in this thesis.

Whilst there is a growing literature that acknowledges the role of multiple stakeholders in drug policy processes (Hellman, Berridge, Duke, & Mold, 2016; Hellman et al., 2015), as well as the role of NGOs in influencing drug policy in Australia (Lancaster & Ritter, 2014b; McDonald et al., 2005; Ritter et al., 2011; Spooner & Dadich, 2009, 2010) and internationally (Mold & Berridge, 2010), overall there has been relatively little attention paid specifically to the policy role of NGOs in the Australian context. Although the existing literature provides a level of empirical detail about partnership working in the drug field, there has been less attention paid to the particular history of non-government/government relations in the Australian drugs field, how the idea of government/non-government partnerships has been constituted in drug policy, and how NGOs contribute to drug policy in Australia. There are very few studies that draw on the perspectives of representatives from AOD NGOs in Australia (for exceptions, see Spooner & Dadich, 2009, 2010). There is scope here for critical, in-depth and historically and contextually grounded analysis of government/non-government relations in the drugs
field. The purpose of this thesis is to begin addressing this gap in the literature, by unpacking some of the social, historical and political factors influencing and shaping the nature and outcomes of government/non-government relations and NGO’s policy role in the Australian drugs field.
Chapter 3: Methodology and Research Design

In the last chapter, I drew attention to the trend towards government/non-government partnerships and the increasing involvement of a range of stakeholders in drug policy processes, demonstrating that there is a need for empirically, historically and contextually grounded study of the role of NGOs and their relations with the state in the Australian drugs field. I concluded by acknowledging that while scholarly literature has started to provide some detail about partnership working in this area, less attention has been paid to the history of government/nongovernment interaction and if and how NGOs have been and are able to contribute to the development of policy in the drugs field. Consequently, this research aimed to investigate the role of NGOs in Australian drug policy and their relationships with the state. To do this, the following research questions were pursued:

1. What are the key historical, social, and political conditions that have shaped government/non-government relations and the development of ‘partnerships’ in the drug policy field?
2. What are the contemporary conditions shaping the role and work of NGOs in the Australian AOD field?
3. What is the relationship between the rhetoric of government/non-government ‘partnerships’ and the experiences of NGO representatives in drug policy processes?
4. How have NGOs engaged with, and attempted to shape, drug policy?

These questions called for a qualitative research design. Qualitative research methods are particularly well-suited to answering research questions focused on describing the how, what, why, when and where of particular phenomena (Berg & Lune, 2017). Qualitative research, at its core, focuses on processes, understandings and social meaning, and aims to provide richly descriptive accounts of social phenomena (Merriam, 2009).

This chapter describes the methodology and research design of the project. It begins by outlining my theoretical frame through a discussion of how governmentality and critical policy studies informed the methodology of the research. Building on this foundation, this chapter systematically documents the
research design of the project, including the study aims, particular research methodologies engaged, data sources, data collection processes, analytical procedures, ethical considerations and the limitations of the study. The final section of the chapter reflects on how I ensured quality in my research design.

**Methodology**

Qualitative research is an umbrella term that encompasses a broad range of methods, theoretical positions and orientations (Merriam, 2009). As outlined in Chapter 1, the methodological approach in this study is informed by governmentality studies and the critical policy studies literature, and as such is underpinned by a social constructionist “orientation to knowledge” (White, 2004, p. 7). Burr (2003) distinguishes between micro-constructionist approaches and macro-constructionist approaches. Where micro-constructionist approaches are concerned with the complexities of how individuals use language in interaction, macro-constructionist approaches to discourse analysis — within which this research is situated — concentrate on “the way that the forms of language available to us set limits upon, or at least strongly channel, not only what we can think and say, but also what we can do or what can be done to us” (Burr, 2003, p. 22). So the focus here is not on how individuals use language per se, but on the broader view of how discourses operate in wider social structures, relations and institutions. Macro-constructionism is influenced by the work of Foucault, in that it “acknowledges the constructive power of language but sees this as derived from, or at least related to, material or social structures, social relations and institutionalised practices” (Burr, 2003, p. 22). Thus, constructionism rejects the positivist assumption that there is an objective nature to social reality, or that academic researchers can accurately or objectively observe and represent that reality (Burr, 2003). In doing so, the approach also rejects a positivist approach to knowledge, emphasising instead the contingent and socially constructed nature of that knowledge (Burr, 2003). This thesis takes a macro-constructionist approach because it problematises the taken for granted idea of government/non-government ‘partnerships’ in the drugs field, and seeks to understand how the contemporary role of NGOs in drug policy is contingent on various historical, political and social dynamics. Below, I describe how the critical policy studies literature and governmentality informed the methodology for this study.
Critical Policy Analysis and Governmentality

As outlined in Chapter 1, this study presents a critical analysis of government/non-government partnerships and the role of NGOs in the Australian drug policy field. Governmentality here is used as an analytical tool for conducting a critical policy analysis of ‘partnerships’ between government and non-government organisations in the Australian drugs field. Key to the critical policy studies literature is attention to power and problematisations in policy (Orsini & Smith, 2006). This research is thus aligned with the critical drug policy studies literature that sees policy-making as a problematising activity (Colebatch, 2002; Lancaster, 2014; Lancaster et al., 2015; Lancaster & Ritter, 2014a). Bacchi (2015) distinguishes between two approaches to ‘problematisation’ in the critical policy studies literature: interpretivist and post-structural. Key concerns for interpretivists are how problems get defined as ‘policy problems’, how actors or claims-makers contribute to problem-construction, and in turn how problem construction affects the solutions proposed (Fischer, 2003; Yanow, 2000). They highlight how the very construction of policy problems and resolutions is a highly political process involving numerous actors who bring with them different interests, values, knowledges, and interpretations to the policy process (Fischer, 2003; Yanow, 2000). Whilst interpretivists emphasise the social agency of actors in constructing policy problems, poststructuralists prefer to analyse “the conceptual underpinnings of identified governmental problematisations” (Bacchi, 2015, p. 3). As highlighted in the introduction, this is not a post-structural study but it does draw on some of Foucault’s tools — in particular, the idea of governmentality — as tools for analysing problematisations in policy.

There are a range of methodological approaches within the critical policy studies literature (Diem, Young, Welton, Mansfield, & Lee, 2014; Fischer et al., 2015; Orsini & Smith, 2006). Although approaches vary, studies in the field of critical policy studies are united in their sceptical view of positivist and traditional methodologies for studying the policy process (Diem et al., 2014; Fischer et al., 2015; Orsini & Smith, 2006). Whilst traditional approaches to policy analysis view policy-making as akin to a reactive process of identifying and responding to concrete problems as if this were a value-
neutral, a-political process, critical approaches direct us to questions of politics, power and representation (Bacchi, 2009). In the context of the current study, a critical policy studies framework directs attention to how normative and moral assumptions operate to construct policy problems, which complements the study of political rationalities and the moral and ethical justifications for government studied under governmentality (Gordon, 1991). Governmentality provides the study with a framework for understanding “the complexity of the processes through which government is ‘assembled’ from a complex of institutions, practices and ways of thinking” (Colebatch, 2002, p. 417). Methodologically, it highlights the constitutive role of language but does not ignore practice, instead seeing them as interconnected: “a governmentality perspective appreciates the mutually constitutive relationship of language and practice, the complex interweaving of representation and intervention” (Merlingen, 2003, p. 371). In viewing modern government as an inherently problematising activity (see the discussion on pp. 10-11), governmentality calls attention to the relationship between language, representation, power and knowledge.

Attention to power is a crucial element of any critical policy analysis (Orsini & Smith, 2006). For scholars of governmentality, governing is inextricably bound up with relations of power, knowledge, and expertise. Governmentality scholars are concerned not only with how the state exercises power, but with the operation of power/knowledge through a multiplicity of strategies, technologies and programmes for ‘the conduct of conduct’. Power, in its most basic sense, is “actions upon others’ actions” (Gordon, 1980, p. 5). However power — in a Foucauldian sense — is not conceived of as something that can be ‘possessed’ and then wielded as a tool of domination over others, but rather as something that is exercised:

Power must be analysed as something which circulates… and not only do individuals circulate between its threads; they are always in a position of simultaneously undergoing and exercising this power….individuals are the vehicles of power, not its point of application (Foucault, 1980, p. 98).

Furthermore, mechanisms of power are tied to the production and circulation of different types of knowledge. Here, Foucault (1980) discusses the reciprocal relationship between knowledge and power:
“knowledge and power are integrated with one another, and there is no point in dreaming of a time when knowledge will cease to depend on power…It is not possible for power to be exercised without knowledge, it is impossible for knowledge not to engender power” (p. 52). Following the thinking of Foucault (1980), the governmentality literature sees power and knowledge as indivisible from each other.

Rose and Miller (1992) elaborate on what ‘knowledge’ means for governmentality scholars: “knowledge here does not simply mean ‘ideas’, but refers to the vast assemblages of persons, theories, projects, experiments and techniques that has become such a central component of government” (p. 275). To govern, then, is contingent on ‘knowing’ what is to be governed — the objects of government. Knowledge is what makes reality ‘programmable’, what makes “action upon action” possible (Gordon, 1980). In modern liberal forms of rule, for example, the collection of information on all aspects of ‘the domain’ to be governed — on aspects such as the population, the economy and so on — is a crucial part of understanding the objects that are to be governed, and for allowing action upon those objects (Rose, 1999). In line with this, modern government draws on forms of expert knowledges, such as medicine and psychiatry, to more fully understand the objects and subjects that are to be governed (Dean, 2009; Rose, 1999). However, power/knowledge is not conceived of as a purely negative force, but as a productive one: “We must cease once and for all to describe the effects of power in negative terms…power produces; it produces reality; it produces domains of objects and rituals of truth” (Foucault, 1979, p. 194). In this way, power/knowledge and the study of governmentality is also linked up with problematisations and representation in discourse.

Interpretations of the term ‘discourse’ vary widely, and the way an author uses the term generally stems from their theoretical orientation. Jorgensen and Phillips (2002) observe that most contemporary discourse analysis draws on Foucault’s conception of discourse. In The Archaeology of Knowledge, Foucault (1972) defines discourse as:

…a group of statements in so far as they belong to the same discursive formation… it is made up of a limited number of statements for which a group of conditions of existence can be
defined. Discourse in this sense is not an ideal, timeless form...it is, from beginning to end, historical — a fragment of history...posing its own limits, its divisions, its transformations, the specific modes of its temporality (p. 117).

This definition emphasises the historical and contextual features of discourse. A Foucauldian conception of discourse links discourse with social practice. Foucault understands discourse as “practices that systematically form the objects of which they speak” (Foucault, 1972, p. 49). This means that discourses are understood not just as language or ways of talking about objects, but as practice too. To say discourses “form the objects of which they speak” means that discourses are constitutive, they shape or represent whatever object it is they refer to in a certain light:

a discourse refers to a set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events...there may be a variety of different discourses, each with a different story to tell about the object in question, a different way of representing it to the world (Burr, 2003, p. 64).

Furthermore, discourses are not static; they are constantly undergoing processes of change (Foucault, 1991b). Discourse analysis in the Foucauldian sense has been described as an orientation or approach to research, rather than a set of methods or a blueprint for research per se. Foucault referred to his writings as a “toolbox” of concepts for others to draw upon, but never defined a method for doing discourse analysis in a Foucauldian sense (McLaren, 2009). Thus, there is no one way to approach a study using Foucauldian concepts (Arribas-Ayllon & Walkerdine, 2008; Graham, 2005; Kendall & Wickham, 1999; McLaren, 2009); however, the focus of governmentality studies on political rationalities, problematisations, power, and discourse influenced the methodological approach taken in this study.

**Realist Governmentality**

The work presented in this thesis draws on an approach to governmentality that has largely developed within criminology and has been extended in critical social policy studies (Garland, 1997; Lippert & Stenson, 2010; McKee, 2009; Stenson, 2005). The aim of this line of governmentality studies is to address some of the limitations of ‘discursive governmentality’ studies (Stenson, 2005). Rather than focusing on the analysis of official discourses, as is typical in studies focused on discursive formulations
of governmentality, the ‘realist governmentality’ — as Stenson termed it — approach used here is concerned to document the local and specific practices of governing by employing techniques drawn from ethnography (McKee, 2009). Whilst recognising that policies have a discursive element, the point is to use empirical evidence about practices to avoid the tendency in the governmentality literature to try and equate what is contained in official text with what is actually accomplished through the application of policies. Following Garland (1997), the aim is to provide a “grounded social analysis that tries to make sense of a field as it actually operates and as it is experienced by those who inhabit it” (p. 201). The point is to “reintroduce the social actor into empirical analysis” (Phoenix & Kelly, 2013, p. 426), to provide an analysis that recognises that “social actors have the capacity to make choices based on their knowledge of the world around them and their experiences of it, albeit in conditions that constrain, limit and at times determine their actions” (Phoenix & Kelly, 2013, p. 426).

Where traditional discursive governmentality studies have been accused of not paying enough attention to the specific contexts and processes of government, the ‘realist governmentality’ framework addresses these critiques by combining discourse analysis of governmental rationalities with empirically grounded, realist analysis using methods such as interviews. In this way, it offers a conceptual and methodological framework that is useful for studying the ‘who, what, how and why of modern governance’ (Hobson, 2010, p. 259). I use this approach to move beyond an account focusing on partnerships in policy rhetoric, towards an empirically grounded analysis of the complexities involved in NGOs’ role in drug policy (Parr, 2009).

To gain a more nuanced understanding of the relationship between “discourses and practices ‘from below’” with those “from above” requires analysis that is grounded in empirical detail about historical, social and political context (Lippert & Stenson, 2010). Garland (1997) explains that to properly understand how particular rationalities are deployed, and in what circumstances, requires attention to politics. He goes on to suggest that governmentality

must concern itself with struggles and conflicts and low politics — phenomena that don’t involve the invention of new problematizations or the transformation of rationalities, but do

He elaborates on these ideas in relation to crime control, noting that the field has been shaped as much by historical and political factors as it has been by governmental rationalities (Garland, 1997, p. 202). Combining both textual analysis and interviews allowed this research to provide a fuller picture of rationalities and programs of government, and how politics affects their realisation in practice. As such, combining these methods allowed this study to investigate how problems are represented in government texts, along with how these programmes of government are ‘experienced’ by social actors, and how politics shapes relations of power in the drugs field. Textual analysis of governmental documents allowed for the identification of political rationalities, programs and strategies of government, whilst semi-structured interviews with representatives from NGOs offered insight into how political rationalities, strategies and programs of government are experienced and responded to by social actors in the drugs field. In the section below, I discuss the specific methods I employed in this study in more detail.

**Research Design**

The literature that sketches out the terrain of governmentality, critical policy studies and discourse analysis is not methodologically prescriptive — it merely presents a range of advice and some specific orientations to research practice. In the context of the current research, realist governmentality and critical policy studies informed my methodological approach by demanding attention to power relations, problematisations and their effects, and the historical, social, political and culturally contingent nature of policy. Ultimately, the actual methods employed must be tailored to the purposes of the specific research task at hand. In the following section, I specify the research design followed for the study, including methods and data collection, their relationship to the research questions in this study, ethical considerations, and issues of quality.
Methods and Data Collection

This thesis provides empirical detail on both the historical and contemporary context shaping the role of NGOs in the Australian drug policy field. The project involved a combination of documentary analysis, policy analysis and semi-structured interviews with representatives from NGOs involved in policy work in the drug and alcohol sector in Australia. This qualitative approach allowed for the collection of rich, in-depth data that could be used to address the research questions. Table 2 below maps the relationship between each research question and the data sources drawn on in the study, as well as the chapters that respond to each question.

<table>
<thead>
<tr>
<th>Research Question</th>
<th>Data Sources</th>
<th>Chapter</th>
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<tbody>
<tr>
<td>1. What are the key historical, social, and political conditions that have shaped government/non-government relations and the development of 'partnerships' in the drug policy field?</td>
<td>• Government drug policy&lt;br&gt;• Interviews&lt;br&gt;• Secondary literature</td>
<td>Chapter 4</td>
</tr>
<tr>
<td>2. What are the contemporary conditions shaping the role and work of NGOs in the Australian AOD field?</td>
<td>• Policy documents&lt;br&gt;• Interviews&lt;br&gt;• Alcohol and other Drug Treatment Services National Minimum Dataset (AODTS-NMDS)</td>
<td>Chapter 5</td>
</tr>
<tr>
<td>3. What is the relationship between the rhetoric of government/non-government 'partnerships' and the experiences of NGO representatives in drug policy processes?</td>
<td>• Interviews&lt;br&gt;• Secondary literature</td>
<td>Chapter 6</td>
</tr>
<tr>
<td>4. How have NGOs engaged with, and attempted to shape, drug policy?</td>
<td>• Governmental drug policy, documents and reports&lt;br&gt;• Organisational documents&lt;br&gt;• Secondary literature&lt;br&gt;• Interviews</td>
<td>Chapter 7</td>
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Textual analysis: Document selection

I undertook a broad-based analysis of policy documents, government reports, organisational and unofficial documents, and academic literature. The process of document selection and analysis was inductive and iterative. Document selection was informed by a range of sources, including:
1) Key documents identified by other authors throughout the course of research

2) Key policy documents produced by government

3) Key policy documents produced by organisations

4) Emerging policy

5) Secondary sources such as academic journal articles, news articles

Extensive internet searches — using both directed internet searches informed by the sources outlined above, as well as key word searches (using a combination of words such as non-profit, drugs, non-government, and substance) in Google — helped to identify relevant policy and organisational documents. Document analysis also helped inform the identification and selection of potential organisations to target for recruitment for the semi-structured interviews, described below.

**Interviews**

To complement the documentary analysis, I conducted semi-structured interviews with 19 representatives from the Australian non-government AOD sector. The use of the semi-structured interview format allowed for the collection of rich data about the different aspects of the role of NGOs in drug policy to answer the research questions outlined above. To identify potential organisations and participants, a listing was made of non-government organisations involved in the drug policy process. The listing was developed by compiling information from a range of sources, including: 1. Organisations identified by secondary sources (e.g. Organisations identified by McDonald et al. (2005)); 2. Organisations identified as having made submissions to selected governmental inquiries and public consultation processes (identified through publicly available submissions on governmental websites) and 3. Internet searches for relevant non-profit organisations.

I compiled a list of organisations that made submissions to the following inquiries and public consultation processes: the Commonwealth House of Representative Inquiry into Substance Abuse in Australian Communities (2002-2003); the House of Representatives Inquiry into the Impact of Illicit Drug Use on Families (2007); the New South Wales Inquiry into Drug and Alcohol Treatment (2012); the National Drug Strategy 2010-2015 first and second round public consultations; and the Victorian
Drug Strategy Consultation (2011). These inquiries were chosen because they involved public consultation processes and submissions were available online. I manually entered details of organisations that made submissions to these inquiries using a table format so I could see how many times organisations contributed submissions across these consultations. This allowed me to focus my participant recruitment strategy by focusing firstly on organisations that made the most submissions. I then conducted internet searches on these organisations and developed a list with contact details.

Sampling was purposive, supplemented by snowball sampling (Berg & Lune, 2017). Participants were targeted for recruitment based on the following criteria: staff member of an NGO identified through the initial listing described above, who as a part of their work engages in or assists with advocacy and policy work, or who has assisted with this work in the past. Due to the practical constraints of the research, the potential participant pool for the interviews was limited to Queensland, New South Wales, Victoria and the Australian Capital Territory. Organisations were contacted via telephone in the first instance, then emailed a copy of a recruitment letter (see Appendix A). Access to some participants was facilitated by an academic ‘gatekeeper’, and in one case a participant suggested that another participant be interviewed.

In total, I conducted semi-structured interviews with 19 representatives from 19 different non-government organisations. Representatives were drawn from a range of organisations performing a diversity of functions including the service provision, advocacy/representation, harm reduction, prevention, support and treatment. Participants were drawn from across Queensland (4), Victoria (6), New South Wales (5) and the Australian Capital Territory (4). A total of 9 males and 10 females were interviewed. Interviews were conducted between September 2014 and April 2015. They lasted between 15 minutes and 1 hour and 30 minutes, with most lasting approximately an hour. Participants were drawn from a diverse range of organisations and generally held senior or leadership positions. All but one interviewee held a current role with an NGO involved in commenting on drug policy. All participants had experience of drug policy work, defined as preparing submissions, policy positions and
sitting on committees or other participatory processes. Some participants worked with or had worked with multiple organisations, and had also held roles in government.

A semi-structured interview was selected as an appropriate format for the interviews to collect rich, in-depth information to answer the research questions. In semi-structured interviews, “either all of the questions are more flexibly worded, or the interview is a mix of more or less structured questions” (Merriam, 1998, p. 74), allowing for the interviewer to clarify responses or use probing questions to elicit more information. The interviews were conducted by the author using an interview guide addressing broad themes around the policy process, government/NGO relations, partnerships, and drug policy issues (see Appendix B). In the following section I outline the processes of document selection and data analysis for each chapter in more detail.

**Research Approach and Analysis**

The data collection and analysis phases were iterative and dependent on the research question. Chapter 4 presents a genealogy of government/non-government partnerships in drug policy at the national level, and provides the grounding for this thesis by outlining the ‘conditions of possibility’ for the contemporary role of NGOs in Australian drug policy. I draw on Garland’s (2014) interpretation of genealogy here as a tool for critical policy analysis. Genealogy proceeds by identifying and problematising some existing practice, idea or issue — in this case government/non-government partnerships in drug policy — and tracing its historical, social and political emergence and development with a view to critically analysing the chosen phenomena (Garland, 2014; Howarth, 2000). The aim is not to produce a ‘total history’ of the phenomena under investigation, but rather a more nuanced perspective that reflects and accounts for political, social and historical influences and events. As Garland (2014) explains, historical materials are used to:

...trace the struggles, displacements and processes of re-purposing out of which contemporary practices emerged, and to show the historical conditions of existence upon which present-day practices depend (p. 372).
So, whilst as a methodology genealogy demands attention to history, it does so from an orientation firmly rooted in the present (Garland, 2014).

The analysis presented in Chapter 4 covers the period 1960-2015. The 1960s were chosen as an appropriate starting point for the chapter based on the review of literature (presented in Chapter 2), because this is when government and non-governmental activity around drugs began to proliferate. To identify relevant drug policy directions and governmental and organisational documents published prior to the 1990s (since most of these documents and organisations have not been digitised), I searched academic literature for references to relevant organisations and documents. To locate these documents, I searched the collections held at the National Library of Australia, the New South Wales State Library and the Victorian State Library, as well as the University of Queensland library, using a combination of key words and organisational titles identified during my initial reading of academic literature. I also identified and collected each of the National Drug Strategy documents and evaluation reports that have been produced since 1985 (when the first Australian national drug policy document was published). Where drug policy documents were not available — as was the case during the period of the Abbott government — I searched parliamentary websites, minister’s websites and newspaper articles to identify relevant indications of emerging policy strategies. The documents identified as relevant to this study were used in conjunction with other sources of information, to situate the relevant statements in their broader historical, social or cultural context.

The documents selected can be divided into five categories: (1) Government drug policy documents, including all national drug strategy documents released since 1985, and evaluations of these documents; (2) Policy documents and government statements about the non-government sector (e.g. the Rudd-Gillard government’s National Compact, see page 116) as well as inquiry reports; (3) Documents produced by NGOs in the AOD sector; (4) Emerging policy at the time of analysis, as documented on government websites; (5) Academic literature, newspaper articles and other sources. The sampling strategy aimed to achieve a balance between ‘official’ accounts, as contained in policy documents, and
unofficial accounts as contained in organisational documents, newspaper articles and other unofficial sources.

The aim of the analysis in Chapter 4 was to present a coherent historical narrative of the development of government/non-government partnerships in Australian national drug policy. To turn the genealogical ethos outlined above into a practical method for analysis, I followed a process similar to that of ‘discourse tracing’ outlined by LeGreco and Tracy (2009). I identified and collected documents using the process outlined above, and assembled the data set in NVivo 10 and 11. The aim was to assemble it chronologically to trace changes over time. Textual analysis then involved reading the documents, noting the particular language or terms used, and continuities and changes over time. I searched each document for references to the voluntary, community, non-government or not-for-profit sector, and for use of the term partnerships, intersectoral, or collaboration. I then analysed the context in which these terms were used. The following two questions acted as a guide for textual analysis: 1. How are NGOs and the non-government sector represented (i.e. how is their role or purpose discussed)? 2. How do documents discuss the respective roles of government and non-government organisations, and how are they to interact? The chapter also draws on the experience of interviewees where relevant.

Chapters 5, 6 and 7 approached the data taking into account the ‘realist governmentality’ concern to examine “the interplay between discourse and its effects in the ‘real’” (McKee, 2009, p. 479), and relied on a combination of thematic and discourse analysis. Discourse analysis does not have defined procedures as such but provided a theoretical perspective to link the thematic analysis with “broader assumptions, structures and/or meanings” around drug policy, constructions of policy, NGOs and governments, and power relations (Braun & Clarke, 2006, p. 85). Braun and Clarke (2006) note the compatibility of thematic analysis and discourse analytic frameworks. Thematic analysis was used to provide a “grounded, empirical, realist analysis” (Stenson, 2005, p. 266) of the interview data, while discourse analysis provided an approach to link the thematic analysis with broader meaning structures around political rationalities. The process of thematic analysis followed the steps outlined by Braun and Clarke (2006). I began by familiarising myself with the data by transcribing the interviews and reading
the transcripts, then generated initial codes using both inductive and deductive coding based on theoretical ideas drawn from the literature. Following this I searched for over-arching themes and reviewed the data in light of those themes. NVivo 10 and 11 was used to assist with the practical aspects of storing, managing and coding of the interview and documentary data.

Chapter 5 responded to the second research question, “What are the contemporary conditions shaping the role and work of NGOs in the Australian AOD field?” through a discourse and thematic analysis of state and territory and national drug policy documents, semi-structured interviews and statistical data. I collected and analysed drug strategy documents released since the mid-2000s from the ACT, NSW, QLD and VIC. I compiled tables outlining and comparing the major principles of each document, as well as the major themes of each document. Statistical data collected by the Australian Institute of Health and Welfare Alcohol and other Drug Treatment Services National Minimum Dataset (AODTS-NMDS) was analysed to investigate and establish some broad trends in the AOD sector. I accessed the data-cubes that are publicly available on the Australian Institute of Health and Welfare website (Australian Institute of Health and Welfare, 2016).

The analysis in Chapter 5 combined discourse and thematic analysis in an analysis of drug policy documents and the interviews. I began by reading the policy documents and coding them in NVivo using the process of thematic analysis outlined above. Once I had a list of codes, I began refining these into larger categories or themes. I then used discourse analysis to link some of these themes with broader, overarching discourses present in the drug policy documents and interviews. I also analysed data from the AODTS-NMDS (as described above) and present this as evidence for some of the key trends I identified.

Chapter 6 relied mainly on thematic analysis of the semi-structured interview data (discussed above). I followed the process of thematic analysis outlined by Braun and Clarke (2006). The process of analysis was directed at answering the research question, “What is the relationship between the rhetoric of government/non-government ‘partnerships’ and the experiences of NGO representatives in drug policy
As such, I analysed the interviews looking at how participants discussed their relationships with government, the purpose of NGO involvement in policy, and how they are involved in drug policy. NVivo 11 was used to manage the coding process. The literature reviewed in Chapter 2 about neoliberalism and its impact on NGOs, governmentality, government at a distance and responsibilisation provided the conceptual framework informing the data analysis presented in Chapters 4, 5, and 6. In each of these analytical chapters, ideas from the data are related back to ideas discussed in this literature.

Chapter 7 is a focused analysis of ‘new recovery’ to further explore the policy role of NGOs. During internet searches for documents in 2012, I identified ‘new recovery’ as an emerging point of policy discussion in the Australian AOD sector at that time, and a number of NGOs had released their own position papers on the topic. Thus, ‘new recovery’ was chosen as a case for the thesis to answer the final research question, “How have NGOs engaged with, and attempted to shape, drug policy?”. The chapter draws on an analysis of the interview data and documents related to recovery policy. I searched for and collected documents produced by NGOs and the ANCD regarding new recovery, and I asked about the topic during the semi-structured interviews. Policy transfer and policy translation was used as a framework to guide this analysis (see pp. 213-216). These frameworks focus on how knowledge and ideas about policies, administrative arrangements or institutions are ‘transferred’ or ‘translated’ from one policy context to another (for example, across different jurisdictions or different policy areas) (Stone, 1999, 2012). Work on policy transfer has been conducted from within the rationalist/traditional policy studies, as well as in critical and social constructionist approaches to policy analysis (McCann & Ward, 2012). The analysis presented in Chapter 7 is aligned with a social constructionist approach to policy analysis. The ideas of policy transfer, policy mobilities and policy translation have been critiqued and extended in the critical policy studies literature (Lendvai & Stubbs, 2007; McCann, 2008; McCann & Ward, 2012; Peck & Theodore, 2012), and as such are compatible with the critical policy studies framework used in this study.
**Ethics**

Ethical clearance was obtained through Griffith University Office for Research, protocol number CCJ/43/13/HREC. All participants were provided with an information sheet (Appendix C) outlining the details of the project, as well as a consent form (Appendix D). All interviews were recorded and transcribed by the author. All participants agreed to have their interview recorded and transcribed. All data was de-identified during the transcription process.

To ensure the anonymity of participants, limited demographic and organisation data is presented here and identifying details have been omitted (Lancaster, 2016a). The drug and alcohol sector in Australia is a relatively small, contained field and presentation of demographic information may risk identifying participants. Interview transcripts were de-identified — references to respondent’s organisations, roles or particular people were removed. General professional descriptors are included here where relevant, but not linked with jurisdictional information to ensure anonymity (Lancaster, 2016a). This presents a methodological limitation but was necessary to protect the identities of participants in the study.

**Position of the Researcher**

My interest in the topics addressed in this thesis arose during my undergraduate studies and during my honours year, when in the process of analysing drug policy documents I saw the notion of ‘partnership’ recur time and time again. During my honours year, I spoke with representatives from NGOs who were involved in providing treatment to criminal justice clients; this spurred my interest further in NGOs’ roles in governance in the drugs field. I also want to emphasise my position as a researcher in this project — not as an objective interpreter of documents or interview transcripts, but as a particular filter for the research, as I selected the major ‘ruptures’, points for investigation and issues of concern. I carried particular assumptions into the research process, including the assumption that NGOs do have a role to play in policy processes and in challenging relations of power, but that it is necessary to be critical of how NGOs can be involved in reproducing and perpetuating dominant power relations.
Ensuring Quality

Despite the rejection of positivist approaches to knowledge, issues of quality are still a major concern in qualitative research. The ideas of validity and reliability that are wedded to the quantitative research paradigm are inappropriate for qualitative research. Instead, qualitative researchers generally use different criteria for ensuring quality, including rigour, trustworthiness, credibility and transferability. There is debate in the literature about the most appropriate ‘measures’ of quality in qualitative research. Tracy (2010) outlines eight broad criteria that usefully summarise the key markers of quality discussed in the literature. These eight criteria are: 1. Worthy topic; 2. Rich rigor; 3. Sincerity; 4. Credibility; 5. Resonance; 6. Significant contribution; 7. Ethics; and 8. Meaningful coherence (Tracy, 2010, p. 837).

Having already covered a number of these criteria in this chapter and in the ones preceding it, I will focus here on rigour and credibility. Studies that are rigorous outline rich and ‘thick’ description and explanation, drawing on data to adequately support the points made (Tracy, 2010). According to Tracy (2010), the credibility of research relates to its ‘trustworthiness’ in description, and thick description helps to ensure credibility. Credibility can also be ensured through ‘crystallisation’ in critical research, which “encourages researchers to gather multiple types of data and employ various methods, multiple researchers, and numerous theoretical frameworks” (Tracy, 2010, p. 844). The inclusion of multiple voices adds to the credibility of research (Tracy, 2010). I have tried to ensure that this study is rigorous and credible both with an adequate sample of documents and interviews (in terms of both breadth and diversity of voices), and by presenting quotations from the documents collected, and from the interview data, to support my analysis through ‘thick description’ of the research results. I did not use processes of member-checking as this is not directly consistent with critical, poststructural and constructionist paradigms (Tracy, 2010).

33 In chapters 1 and 2, I established that the topic is worthy of investigation. Chapter 1 and Chapter 8 outline the contribution of the study. This chapter (Chapter 3) covered ethics and established the ‘sincerity’ of the research by being transparent about the methods employed in the study and reflected on my position as a researcher.
Conclusion

This chapter presented the methodological framework and research design that was used in this study to investigate the role of NGOs in Australian drug policy. Governmentality and the critical policy studies literature guide the critical analysis of government/non-government partnerships contained in this thesis. Using realist governmentality — an approach that emphasises both discourse analysis and empirical methods — allowed me to strengthen the research design through the collection and analysis of both official discourse, as contained in policy documents and government reports, and ‘unofficial’ discourse through semi-structured interviews with representatives from NGOs. This allows for a fuller appreciation of the effects of the governmental discourse of government/non-government partnerships in drug policy. In the following four chapters, I present the results of this work to provide a better understanding of the dynamics of government/NGO relationships and NGOs policy role in the drugs field. The next chapter provides the foundation for this thesis, by tracing the ‘conditions of possibility’ for the contemporary role of NGOs in the Australian drug policy environment.
Chapter 4: The Rise of Partnerships: A Genealogical Account*

This chapter traces the ‘conditions of possibility’ for the contemporary role of non-government organisations in the drugs field through a genealogy of the idea of government/non-government ‘partnerships’ in Australian drug policy. The chapter responds to the first research question by unpacking some of the social, historical and political factors influencing government/non-government relations in the Australian drug policy field. Although the existing literature provides a level of empirical detail about partnership working in the drug field, there has been less attention paid specifically to the history of government/non-government relationships in drug policy, and how governments have shaped a space for the non-government sector through policy documents. This is important because, as Bacchi (2000) notes, the meanings constructed through policy and discourse impose constraints by shaping conceivable and practicable action. Using genealogy — as interpreted by Garland (2014) — and discourse analysis as tools for a critical policy history, the chapter charts the emergence of the discourse of partnerships in the AOD field. The chapter is based on a close reading of all national drug strategy documents since 1985, as well as government reports, and non-government reports. Where relevant it also draws on the interviews described in Chapter 3 to add a level of empirical detail about government/non-government relations.

Whilst it was established in the literature review (Chapter 2) that the state and the non-government sector have a long history of relations in the drug and alcohol field, this chapter will establish that it is not until relatively recently in that history that governments have come to articulate NGOs’ role in drug policy in terms of ‘partnerships’. The chapter identifies a number of ‘conditions of possibility’ shaping the contemporary role of NGOs in drug policy, including the formation of peak bodies and drug


34 As Henry-Edwards and Pols (1991) note, “voluntary agency and private practitioner response to need appears to have preceded governmental responses in most jurisdictions” (p. 42).
and alcohol foundations from the 1960s, the association of NGOs with the idea of ‘community’ since at least the 1970s, and the rise of neoliberal political rationalities from the 1980s. The chapter argues that the policies of the Hawke/Keating Labor government during the 1980s set the stage for the contemporary role of NGOs in drug policy, namely through the embrace of neoliberal policies and through Hawke’s introduction of the first national drug policy in the form of the National Campaign Against Drug Abuse (NCADA). With the strengthening of neoliberal rhetoric under the Howard Coalition Government (1996-2007) — and its augmentation through this Government’s embrace of neo-conservative values — the non-government sector was officially positioned as a ‘partner’ to the National Drug Strategy.

**Beginnings of a ‘Sector’: Drug and Alcohol Foundations**

The first point of departure in this genealogy of government/non-government partnerships is the formation of peak bodies and drug and alcohol foundations from the 1960s. The founding of these agencies contributed to the emergence of an alcohol and other drug ‘sector’ that the state could engage with. Peak bodies representing clusters of voluntary organisations focused on the welfare of the population began to form in the middle of the 20th Century. First amongst these was the New South Wales Council of Social Service, formed in 1936 to co-ordinate the service provision of a range of charities and organisations during the Great Depression (O’Brien, 2008, p. 7). The first national peak body, the Australian Council of Social Services, was founded in 1956 (O’Brien, 2008). As the state’s role in welfare expanded through the 1940s and 1960s and 1970s, so too did the role of these peak bodies. Over time these peak bodies — also called ‘umbrella organisations’ — took on a more political role, providing a ‘voice’ for the non-government, ‘community’ sector to advocate for funding and services for the disadvantaged, vulnerable, and marginalised members of society (Melville, 2008; Mendes, 2008). Governments funded these organisations thereby legitimating their political role and purpose (Mendes, 2008; O’Brien, 2008).

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35 There are, of course, other important issues that contribute to the contemporary role of NGOs in drug policy that will not be discussed in this chapter in any great detail — these include the history of non-profit action on drugs (already discussed in Chapter 2) and shifts in thinking about drugs.
As discussed in Chapter 2 (pp. 39-41), during the late 1950s and 1960s a number of state foundations focused on alcohol were established (Lewis, 1988, p. 398). During the 1960s and 1970s, the state foundations increased their activities with government support, and began including drug dependence in their remit — largely to further their aims of helping to raise awareness of alcohol and tobacco as drug issues (Drew, 2014). While illicit drug use was “very low during the 1940s and 1950s” (Hamilton, 2001, p. 100), the 1960s saw an increase in the use of drugs such as cocaine, marijuana, and heroin (Lewis, 1988, 2003). During this time, a number of acts were passed during the 1960s that also allowed for the treatment for alcoholism and drug ‘dependence’ (Manderson, 1993; Stolz, 1978). Reflecting this change in thinking, most of the state foundations changed their names to reflect their new inclusion of drug dependence within the briefs, beginning in the 1960s when FRATA changed its name to the Foundation for Alcoholism and Drug Dependence (FRATADD) (Seaborn & McBridge, 1978). In a personal reflection of responses to AOD in Australia, Les Drew — Senior Medical Adviser on Alcohol and Other Drugs 1975-1988 with the Commonwealth Department of Health — observed that the prohibition of drugs (solidified with the Single Convention of 1961) threatened “the focus on alcohol as our primary problem drug” (Drew, 2014). He argued that although there was professional resistance to prohibition, “community organisations incorporated drugs within their agenda to ensure the acceptance (by the liquor industry) of alcohol and tobacco as ‘drugs’” (Drew, 2014, p. 2).

36 The first of these was FRATADD discussed in Chapter 2. Other state foundations included the Alcoholism Foundation of Victoria (later known as the Victorian Foundation on Alcoholism and Drug Dependence and currently known as the Alcohol and Drug Foundation [ADF]) in 1959, and the South Australian Foundation on Alcoholism and Drug Dependence (SAFADD) in 1963. By the 1970s, the other states also had foundations which fulfilled a similar role to FRATADD, VFADD and SAFADD: the Tasmanian Foundation on Alcoholism and Drug Dependence (1975), the Australian Capital Territory Foundation on Alcoholism and Drug Dependence (1977), the Alcohol and Drug Problems Association of Queensland (1974), and the Northern Territory Foundation on Alcoholism and Drug Dependence (1976) (Drew, 1985).

37 Beginning in the 1960s, the following states and territories enacted legislation: South Australia passed the Alcohol and Drug Addicts Treatment Act in 1961, and it was in operation by 1965; the Alcohol and Drug Dependency Act was enacted in Tasmania in 1968; the Western Australia Alcohol and Drug Authority Act in 1974 established a statutory authority on drug and alcohol. In Victoria there was a special branch under mental health created through the Alcoholics and Drug Dependent Act of Victoria in 1968 (proclaimed 1974) which led to the formation of the Alcoholics and Drug Dependent Services Branch under the Mental Health Authority in 1972. QLD amended old legislation (the Inebriates Act of 1896) in the 1960s to allow for voluntary admission of alcoholics into the Wacol clinic (Lewis, 2003).
These foundations assumed an important role not only in treatment and rehabilitation, but also advocacy, information and education around drug and alcohol issues (Lewis, 1988, 2003; Rankin, 2003; Stolz, 1978). The foundations were strongly connected with medical professionals as well as Government departments, and joined forces with public servants to raise community awareness and lobby for services (Stolz, 1978). As Drew (1985) noted, however, while the foundations brought together medical and other professionals to fulfil a range of objectives (such as community awareness raising, stimulating government action, encouraging treatment services, improving professional practice, and to encourage research), “research played a relatively minor role” in their activities for most of them (p. 345). The foundations engaged in a range of community awareness raising activities, including holding public education sessions, conferences, and in the case of FRATA, holding an annual ‘Alcoholism Information Week’ to promote the idea of alcoholism as a treatable disease (Foundation for Research and Treatment of Alcohol of NSW, 1964, 1965). Stolz (1978) argues that in those states where the ‘foundation movement’ began (NSW, VIC and SA), the effect they had on community awareness resulted in those states being “ahead of others in actual services” (p. 233). The foundations were involved in delivering services themselves, but also sponsored the development of other services (Seaborn & McBridge, 1978; Stolz, 1978).

The formation and activities of these foundations and peak bodies can be seen as the initial beginnings of a constitution of the alcohol and other drug (AOD) ‘field’ in Australia. During the 1970s, efforts to improve community awareness of drug and alcohol issues increased, and there was major growth in the treatment and service network (Room, 1988). Robin Room (1988) observes that the Australian drug and alcohol treatment and service network experienced major growth during the mid-1970s. A number

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38 There was an intertwining of efforts in the medical profession and efforts in the non-profit sector in the Australian drug and alcohol field. AFADD had close links with the medical profession, with a large proportion of their membership being doctors (Stolz, 1978). In 1981, the Australian Medical Society on Alcohol and other Drugs (AMSAD) was established. While initially the organisation was largely formed from the medical profession, the society began to accept non-medical professions as full members and changed its name to reflect that change. It is currently known as the Australasian Professional Society on Alcohol and other Drugs (APSAD); it has a broad-based, multidisciplinary membership. The organisation was funded by the Commonwealth government to produce a journal, then known as the Australian Drug and Alcohol Review, now Drug and Alcohol Review.
of important activities were undertaken during the 1970s and 1980s — often led by AFADD — to advance the profession. The foundations were involved in a range of professional activities such as organising conferences and publishing scholarly journals, beginning with FRATADD publishing a journal in 1972 (Seaborn & McBridge, 1978). AFADD began a library and a journal, the Australian Journal on Alcoholism and Drug Dependence in 1974 (Stolz, 1978). They established several committees including a Professional Education Committee, and a National Alcohol and Drugs in Industry Committee. Community Alcohol and Drug Awareness Programs were established in each state. A series of conferences were held by AFADD throughout the 1970s and 80s. Governments also supported these activities, with conferences often being supported by and attended by government representatives, and journals also established with the assistance of government funding (Seaborn & McBridge, 1978; Stolz, 1978).

As discussed in Chapter 2 (pp. 43-45), during the 1970s and 1980s state-based peak bodies emerged to represent non-government alcohol and other drug organisations in their states. This period also saw a range of government ‘experiments’ with statutory drug and alcohol authorities. In some states, both statutory authorities and peak bodies were established to improve relationships and co-ordination between the government and non-government sectors. For example, in New South Wales “the primary motivation for the creation of the Drug and Alcohol Authority in 1977 had been to improve co-ordination between the government and non-government sector” (New South Wales Standing Committee on Social Issues, 1990, p. 19). This authority established the NSW peak body for non-

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39 In 1972 FRATADD NSW began a journal named FRATADD. Rodney Seaborn, the president of FRATADD, writes in the president’s introduction that the journal was intended “to be the mouthpiece in Australia, not only of the Foundation’s own activities, but of all the more important and salient activities and problems concerning alcoholism and drug dependence throughout Australia and the rest of the world and also to be an important avenue whereby those Overseas would know the Australian picture” (Seaborn & McBridge, 1978, p. 7).

40 FRATADD was set up with the co-operation of government agencies, including the NSW Department of Health and the Liberal-National coalition government.

41 The Western Australia Alcohol and Drug Authority Act in 1974 established a statutory authority on drug and alcohol; and the New South Wales Drug and Alcohol Authority formed later in 1977. In Victoria there was a special branch under mental health created through the Alcoholics and Drug Dependent Act of Victoria in 1968 (proclaimed 1974) which led to the formation of the Alcoholics and Drug Dependent Services Branch under the Mental Health Authority in 1972. QLD amended old legislation (the Inebriates Act of 1896) in the 1960s to allow for voluntary admission of alcoholics into the Wacol clinic (Lewis, 2003). In QLD, ACT, SA, NSW and NT, Health departments have mostly had responsibility for drug and alcohol (apart from the relatively short-lived statutory bodies in SA and NSW already mentioned).
government AOD services, the Network of Alcohol and other Drug Agencies (NADA) in 1978. This was “aimed at facilitating the integration of government and non-government drug services, aiding the development of uniform policies, and obviating the competitiveness among drug agencies” (New South Wales Standing Committee on Social Issues, 1990, p. 19). The emergence of these peak bodies further augmented the relations between state and non-profit action, adding to the capacity for the political participation of non-government organisations in the drug and alcohol policy space.

**Drug policy from the 1960s-1984: The Push for a National Approach**

Another major point in the genealogy of government/non-government ‘partnerships’ is the increase in activity of the ‘welfare state’ initiated under the Whitlam government (1972-1975), which contributed to an increase in NGOs working in the health and welfare fields. Further to this, since the 1970s, there has been a proliferation of governmental and non-governmental activity around drugs and an aligning of the non-government sector with the idea of ‘community’.

**Mobilising Community**

The Whitlam government elected at the end of 1972 championed a public health agenda that shaped the form of drug policy in the 1970s, and moved the Commonwealth, State and Territory Governments from a passive role to active participation in drug policy formulation and service delivery (Task Force on Evaluation, 1992). The ideals of social democracy heavily influenced the Whitlam Labor Government when it made sweeping changes to social welfare policy, by providing funding for a whole range of social services and encouraging the formation of a range of new non-government, community-based organisations (Graycar, 1979). Indeed, the Whitlam government has been credited with the ‘re-invigorating’ of the voluntary sector and with reshaping forms of voluntary action in Australia (Oppenheimer, 2008). In 1973 it instituted the National Community Health Program (NCHP), which later incorporated the Community Mental Health, Alcoholism and Drug Dependency Program. Direct funding specifically for agencies addressing drug and alcohol problems allowed a range of services including drop-in centres, crisis and drug referral centres to be established (Everingham, 1975).
peak body AFADD was funded under this Community Health Program to provide representation for the NGOs, government services and professionals in the area of AOD (Henry-Edwards & Pols, 1991). A 1975 annual report from AFADD indicated that it received government support for political activities, legitimated through the foundation’s representation as a ‘community voice’:

...an aroused community will be the major instrument in determining the necessary political and administrative reforms in an effort to contain all the damaging ramifications of alcoholism and drug dependence. The need for a community voice is expressed in the Australian Government’s recognition that we are a Foundation with freedom to express opinions at all levels including the political arena (Australian Foundation on Alcoholism and Drug Dependence, 1975, p. 1).

The president of AFADD at the time, John Moon, noted that the Foundation would need to take the lead in contentious areas of reform that are still relevant today, including: liquor trading hours; advertising; legalisation of cannabis; and decriminalisation of alcoholism and drug dependence (Australian Foundation on Alcoholism and Drug Dependence, 1975). Moon stressed the need for the foundation’s voice to remain “responsible and balanced”, but that “one would rather see such active involvement from the fence sitting timidity of non-action” (Australian Foundation on Alcoholism and Drug Dependence, 1975, p. 2). The Whitlam government encouraged the joint working of state and ‘voluntary’ authorities in implementing legislation, research, policy initiatives and programs (Everingham, 1975).

The lack of adequate funding from governments for AOD services has been an ongoing issue of concern and was identified as early as the 1970s when a drug services sector was being formed (Australian Foundation on Alcoholism and Drug Dependence, 1976, 1977, 1980, 1981, 1982). AFADD Annual Reports from 1976 to the 1980s discuss the lack of adequate financial support for the drug and alcohol service sector (Australian Foundation on Alcoholism and Drug Dependence, 1976, 1977, 1980, 1981, 1982). In the introduction to the 1975 AFADD Annual Report, the President John Moon wrote about the “conflict between fiscal and health responsibilities of Government”, but that in his own view, “there
is a gross imbalance in this regard at present” (Australian Foundation on Alcoholism and Drug Dependence, 1975, p. 2). He goes on to say that:

Whilst one does not doubt the honest conscience and idealism of many individuals, one at times despairs at the apathy, indifference, ignorance and even prejudice of some habituated perspectives of our present cultural awareness. We are all grateful for the vision which has led the Australian Government to take steps to provide moneys for state instrumentalities and the work of the foundations, but even moderate appraisal will indicate that the amount of money provided to date is absurdly small when compared to the needs (Australian Foundation on Alcoholism and Drug Dependence, 1975, p. 3).

A study conducted by the Victorian foundation (VFADD) came to similar conclusions, noting that while both the Commonwealth and Victorian governments had accepted some responsibility for drug and alcohol funding, their response overall had been disappointing (Victorian Foundation on Alcoholism and Drug Dependence, 1974). Other documents analysed from this period similarly lament the lack of awareness in relation to alcohol and drug issues in the community, highlighting that the foundations and NGOs have a ‘responsibility’ to mobilise action in this area (Australian Foundation on Alcoholism and Drug Dependence, 1976, 1977, 1980).

Part of the rationale behind increasing community awareness of drug and alcohol issues was to responsibilise and mobilise the community in ways that would support self-directed action on health — the state should not be considered solely responsible for community health. At the 1975 AFADD conference, Dr Doug Everingham, then Minister for Health explained:

We [members of the population] have been conditioned to believe that the onus for our own health is no longer on us... We, the Government, the Foundation, the Community, must help to reverse this thinking. The health of the community is the responsibility of the community. We can and should but guide and tutor, not prescribe and soft-soap. Governments and single organisations however fired with evangelical zeal are failing. The community itself must be motivated and must mobilise (Everingham, 1975, p. 5).
Indeed, it appears that the foundations also supported this approach, with most documents from the period making reference to the need for community to take responsibility for health issues and for drug and alcohol issues (Australian Foundation on Alcoholism and Drug Dependence, 1976, 1977, 1980).

**The ‘Age of Inquiries’**

Despite the activity around drugs at the Commonwealth and state levels, there was still nothing approaching a co-ordinated national approach to drug policy. Manderson (1993) noted that the 1970s was ‘the Age of Inquiries’ into drug issues (see Table 3 below), most of which highlighted the lack of co-ordination between the states and territories, and the need for the federal government to take a leadership role in relation to drug policy. These reports also highlighted the ‘epidemic’ of illegal drug use, or an increase in illegal drug use, that occurred during the 1970s.

<table>
<thead>
<tr>
<th>Year</th>
<th>Inquiry Name</th>
<th>Jurisdiction</th>
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<tbody>
<tr>
<td>1971</td>
<td>Senate Select Committee on Drug Trafficking and Drug Abuse (the Marriott report)</td>
<td>Commonwealth</td>
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<tr>
<td>1977</td>
<td>Senate Standing Committee on Social Welfare (the Baume report)</td>
<td>Commonwealth</td>
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<tr>
<td>1978</td>
<td>New South Wales Joint Committee upon Drugs</td>
<td>New South Wales</td>
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<tr>
<td>1979</td>
<td>Royal Commission into the Non-Medical Use of Drugs (Sackville report)</td>
<td>South Australia</td>
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<td>1979</td>
<td>Royal Commission into Drug Trafficking (Woodward report)</td>
<td>NSW</td>
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<tr>
<td>1980</td>
<td>Australian Royal Commission of Inquiry into Drugs (Williams report)</td>
<td>Commonwealth</td>
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In 1971, the report of the first major Commonwealth inquiry into drugs was released under the name *Report of the Senate Select Committee on Drug Trafficking and Abuse* (otherwise known as the Marriott report) (Senate Select Committee on Drug Trafficking and Drug Abuse, 1971). Overall, the Marriott report emphasised the importance of conceptualising drug problems as individual problems requiring treatment rather than punishment:

> The evidence is clear that drug abuse in Australia is mainly a problem within the individual and therefore greater emphasis should be placed on the treatment of an illness rather than a punishment for a crime (Senate Select Committee on Drug Trafficking and Drug Abuse, 1971, p. 3).
The committee encouraged a change in attitudes so that drug dependence should not be treated as a crime but as “a sickness” (Senate Select Committee on Drug Trafficking and Drug Abuse, 1971, p. 62).

The Committee made a point of emphasising the shared responsibility for addressing drug issues:

…drug abuse will require concerted action by the community as a whole. The range of measures necessary should not and cannot be left to any one sector. Governments can undoubtedly help but this is not a field wholly appropriate to government agencies (Senate Select Committee on Drug Trafficking and Drug Abuse, 1971, p. 50).

The report commented on the role of voluntary organisations a number of times, and recommended that “every encouragement should be given to the development of voluntary organisations in the community available for counselling those with personal problems and for providing emotional support to those needing it in times of stress or crisis” (Senate Select Committee on Drug Trafficking and Drug Abuse, 1971, p. 91). The important role of voluntary organisations in treatment provision was reiterated several times, and the report recommended that governments support them financially, minimally on a dollar for dollar basis. The findings of this inquiry provided the foundations with a strong backing to push for more government support — the foundations dedicated significant activity to lobbying government, and in October 1972 the Federal government provided funding for AFADD to open a national secretariat (Stolz, 1978).

Another Commonwealth inquiry, the Senate Standing Committee on Health and Welfare, released its report *Drug problems in Society — An Intoxicated Society?* in 1977 (otherwise known as the Baume Report) (Senate Standing Committee on Health and Welfare, 1977). This inquiry investigated the use of alcohol and tobacco as well as illegal drugs in Australian society, noting the problems associated with these legal drugs as well. The committee advocated a public health approach aimed at minimising the harms of these drugs. It also recommended the decriminalisation of personal possession of cannabis, and noted the disconnection between the legal status of drugs and their social and health effects. Furthermore, it noted the lack of co-ordination between State/Territory and Commonwealth Government efforts and laid out a model for a national drug strategy (Senate Standing Committee on
The government response to the recommendations of the Baume report was mixed, and slow in forthcoming. In 1980, however, a public health approach was endorsed by the Fraser government (more than two years after the report was released). Others in the government were openly hostile and a Royal Commission of Inquiry into Drugs was initiated almost immediately after the Baume report was released. The terms of reference for this inquiry were a lot narrower than the Baume inquiry and focused only on illegal drugs, and in particular legal frameworks and law enforcement.

In 1980 the Commonwealth Royal Commission of Inquiry into Drugs released its report, which provided a comprehensive report on drug issues in Australia. It is a huge report split over 6 volumes. Although it mainly covers law enforcement issues and legal frameworks, there is also a section that looks at treatment, and representatives from the voluntary sector made submissions to the inquiry process. The inquiry was notable for its heavy focus on crime and law enforcement issues. The report noted the important role of voluntary organisations in providing treatment, as well as drug education (Australian Royal Commission on Drugs, 1980): “voluntary and community organisations in all States and Territories conduct individual prevention, treatment and rehabilitation programs which [sic] Government organisations, because of their more rigid structure, are unable to provide” (Australian Royal Commission on Drugs, 1980, p. C3). The report added that according to some witnesses some treatment facilities “are better provided by voluntary agencies rather than government-run institutions. Voluntary agencies usually form in response to the identification of some need perceived within the community. They are faster to react than government-run agencies” (Australian Royal Commission on Drugs, 1980, p. C21). These examples discursively positioned the sector as being able to fulfil a role that the government does not have the capacity to do. The position of the sector ‘in the community’ is the source of its legitimacy and effectiveness in terms of service provision.

A number of states also initiated their own inquiries into drug use during this period, such as the New South Wales Joint Parliamentary Committee on Drugs (1978), the South Australian Royal Commission into the Non-Medical Use of Drugs (the Sackville report) and the New South Wales Royal Commission into Drug Trafficking both in 1979. The Sackville report similarly recommended harm reduction measures.

The government implemented an excise tax on alcohol, which now funds the organisation Foundation for Alcohol Research and Education (FARE)
These examples show how during the 1970s and 1980s the role of the non-government drug and alcohol sector came to be associated with the idea of ‘community’. Community here is used in a post-war welfarist sense, where the rhetoric of community fulfils “several imperatives simultaneously” (Lacey & Zedner, 1995, p. 304) by acknowledging both state responsibility for the welfare of citizens and the inefficiencies associated with state provision of services (Thomas, Bull, Dioso-Villa, & Smith, 2016). The meaning of community is, of course, not objective and fixed — there is no clear definition of the term ‘community’, and it is used to mean different things in different contexts (Crawford, 1999b). Despite this, the idea of ‘community’ has continued to profoundly shape the ways that the role of NGOs is thought about and expressed, as will be shown in the analysis presented below.

Laying the Antecedents of Partnership: The Australian Approach to Drug Policy from the 1980s – mid 1990s

Although the period of the Whitlam government saw important changes in drug policy and the relationships between governments and NGOs, the widespread restructuring of the welfare state and social policies that have occurred since the 1980s provided the key conditions to allow the ‘partnerships’ rhetoric to flourish (Thomas et al., 2016). During the 1980s to 1990s, neoliberal policy approaches — as promoted in the UK and US, under Thatcher and Reagan respectively — concerned with the excesses of the welfare state and the application of market-based logics to public services became increasingly influential in the Australian political landscape, and laid the foundation for the emergence of government/non-government partnerships discourse in drug policy.

During the late 1970s to early 1980s, the federal Liberal-National Fraser Government (1975-1983) sought to deal with economic downturn and rising inflation rates by attempting to cut public spending and create incentive structures for private expenditure (Mendes, 2008). The Fraser government dismantled universalist welfare programs (e.g. dismantling Medibank) and instead set about instituting residual welfare, balancing the provision of compassionate ‘safety nets’ for the poor on the one hand
with the move against ‘big government’ and encouraging self-reliance on the other (Mendes, 2008). It sought to delegate funding responsibility back onto state and territory governments, therefore national funding programs for community organisations provided under the Whitlam government were cut (Oppenheimer, 2008). Towards the end of the 1970s, the evaluation and accountability of government performance started becoming prominent concerns. In Australia, a federal inquiry was conducted into evaluation in health and welfare services. In 1979 the ensuring report entitled ‘Through a Glass, Darkly’ recommended the ongoing evaluation of government programs, and highlighted the need for data and the development of standards, performance indicators, and accountability criteria (Senate Standing Committee on Social Welfare, 1979).

The economic downturn of the early 1980s increased pressure on the Commonwealth government to engage in new fiscal strategies to increase Australia’s competitiveness in the emerging global marketplace. This set the stage for the newly elected Hawke Labor Government to implement a different set of economic ideas that has since shaped the direction of the Australian political economy (Collins & Cottle, 2010). It is outside the scope of this thesis to review all the changes undertaken by this government; suffice it to say most authors cite the Hawke government as the initiators of ‘neoliberalism’ in Australia (Collins & Cottle, 2010). The Hawke and Keating Labor Governments (1983-1996) implemented changes that reconfigured the relationship between state and voluntary action, as they reinstated funding for community service NGOs (that the Fraser government had decreased) and at the same time increasingly used the non-government sector to deliver what were essentially government-mandated social policy initiatives (Lyons, 2001).

The neoliberalism of Hawke-Keating Labor governments was still heavily influenced by the social democratic welfare model, and thus was a predecessor to the ‘third way’ discourse of the US and the UK (Smyth, 2002, p. 426). The ‘third way’ “suggests that government work with organizations outside of government to address social issues” (Carey & Riley, 2012, p. 695), bypassing tensions between neoliberal and social-democratic politics around the role of the state in the delivery of welfare (Giddens, 1998). There are parallels between third way discourse and the actions of the Hawke Government in
reducing the direct provider role of the state and encouraging new forms of social provision (Pierson & Castles, 2002). The Labor governments of this period also implemented policies that enhanced the organisation and political capacity of the non-government sector: they provided considerable funding and support for peak bodies to try and streamline interactions between public authorities and NGOs (Sawer, 2002). The policies of this period increased the capacity for political participation by NGOs and contributed to the professionalisation of the sector through managerialist agendas encouraging performance indicators and measurable outcomes (Sawer & Jupp, 1996).

**Drug Policy: A National Strategy**

The 1980s were a defining period for Australian drug policy (Thomas et al., 2016). By the mid-1980s, there was growing recognition of the need for a national, co-ordinated approach to drug policy. Reflecting the calls of various committees and inquiries during the 70s, the federal government was to play a leadership role in the development of a national strategy. Drug policy was of personal interest to then Prime Minister, Bob Hawke, who publicly revealed that his own daughter had struggled with a heroin addiction (Bull, 2008). In 1985, following community consultation and a special Premiers’ Conference, the Hawke Government introduced the National Campaign against Drug Abuse (NCADA) — this marked the beginning of a codified, coordinated national policy approach to addressing alcohol, tobacco, and other drugs in Australia (Department of Health, 1985). Although policy in the health bureaucracy versus law enforcement bureaucracy had generally developed along different tracks, in NCADA they coalesced. NCADA’s response to the ‘drug problem’ combined a focus on education, treatment and law enforcement. Indeed, crime and corruption and law enforcement had become central governmental concerns in the mid-1980s as a series of events within the NSW police force destabilised the NSW government, and later the Queensland government with the Fitzgerald inquiry (Bennett, 2008). These events also became prominent in the lead up to the 1985 federal election. Bennett (2008) has argued that the introduction of NCADA was a political response to a range of problems associated with crime and corruption, rather than simply a response to health or drug abuse per se.

44 See Bennett (2008) for a detailed description of these events.
This is not to overstate the concerns around crime and corruption in the lineage of NCADA, nor to downplay concerns around health; rather it demonstrates the complex genealogy of the national response to drugs embodied in NCADA. No doubt, the various inquiries and activities mentioned above also played a role in this genealogy. While reflecting on the relationship between governments and NGOs, one informant — who had been involved in the sector throughout this period — observed that the 1980s was a time of major change for drug policy, and felt that the federal government was open to new possibilities:

Look I think unfortunately it’s been, there’s been a lot of times where it’s been quite poor. There’s also been some times when it’s been good. You know, you go back to the Hawke days, of course Bob Hawke breaking down on TV, probably a long time before you would know about this but you’ve heard about it. So when was it, ’85, Bob Hawke breaking down on TV and talking about his daughter’s heroin use meant that he was suddenly open and the government was suddenly open to hear about new possibilities. (Interview 5)

The non-government sector played a consultative role in contributing to the development of NCADA and a particularly important role in the development of the ‘harm minimisation’ focus of the policy (Blewett, 1988). Reflecting on NCADA’s first years in 1988, Health Minister Neal Blewett noted the extensive community consultation that occurred before the Drug Summit in April 1985. The peak body ADFA also played an important role in the development of the strategy. With Capital Territory Health, ADFA organised a joint workshop bringing together key stakeholders to develop a unified proposal for the strategy. A key outcome of this workshop was the initial formulation of the ‘harm minimisation’ policy (DA:NA Organising Committee, 1984). Although the term is not fully articulated in NCADA, this national document marked the beginning of Australia’s ‘harm minimisation’ approach to drug policy (Lancaster & Ritter, 2014a). The overall aim of the NCADA was to “minimise the harmful effects of drugs on Australian society” (Department of Health, 1985, p. 2).

45 For a more detailed discussion of the development and intersections of discourse and policy on drugs, crime and corruption in Australia, see (Carney, 1980; Manderson, 1993)
The NCADA laid out the antecedents to inter-sectoral partnerships (Thomas et al., 2016) by identifying drug use as a ‘national issue’ requiring “a national approach…with co-operative effort and mutual support across jurisdictional boundaries” (Department of Health, 1985, p. 3). The document also identified and defined the role of a number of different stakeholder groups including hospitals, the media, and ‘voluntary agencies’. It provided an indication of the nature of the relationship between the state and non-government sector in the drugs field: “many voluntary agencies could be provided with an increased level of support from Government services and should operate and be seen as an integral part of a balanced package of services” (Department of Health, 1985, p. 7). Consequently, NCADA laid the foundation for the future inclusion of the non-government sector as ‘partners’ in the national drug strategy.

The non-government sector is associated with ‘the community’ throughout NCADA. One underlying principle of NCADA is that “a major emphasis should be to strengthen the capacity of existing institutional and other community structures to deal with drug abuse” (Department of Health, 1985, p. 3). NCADA elaborated the basis for the non-government sector’s involvement in the drug field under the heading of ‘community-based services’, where ‘voluntary agencies’ are identified and valued through their position within the community. The report notes that government services and hospitals “may remain distant from the local community” (Department of Health, 1985, p. 7), as opposed to ‘community groups’ who are able to respond to ‘perceived needs’ in the community. The campaign suggests that voluntary agencies be provided with increased “support from Government services and should operate and be seen as an integral part of a balanced package of services” (Department of Health, 1985, p. 8). It goes on to note that agencies receiving government funding would be held “accountable” for the expenditure of such funds, and “contribute to the provision of statistical information” (Department of Health, 1985, p. 8). Speaking about NCADA in 1988, then Health Minister Neal Blewett (1988, p. 199) noted that resources from the campaign “have been directed to expanding existing networks, creating opportunities for anti-drug actions within existing communities and to providing non-professional community organisations with the wherewithal to participate in the National Campaign”. Thus while the emphasis in NCADA is largely on voluntary organisations place in the
community, as service providers, this pointed to their role in the broader policy direction of the Campaign.

NCADA represents the crystallisation of a particular discursive landscape, one that positions the voluntary sector as one of the sites through which drug problems can be addressed through ‘community’ (Thomas et al., 2016). At the same time, NGOs are responsibilised and held accountable for their expenditure through the responsibility to collect statistical information (as noted above), reflecting the neoliberal preoccupation with accountability and auditing (Garland, 2001; Rose, 1999). The Hawke government’s concern to further managerial techniques such as evaluation is evident within NCADA, as voluntary organisations are further charged with the responsibility of acting as an extension of government in the collection of information on drug users, facilitating collection of information on the population to be governed and on their own activities (Ministerial Council on Drug Strategy, 1988).

**Harm Reduction and Health in National Policy**

The HIV/AIDS epidemic and government/non-government responses to this also played an important role in shaping contemporary Australian drug policy. Although the policy response to HIV/AIDS developed on a somewhat different track to NCADA, because it was managed by different parts of the Commonwealth Department of Health (Siggins-Miller, 2009), harm reduction and ‘partnerships’ featured heavily in the HIV/AIDS policy area — the efforts of NGOs were considered central to this response (Bennett & Donovan, 2009). The federal government recognised and funded a range of NGOs, including drug-user organisations, to provide services including peer-education, information, counselling and care (Bennett & Donovan, 2009; Crofts & Herkt, 1995).

The ‘HIV/AIDS epidemic’ of the 1980s saw the mobilisation of a range of non-government organisations all seeking to influence governmental policy to address rising infection rates. Initially, ‘gay organisations’ (Crofts & Herkt, 1995) were particularly outspoken in relation to this issue. This era saw the first major studies of the risk factors impacting on HIV/AIDS infection rates, where injecting
drug use and shared needle use was ‘discovered’ as a major risk factor for contraction (Crofts & Herkt, 1995). Around this time, ‘grass roots’ drug user organisations began forming in Australia, but they were relatively under-resourced. During 1987 VIVAIDS — now known as Harm Reduction Victoria— formed from an amalgamation of Victorian user self-help groups (Crofts, & Herkt, 1993). Shortly after its formation, the group was funded by the AIDS/STD unit of the Victorian Health Department, and with this grant they opened the state’s first needle exchange in Melbourne. User groups in other states (e.g. QuIVAA in QLD and NUAA in NSW) also provided services including needle exchange and peer education programs (Crofts & Herkt, 1995). A national organisation known as the Australian IntraVenous League — now the Australian Injecting and Illicit Drug Users League (AIVL) — began informally in 1988; in 1992 they were formally constituted as the national peak body representing drug user organisations. The group has a particularly important policy role in the HIV/AIDS community, providing representation on committees, and advisory bodies (Australian Injecting and Illicit Drug Users League, 2012a; Crofts & Herkt, 1995).

The Australian National HIV/AIDS Strategy went through a consultation period in 1988-89, where a drug user representative was included on the advisory committee (Crofts & Herkt, 1995). State consultations also included representations from drug user organisations. The ‘grass-roots’, bottom-up development of Australia’s approach to the HIV/AIDS epidemic has been highlighted, with the government acknowledging that “no effective policies could be implemented by the government and medico-scientific community without the close and direct involvement of at-risk groups, themselves” (Crofts & Herkt, 1995, p. 602). The National AIDS strategy articulated a community-based approach for programs, with drug user programs based upon harm reduction ideas. This policy encouraged the strengthening of drug user political activity by providing funding for drug user organisations. Crofts and Herkt (1995) note that much of the strategy was “simply recognizing and legitimating organisations which were already in existence” (p. 602), providing Commonwealth support and a level of coherence to the process.

Partnerships with the affected community — people who use drugs — were considered central to the
success of the HIV/AIDS strategy, and drug user organisations in particular have played an important role in the development of harm reduction programs such as needle and syringe exchanges and peer-based education programs (Australian Injecting and Illicit Drug Users League, 2012a; Crofts & Herkt, 1995). An informant interviewed for this study underlined the importance of HIV/AIDS in opening up a space for drug users to be ‘invited to the table’:

… I think it was truly the era of the threat and epidemic of HIV that, the fear was so great that these other fears were overshadowed by the fear of this impending epidemic. And I suppose that we were encouraged and invited to the table in that early era…And I do think it was, it was an extraordinary time in history, an extraordinary group of politicians that just did it, they didn’t put needle and syringe programs out for community consultation, they just implemented them, and they made a lot of really courageous decisions before there was evidence to support them...So I think it was just a unique combination of factors that made that early era so unique.

(Interview 19)

A combination of factors thus allowed for the introduction of harm reduction measures during the 1980s, including the political emergency of the HIV/AIDS crisis and willing politicians (Bull, 2008).

The national HIV/AIDS policy meant that there was government funding and legitimation of a range of harm reduction measures, including needle and syringe programs and peer-based health education. With the introduction of a national approach to drug policy in the form of NCADA as well, there was an increase in funding and growth in AOD treatment. The introduction of NCADA saw a large injection of funds into the drugs treatment field through cost-shared funding (Task Force on Evaluation, 1992). The first evaluation of NCADA in 1988 notes, however, that there had been less funding provided for prevention activities such as education and early interventions (Ministerial Council on Drug Strategy, 1988).

The introduction of NCADA had a large impact in shaping the national response to drugs to include both public health and law enforcement measures. Overall the 1992 evaluation taskforce assessed NCADA positively: “The Task Force believes that, despite some difficulties and disagreements, the Campaign has on the whole tended to have a positive impact on relations between the Government and
non-Government sectors” (Task Force on Evaluation, 1992, p. x). A number of key stakeholders interviewed echoed this overall positive view of NCADA. Reflecting on relationships between governments and NGOs in the drugs field, one interviewee stated that there were positive changes happening in drug policy during the 1980s:

… at federal level and also all states and territories at some time have had think tanks, conferences, they’ve had the opportunity where people have been able to come together and actually input. Some of that can be really exciting, and certainly in the 80s it was. Because you actually did feel that something — what I’m saying here is actually making a difference, someone is listening, and some things started to be put in place. And certainly there was a lot of money coming into treatment and so on. (Interview 5)

Evaluations of NCADA (Task Force on Evaluation, 1992) indicate that the inclusion of NGOs in consultation processes and policy development was an ongoing area of concern yet to be properly addressed. In particular, the roles of the Commonwealth versus states/territory authorities in involving NGOs in the NDS appears to have been a point of contention. The evaluation noted:

Some representatives of non-Government organisations, on the other hand, argued that the Commonwealth had left the States and Territories with too much discretion, and that one result of this had been that the interests of non-government agencies had not received the degree of consideration they deserved” (Task Force on Evaluation, 1992, p. 8).

The evaluation notes that while all states and territories had taken some steps to involve NGOs in NCADA, approaches varied across jurisdictions. NGO satisfaction with their involvement also varied (Task Force on Evaluation, 1992). The taskforce also recommended that NCADA be relaunched as an “integrated approach” to drug problems, to be called the National Drug Strategy.

The Early 1990s and the NDSP

Evaluations of NCADA spurred some changes to the direction of the campaign. In particular, the 1992 evaluation *No Quick Fix* noted the uncertain role of law enforcement in going forward in the campaign as well as the contention over the balance of funding for treatment, education and law enforcement (Task Force on Evaluation, 1992), and consequently recommended that the partnership between law
enforcement and health be enhanced. This was achieved in 1992 by increasing the proportion of cost-shared funding to 10% over three years, and by establishing the National Drug Crime Prevention Fund (Single & Rohl, 1997).

In 1993, under the Keating Government, NCADA was relaunched as the National Drug Strategic Plan (NDSP). The 1993-1997 NDS expressly articulates the ‘harm minimisation’ approach to drug policy:

Harm minimisation is an approach that aims to reduce the adverse health, social and economic consequences of alcohol and other drugs by minimising or limiting the harms and hazards of drug use for both the community and the individual without necessarily eliminating use (Ministerial Council on Drug Strategy, 1993, p. 4, emphasis added).

Where NCADA acknowledged the service delivery role of ‘voluntary agencies’, and called for cooperation between Commonwealth and State/Territory Governments particularly, the NDSP broadened this initiative and encouraged an ‘intersectoral’ approach to addressing alcohol and drug problems: “the plan needs to develop strong intersectoral linkages between all relevant sectors, including health, education, community services and law enforcement” (Ministerial Council on Drug Strategy, 1993, p. 6). It goes on to note that the development and implementation of the Plan needs to be a collaborative effort, involving governments across all levels, jurisdictions, as well as the community sector.

Non-government organisations are mentioned in terms of service delivery and their importance for harm minimisation efforts. Under the development strategies of the NDSP, “community development”, community-based programs and services, local self-help groups and voluntary groups are to “assist in creating a supportive local climate of norms and values and provide assistance and social support for responsible use and harm reduction” (Ministerial Council on Drug Strategy, 1993, p. 20). Through the language of community and ‘community development’, non-government organisations are assigned a role in creating and participating in drug policy and interventions to reduce the harms caused by drug use.
The evaluation of this phase of the NDS (Single & Rohl, 1997) introduced the language of partnerships, noting that the policy rhetoric was not matching practice: “the NDS does not sufficiently involve nongovernment organisations in the management of the Strategy” (Single & Rohl, 1997, p. 68), an idea reflected in other documents produced by NGOs at the time (Crosbie, Quinlan, & Richards, 1995). The peak non-government organisation (ADCA), for example, began to take a role in encouraging public accountability in drug policy by producing a series of reports called Drugs, money and governments from 1993 (Crosbie et al., 1995). The reports were based on a review of funding and expenditure allocation and program performance in the drug field and a survey of key informants in each state rating the performance of government in particular areas. Drugs, Money and Governments, published by ADCA throughout the mid-1990s, highlighted the ongoing problems related to the involvement of NGOs in policy and decision making. A key recommendation across these reports is that “Governments must begin to involve non-government organisations, local communities and consumer groups in the process of decision making, especially in areas such as service delivery, research, policy development and planning” (Crosbie et al., 1995, p. 2).

Non-government organisations were also involved in mobilising both government and non-government stakeholders in the collection of data. During this period, calls for more effective treatment were being ramped up, and the lack of reliable or comprehensive data on treatment services in Australia was identified as a significant barrier to effective treatment systems. In 1996, ADCA arranged a forum to identify barriers between research and treatment, where a lack of treatment data was identified as an obstacle for the overall effectiveness of AOD service provision (Australian Institute of Health and Welfare, 2011). To address this, the Commonwealth Department of Health and Family supported the first phase of the Minimum Data Set Project for Alcohol and Other Drug Treatment Services, which was to become the Alcohol and Other Drugs Treatment Services National Minimum Treatment Data Set (AODTS-NMDS) administered by the AIHW (Australian Institute of Health and Welfare, 2011). This is now the major source of treatment data in Australia. These actions demonstrate how the peak body, ADCA, was important in influencing the field by encouraging the collection of data by
government departments to measure accountability, evaluate value for money and provide information to improve service delivery.

The Rise of Partnership Rhetoric in Drug Policy: ‘Building Partnerships’

While NCADA and the subsequent NDSP laid down the foundations of an intersectoral approach, it was not until the conservative Liberal-National Coalition Government, led by John Howard, introduced the *National Drug Strategic Framework (NDSF) 1998-99—2002-2003: Building Partnerships* in 1998 that the term ‘partnerships’ was explicitly articulated as key element in Australia’s drug policy (Thomas et al., 2016). ‘A partnership approach’ is one of the key principles of the NDSF. It is defined as:


The document specifically mentions building partnerships with ‘community-based organisations’, pointing to the evaluation of the NDSP by Single and Rohl (1997), which recommended the need to enhance partnerships with other sectors of government, industry, and ‘community-based organisations’. Overall, the NDSF talks about partnerships as “the need for a cooperative effort” between stakeholders (Ministerial Council on Drug Strategy, 1998, p. 21).

The NDSF provided a rundown of the role of community-based organisations, describing four “important areas”: (1) Service delivery (counselling, support, treatment); (2) Education, information aimed at preventing or reducing drug-related harm; (3) Contributing to policy and program development, delivery and evaluation; and (4) Advocating for specific policies or programs. It was the first national policy document to explicitly identify NGOs as policy actors, and acknowledge their role in policy development and advocacy (Thomas et al., 2016). It does so without diminishing the significance of their role in service delivery, stating its importance in economic and rational terms: “The National Drug Strategic Framework recognises that investment in community-based organisations is

To deliver its message the NDSF relies heavily upon the language of community (Thomas et al., 2016). Under the aim of strengthening existing partnerships and expanding them, the Framework promises “a commitment to consultation on all aspects of Australia’s response to drug-related harm, emphasising community involvement” (Ministerial Council on Drug Strategy, 1998, p. 21). In particular, NGOs are presented as experts well-placed to address community needs through service delivery:

Community-based organisations represent a source of expertise and knowledge in relation to the needs and circumstances of specific groups in the community. Some organisations are able to target and provide services to particular population groups and to establish continuing relationships with local communities (Ministerial Council on Drug Strategy, 1998, p. 38).

Community-based organisations are also positioned as able to represent community through policy: “Community-based organisations are uniquely placed to assess and advise government on appropriate responses and to provide feedback on the effects of policy and programs on specific groups in the community” (Ministerial Council on Drug Strategy, 1998, p. 38).

The NDSF established structures to facilitate the role of NGOs in the strategy. In positioning ‘community based organisations’ in the strategy, the NDSF notes that “The integral role of the community-based sector is acknowledged by the inclusion of experts from this sector in the membership of the Australian National Council on Drugs and the national expert advisory committees” (Ministerial Council on Drug Strategy, 1998). One of the strategies listed under the principle of ‘building partnerships’ with community was the establishment of the Australian National Council on Drugs (ANCD) “to enhance the partnership between government and the community” (Ministerial Council on Drug Strategy, 1998, p. 22). ANCD was established in 1998 as an advisory body to the Ministerial Council on Drug Strategy (MCDS) to facilitate partnerships with the non-government sector. In particular, the policy role of the non-government sector was affirmed through its establishment: “the Council ensures that the voice of non-government organisations and individuals working in the drug
field reaches all levels of government and influences policy development” (Ministerial Council on Drug Strategy, 1998, p. 34). Through the ANCD, the drug policy field was reconfigured, and the “federal bureaucracy was able to improve its policy relevance by drawing closer to third sector organisations working in the field” (Stewart & Maley, 2007, p. 284). On a practical level, the Howard Government changed the advisory structures for drug policy by establishing the ANCD, and also provided material support for NGOs for their service delivery activities by establishing flexible funds for NGOs such as the Non-Government Organisation Treatment Grants Program (NGOTGP), and the Community Partnerships Initiative (CPI) (Thomas et al., 2016).

The Evaluation of this phase of the NDS addresses a number of issues relevant to NGOs in the direction of the strategy (Success Works, 2003). Respondents to the evaluation signalled that there was a continued need for NGOs in the decision-making process (Success Works, 2003). The report notes that ADCA represented the NGO sector at the national level but that some respondents felt there was a need for the various jurisdictional peak bodies to be represented at the national level, and that ‘peak representation needed to encompass a range of stakeholders’ (Success Works, 2003, p. 56). The report also discusses some of the confusion around the ANCD: it acknowledges that the ANCD was established to facilitate partnership with NGO sector but notes that respondents felt that the relationship between NGOs and government could be strengthened through a NGO partnership, perhaps in the form of a committee or through strengthening the role of the ANCD to represent the NGO sector (Success Works, 2003). The report advocates that this body should be broadly representative. It mentions the need for workforce development strategies including national accreditation and of the AOD workforce, the development of a workforce strategy, development of career opportunities and “building the skills necessary to undertake increasingly complex work based on emerging evidence of effective practice” (Success Works, 2003, p. 66). The evaluation states that these issues are particularly salient as the AOD workforce “has been increasingly outsourced to the non-government organisation (NGO) sector across the jurisdictions” (Success Works, 2003, p. 66).
While the Howard government formalised channels of communication between NGOs and the state in the drug policy arena through the ANCD, as noted in Chapter 2 scholarly work suggests that relations between this government (from 1996-2007) and the non-government sector were generally strained — or at least ambivalent (Maddison & Denniss, 2005; Maddison et al., 2004; Staples, 2007). Reasons for this included non-acknowledgement of the importance of NGOs, under-funding or de-funding of peak organisations, attacks on non-government sector legitimacy and accountability, increased regulation and reporting requirements, and constraints placed on advocacy work (Maddison & Denniss, 2005; Maddison et al., 2004; Staples, 2007).

**Political Conservatism as a Key Driver of Partnerships**

Another key reason for the adoption of ‘partnerships’ with the non-government sector in drug policy can be found in the Howard Coalition Government’s political conservativism, their admiration and connection with conservative and religious organisations and desire to involve them more heavily in policy advice. The Howard government has been widely criticised for pursuing a socially conservative, values-based agenda in drug policy and for strategically positioning representatives of like-minded organisations in the network of governmental relationships to produce the types of policy outcomes it desired (Bessant, 2008; Mendes, 2001, 2007). The Howard Government positioned a well-known conservative figure and advocate of abstentionist policies, Major Brian Watters, as the chair of the Australian National Council on Drugs (Brook & Stringer, 2005; Fitzgerald, 2005). Fitzgerald (2005) analysed the strategic positioning of ‘conservative’ or prohibitionist members on the ANCD. He observes that while the original council membership of the ANCD represented a broad range of interests, including abstinence advocates as well as harm reduction advocates, the second council was more heavily weighted towards abstinence-focused members. As a consequence, rather than acting as a facilitator of partnerships with the NGO sector, the ANCD served an altogether different purpose by facilitating “a specific interest of the prime minister to more directly control the drug policy arena” (Fitzgerald, 2005, p. 271). Funding was greatly increased for abstinence-oriented organisations during
the term of the Howard government, and under then Health Minister Tony Abbott (Siggins-Miller, 2009).

While the policy of harm minimisation has supposedly enjoyed bipartisan support since its inception, this has not always been apparent in the federal political arena. Although it has continued to be the official policy as stipulated in Australia’s national drug strategy documents, the guiding policy of ‘harm minimisation’ was a point of contention during the term of the Howard Government (Mendes, 2001). Howard made public statements indicating that his government did not support harm minimisation, and instead encouraged a ‘zero tolerance’ approach. In 2007 Prime Minister John Howard stated that

  [T]his government will never give up in the fight against drugs. We will never adopt a harm minimisation strategy; we will always maintain a zero tolerance approach (Commonwealth of Australia. House of Representatives, 2007, p. 79)

Bessant (2008) argues the rhetoric of the Howard government reconfigured the meaning of harm minimisation and oriented Australian drug policy towards an authoritarian, ‘zero tolerance’, law and order approach. While the ‘harm minimisation’ approach largely enjoyed widespread political support by the mid-1990s, the Howard government tended towards conservatism and vigorously opposed many ‘harm reduction’ oriented programs — at least in the public arena. It vetoed the proposal for a feasibility study of medically prescribed heroin in the ACT, opposed marijuana law reform in Victoria, and opposed establishment of safe injecting facilities in NSW and Victoria (Mendes, 2001).

There were two major Commonwealth inquiries into drugs during the term of the Howard government, both of which effectively challenged the policy of harm minimisation. The first, the Inquiry into Substance Abuse in Australian Communities (2000-2003) was chaired by Kay Hull, and released its report in 2003 entitled the Road to Recovery (House of Representatives Standing Committee on Family and Community Affairs, 2003). The report listed 138 recommendations, including the reorientation of Australian drug policy to a policy of ‘harm prevention’ and treatment:

  the committee recommends that the Commonwealth, State and Territory governments replace the current focus of the National Drug Strategy on harm minimisation with a focus on harm
prevention and treatment of substance dependent people” (Standing Committee on Family and Human Services House of Representatives, 2007, p. 297).

The federal government did little to adopt any of the report’s recommendations. A further inquiry, this time with an explicit goal of inquiring into harm minimisation policy, was conducted in 2007 and chaired by Bronwyn Bishop.

The Inquiry into the Impact of Illicit Drug Use on Families was established to investigate “the impact of the importation, production, sale, use and prevention of illicit drugs on families” and one of the terms of references included an interest to “investigate the impact of harm minimisation on families” (House of Representatives Standing Committee on Family and Human Services, 2007). The committee report was highly critical of harm minimisation and what they called the ‘drug industry elite’.

Drug industry elites benefit directly from the continuation of current approaches and expanding numbers of people in drug ‘treatment’ as well as research funding that is applied to finding the ‘benefits’ of harm minimisation approaches. Several drug industry elites are also associated with the push to legalise drug use under the name of ‘drug policy reform’, making the mixed messages from current approaches to drug policy even stronger (Standing Committee on Family and Human Services House of Representatives, 2007, p. 16).

The major recommendation of the report centred around the reorientation of the national drug policy from harm minimisation to a policy of harm prevention, which focuses on preventing individuals from using drugs in the first place, and for those who do, encouraging them to become and remain drug free:

The committee considers that the ultimate goal of a national illicit drugs strategy should be harm prevention — that is, to prevent people becoming drug users and to enable individuals who break the law and use illicit drugs to become and remain drug free for the benefit of

46 Subsequent to the report, the Inquiry and its chair Bronwyn Bishop were heavily criticised for pursuing their own agenda and attacking drug policy experts. A dissenting report from Labor members noted this:

Some experienced outright hostility because their expert views did not accord with the personal beliefs or political aims of those questioning them. Such behaviour brings no credit to the committee process and puts at risk future inquiries which may rely on expert opinion to help shape future policies aimed at improving the health and wellbeing of Australians. (p. 313).

In the end, like so many other inquiry reports before it, the Winnable War on Drugs had little impact on drug policy, with the Howard government defeated at the 2007 election. The newly elected ALP government rejected the report recommendations. These inquiries, however, reflect the overall influence of neo-conservative values on the Howard administration’s attitude towards drug policy.

It should be noted, however, that the ‘tough on drugs’ narrative and opposition to harm reduction that came to be associated with the Howard government did not unilaterally translate into practice (Wodak, 2004). While funding was increased for abstinence-oriented treatment and NGOs (Siggins-Miller, 2009), the government also delivered enhanced funding for needle and syringe exchange programs (Wodak, 2004). While politicians in the Coalition were making public statements that were critical of harm minimisation, those working as part of the bureaucratic structures that supported the NDS and the Commonwealth Department of Health continued to work to deliver the harm minimisation framework. This is a theme that re-emerges in Chapter 6 (pp. 169-171).

**Drug Policy: 2010 Onwards**

**Responsibilising Through Reform?**

The Rudd and Gillard Labor governments (2007-2013) made significant changes to the broader policy structures shaping state-non-government sector relations. They sought to ‘repair’ relations with the sector by removing the gag-clauses on contracts between the government and organisations. In an article appearing in *The Australian*, Julia Gillard — who was acting Prime Minister at the time — commented that the non-government sector had been living in a “climate of fear” (Franklin & Lunn, 2008, p. 4) under Howard, and that the new government did not want to “stifle debate” (Franklin & Lunn, 2008, p. 3). In 2013, the Gillard government introduced the *Not-For-Profit Sector Freedom to Advocate Bill 2013*, which banned the use of gag clauses in Federal Government contracts with the not-for-profit
sector. The bill was passed in 2013. The *Not-For-Profit Freedom to Advocate Act 2013* prohibits Commonwealth agreements or contracts with non-profit entities from restricting their advocacy activities.

As a part of the Rudd and Gillard governments’ Social Inclusion Agenda (SIA), ‘not-for-profit’ organisations were recognised as playing a critical role in delivering services, and supporting and advocating on behalf of vulnerable and disadvantaged people (Carey & Riley, 2012). Carey and Riley (2012) observe that the SIA draws heavily on the discourse of the third way, where the non-government sector is positioned as a key site for addressing social issues. Strong relationships between government and the not-for-profit sector were promoted as an essential element of the SIA. In March 2010, as a part of the SIA, and in particular the priority of not-for-profit reforms, the Labor government also launched the *National Compact: Working Together*. Compacts are formal and legal instruments for governance of the relationship between the non-government sector and government. Where most states and territories already had government/non-profit compacts — although whether they have actually been implemented or successful is another matter (Andrew, 2006; Butcher, 2015b) — this was the first attempt at a formal compact at the national level. This broad-based strategy was intended to increase cooperation between the national government and the non-government sector. The National Compact outlined the eight priority actions, including promoting the value and contribution of the non-government sector, protecting their right to advocacy, recognising sector diversity in consultation processes, and reducing “red tape” (Australian Government, 2010, p. 10).

The introduction of the national compact was talked about positively by one participant:

> I think there was a lot of intention, a lot of good intention and a lot of hope around that…certainly they were trying to work collaboratively with NGOs and organisations they funded rather than being dictatorial. And tried to keep open communication, and I think that was very admirable. (Interview 3)

Speaking about whether the compact had an effect on relations between NGOs and government, another interviewee stated:
Yes and no. I think yes in terms of, it was part of a much larger body of work about valuing NGOs, but right now it’s an example of needing a Compact, although it’s been deleted and is gone. In many ways it was part of the, they had the not-for-profit sector they did the productivity commission report, there was the ACNC — there was a huge body of work that was done that was kind of propelling NGOs forward. As such I think it didn’t really need to be used as much. (Interview 2)

This interviewee continued on to note that despite the rhetoric of the national compact and relations between the non-profit sector and the government, this was not reflected in funding processes in the AOD sector:

That being said, within that body of time is when there was a terrible process that went on in terms of funding non-government services by the federal government… (Interview 2)

During the period of the Rudd-Gillard government, the Government initiated a reform of funding for health, and also reformed funding under the NDS by instituting the Substance Misuse Service Delivery Grants, which pooled a number of flexible funds. The NGO-TGP was retained.

The current National Drug Strategy 2010-2015 was released by the Gillard Labor Government in 2011 (Ministerial Council on Drug Strategy, 2011). The most recent evaluation of the NDS available, the evaluation of the NDS 2004-2009, noted that a number of key issues need attention, including: enhancing partnerships and engagement, strengthening capacity within the NDS framework for evidence-based policy debate in the public arena, and focusing greater attention on the social determinants of health and drug-related harm, in part through the development of a comprehensive prevention agenda (Siggins-Miller, 2009). The NDS 2010-2015 maintains the focus on quality reform of the drug and alcohol sector initiated under Howard (with quality featuring heavily in both the 1998 and 2004 National Drug Strategies), identifying areas such as the workforce and introduction of evidence-based service delivery and performance measures as priorities; this reflects an influence of neoliberalism and new public management. Quality reform in the non-government AOD sector was

47 The 2009 evaluation of the NDS reflects the controversy around harm minimisation policy during the term of the Howard government, recommending “a more appropriate term than ‘harm minimisation’ to communicate the essence of the NDS, with greater emphasis on prevention” (Siggins-Miller, 2009, p. x)
explicitly mentioned. The goal of this state-initiated reform of the non-government drug and alcohol services sector was: “to move towards a nationally consistent approach for non-government treatment services including quality frameworks and reporting requirements” (Ministerial Council on Drug Strategy, 2011, p. 12). A major review of funding for the AOD sector was also initiated during this period (Ritter et al., 2014). This funding review will be discussed in greater detail in the next chapter (Chapter 6).

The language of social inclusion is reflected in the NDS 2010-2015, where the community is positioned as a key means of achieving broad social inclusion. The NDS 2010-2015 continues the dialogue on partnership with the non-government sector and the community:

the framework builds on longstanding partnerships between the health and law enforcement sectors and seeks to engage all levels and parts of government, the non-government sector and the community (Ministerial Council on Drug Strategy, 2011, p. 1).

Thus, the current strategy continues to position the sector as a key partner in drug policy. The strategy makes heavy reference to ideas of ‘the community’, and links the goals of harm minimisation with building “safe and healthy communities” (Lancaster & Ritter, 2014a; Ministerial Council on Drug Strategy, 2011, p. 4).

**Extending the Neoliberal Dialogue on NGOs**

The Liberal-National Coalition Government, elected in 2013, initiated changes to social and welfare policy that altered both the rhetoric and policy structures around the non-government sector. The reforms initiated by the Rudd-Gillard Government such as the Social Inclusion Unit and the Office for the Not-for-Profit Sector were disbanded, and the National Compact was made redundant. Compacts between the non-profit sector and the government still exist at the state/territory level in most jurisdictions (Butcher, 2015a). These lay out rules for the relationships between government and non-government organisations in these jurisdictions. The formal arrangements in each jurisdiction differ. For more information on the form of compacts in each jurisdiction, refer to Butcher (2015a).
The political environment around NGO advocacy at the national level was ambivalent during the term of the Abbott Government (2013-2015). The Abbott Coalition Government defunded advocacy and peak bodies in other sectors, including housing and homelessness, drawing on a discourse of economic efficiency (Aston, 2014). Assistant Health Minister Fiona Nash announced in 2013 that the Coalition Government was defunding the Alcohol and other Drug Council Australia (ADCA), the national peak body for the AOD sector. Senator Richard DiNatale, health spokesperson for the Australian Greens [and a former drug and alcohol clinician], announced in a press release that the defunding of ADCA was “an attempt to stymie debate on illicit drug policy”, saying that “the Abbott Government is determined to hide evidence, sideline experts and silence advocates” (The Greens, 2013, para. 1). While the defunding of ADCA might be understood as part of a broader Coalition government trend in defunding advocacy and peak bodies, it signals the uncertainty that was characteristic of the AOD field during the period (2013-2016), and raises questions about whether this was an ideologically-driven, strategic decision on the part of the government to silence harm-minimisation advocacy (Davidson, 2013).

The Australian political environment at the federal level continues to be characterised by instability, with five changes in Prime Minister in the last five years. In September 2015 then Prime Minister Tony Abbott was challenged for the leadership of the Liberal party, which saw a new Prime Minister, Malcolm Turnbull, sworn in on 14 September 2015. With no official release of a new National Drug Strategy, the rebooted Coalition Government’s position on drug policy is currently not entirely clear. A draft National Drug Strategy 2016-2025 was released for public consultation in 2015 (Intergovernmental Committee on Drugs, 2015a) but the new NDS is yet to be officially released. The discussion below gives an indication of national drug policy under the Abbott-Turnbull Coalition Government.

During this period (2013-2016) there was uncertainty over the fate of the Commonwealth flexible funds — the SMSGDF and the NGOTGP — that a number of AOD NGOs relied on as a key source of
funding. Early reports indicated that funding was going to be cut for these flexible funds; however after a backlash from health groups, the Government announced that funding would be extended for another 12 months (Scott, 2015). The Coalition Government also engaged in reform of the health system, establishing 31 new Primary Health Networks (PHNs), following a review of Medicare locals established under the previous Labor administration (Booth et al., 2016). AOD NGOs will now be funded and commissioned through PHNs (Department of Health, 2016b). Advice from the Department of Health (2016b) stated that “PHNs role in commissioning treatment services at the local level will complement their new role in coordinating Commonwealth-funded mental health programmes at the local level, as well as build linkages with primary care” (para. 5). It is too early to comment on the results of this decision for the AOD NGO sector.

Changes to the advisory structure for drug policy, initiated during Abbott’s term, may indicate a shift towards a more conservative approach to drug policy. In December 2014, the Assistant Minister for Health, Fiona Nash, announced a reshaping and renaming of the ANCD to the Australian National Council on Alcohol and Drugs (ANACAD). Changes to ANACAD membership link back to the Road to Recovery report, as Kay Hull is now the chair of the council and Jo Baxter of Drug Free Australia is a member of the council. Significantly, ANACAD does not include members from any representative NGO peak bodies (apart from Drug Free Australia), harm reduction organisations or drug user organisations. This is a theme that will be picked up on in Chapter 6. One of the major roles for ANACAD included investigating the ‘ice problem’ in Australian communities, and in 2014 the federal government also initiated a national ‘Ice Taskforce’.

The Ice taskforce released its report in 2015. The report makes heavy reference to the need for prevention and treatment, and also references the role of community organisations quite heavily. While the report discusses the importance of demand reduction including prevention and treatment, harm reduction measures receive less attention: “There was some support for harm reduction approaches by experts, communities and in submissions, but it was not a strongly prevalent theme in the consultations” (National Ice Taskforce, 2015, p. 168). In response to the report, the government announced the
National Ice Strategy in December 2015 (Council of Australian Governments, 2015), which included an extra $300 million in funding to be given to ‘grassroots organisation’, to be distributed through the new primary health networks (Department of Health, 2015a). A number of law enforcement figures acknowledged that the issue could not be tackled by law enforcement alone and that demand reduction was also important (Fogarty, 2015). The decision to use the PHN’s to coordinate this activity is not without problems however; as Booth et al. (2016, p. 1) note, one of the challenges ahead for PHNs include the “complexity of dealing with all primary health care stakeholders”, which include a range of different professionals, agencies and organisations. The report and the response has since been criticised for a relative lack of attention to harm reduction programs (Harm Reduction Australia, 2015b).

Conclusion

This chapter traced the conditions of possibility for government non-government partnerships in the drugs field, tracing government relationships at the national level from the 1970s until the mid-2010s with a particular focus on how the word ‘partnership’ came to feature in the national drug strategy. The genealogy of the idea of ‘partnerships’ in national drug policy showed that whilst government/NGOs have long had a relationship in this space, the development of neoliberal policies since the 1980s laid the political foundations for the emergence of the rhetoric of government/non-government ‘partnerships’ in drug policy.

The chapter highlighted a number of historical, social and political conditions shaping government/NGO relationships in the Australian drugs field. It established that one of the first prerequisites for the current contemporary relationship between governments and NGOs, and for the current role of NGOs in drug policy, was the emergence of peak bodies and specialist drug and alcohol foundations during the mid-20th Century. While the rise of neoliberal discourses of governance and the accompanying changes in how the service delivery role of the state is thought about contributed to the ‘conditions of possibility’ for partnerships, the ‘non-government sector’ has had some role in drug and alcohol services since well before neoliberal ideas were popularised. As highlighted in the literature
review, this involvement goes back to the temperance movement campaigning for government action on alcohol matters, and religious organisations such as the Salvation Army being involved in the treatment of inebriates. The influence of welfare ideas encouraged the growth of the community sector in the 1970s and 1980s, and the role of NGOs in AOD service provision was recognised and encouraged by governments during this period; the role of NGOs in the drug and alcohol field was also recognised by governments, for example in the reports of major inquiries. The early drug and alcohol organisations participated in a range of activities that helped to build a kind of drug and alcohol ‘sector’ and set the scene for the contemporary relations we see between governments and NGOs in the drugs field today.

The genealogical analysis presented here demonstrated that since the 1970s at least, the role of non-government organisations in drug policy has been articulated in relation to ‘community’. However, the political image of community has changed since the 1970s. Examining changes in political discourse, governmentality scholars have observed how there has been a shift from ‘governing through the social’ under welfare liberalism, to ‘governing through community’ in neoliberalism (Rose, 1999). Rose (1999) observes that “the term ‘community’ has long been salient in political thought”, but that from the late 1970s community came to be presented as an alternative solution to the problems “that the social had not been able to address” (p. 175). Under neoliberalism, notions of collective and individual responsibility are combined as the community is activated and made responsible for a whole range of problems:

…in the institution of community, a sector is brought into existence whose vectors and forces can be mobilized, enrolled, deployed in novel programmes and techniques which encourage and harness active practices of self-management and identity construction, of personal ethics and collective allegiances (Rose, 1999, p. 176).

For non-government organisations, the community is the site through which they operate, that they are to be identified with, to the extent of responding, activating, working for/with and representing ‘the community’. The language used to describe the sector has also changed over time. Where the words ‘voluntary’ was largely used during the 1970s and 1980s, this has come to be replaced by the term ‘non-
government’, or ‘community sector’, reflecting changes in thought about the role of these organisations and their position in drug service and policy systems.

Whilst the genealogy showed that government/NGOs have long had a relationship in this space, the actions of the Hawke government and the expansion of neoliberal policies since the 1980s laid the political foundations for the emergence of the rhetoric of government/non-government ‘partnerships’ in drug policy (Thomas et al., 2016). More broadly, the neoliberal economic and social policies favoured by the Hawke-Keating governments led to increased contracting of the non-government sector for the delivery of services. The introduction of the first national drug policy by the Hawke government contributed significantly to the development of the partnerships rhetoric in the national policy environment. With the introduction of the first national drug strategy, NCADA, during the term of the Hawke government in 1985 (Department of Health, 1985), voluntary and community services were officially recognised in policy for their role in information, education, prevention and treatment activities. Drawing in the evidence presented in this chapter the analysis established, however, that evaluations of NCADA and its successor showed that NGOs did not feel they were properly involved in the planning, co-ordination or policy aspects of the strategies. The rise of HIV/AIDS during the 1980s also provided some of the impetus for a change in relations between NGOs and governments in drug policy. In particular, the epidemic provided the impetus for governments to partner with drug user organisations and implement harm reduction measures such as needle and syringe exchanges.

Whilst the introduction of the national drug strategy represented the antecedents to ‘partnerships’, it was not until 1998 and the release of the National Drug Strategic Framework 1998-99 to 2002-03: Building Partnerships that the term ‘partnerships’ was officially introduced into the drug policy lexicon of the NDS (Ministerial Council on Drug Strategy, 1998). Drawing in the evidence presented in this chapter, it is argued that the Howard Government’s drug policy framework, Building Partnerships, formalised partnerships and introduced institutional mechanisms to facilitate ‘partnerships’ at the national level through the introduction of the ANCD. Since the introduction of the NDS Building
Partnerships, partnership rhetoric has become increasingly central to federal and state/territory drug policy (Thomas et al., 2016).

The relationships between governments and NGOs have been considerably more complicated than the discourse of partnerships would suggest. The respective roles of different NGOs and the roles afforded them by government are fluid according to time, situation, issue and location. Certain NGOs may be privileged in drug policy by different political parties, at different points in time or in responding to particular issues. At the level of politics, the status of political parties as influenced by neo-conservative or social democratic values may also play a role in influencing the relationships between NGOs and governments. For example, the discussion in this chapter highlighted how under the conservative Howard Coalition Government, representatives from conservative, abstinence oriented organisations were selected as members of the advisory council to the government, the ANCD. At the same time, however, the Howard government was criticised for stifling the advocacy activity of the NGO sector. The rhetoric of the more socially democratic oriented Labor party, on the other hand, highlighted the value of NGOs and promised to create a political environment encouraging of advocacy activities. More recently, government decisions have effectively undermined NGO participation in the federal drug policy scene — Assistant Health Minister Fiona Nash under the conservative Abbott-led Coalition Government discontinued funding to the national peak body, ADCA (Davidson, 2013), and changed the membership and terms of reference for the ANCD (now ANACAD) in a way that appeared to support a more conservative ethos (Wodak, 2014).

This chapter has presented a historical narrative of the changing relationships between federal governments and NGOs through a genealogy of ‘partnerships’ in Australian national drug policy. Changes to welfare provision, and the accompanying rise in influence of neoliberal rationalities of government have had profound effects across western states in diverse arenas. In this chapter, I argued that the rise of neoliberal policies created the broad conditions facilitating the emergence of government/non-government partnerships rhetoric in Australian drug policy. In the next chapter, I
explore the influence of neoliberal rationalities of government on the contemporary Australian drug policy environment and the effects this has had on NGOs’ role in the drugs field.
Chapter 5: Normalising Partnerships? Discourses of Neoliberal Political Rationality in the Drugs Field

The previous chapter traced the development of the discourse of ‘partnerships’ in national drug policy, and identified some of the historical, social, and political dynamics that have shaped relationships between the government and the non-government sector in this field. Whilst Chapter 4 presented a broad narrative of the development of government/non-government relations and the emergence of ‘partnerships’ discourse focused at the national level, this chapter focuses on the discourses that shape the expression of those partnerships and the policy work that NGOs can do. As such, the chapter responds to the second research question: ‘What are the contemporary conditions shaping the role and work of NGOs in the Australian AOD field?’. To do so, it draws on an analysis of national and state and territory drug policy documents and the semi-structured interview data collected according to the processes outlined in Chapter 3.

As described in the literature review and methodology presented in chapters 2 and 3, government is inherently a problematising activity. As such, this chapter explores the problematisations of government that shape the role of NGOs in the drugs field through a discussion of the four major discourses identified through my analysis: economic discourses, scientific discourses, instrumental discourses, and communicative discourses. The chapter begins with an overview of the nature of these discourses. In considering economic discourses, I interrogate how neoliberal economic discourses and problematisations have influenced the Australian drug service system and impacted on NGOs. According to my analysis of data gained from the major drug treatment information system, the AODTS-NMDS, the non-government sector has increased in importance. Funding for drug services, however, has been a major issue of concern for both governments and NGOs. Neoliberal economic discourses and problematisations are evident in discussions of ‘cost-effectiveness’ and the professionalisation of the drug services sector through improving accountability, capacity and quality (Rose, 2008). I describe how a concern for quality in the drugs field has also seen the rise of a scientific
discourse, as documents and representatives in the field position ‘evidence-based’ policy and services as key objectives. Linked to this has also been the emergence of harm minimisation as a dominant instrumental discourse that features across Australian drug policy. It provides an organising framework that outlines the goals and aims of drug policy and the means of achieving them. Finally, the chapter argues that neoliberalism has encouraged a communicative discourse that emphasises governance and ‘partnerships’ rhetoric in defining the governance and policy roles of NGOs. Ultimately, the chapter demonstrates how neoliberal rationalities of government have permeated the drugs field through particular economic, scientific, instrumental and communicative discourses that act to shape the work and activities that NGOs can do.

Drug Policy Discourses

The rise of neoliberal rationalities in the drugs field has been accompanied by changes in the discourses in Australian drug policy. My analysis of drug policy documents and the semi-structured interviews identified four major discourses that impact and shape NGOs’ role in the drug policy space: economic discourses, scientific discourses, instrumental discourses, and communicative discourses. Here Yvonne Rydin’s (2003) discussion of procedural and substantive rationalities in policy-making is helpful. She distinguishes between procedural rationalities, which are concerned with the ways in which the policy process is conducted (i.e. its procedures) versus substantive rationalities, which are more about the goals and content of policy than procedures. In her research, she identifies several substantive rationalities in environmental policy, including scientific, economic and communicative rationalities. Table 4 below takes Rydin’s discussion and applies it to the drug policy strategy documents I analysed. It outlines some of the key features of the economic, scientific, instrumental and communicative discourses in the drugs field and how they are articulated in policy. These are the knowledges and ways of thinking that reflect the influence of neoliberal rationalities in Australian drug policy.
Each of the sections that follow expands on and describes how these discourses have shaped and influenced the work of NGOs and their role in drug policy in this country.

**Economic Discourse**

As outlined in Table 4, neoliberal economic discourses represent the problem in the drugs field in economic terms — drug use and related problems are a cost to productivity, and a cost to Governments, individuals, families and communities particularly through the health system. At the core of these economic discourses is the assumption that the expense of providing alcohol and other drug services...
can be minimised through the application of market mechanisms for the delivery of public services. As outlined in Chapter 4, with the rise of neoliberal political discourses, governments have positioned NGOs as fulfilling two broad roles in the drug and alcohol field: service delivery and policy work. Neoliberal and market-based models have encouraged the push towards governments outsourcing and contracting out services previously delivered in the public sector. Market-based models of service delivery have been influential in the health and welfare sectors, and consequentially have also impacted on activities carried out in the AOD sector (Ritter et al., 2014). Since the 1980s, funding for drug and alcohol services have moved more and more towards market-based models in many countries, including in Australia, the UK, the US, Sweden and other countries (Edman, 2016; Mold & Berridge, 2010). Ritter, Chalmers, and Berends (2015), examined health expenditure on alcohol and other drug treatment, noting that there was a higher proportion of expenditure on AOD treatment programs outside hospitals, concluding that “this is consistent with the community-focused models of care for AOD treatment” (Ritter et al., 2015, p. 401). In this context, the non-government sector has become an important means through which drug services and interventions are delivered. In Australia, for example, there have been funding streams made available to non-government organisations specifically to fund service delivery in the non-government drug and alcohol sector (for example, the Non-Government Organisation Treatment Grants Program (NGO-TGP), and the Community Partnerships Initiative (CPI) established under the Howard national government) (Ritter et al., 2014).

Data from the Alcohol and other Drug Treatment Services National Minimum Treatment Dataset (AODTS-NMDS) demonstrate that the proportion of services provided in the non-government sector has increased. As discussed in Chapter 4, the AODTS-NMDS provides data on publicly funded treatment services in Australian jurisdictions. Only services receiving public funding are included in the collection, although there are a number of other exclusions (data collection excludes the following: agencies whose sole activity opioid pharmacotherapy maintenance treatment; halfway houses, sobering up and health promotion services, AOD treatment units in acute care or psychiatric hospitals, and private agencies not receiving government funding). The NMDS also may undercount Indigenous services; because Commonwealth Government-funded Indigenous services providing AOD treatment are not all
required to supply data under the AODTS-NMDS. These organisations supply data under the Online Services Report (OSR) data collection, which collects information from Aboriginal and Torres Strait Islander health organisations that received Australian Government funding. Nevertheless, some general trends can be gleaned from the AODTS-NMDS. The graph in Figure 1 below is drawn from the AODTS-NMDS, and shows the number of non-government to government alcohol and other drug treatment services. Over the course of this AODTS-NMDS data collection (from 2003-2014), the proportion of non-government agencies has seen a general increase to the point where they now outnumber government agencies (although this may have more to do with changes in reporting for the NMTDS than actual number of agencies).

Figure 1: Government and Non-government alcohol and other drug treatment service providers

![Graph showing the number of government and non-government alcohol and other drug treatment services from 2003 to 2014.](source: AIHW NMTDS Data Cubes (Australian Institute of Health and Welfare, 2016))

The mix of government versus non-government alcohol and other drug treatment services differs by state (see Figure 2 below). In NSW, the majority of services are in the government sector. In South Australia, the service mix is almost equal across the government and the non-government sectors. In

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48 The Alcohol and Other Drugs Treatment Services National Minimum Treatment Data Set (AODTS-NMDS) is administered by the Australian Institute of Health and Welfare and is the major source of drug and alcohol treatment data in Australia.
Victoria all agencies are non-government. In QLD, the ACT, WA, and NT, the majority of services are non-government.

**Figure 2: Treatment agencies by service sector, states and territories, 2013-2014**

![Graph showing treatment agencies by service sector, states and territories, 2013-2014](image)

Source: AIHW NMTDS Data Cubes (Australian Institute of Health and Welfare, 2016)

Nationally, the vast majority of closed treatment episodes were provided in the non-government sector (Figure 3).\(^{49}\) In general, the number of treatment episodes provided in the non-government sector increased between 2003-04 (75,645) and 2013-14 (113,478), while the closed treatment episodes provided by government agencies only slightly increased (61,224 in 2003-04 to 67,235 in 2013-14). The number of overall treatment episodes increased between 2003-04 (136,869) and 2013-14 (180,713).

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\(^{49}\) A closed treatment episode is the main counting unit of the AODTS NMDS, “defined as a period of contact between a client and a treatment provider (or team of providers) that is closed when treatment is completed or has ceased, or there has been no further contact between the client and the treatment provider for 3 months” (Australian Institute of Health and Welfare, 2014, p. 3).
Figure 3: Treatment episodes by service sector, states and territories, 2003-04 to 2013-2014

Source: AIHW NMTDS Data Cubes (Australian Institute of Health and Welfare, 2016)

Breaking this down by jurisdiction, the proportion of closed treatment episodes delivered in the non-government sector increased across most jurisdictions. Figure 4 below compares the number of treatment episodes delivered in the non-government versus the government sector in each jurisdiction in 2003-04 versus 2013-2014. This increase was most prominent in QLD.

Figure 4: Treatment episodes by service sector, states and territories, 2013-2014

Source: AIHW NMTDS Data Cubes (Australian Institute of Health and Welfare, 2016)
The majority of representatives interviewed for this study noted the importance of NGOs for service delivery in the Australian AOD field. According to one participant, the role of NGOs in governance was concentrated in this service delivery rather than policy work:

Well as the main provider, other than methadone programs which are largely government services through hospitals and clinics, other than that we’re the main providers of drug and alcohol services, the NGO sector. On a numbers basis if you include people that are dosed on methadone, and there’s 44,000 of them across the country; imagine that means there’s 44,000 incidences of service each day. And of course that means they’re the largest. But if you take the methadone out of the scope, then the NGO sector is dealing with pretty much everything else. And as far as the residential treatment programs are concerned, that’s exclusively, there’d only be a small percentage that are government run services, they’re overwhelmingly in the NGO sector. So our part is in the sense in that service provision part, not necessarily the policy part. (Interview 6)

As this participant notes, NGOs are particularly important in most areas of treatment apart from methadone maintenance and pharmacotherapies. He also notes that residential treatment programs are almost entirely run by NGOs. Therapeutic communities remain important providers of residential rehabilitation in Australia. In fact, most residential treatment in Australia is provided in therapeutic community settings, and almost all therapeutic communities are non-government agencies (Lloyd & O'Callaghan, 2001). They rely on funding from a variety of sources, including government funding as well as contributions from clients — often as a portion of a Centrelink [welfare] payment (Lloyd & O'Callaghan, 2001).

Access to adequate funding and resourcing is essential for NGOs to effectively engage in service delivery, advocacy and policy activities. Non-government organisations in the Australian AOD sector are funded from a wide range of different sources (Australian National Council on Drugs, 2013). Chalmers, Ritter, Berends, and Lancaster (2015) mapped the sources and flow of funds for alcohol and other drug treatment services in Australia. They describe how, like other health and welfare service areas, there are a diverse range of funding sources in the AOD sector, including Australian and state
and territory governments, philanthropy and private sources, fund-raising and contributions from clients (Chalmers et al., 2015). Some organisations draw on a wide range of different funding sources, which Chalmers et al. (2015) note increases complexity and administrative workloads but smooths “the risk of funding shortfalls” (p. 1). Most AOD NGOs are heavily reliant on government funding (Australian National Council on Drugs, 2013). While a number of representatives interviewed for the current study noted that some organisations had been successful in getting philanthropic funding, not all organisations are able to raise funds in this way. Two participants considered that AOD organisations are at somewhat of a disadvantage in terms of fundraising for alcohol and other drug issues because of a perceived lack of community sympathy and the stigma around drug use. For these participants, there was a sense that AOD is not the kind of cause that people want to donate to. One participant explained that:

We’re not a… our particular sector, for example if you’re trying to raise money in our sector it’s very difficult to do; but if you’re trying to raise money for SIDS or breast cancer…. It’s easy to get the sympathy of the community for those sorts of worthy endeavours, but it’s much less easy to get the sympathy of people for us. (Interview 18)

This idea has some support from literature. For example, a survey of Australian philanthropic and ‘giving’ behaviour found that individual donators in Australia “particularly wanted to support those innocent of the problems they experienced (with some prejudices expressed regarding drug addicts and single mothers)” (Australian Council of Social Service, 2005, p. 32). Some AOD NGOs are able to attract donations of course; in the wider non-government sector, religious and faith-based organisations have been particularly successful in this regard (Australian Council of Social Service, 2005).

Health is one of the largest areas of government expenditure, and governments have been concerned to make sure that public funds are being spent in the most efficient, effective and accountable manner (National Commission of Audit, 2014). The AOD field has not escaped this push for cost-effectiveness: there have been a range of funding reforms and reviews in the AOD field across a number of Australian jurisdictions — for example at the national level (Ritter et al., 2014), in Victoria (Ritter & Berends, 2016), and in NSW (Network of Alcohol and other Drug Agencies (NADA), 2015). The role of the Commonwealth Government in funding AOD services has been a point of contention for federal
governments (Ritter et al., 2014). As noted in the previous chapter, the Rudd-Gillard government initiated a review of drug and alcohol services sector funding at the national level, to investigate models of funding for drug and alcohol services by the Commonwealth Government. This review was completed by the Drug Policy Modelling Program, with the report made public by the Department of Health in 2015 (Ritter et al., 2014). The authors, Ritter et al. (2015), released a paper examining health expenditure on alcohol and other drug treatment, finding that state and territory governments accounted for the majority of this funding at 51% of the total, with the Commonwealth Government also contributing a not insignificant amount at 31%, and private sources 18%. Successive Victorian governments have also attempted to reform the drug and alcohol services sector in that state (Ritter & Berends, 2016; State of Victoria Department of Health, 2013a).

Neoliberal economic discourse draws heavily on notions of cost-effectiveness and the associated techniques of ‘new public management’ (NPM) to achieve efficiency (Bevir, 2011). New public management techniques have impacted on funding models in the Australian AOD sector (Ritter et al., 2014). New public management assumes that market-based management models (contracting and competition) used in the private sector can be usefully applied to public sector services to make them more efficient (Ritter et al., 2014). As one participant explained of the move to purchaser-provider frameworks in the AOD field:

So grants have gone, y’know the liberal governments have come in at both the state and federal level and so today we’re operating under a purchaser-provider framework with contracts. So they’ve commercialised in a sense what should be seen as an adjunct arm of health, do you know what I mean? We should be seen as part of the health sector. (Interview 6)

Ritter et al. (2014) point out that NPM techniques are associated with a range of challenges when applied to complex social problems like those encountered in health, social and welfare services. Representatives from NGOs that I talked to for this project were mindful and reflexive about the challenges presented by NPM:

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50 As the authors note, the complexity of the different funding streams and systems presents challenges for estimating expenditure and for comparing internationally (Ritter & Berends, 2016). There are also different government agencies (such as social services) that fund drug services which were not included in their estimate.
influence of neoliberal, market-based models of service delivery and their effect on AOD services. Here, another participant reflects on some of the difficulties associated with using market models for social issues, noting that AOD services are publicly funded because of ‘market failure’:

I think that there’s a real problem in terms of the way in which governments see taking things to market as the way to go. I think in many ways, the AOD treatment system is public funded, arose out of market failure, because public health systems don’t deal with it, the doctors don’t want those clients in there, people clog up the prison system and the justice system unnecessarily. So it’s all about market failure, and yet there’s increased discussion, the National Competition Policy level, and Productivity Commissions, about the market providing the solutions. I just don’t see it. Once they open up the market to, how can you have a much more effectively targeted and functioning system if you bring in for-profit providers to milk profits out of what you see are clients, how do they create their efficiencies, who gets less than what’s provided, they need savings somewhere. Some of them might be administrative systems, some of it’s got to be what service they actually provide. (Interview 13)

The drive to create efficiency in public funding similarly creates a situation where there is a gap between provision and demand. Another representative noted the problems with governments trying to create efficiency by avoiding ‘duplication’ of services in tendering processes:

The bureaucrats who put out the tenders every couple of years, they don’t really have a sense of what non-government organisations, I’m not just talking about [NGO] or drug organisations, just non-government organisations in general. They say things like they don’t want any duplication of service and things like that, yet they don’t understand that duplication of services is absolutely needed, like we’ve got waiting lists that are really long because a lot of services have been defunded. So it’s absolutely vital that you would have a number of services doing the exact same thing. (Interviews 14).

This gap in demand versus service level and underinvestment in the AOD area was an ongoing theme raised during interviews.

The level of funding for addressing AOD problems in the community has been a point of contention since at least the 1970s (as noted in the last chapter) and has been an ongoing source of concern in the sector (Spooner & Dadich, 2009, 2010). Ritter et al. (2015) estimated health expenditure on AOD treatment in Australia to be AUD$1.2 billion in the period 2012/2013; this amounted to 0.8% of total
health care spending (Ritter et al., 2015). In the report, the authors noted that investment in AOD treatment is small compared to the prevalence of AOD problems at the population level and the level of unmet demand. Interview participants for this project also highlighted that the drug and alcohol area had been significantly under-invested. As one participant explained:

...So the waiting lists are way too long in so many areas, there’s still an under-investment for the need compared to many other areas still that attract a lot greater attention and therefore a lot greater investment, for the burden of disease that those issues cause. We’re really underinvested… (Interview 12)

Another participant suggested that while it is positive that public funding is available for AOD treatment, there have also been a range of practical problems associated with inadequate levels of funding:

Although funding for treatment services has been inadequate, there has been funding for public treatment services, so that’s a good thing. But we have situations where the majority of non-government treatment services do not receive adequate funding from either federal or state to actually be able to operate those services. (Interview 15)

While NGO representatives recognised that policy change in the drugs area is difficult, there was a sense of injustice at the level of resourcing of the AOD sector:

That we should have the sort of service system that works under the strain that we are, not being effectively funded, is really unjust, for a problem that’s really very widespread, and in many cases we’re able to save people, keep them alive and get them over their issues. Some people are just into blaming and that’s not going to work in this sector, it’ll just complicate it further. And the sooner governments wake up to that sort of thing the better it is. (Interview 13)

This participant also hints at the idea that under-funding can lead to compromises in quality in the service system.

In Chapter 4 it was noted that the efficiency of NGOs has been a key feature of political discourse legitimising their position as key service providers. Participants expressed the idea that NGOs are able to deliver services more efficiently than governments and other agencies. Although this efficiency
enhances their competitiveness in tendering environments, it also makes them vulnerable to under-funding. One participant explained this challenge for the non-government sector in the following way:

… one of the things that often happens for NGOs is the fact that because they can do things cheaper, is that they get less money to do things. And that then really stretches the resources. You have the jam sandwich syndrome, where the jam is spread far too thinly and you need to be I think prepared to if not fund at the same level — and certainly NGOs can do things much more efficiently and don’t need, because of the lack of red tape, don’t need all the same kind of level of funding; but their workers need to be paid appropriately. They need the resources in order to be able to deliver a service. So they do need the funding, even if it’s not at the same level, they do need the funding in order to be able to do the job efficiently and effectively. (Interview 5)

As Interviewee 5 notes, the tendency to fund NGOs at lower levels creates problems in terms of providing job security, good working conditions and salary for staff. The funding reforms, and the lack of clarity around future funding arrangements, had created a sense of relative insecurity for NGOs. At the time of some interviews, many organisations had not received confirmation that their Commonwealth Government funding would be continuing. Because the Commonwealth Government is a significant funder of AOD treatment services, this created a sense of uncertainty:

I mean two months security is not enough for staff, and how do you deal with your leases for your properties, your cars, other contracts that you’ve got to put in place to manage those programs, staff. (Interview 12)

Participants noted a number of practical problems associated with uncertainty around funding, including the inability to plan, maintain leases, and attract and retaining quality staff. At the time of writing of this thesis, the commonwealth had changed the way it funds AOD and other health services and communicated this to drug and alcohol services (Department of Health, 2016b). Funding for the health flexible funds — such as the NGO-TGP and the SMSDGF — had been discontinued; funding now goes to the Primary Health Networks (PHNs) (Department of Health, 2016b). The PHNs commission services at the local level (Department of Health, 2016b). It remains too early to tell how this will affect NGOs in the drug and alcohol service sector, although this would be an interesting area for future research.
NPM techniques put organisations in competition with each other for contracts to deliver public sector services (Pollitt, 2003). NGO representatives interviewed for this study noted both positive and negative results from competitive tendering processes. A number of participants described entering into partnership models, including consortiums, with other organisations and also described these partnerships in positive terms. For governments, encouraging consortiums and partnership models have a range of advantages, including increasing administrative efficiency (Spooner & Dadich, 2009):

Consortiums seem to be the in-thing at the moment, and it just means that the government have to deal with less individual services, and only groups of services. (Interview 14)

On the other hand, funding processes can actively undermine partnerships between services. As another participant explained, governments have tried to encourage partnership models through tendering processes

…but those partnership models become really difficult when you start waving money around and you start putting people into competition with each other. And that’s the difficulty, and unfortunately that’s getting worse in some areas and needs to have a better, there needs to be some changes about the way that that tendering process operates. (Interview 5)

Although participants considered partnerships to have a number of positive benefits including increasing collaboration, information sharing, resource sharing, and increasing competitiveness in the funding environment — ideas also outlined by Spooner and Dadich (2009) in their study of the AOD NGO sector — participants also described some of the more perverse effects of competitive tendering models.

The actual practical demands of being involved in a range of partnerships for services can create a strain on organisations. For one participant, the many partnerships their organisation was involved in had led to:

…so many meetings, so intensive and I wonder if we’ve got a bit too far, in partnership overload. (Interview 12)
According to some interviewees, competitive tendering models actually presented an impediment to ‘partnership working’ by creating distrust between services:

…but in reality doesn’t happen much. And again, I think it’s because of the competitiveness of the funding process. Because of that, there’s not a lot of trust, and therefore not many people do get together and form partnerships. (Interview 17)

Considine (2003) also noted the distrust that competitive tendering processes can create between organisations involved in these processes. For some organisations, particularly smaller organisations or those with a unique service or function, entering into consortiums could present a risk to their service:

But I think that was a real risk, do we decide to apply for funding on our own, or do we go, because consortiums do seem to be a real, they’re everywhere at the moment. It’s this sense of forced partnerships between organisations, and it’s a weird dynamic. (Interview 14)

Here, this participant notes that the popularity of partnership models and their increasing necessity for NGOs to remain competitive in funding processes meant that organisations could feel pressured or coerced to enter into partnerships with other organisations.

A further problem with competitive tendering models of service delivery is the potential for it to interfere with the independence and social functions of NGOs through an economically coercive alignment of their activities with the wishes of funding bodies (Helminen, 2016). To both win contracts and retain funding, NGOs must be willing to conform closely to the guidelines of funding agencies — potentially introducing requirements that may not be directly in line with the mission of the NGO (Spooner & Dadich, 2009, 2010). This idea will be explored in greater detail in the next chapter.

**Issues of Quality, Accountability and Cost-Effectiveness: Improving the Sector**

In ‘governing at a distance’, in neoliberal economic discourse — particularly NPM — the role of the state is to create the ‘environmental’ conditions, through ‘market governance’ techniques such as budgets, audits, and standards, so that ‘the market’ and individuals are autonomised and responsibilised, and able to regulate themselves (Larner, 2000; Rose et al., 2006). Here, neoliberal economic discourses
represent the problem in the AOD field as the lack of ‘capacity’ of the sector, particularly the lack of training and accreditation of drug and alcohol workers, and the lack of outcome and quality frameworks for the sector. At the time of writing, there had been a wide-ranging body of work being done on quality improvement, workforce development and funding in the Australian AOD sector; see for example, the funding review completed by Ritter et al. (2014), or the work done by the National Centre for Education and Training in the Addictions to prepare a workforce development strategy for the AOD NGO sector (Intergovernmental Committee on Drugs, 2015b; Roche & Pidd, 2010).

Workforce development strategies have been a key focus in quality improvement for the sector, and represent a significant example of how neoliberal government seeks to mobilise particular forms of action through incentive structures that encourage NGOs to conform to the behaviour desired by public agencies. At the national level, a workforce development strategy has recently been released (Intergovernmental Committee on Drugs, 2015b). The key goals of the strategy centred around capacity and sustainability:

To enhance the capacity of the Australian AOD workforce to prevent and minimise alcohol and other drug-related harm across the domains of supply, demand and harm reduction activities. [and] To create a sustainable Australian AOD workforce that is capable of meeting future challenges, innovation and reform (Intergovernmental Committee on Drugs, 2015b, p. iv).

The key outcome areas included attention to recruitment and retention issues, improve child and family sensitive practice; increase the responsiveness of the sector for particular groups of clients (including older AOD clients, CALD clients, Aboriginal and Torres Strait Islander peoples; lesbian, gay, bisexual, transgender and intersex individuals); develop the generalist health, community, welfare support workers, criminal justice workers and the education sector to prevent and reduce AOD harm (Intergovernmental Committee on Drugs, 2015b).

Governments have attempted to improve the sector through funding agreements, stipulating requirements for accreditation or minimum qualifications in contracts (Rose, 2008). A number of the strategies make explicit reference to accreditation programs. For example, an agreement with non-
government operated AOD programs funded by ACT Health on a Minimum Qualification Strategy was reflected in funding agreements (ACT Health, 2010). In NSW, a compulsory non-government organisation accreditation program was established “to improve the capacity of service delivery in the non-government sector” (NSW Department of Health, 2006, p. 8); the government also established an infrastructure grants scheme to assist NGOs to comply with the accreditation program (NSW Department of Health, 2006).

Governments have identified capacity building as a key goal for the alcohol and other drug sector (McDonald, 2015). The NSW Drug and Alcohol Strategy 2006-2010 highlights the importance of increasing capacity and competency of the drug and alcohol workforce (NSW Department of Health, 2006). Similarly, the QLD Mental Health, Drug and Alcohol Strategic Plan 2014-2019 contains shared commitments including “a responsive and sustainable community sector”, and “integrated and effective government responses”, which include commitments to capacity building activities such as organisational and workforce planning and training (Queensland Mental Health Commission, 2014).

Governments have supported the non-government sector by encouraging and funding capacity building projects (McDonald, 2015). Workforce development and capacity building activities should not be seen as solely directed by government, however. In a report outlining funding principles for the non-government AOD sector, the Australian National Council on Drugs (2013) noted

> Demand for quality improvement/accreditation for AOD treatment and prevention services has largely arisen from AOD NGOs themselves, and is important for improved service to clients (p. 9).

There is often co-operative effort between government agencies, NGOs, and other agencies (e.g. research-focused organisations) in workforce development projects. The state and territory peak bodies were provided with funding for a capacity building program by the Commonwealth Government Department of Health under the Substance Misuse Service Delivery Grants Fund (McDonald, 2015); these grants ran from July 2012 until June 2015 and were subsequently extended until 30 June 2016 (McDonald, 2015). David McDonald (2015) has since completed an evaluation of this program. The
capacity building strategies were focused on the peak bodies themselves to develop their own capacity to operate effectively and efficiently, to develop their capacity to develop capacity in other organisations, and directly developing capacity in other organisations (McDonald, 2015, p. 14). The capacity building strategies used by the peaks were (in order of frequency of their use): Building sustainable linkages and strategic partnerships; Assisting services to undertake service improvement; Identifying and facilitating training opportunities; Developing and promoting information and resources (McDonald, 2015, p. 6).

Although the state peak bodies have been heavily involved in capacity building, the defunding of the national peak body ADCA had an effect on workforce development. One participant described the benefits derived from a resource produced by ADCA to help new recruits to the drug alcohol field:

When I arrived I didn’t really understand AOD at all, so I tried to get my head particularly around that sort of stuff. And that’s something that ADCA did that was really useful was provide their ‘Tips and Tricks for Newcomers’, which I feel like is a bit of a shame that nobody’s picked that up or is going to continue with it. (Interview 11)

Being a national peak body for drug and alcohol services, ADCA were involved in workforce development programs and housed a significant library of drug and alcohol related information, the National Drug Sector Information Service — an important resource for the AOD workforce and others.

Rose (1999) notes that the new public management involves a shift to private management models, where “the focus is upon accountability, explicit standards and measures of performance, emphasis on outputs, not inputs, with rewards linked to performance, emphasis on outputs, not inputs, with rewards linked to performance” (p. 150). In line with this idea, to try to improve ‘quality’ in services, governments and NGOs have also concentrated efforts on listing outcomes and describing quality frameworks in the drug and alcohol area. For example, the last ‘reform’ of the Victorian drug and alcohol treatment system included an explicit focus on activity based funding and ‘performance measures’ (Ritter & Berends, 2016).
Of course, quality and outcomes measures and performance measures are not the same thing. The development of outcomes and quality frameworks at a system-level was viewed as a positive and necessary goal for the sector by many participants. This was to be distinguished from ‘performance management’ style governing, which add to the burden on organisations through the need to report to multiple funders across a range of criteria not related to client outcomes — an issue highlighted in a survey by the ANCD on the burden of submission and report writing for the non-government AOD sector (Australian National Council on Drugs, 2009). A number of participants expressed support for the overall intention behind the development of outcomes and quality frameworks. One participant highlighted the distinction between outcomes frameworks and performance management:

I think we all want an outcomes framework because we want clarity around what we’re working towards. We want to be able to articulate and document better what we are achieving as a system, and even individual organisations and with individual clients. I don’t think there’s any intention to fund on the basis of that, but there would be some policy decisions made around you know, where we are succeeding, where we are struggling; it might shape allocation of funding and how resources are funded at a systemic level, which again we’d welcome, rather than at an organisational level, performance management sort of sense. (Interview 12)

This interviewee hints at hesitancy at the idea of funding purely on the basis of client outcomes, but also notes that it might be a factor in shaping future resource allocation.

At the more extreme end of the application of neoliberal economic discourse and market models to the health field are those that try to encourage efficiencies through outcomes-based funding or ‘pay-by-results’. Payment by results is the practice of funding organisations based on ‘outcomes’, what organisations actually do or produce (Roberts, 2011). These models have been introduced in drug and alcohol in various forms in international jurisdictions such as the US (Stewart, Horgan, Garnick, Ritter, & McLellan, 2013; Stewart, Lareef, Hadley, & Mandell, 2016), and in the UK (Gosling, 2016; HM Government, 2010). In 2010 the Coalition Government in the UK released a drug strategy focused on recovery, and that included an intention to implement Payment by Results — already operating in hospitals under the National Health Service — in alcohol and other drug services (HM Government, 2010). The outcome areas were focused on four areas: being free from drugs of dependence;
employment; offending; and health and well-being — although employment was later removed as an outcome area (Gosling, 2016). One concern with applying results based funding to areas such as drug and alcohol (or mental health or similar areas) is encouraging organisations to ‘cherry-pick’ clients that are more likely to achieve these objective outcome measures. Certainly the risk with results-based funding models is the creation of incentive-structures that discourage organisations from treating clients with complex or hard-to-treat problems. The idea of results-based funding was noted by several participants, for example:

And that’s a legitimate concern and one I think the sector needs to make sure we’re educating people against the dangers and the unintended consequences of cherry-picking and going down results-based funding and all of that, so I think there’s a responsibility there. (Interview 12)

Whilst payment by results has become a reality in the UK and the US, this has largely been avoided in the Australian context thus far (although there has been a move to ‘activity-based’ funding in a number of jurisdictions including Victoria and NSW) (Ritter et al., 2014). Participants considered this to be a positive feature of the funding models in Australian jurisdictions. Interviewee 5 considered that NGO treatment services in Australia had been reasonably well-funded, and was thankful that pay-by-results schemes had largely been avoided:

In terms of treatment we’ve also been, from my point of view, the [NGO], the drug treatment services have been reasonably well supported. There’s been some things overseas that have happened which have been alarming and which haven’t occurred here. So for instance, the pay-by-results scheme. They’re things that you wouldn’t want the Australian government or policymakers to be looking at and thinking ‘oh that’s a great idea, let’s do it here’. So I think that Australia has been prepared to actually take a real role. (Interview 5)

Thus, despite problems with funding models, participants were generally appreciative that the Australian AOD field had escaped some of the more extreme manifestations of NPM and generally enjoyed a tradition of government funding for alcohol and other drug services.

As highlighted in this section, the influence of neoliberal economic discourses on the Australian AOD field can be identified in the moves towards greater provision of treatment and interventions in the non-
government sector, as well as the push for ‘cost-effective’ services through contracting, capacity building, outcomes frameworks and performance management. This focus on performance measurement in new public management runs parallel with a ‘scientific discourse’ that promotes ‘evidence-based policy making’ and ‘evidence-based practice’.

**Scientific Discourses**

The institutionalisation of new public management has coincided with and been reinforced by the popularisation of ‘evidence’ as a fundamental underlying basis for policy. Since the 1990s, the idea of ‘evidence-based policy’ has risen in importance and this has impacted the drug and alcohol space (Lancaster & Ritter, 2014a). The scientific discourse of evidence-based policy-making (EPM) positions the problem in the Australian drug policy environment as a lack of an evidence base for rational approaches to ‘what works’. In their analysis of Australian drug strategies since 1985, Lancaster and Ritter (2014a) note that the increasing reliance on evidence as a way of ‘knowing the problem’ has resulted in shifts in the way drugs have been problematised across the strategies. They note that while NCADA did not refer to the causes of drug use in the main, over time the documents have increasingly drawn on ‘evidence’ to construct an authoritative description of the drugs as a ‘policy problem’ to the point where the latest drug strategy states that the harms of drugs are ‘well known’ (Lancaster & Ritter, 2014a).

Although both seek to increase the effectiveness of policy, Triantafillou (2013) observes that ‘evidence-based policy-making’ is to be distinguished from the performance management techniques of NPM, because EPM draws on a scientific discourse that privileges ‘scientific’ forms of knowledge production. The ideas of evidence-based treatment, services and practice are referenced across the most recent national drug strategy and the state and territory strategies. The NDS 2010-2015 states that it is underpinned by a commitment to “evidence-based and evidence informed practice, innovation and evaluation” (Ministerial Council on Drug Strategy, 2011, p. ii). The majority of state and territory documents also discuss evidence-based policy. For example, the NSW Drug and Alcohol Strategy
2006-2010 highlights the importance of ‘evidence based treatment’, as well as the goal “to set directions based on high standards and the best scientific evidence to treat drug and alcohol related problems” (NSW Department of Health, 2006, p. 4). The Victorian strategy 2013-2017 notes that the government commits to “building alcohol and drug policies on the solid foundations of evidence and collaboration” (Victorian Department of Health, 2013, p. 9).

What constitutes ‘evidence’ in evidence-based policy-making is very much based on a positivist approach to knowledge, an approach that privileges the application of scientific methods to the study of social problems. The most well-known expression of this is the ‘hierarchy’ or ‘pyramid’ of evidence, which ranks the quality of types of evidence based on research design. This model situates randomised controlled trials at the ‘top’ of the pyramid, representing the ‘gold standard’ by which other evidence should be judged. One interviewee noted the barriers to building an ‘evidence-base’ for particular types of services — here mentioned in terms of recovery-focused services such as NA and TCs — because of the ‘hierarchy of evidence’, which puts qualitative or anecdotal evidence at the bottom of the ladder:

The anecdotal evidence is overwhelming for us, but because your NAs and your therapeutic communities don’t keep as many records — although they do now — don’t keep the records that the other ones do, that’s hard too. That’s what’s frustrating. They love to throw the word ‘evidence-based’ around, ‘evidence base, evidence base, show me the evidence’. And then you line up a whole bunch of people, ‘oh yeah but that’s stories’. (Interview 10)

This participant also went on to question the evidence on the effect of NSPs on HIV/AIDS, considering it to be less than equivocal:

For example, recently the needle and syringe programs. Classic. Information that keeps coming out from the same groups, the same groups using the same research models, are saying ‘we are making a difference on HIV/AIDS’. Well we’ve done the maths, and we’ve done the science and it’s not. HIV/AIDS is going up, Hep C is going up, and it’s not because of the syringe program, most of it is because of inappropriate sexual activities that’s causing the problem. So the question is, why do we continue to spend all this money on syringes when they’re not having an impact. (Interview 10)
In contrast to this account, a large number of participants cited harm reduction measures, such as NSPs, as one of the areas that had a solid evidence base and is cost-effective. Scientific and economic discourses are linked in drug policy, in that interventions that are ‘evidence-based’ are seen to be ‘cost-effective’, whereas those that have no effect are deemed a ‘waste of money’. This struggle over what constitutes evidence reflects the politics of evidence in the drug policy space. Lancaster (2014) notes how a constructionist perspective provides a framework for critically analysing the ways in which ‘policy-relevant knowledge’ may not be a stable concept but rather one which is constructed through the policy process, and, through a process of validation, is rendered useful (p. 948).

She notes that the validity of evidence in the policy process is not fixed or objective but is a process of negotiation based on context, interpretation and contestation (Lancaster, 2014, 2016b).

Despite these drawbacks of the ‘evidence-based policy-making’ paradigm, it still presents a framework guiding how organisations and policy-makers orient themselves in the policy space and judge the merit of policies, services and interventions. The idea of ‘evidence-based policy’ and interventions has become central to contemporary policy-making, and in the drugs field it has meant that both service and research funding has been redirected towards research that can contribute to ‘evidence-based policy’ and services that can demonstrate an evidence-base or a willingness to collect one. Research and the collection of data are key to the operation of this scientific discourse in drug policy. Governments have linked funding with data collection requirements. For example, all publicly funded treatment agencies are required to collect and provide data to the NMTDS (Australian Institute of Health and Welfare, 2016). The most recent strategies all mention the collection of data. For example, the NDS 2010-2015 states that “data collection and management is vital to the delivery and evaluation of services and broader policy development” (Ministerial Council on Drug Strategy, 2011, p. 5). The link between data collection and broader policy goals is also recognised in the non-government sector. Khoo, Merinda, and Network of Alcohol and other Drug Agencies (NADA) (2009) outlined a project developed by the NSW drug and alcohol peak body, NADA, that aimed to develop a data collection system for routine measurement of treatment outcomes for clients presenting specifically to AOD
NGOs. Khoo et al. (2009) stress the importance of this strategy beyond the simple collection of data, working “towards organisations and a sector that has a convincing body of evidence on the effectiveness of the services they provide that can be used in advocacy, funding submissions and internal review, evaluation and continuous improvement” (p. 2). Thus the non-government sector also recognises the importance of data collection and evidence, and the improvement of services.

For organisations, there was an awareness of the importance of evidence-based practice and building the capacity for research within the community sector:

Something that I’ve been really passionate about is engaging our sector with research and with researchers to build the research capacity of the sector. But also to have research done within our sector, because we get told “you need to be providing evidence-based services” but all the research dollars go to medical parts of the addictions rather than the community sector so we’ve been really advocating for more research bodies to come in and do research on interventions delivered in the NGO sector, to get them published. (Interview 1)

Although Triantafillou (2013) views evidence-based policy making “as a technocratic and potentially authoritarian form of governing depending on quite narrow and exclusive forms of knowledge production” (p. 168), for providers evidence is linked with providing quality services and outcomes for clients. Evidence, effectiveness and quality are linked in drug policy discourse. Evidence-based policy and practice is linked with effectiveness in one of the listed aims of the Australian Capital Territory’s Strategy: “develop evidence-based policies and initiatives to ensure that issues associated with harmful alcohol, tobacco and other drug use are addressed in an effective way” (ACT Health, 2010, p. 4). The Queensland Drug and Alcohol Action Plan 2015-2017 does not specifically use the terms ‘evidence-based policy’, but it does discuss the idea of ‘what works’ (Queensland Mental Health Commission, 2015, p. 10).

This emphasis on effective interventions is, of course, also synergistic with instrumental discourses; evidence-based and quality services are important goals for the sector to work towards. Below, I explore the main features of instrumental discourses relevant to NGOs in the Australian drugs field.
Instrumental Discourses

Instrumental discourses are focused on the achievement of particular goals and objectives within drug policy. In particular, ‘harm minimisation’ is central to instrumental discourse in Australian drug policy, providing an overarching framework shaping and guiding action in the field. In essence, harm minimisation poses the problem of AOD in terms of the continuum of harm caused by drug use (Bull, Denham, Trevaskes, & Coomber, 2016). As Bull et al. (2016) note, harm minimisation thus locates the solution to these problems in terms of a comprehensive approach addressing a broad range of harms and the adoption of pragmatic responses over moralising discourses.

Harm Minimisation

As discussed in the last section, harm minimisation has served as an instrumental discourse for the achievement of drug policy goals at the national level and state and territory level for quite some time. As Lancaster and Ritter (2014a) note, “throughout the process of evaluation and renewal of the National Drug Strategies, there has been a desire for the ‘Australian approach’ to be understood as comprehensive and consistent since its inception” (p. 82). The policy framework of ‘harm minimisation’ is articulated as a comprehensive, balanced approach because it addresses the ‘three pillars’ of supply reduction, demand reduction and harm reduction. All of the drug policy documents reviewed draw heavily on this instrumental discourse of harm minimisation — hardly surprising, considering this concept has been the accepted foundation for the national approach for 30 years.

While the responsibility for the enforcement of drug law and policy — particularly those activities under the heading of ‘supply reduction’ — primarily lies with state agencies (with some exceptions), the non-government sector has been positioned as central to achieving the goals and activities associated with ‘demand reduction’ and ‘harm reduction’; it is with these pillars that the non-government sector has generally been associated in Australian drug policy. This is consistent with the observations of Bull et
al. (2016) that harm minimisation seeks to share the burden for minimising harm across all service sectors.

The majority of participants expressed support for the harm minimisation framework as a guiding policy framework, with most citing its key strengths as allowing for a ‘balanced approach’. Harm minimisation allows for a range of different services to come under the one policy framework:

But our, [NGO], is supportive of the harm minimisation approach and within that, there is a continuum of approaches through from harm reduction through to abstinence-based service providers and there is a place for all of those under the harm minimisation policy framework. (Interview 1)

The balance of the pillars *in practice* was a point of contention, however, with several participants considering that the focus of Australian drug policy had been on law enforcement and supply reduction issues, to the detriment of treatment, prevention and harm reduction measures. A number of participants (5) noted that law enforcement held a lot of power, and also received the most funding.

Well you know I think that basically what happens is the biggest say of all comes from the law enforcement sector, it certainly gets the largest slice of the drug money, so to speak if you want to call it that. You know I think things like treatment and prevention are poor second cousins to that, yet in the sense they are the ones that are really kind of dealing with the fall out of what happens at the human level in relation to drug use. (Interview 6)

This idea is reflected in mapping expenditure on Australian drug policy — law enforcement gets the largest portion of funding, followed by treatment, prevention and harm reduction respectively (Moore, 2008; Ritter, McLeod, & Shanahan, 2013). A number of participants stated that this was division of money was not evidence-based:

I think it’s been great that we’ve had the three pillars, that we haven’t gone done a purely ‘war on drugs’ model. At the same time, the fact that the supply reduction pillar takes up 80% I think is the figure of the budget is ridiculous, and is not evidence-based. (Interview 15)
The idea that prevention, treatment and harm reduction should receive more funding was reiterated by a number of NGO representatives. Interviewee 8 spoke about it in economic terms, highlighting returns on investment:

Yes well harm minimisation is about harm reduction, demand reduction and supply reduction. What that means is that supply reduction gets most of the money, and most of the resources, and law enforcement — if there was serious research into the return on investment in that, we would really see that it’s not good use of money. Much of that money being put back into treatment and harm reduction services would make for a much healthier community. (Interview 8)

This reflects an argument drawing on justice reinvestment principles — the idea of taking money spent on law enforcement and investing it back into the community, in order to reduce recidivism (Brown, 2013).

Prevention had been relatively under-funded, according to several NGO representatives. Some linked this with the short-term focus of governments and election cycles discouraging investing in prevention because the results would only become apparent in the longer-term. The balance between treatment and prevention funding was highlighted by another participant:

To us, when you’re looking at treatment versus prevention it often seems like treatment is a bit of a black hole in terms of money. It’s so costly, and there just never seems to be enough money invested in it. I think we all think that treatment is absolutely vital, but what we would like to see is a bigger investment — not at the expense of treatment — but a bigger investment in prevention so that we could actually start making a change about the number of people who are seeking it. Because we all know that recovery is a lifetime process and that one period of treatment often is not enough to prevent someone from relapsing numerous times throughout their life. (Interview 11)

Here, this participant draws on economic discourse — particularly the idea that treatment is costly because of relapse — to highlight the necessity for more funding for prevention to try to stop this happening in the first place. At the same time, the participant draws on this same discourse to highlight the potential cost of treatment whilst acknowledging the political drawbacks of prevention in terms of its lack of short-term or immediately visible outcomes. This illustrates the pervasiveness of NPM in
that economic and instrumental discourses in drug policy are interlinked through economic justifications for instrumental activity.

The drug policy documents also draw on an instrumental discourse that situates part of the problem of drug policy in terms of harms caused by the criminal justice system itself. The ‘solution’ to drug problems is posed in terms of programs that aim to minimise the harms caused by criminalisation by diverting people from formal criminal processing.

**Criminal Justice and Diversion**

A significant body of literature has built up around criminal justice-based treatment and diversion programs, and it is not within the scope of this chapter to review this here (Bright & Martire, 2013; Bull, 2005; Hughes & Ritter, 2008; Stevens et al., 2005). Instead, I want to concentrate my discussion on how these trends have shaped the role of NGOs in the Australian drugs field.

During the term of the Howard government, funding was provided for a national program supporting the diversion of drug users from the criminal justice system into assessment and treatment (the Illicit Drugs Diversion Initiative). Non-government organisations played a significant role in the push towards the implementation of diversion programs in Australia, and the implementation of one of the key programs under *Tough on Drugs*, the national Illicit Drugs Diversion Initiative (IDDI) (Hughes, 2009). While diversion programs had been operating in some jurisdictions, this initiative established a national, co-ordinated approach to diversion programs.51 In an introduction to the ANCD’s Annual Report in 2000, Prime Minister John Howard states that “Diversion is a fine example of the Commonwealth, state and territory governments and the non-government and community sectors working together on a shared problem” (ANCD, 2000, p. 4). The initial roll-out of the IDDI was criticised for not sufficiently

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51 Perhaps unsurprisingly as the national peak body, ADCA played an important role in a number of drug policy changes, including the IDDI. In her study of the key events surrounding the implementation of the IDDI, Hughes (2009) argues that persuasive advocacy by a group of non-government experts was one of several key driving force in the move towards the IDDI.
involving the non-government sector, and in the second phase of funding from 2004-05 to 2007-08 the agreements between the Australian Government and some states and territories incorporated a condition about increasing the level of IDDI service delivery by NGOs (Australian Institute of Health and Welfare, 2008).

The criminal justice system now represents a significant source of referral for drug and alcohol services in Australia. The AODTS-NMDS collects data on source of referral. The 2013-14 data-set breaks sources of referral down into self/family, health services, corrections, diversion, and other. As seen in figure 5 below, overall, self or family is the most significant source of referral for all closed treatment episodes, followed by health services, diversion correction, and other.

**Figure 5: Total closed treatment episodes by source of referral, 2013-14**

![Graph showing referral sources](source: AIHW NMTDS Data Cubes (Australian Institute of Health and Welfare, 2016))

The linking up of drug service systems and the criminal justice system through diversion and other programs reflects the neoliberal focus on the management of risky groups and ‘at-risk’ individuals — such as those identified as ‘at-risk’ through their contact with agencies of criminal justice. The ‘management’ of these groups increasingly falls to actors and agencies outside the state, such as NGOs, who are assigned with the delivery of services designed to increase their capacity for self-governance.
Rose (1999) asserts that the marginalised are increasingly allocated to new “para-professional” non-government sector agencies and the technologies of government directed at them are increasingly punitive; however, at the same time, experts within these new paraprofessional agencies seek to govern their marginalised clients while drawing on the language of choice and autonomy (Rose, 1999).

In the case of these ‘coerced treatment’ programs, particularly Drug Courts, partnerships between the CJS and non-government organisations are important to the functioning of these programs (Thomas & Bull, 2013). NGOs working with clients in a criminal justice context face a particular set of issues in relation to power (Corcoran, 2010; Tomczak, 2013). Workers in this context face challenges to their independence (Weston, 2016). In the UK, where there was a large emphasis on the relationship between drugs and crime in policy during the term of the New Labour Government (1997-2010), there was significant investment and expansion of drug treatment services in Britain, along with a linking and investment in criminal justice system and treatment (Duke, 2010). British drug policy scholar Karen Duke discussed how the intertwining of criminal justice and treatment functions have actually encouraged the professionalisation of the AOD sector (Duke, 2010). In the linking up of different systems — specifically, criminal justice and treatment systems — the problem of the drugs field is posed in terms of the fragmentation of services and the siloing of different departments.

**Communicative Discourses**

Contemporary Australian drug policy is underpinned by a communicative discourse that legitimises government policy through ‘engagement with the community’, governance and partnerships. The key problems identified in this neoliberal discourse are the fragmentation of the welfare state, the isolation of different agencies and stakeholders, and the lack of co-ordinated action on drugs. Neoliberal communicative discourses promote the solution to this problem as practices such as collaboration, consultation and policy debate to construct ‘effective’ policy. As discussed in Chapter 4, contemporary national drug policy draws heavily on a discourse of partnerships with the non-government sector. The discussion below focuses on how ideas of partnership and governance are mobilised in a communicative
discourse that legitimises government policy through ‘engagement with the community’, governance and partnerships.

**Governance and Partnerships in Drug Policy**

The discourse of partnership is anchored in a political rationality that values ‘collaboration’ and ‘comprehensiveness’: drug policy is framed as a complex problem requiring effort from a range of sectors and actors. The underlying principle of partnerships is part of a governmental move that recognises that a ‘comprehensive approach’ cannot be achieved by governments alone. This is in line with Garland’s (1996) writings about preventive partnerships with community agencies being an adaptive strategy on the part of the state in recognition of its limitations in addressing all forms of crime.

In drawing on a discourse of partnership, the national and state/territory drug policies construct the project of ‘harm minimisation’ as requiring effort from a range of stakeholders. ‘Partnerships’ feature heavily across the most recent state and territory drug strategies (ACT Health, 2010; NSW Department of Health, 2006; Queensland Mental Health Commission, 2015; Victorian Department of Health, 2013). For example, the QLD Drug Action Plan 2011-2012 states that “a partnership approach has been one of the hallmarks of Australia’s and Queensland’s approach to drug issues” (Queensland Health, 2011, p. 1). The principle of ‘strengthening partnerships, collaboration and ownership’ has been a strong theme in the ACT documents, as it appeared across both the 2004-2008 and the 2010-2014 strategies (ACT Health, 2004, 2010). The importance of developing a ‘shared vision’, and a ‘common understanding of harmful drug use’ is highlighted, and ‘co-operative planning’ is presented as the way to effective service development and delivery: “the answer to complex social issues does not lie exclusively with any one section of the community” (ACT Health, 2010, p. 51). The 2010-2014 ACT strategy is presented as a partnership between government, the community and non-government organisations (ACT Health, 2010, p. 51).
As Li (2007b) notes, a state agency willing to govern in dialogue with stakeholders including critics, experts and the community can “strengthens its claim to govern” (p. 280). The role of NGOs in the ‘decision-making’ aspects of the strategies is emphasised through the discourse of partnerships. Each of the most recent state and territory strategies refer to the inclusion of NGOs in governance and advisory structures (ACT Health, 2010; NSW Department of Health, 2006; Queensland Mental Health Commission, 2015; Victorian Department of Health, 2013). The NSW plan notes that NADA, the peak body for the NSW non-government drug and alcohol sector, is a partner to the plan. The latest Victorian strategy discusses collaboration between the government and non-government sectors (Victorian Department of Health, 2013, p. 6), identifying the need for a “collaborative, evidence-based approach to decision making” (Victorian Department of Health, 2013, p. 6). It outlines new advisory structures, including a new alcohol and drug advisory board comprised of “no more than 12 non-government leaders, experts and stakeholders” to advise the Government (Victorian Department of Health, 2013, p. 6).

**Consumer Participation**

Consumer involvement in treatment planning and policy directions has been highlighted across most of the recent policy strategies. Since 2004, the National Drug Strategies has emphasised the need for consumer participation, however as AIVL observes, there has been no national framework or approach for consumer participation to guide its development and implementation (Australian Injecting and Illicit Drug Users League, 2008, 2011). The Commonwealth government did, however, provide funding to AIVL to evaluate several consumer participation demonstration projects, the phase one report being released in 2008 (Australian Injecting and Illicit Drug Users League, 2008) and the phase 2 report in 2011 (Australian Injecting and Illicit Drug Users League, 2011). The project aimed to investigate the support for, and feasibility of, involving consumers in the planning and delivery of drug treatment services in Australia.
All jurisdictional policies highlight consumer participation in some form or another. For example, the Queensland Mental Health Drug and Alcohol Plan discusses partnerships with consumers, families and carer representatives:

The Queensland Mental Health Commission will lead this work drawing on the expertise of the Mental Health and Drug Advisory Council and in partnership with consumer, family and carer representatives. Government agencies, representative groups and peak bodies will also contribute to this work (Queensland Mental Health Commission, 2014, p. 18).

One of the stated aims of this is to provide:

Meaningful opportunities for individuals, families and carers to participate as equal partners in the co-design, planning, monitoring and evaluation of mental health, drug and alcohol services and in all levels of policy development (Queensland Mental Health Commission, 2014, p. 18).

The most recent ACT document states that one action under the strategy will be the implementation of a policy framework to guide consumer participation in drug treatment and support services in that jurisdiction (ACT Health, 2010). Interestingly, the NSW document does little to discuss service user involvement, although it does state that services should be client-centred (NSW Department of Health, 2006).

There is a synergy between neoliberalism and the rise of consumer participation in treatment. Rose (1999) notes that neoliberalism shifts the ethos of government from one of bureaucracy to one of business, “dictated by the logics of the market and the demands of customers” (p. 150). Mold and Berridge (2008) note that in Britain, the state has used user involvement in treatment as a key tool in making services more responsive to the needs of the consumer. In the Australian context, governments had also included criteria around including participation in service design in funding agreements, as explained by Interviewee 14:

I think one of the frustrations with partnerships, when you work for a drug user organisation is that obviously a lot of organisations have criteria or outcomes in their funding that relate to either consumer engagement or connecting to their target communities. So that often means that a lot of services want to work with organisations like ours, because we are drug users and
we are drug user organisations, we have really strong connections to those communities. (Interview 14)

The rise of ‘consumer participation’ in treatment planning and policy has been linked with the more general trend of neoliberal subjectivity that encourages ‘consumers’ of health care to be more involved in their own care (Zibbell, 2004). In this model, the drug user is redefined “as a consumer who can make responsible choices with regards to his or her health” (Zibbell, 2004, p. 59). Interviewee 8, for example, discussed a consumer participation program directed at people living with Hepatitis C:

…particularly around consumer participation, we’re doing work around self-managed care for people living with Hepatitis C. (Interview 8)

Other examples include peer-support programs where people who use drugs are encouraged to engage in responsible injection practices. This represents a “reconfiguring of expertise” (Bunton, 2001, p. 232), in which the ‘patient’/client becomes an expert: “the former relations of power that characterised the client/clinician encounter are interrupted and the drug user’s subjectivity becomes reconfigured within the modus operandi of the self-managing, responsible consumer” (Zibbell, 2004, p. 60).

**Governance Instruments**

As Li (2007a) notes, “the practices that constitute an area of intervention and render it technical are crucial to the formulation and implementation of a governmental program” (p. 279). Governance instruments in the drugs field represent some of the ways that communicative and other discourses — including those that position governance, partnership and consumer participation as the key to legitimate drug policy and responses — are ‘rendered technical’ through particular practices. Table 5 below outlines some of the diverse range of governance instruments in the drugs field through which problems of government are rendered technical.
Table 5: Instruments of governance in the Australian drugs field

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional</td>
<td>Regulatory bodies, management arrangements, coordination and partnership mechanisms.</td>
<td>National Level: Intergovernmental Committee on Drugs; Ministerial Council on Drug Strategy (disbanded); ANACAD Expert advisory committees Stakeholder reference groups Peak bodies</td>
</tr>
<tr>
<td>Economic</td>
<td>Funding for research, programs and interventions to address drug problems.</td>
<td>Funding streams Contracts Specific streams e.g. NGO-TGP and SMSDGP</td>
</tr>
<tr>
<td>Technical</td>
<td>Technical measures used to address drug-related problems — e.g. Law enforcement, treatment approaches, harm reduction measures etc.</td>
<td>Law enforcement approaches: interdiction, drug sniffer dogs at festivals Harm reduction and demand reduction measures: needle and syringe programs, methadone, prevention and drug education</td>
</tr>
<tr>
<td>Administrative</td>
<td>Information systems, plans, guidelines and other decision support and management tools related to interventions and services.</td>
<td>AODTS-NMDS Treatment and service guidelines</td>
</tr>
<tr>
<td>Legal</td>
<td>Measures which proscribe, restrict or prohibit different drugs. Measures which prescribe certain behaviours in government-non government relationships.</td>
<td>Drugs Acts Diversion programs Freedom to Advocate Act 2013 Compacts, Memorandum of understanding Contracts</td>
</tr>
<tr>
<td>Communicative / Participatory</td>
<td>Measures to increase awareness of drug issues and mobilise community actors.</td>
<td>Stakeholders forums Meetings Public consultations</td>
</tr>
</tbody>
</table>

Source: Adapted from Plummer and Slaymaker (2007)

Government at a distance is to be achieved through these technologies of government that seek to provide institutional frameworks that facilitate partnerships through economic instruments and communicative instruments. Economic instruments to facilitate partnerships include government contracts and funding streams for NGOs. In terms of policy input and involvement in strategies and policy, governments have sought to involve NGOs in decision-making through advisory structures, representation on committees and consultation mechanisms. They have also funded peak bodies to provide representation for the non-government AOD sector. This is in line with Foucault’s conception of governmentality as comprising a wide range of techniques of control; here, discourses must be studied as inseparable from those institutions and technologies rendered to support them.
Although they appear to permeate the contemporary Australian AOD field, it would be remiss to try and argue here that neoliberal problematisations and discourses are the only ones shaping activities in the area. There are other discourses and problematisations that feature within drug policy discourse, ones that don’t simply focus on individual responsibility — discourses of the ‘the social’ feature in drug policy documents, and in the programs of NGOs. For example, the current ACT Drug and Alcohol strategy emphasises the recognition of the social determinants of health and wellbeing (ACT Health, 2010). The QLD Drug and Alcohol Action 2015-2017 plan discusses the need to “address social factors” and “social determinants” influencing mental health and well-being and problematic substance abuse, which include “education, training and employment, social inclusion, family relationships and access to services such as housing” (Queensland Mental Health Commission, 2015, p. 10). In the emphasis on supply reduction, law enforcement and criminal justice measures across a number of documents, we can see the continuing relevance of conservative and authoritarian approaches to government. These are manifested in techniques of government that operate through legal power and the threat of sanction — for example, in the case of supply reduction measures using law enforcement, criminal justice based treatment, or the criminalisation of drug supply and possession through the various drugs acts.

Advanced liberal governmentality draws on a wide range of techniques and logics of control. ‘Action at a distance’ is often not perfect, in that it still requires considerable state intervention. This is even more so in the drugs field where, by virtue of its regulation through the criminal law, must be ultimately regulated by government and their agencies. Here, neoliberal blending of free market capitalism and interventionist strategies to achieve the goals of drug policy is the result of the tensions between freedom and security in liberal government (Foucault, 2008). As Foucault (2008, p. 65) argues, at the heart of liberal government is security, which is the problem of “the protection of the collective interest against individual interests” (p. 66). He states the governmentality is underpinned by an “interplay of security/freedom which must ensure that individuals or the community have the least exposure to danger” (p. 66). This focus on protecting the collective interest under liberalism justifies “extension of procedures of control, constrain and coercion which are something like the counterpart and counter-
Drawing on arguments previously made by Hindess (2001), both Dean (2007) and Bull (2008) point out that in the governmentality literature, there has been a tendency to concentrate on how neoliberal government governs ‘through freedom’, ignoring the authoritarian mentalities and practices that are deployed in liberal rule, often in the name of managing those subjects who have not attained the ideal liberal capacity for autonomy.

**Conclusion**

This chapter addressed the second research question, which asked ‘What are the contemporary conditions shaping the role and work of NGOs in the Australian AOD field?’. I argued that there has been a clear trend towards the adoption of neoliberal modes of governing in drug and alcohol, seen in the proliferation of techniques of ‘government-at-distance’ where governments are not generally seeking to shape individuals or organisations directly through state intervention, but indirectly by encouraging and incentivising various forms of activity (Rose, 1996, 1999). The analysis traced four major discourses through which neoliberal political rationalities have problematised the drug policy field and impacted on the role of NGOs: economic, scientific, instrumental and communicative discourses.

Neoliberal economic ideas around market-based models of service delivery have presented opportunities and challenges for NGOs in drug policy. With the rise of neoliberal economic discourses in the drug services sector, NGOs have been positioned as key to ensuring cost-effective service delivery in health and other fields, and so the services delivered by NGOs has grown. At the same time, governments and NGOs have also problematised the capacity of the sector to deliver those services through neoliberal economic discourse and techniques of new public management around cost-effectiveness and performance management. On the one hand, tendering processes had encouraged organisations to work together and collaborate more, resulting in an increased sense of partnership amongst some organisations. On the other hand, tendering processes had also created competition between organisations that created a sense of distrust and resistance to partnership or a sense of coerced partnership. Broader government funding reforms across a number of jurisdictions (federal and
state/territory) have been implemented recently with the aims of more efficient funding processes and accountability. These programs of reform had unintended effects, presenting challenges for NGOs by creating a sense of uncertainty and insecurity. The ongoing under-funding for the AOD service system was highlighted as a major challenge for the contemporary sector, one that neoliberal economic discourses have certainly not helped. There are tensions in the neoliberal and managerialist emphasis on efficiency and market-based logics, and the push for improved services and access in the drugs field where services are pushed to do more with less. At the same time as this emphasis on cost-effectiveness and accountability has increased, the collection of data from various sources has also increased; in this way there has been a convergence of economic and scientific rationalities in drug policy.

The majority of documents analysed represent ‘drug problems’ as complex, requiring a comprehensive and balanced approach, and as such position NGOs as an important part of addressing this problem, particularly in terms of their roles in drug and alcohol treatment and interventions. Bull (2008) points out that contemporary drug responses actually draw on hybrid rationalities and techniques of governance. Writing about methadone maintenance in particular, she highlights the tensions that arise through the “coexistence of strategies governing through freedom with those governing through constraint” (Bull, 2008, p. 157). There are a range of programs in the drugs field that operate through ‘hybrid’ modes of governance. As Shiner (2013) notes of the arguments about the criminalisation of social and drug policy — “transformation of penal-welfarism has given rise to a more punitive and coercive approach to drug control, but has not entailed the wholesale replacement of one system by another” (p. 640). In the case of the analysis of NGOs’ role in drug policy presented here, we can see the continuing relevance of treatment and rehabilitation, and discourses of health (Shiner, 2013). In the case of criminal justice diversion and treatment, for example, we can also identify an intertwining of techniques “governing through freedom and those governing through constraint” (Bull, 2008, p. 157).

Contemporary drug policy draws heavily on a communicative discourse that emphasises the importance of ‘partnership’ with the non-government sector in drug policy. As such, partnerships between the government, non-profit, non-government and private sectors are positioned as key to the achievement
of drug policy goals, and drug policy strategy documents etch out a clear role for NGOs in policy as well as service delivery. There is also a role for the ‘user’ here, as governments have sought to increase consumer participation in the treatment design, planning, policy and evaluation. Consumer participation in treatment has become a key tool of neoliberal governments for creating responsive services so necessary within a marketised service delivery environment (Mold & Berridge, 2008, p. 458). However, the strengthening of the medico-penal alliance through diversion and criminal justice treatment are in tension with pushes towards models of consumer engagement in AOD services: how are models of consumer engagement and genuine collaboration to develop in a context where the ‘client’ is so often coerced through the threat of punishment and where domination is such a key feature of power relations.

Since the introduction of the National Drug Strategic Framework Building Partnerships in 1998, I would argue that there has been a ‘normalisation’ of partnership rhetoric in drug policy. Partnerships have come to be an expected feature of policy frameworks in the drug and alcohol field. Whilst the communicative discourse of partnerships has become a key tool of neoliberal government in governing the drugs field, the actual experiences of its targets — in this case, the non-government sector — may differ from the rhetoric contained in policy. The next chapter delves deeper into the communicative discourse of ‘partnerships’ at the policy level by undertaking a critical analysis of the qualitative dynamics that shape NGOs policy role in the drugs field.
Chapter 6: Problematising Partnerships: Current Issues for the Non-Government Sector’s Role in Policy

The analysis in the previous chapter traced the broad conditions shaping the role of NGOs in the contemporary drug policy field, and established that ‘partnerships’ have become a pervasive feature of contemporary drug policy rhetoric in Australian jurisdictions. This chapter problematises this discourse of partnerships at the policy level by engaging in an analysis of the policy role of NGOs in the Australian drugs field. It addresses the third research question, which asked ‘What is the relationship between the rhetoric of government/non-government ‘partnerships’ and the experiences of NGO representatives in drug policy processes?’. The overall goal of the chapter is to contribute to understandings of the ‘messy actualities’ (Larner, 2000, p. 14) of the neoliberal project of drug policy ‘partnerships’ through an empirical investigation of the policy role of NGOs in the drugs field. Li (2007a) suggests that “Since there is always a gap between a plan and its realisation, an ethnographic study of government would be attentive to the practices that form in, around, through or against the plan” (p. 279). Following this suggestion, I am interested in investigating some of the tensions between the rhetoric of government/NGO partnership and practice at the policy level in the drugs field, as described by representatives from the NGO sector.

While there is a considerable literature exploring service provision in the AOD field, and a growing literature on drug policy governance, as outlined in Chapter 2 there is considerably less literature specifically exploring issues around the policy role of NGOs in the AOD field and few studies that explore this from the perspective of Australian NGOs. Consequently, in this chapter I draw attention to the experiences of representatives of a variety of drug and alcohol-focused NGOs, all of whom are involved in some aspect of policy work in the Australian drug and alcohol field. As Li (2007b) notes, the practices of social actors in response to governmental programs should be of concern to those studying governmentality. The strength in applying ethnographic methods, like the interviews used in this study, is to examine what people connected with specific kinds of programs and techniques of
government — in this case, partnerships — are actually doing, and how these practices of government are “interpreted by differently situated subjects” (Li, 2007a, p. 279). Ultimately, this chapter focuses on how representatives from the non-government sector — as the targets of ‘partnership policy’ — interpret their role in the policy domain.

The discussion in this chapter is organised around three key dynamics that impact on the interrelationship between the rhetoric of government/non-government ‘partnerships’ and the experiences of NGO representatives in drug policy processes. First, I analyse some of the justifications put forward for participation in drug policy processes and the potential role envisioned for the non-government sector by NGO representatives. Second, I consider some of the ‘realities’ and tensions of the contemporary drug policy environment that shape the ability of NGOs to contribute to policy-making processes. In the final section, I describe the key challenges impacting on the role of NGOs in contemporary drug policy processes.

Overall, the chapter considers partnerships policy in practice, and uses the experiences of NGO representatives acting in the drug policy field to highlight some of the consistencies and gaps between the policy intention of partnership and experience. I argue that the power relations behind ‘partnerships’ take effect on NGOs policy work by structuring the ways NGOs can engage with policy, creating opportunities for them to contribute but undermining their political capacity in other ways. My analysis suggests that although the rise of neoliberal strategies of government has also coincided with an increase in opportunities for NGOs to participate in the policy space, there are power dynamics in the AOD field — as well as the broader policy and political sphere — that undermine the capacity of NGOs to contribute in the manner envisioned in partnerships discourses.

**The Potential Role for the Non-Government Sector in Drug Policy**

As discussed in Chapter 2, on a theoretical level there are a number of rationales for involving NGOs in policy processes including: enhancing the democratic functioning of liberal societies by addressing
the ‘democratic deficit’ (Maddison & Denniss, 2005); mobilising social capital for communities to act on issues of shared concern; and representing voices of the marginalised in policy processes. The NGO representatives I interviewed for this study drew on similar ideas when talking about the purpose of NGOs participation in drug policy processes. Participants were reflexive about the potential and actual policy role of NGOs: a key thread running through their explanations was that NGOs’ role and expertise in service provision and their ability to represent and mobilise ‘community’ legitimised the role of NGOs in drug policy. In the section below, I analyse how the NGO representatives interviewed for this study articulated the ideal role and functions of NGOs in the policy process in relation to the three themes of community, independence and expertise.

Community
Drug policy processes have been characterised as consisting of a wide range of ‘competing voices’, including those of law enforcement, health, people who use drugs and the community (Lancaster, Ritter, & Stafford, 2013). There was an expectation by participants in this study that in formulating policy, governments should take into account the needs of the ‘community’, people who use drugs, their families and those that will be affected by policy; participants also considered that for governments to do so, they need good advice from actors who are both internal and external to the government. The non-government sector was presented as a way of representing the voice of the community in policy discussions. Interviewee 5 endorsed a pluralist model of policy-making that takes into account community attitudes through NGOs:

And I think that’s the thing; government advisors and policy-makers need to get good advice by being open to the community, through NGOs, through peak bodies, and just the community in general. So community attitudes will have a big bearing. (Interview 5)

Thus the inclusion of multiple voices in the policy process — as in a pluralist model of policy-making (Shaw, 2010) — was seen as desirable.
Non-government organisations were linked either implicitly or explicitly with ensuring the democratic representation of community interests in policy consideration and deliberation. A number of participants (5) expressly outlined the role of NGOs in drug policy in terms of providing a ‘voice’ for the community or other stakeholders in policy processes, as illustrated in the following quotation:

I think we’ve got a huge part to play really, it’s the NGOs that bring civil society to the table. And as cynical as I might appear to be, and as limited as our influence might be I sure think it’s essential that we’re at the table. (Interview 19)

Similarly, participants also noted that NGOs could be the ‘voice’ of service users and services in policy processes. NGOs draw their legitimacy from their ability to speak on behalf of their clients, those who will be affected by decision-making processes. For drug user organisations, it is about ensuring that the voice of drug users is heard in policy processes.

So yeah I guess it’s just constantly pushing to have our voice heard, to get recognition for our organisation, to get people to understand the importance, and not just that but getting people to understand, the World Health Organisation recommends that a really crucial part of a community’s health is people being involved in the decision-making process and being involved in the things that affect them, that community mobilisation. (Interview 14)

According to participants, by commenting on drug policy changes — particularly those around services — NGOs could help clients and also contribute to the broader community:

The object is to try and resist changes we think are somewhat regressive and negative from occurring and improve and pursue our statement and purposes in our constitution, which essentially is about creating better outcomes for our clients as a sector. And also giving our agencies and treatment services the wherewithal to do their work more effectively and in a sense, protect the Victorian community from the harms of substance misuse. (Interview 13)

Effective policy here then is seen as a contribution to community because it could contribute to better outcomes in the community. Interviewees, like the policy documents, talked about their role in the policy process in terms of representing community. Connection to the community was part of the value, and the responsibility, of the non-government sector:

As well as being able to get pro-bono support from grants, fundraising, so in a sense getting the community to support through their own donations and of goods, material, labour, cheap prices,
or just straight dollars; which again government will struggle to do. That’s not so much a policy issue other than, that connection with the community I think is important and to feed up those, if we’re not designing services and systems that really address communities needs and issues, that’s an issue, and I think that government appreciates that it’s difficult for them to do that on their own, and the NGO sector can help bridge that gap. So yeah there’s a responsibility there. (Interview 12)

These examples highlight the non-government sector’s association with the community and their broader social role.

**Independence**

The policy process is characterised by a wide range of voices, and the value of NGOs in the policy space was also seen in providing a counter-voice or a view from outside government and other interests. The independence of NGOs was noted by a number of participants, who considered this a valuable mediatory role in the policy process:

I do think that non-government organisations have a huge part to play, and I do think it’s their independence, as much as they are often tied to governments financially, it is that independent voice. For us, we feel accountable to our membership and to our constituent membership primarily, that’s who we feel accountable to primarily rather than to the government that might assist us to survive. I do think that it’s so many voices that are essential in the formulation of policy. (Interview 19)

Several participants linked this independence to innovation, suggesting that the NGO sector could contribute to more innovative policy responses:

The other part of that is also that we’re a place where new innovations are trialled, and we can take risks that often government can’t take. (Interview 12)

I think it’s helpful to have a view that’s from outside the government process. I think that we have the ability to think a little bit more laterally than what the government can, and what the government departments can. So obviously that means that what we present might not be politically palatable but the ideas, some of these ideas might be able to be run with and be able to be worked with. (Interview 19)
Because NGOs are not as heavily regulated as public departments, they represented a site through which innovative policy and services could be trialled.

According to some participants, the purpose of NGOs was to provide a counter-voice to governments and other actors in the policy process and to resist regressive or negative changes (although there were considerable differences in policy positions). For two participants, this meant providing a conservative counter-voice, as illustrated by this quote:

I think it’s important that our voice is there in that you’ve got people going one way but you’ve got to have a contrary voice to try and pull it back. If we weren’t there it would be easier for them to go further, and way out. (Interview 9)

Having a multiplicity of voices in the policy process then was considered to be important for balanced drug policy.

**Expertise**

Most participants noted a connection between policy/advocacy and representational work and service delivery, and a number of them pointed out that the balance of services is provided in the non-government sector (an idea in line with the discussion about neoliberal economic discourse and NGO service delivery presented in the preceding chapters). Consistent with the manner in which policy documents positioned NGOs (as outlined in Chapter 4 and 5), interviewees talked about NGOs being ‘on the ground’ and closer to communities. In this way, NGOs are constructed as experts of community:

Well I think they know what’s going on. I think they know realistically what’s happening with drug and alcohol policy, and how that affects the people who are affected, the users and their families and the general community. So you’ve got a kind of expert group there that could play a very significant role in giving good advice. (Interview 17)

By virtue of their status as representing people who use drugs, DUOs were considered to have specialist experiential knowledge that could not be replicated by other organisations:

So I think in the first instance I guess it’s really about pushing the organisations and what they do, and the importance and how vital they are, and that no one else sort of does their role, and
you shouldn’t be having these discussions without people who use drugs being present. (Interview 14)

The perspective of NGOs was linked with providing a kind of ‘truth’ of experience to the policy process. A number of participants linked the role of NGOs in the policy process with providing an evidence-based perspective — but that evidence was very much based on experiential knowledge of services and ‘service user’ issues. As one NGO representative indicated:

We present evidence to the government as to what is evidence-based for different policies. Obviously that evidence is in favour of alcohol and other drug treatment, because that’s what we are, we’re an alcohol and other drug treatment [peak body]. But it’s still evidence that we don’t manufacture ourselves, it’s evidence that comes from other respected research bodies. Obviously our communication with the government is as a representative of treatment organisations. (Interview 15)

Involving people who use drugs in policy discussions was also linked with evidence-based policy.

Research shows that involving people in those discussions, whether it be drug user organisations, non-government organisations, people who have some experience of those issues, them being involved in the discussion is beneficial. (Interview 14)

In this way, involving NGOs enhances the legitimacy of policy in the drugs field, ensuring that the ‘experiential knowledge’ of communities, service users and people who use drugs is represented in policy processes.

Part of the purpose of NGOs then is being able to relay an experiential knowledge to government, to ensure that policy is consistent with the ‘on-the ground’ experiences of the drug and alcohol sector, and people who use drugs themselves, that governments might not be able to grasp on their own. Rose and Miller (1992) argue that

The complex of actors, powers, institutions and bodies of knowledge that comprise expertise have come to play a crucial role in establishing the possibility and legitimacy of government. Experts hold out the hope that problems of regulation can remove themselves from the disputed terrain of politics and relocate onto the tranquil yet seductive territory of truth (p. 188).
The disconnection between those who formulate government policy and experience ‘on the ground’ was noted by participants. NGOs were represented as closer to this experience ‘on the ground’ by virtue of their positions in the community as service providers. There was a sense that sometimes policy officers and those involved in formulating policy lack a good understanding of the AOD service sector and what NGOs actually do, and the inclusion of NGOs in policy processes could bridge this gap. One participant talked about it in terms of the divide between policy formulation and being the ones to actually implement policy:

...the most difficult situation and regrettably, most insidious situation really, is that policy is made a long way from where policy is actually implemented. And that kind of divide between someone making the policy and someone actually having to implement it, sometimes what you’re trying to implement makes absolutely no sense. (Interview 5)

This was considered especially problematic when taking into account the complex nature of the drug and alcohol sector.

Several participants directly noted that ‘bureaucrats’ and policy officers often do not have ‘subject-experience’ or lack knowledge of the specifics of the drug and alcohol sector. NGOs were thought of as having a responsibility in this regard — this divide between policy and practice made it more important for NGOs to contribute to the policy process:

So I think what might be a bit different now is, if we look at our bureaucrats at the federal level there’s very little corporate knowledge, lots of them are new…but it’s quite a complex kind of sector and so it’s all the more important for say the NGO sector, however we kind of classify that, or the sector, to keep its corporate knowledge and communicate it about what’s happened before, what’s worked and what hasn’t and to have those key respected people. (Interview 2)

Some interviewees explained that NGOs were able to feed information from the ‘ground’ level higher up to policy-makers. For example:

So look I think NGOs serve an important part of that process because of the fact that they are more likely to be working on the ground with people, they can understand what’s the local situation, can understand what is going to be able to be implemented at a local level. (Interview 5)
In this way, participants considered that NGOs could be privy to experience and information that representatives from governments were not, because of their respective positions and roles (as outlined above in the case of policy officers lacking drug and alcohol knowledge). Again this was also seen as a particular strength of peak bodies, because of their connections with their member organisations. One participant described the role of the peak bodies as ‘intelligence gathering’:

> I think in the kind of treatment and support space I think the state and territory peaks have done really well in that space in terms of providing a kind of national coherence to what’s going on and better national co-ordination to things but also as a kind of intelligence gathering kind of devices. The peaks are able to kind of, unbelievably quickly mobilise into every treatment service, like 90% of treatment services, it can get into and get information from the ground, right back up. And also to interpret that information. (Interview 2)

The value of peak bodies here is described in terms of their ability to be nimble, flexible, and quickly responsive — terms that contrasted with the slow, encumbered nature of bureaucracy. The role of NGOs in information provision was not just limited to advising governments. A number of representatives also talked about their organisations providing information to service users and to other services and organisations.

This experience ‘on the ground’ inspired a sense of responsibility, then, to represent the interests of communities and service users in policy processes and to help inform the design of services. Most participants explained that government representatives appreciated this role:

> I think there’s an appreciation by government that the NGOs bring value to the table, not only in being able to deliver services more efficiently, but that they are closer to the communities which we serve, and are able to therefore have a greater appreciation of the needs of service users, and therefore they have a responsibility and role to inform the design of services or facilitate service users, consumers to have input into that service design. (Interview 12)

For drug user organisations, this experiential knowledge and connection to the affected community meant they possessed a specialist ability as well as responsibility to represent the voice of people who use drugs in policy processes:
Because you might hear about a new policy, some sort of drug policy coming out, that is going to affect the day-to-day lives of people who use drugs and the organisations who support those people, and I think a lot of the time people who use drugs and drug organisations aren’t even at the table. (Interview 14)

NGO representatives considered service providers and people who use drugs to be some of the most important stakeholders in policy processes because of the direct impact of policy decisions on these groups, and questioned the legitimacy of policy that was made without taking into account the experiential knowledge of these groups. In this way, to strengthen the state’s legitimate ‘claim to govern’ in the drugs field, it was considered imperative that the community, service providers, and people who use drugs be represented in policy processes.

By virtue of their position in service delivery and as ‘close to the community’, NGOs act as important translators between the state and ‘the community’. They are considered experts because of the knowledge and experience gained through their service delivery, and experts who are able to represent service users, people who use drugs and the community (Goodwin & Phillips, 2015; Keen, 2006; Phillips, 2006; Phillips & Goodwin, 2013). NGOs were considered to have a responsibility to contribute to policy since their service delivery is shaped by policy which in turn impacts on the lives and experience of service users and people who use drugs. In this sense, the value in the policy role of NGOs is seen in terms of their ability to ‘translate’, or act as an intermediary between individuals, families, groups and communities to state power (Rose & Miller, 1992). As Garland (1997) notes, from a governmental perspective “Power is not a matter of imposing a sovereign will, but instead a process of enlisting the cooperation of chains of actors who ‘translate’ power from one locale to another” (p. 182).

Part of the rationale for involving NGOs in service delivery is their connection to the community and their ability to be involved in responsibilisation strategies (Keen, 2006; Phillips & Goodwin, 2013). Several participants talked about the strengths of NGOs in mobilising community resources to act on issues of shared concern. One participant provided the following example:

…the value that the not-for-profit sector brings, and that’s on a whole range of things, such as that connection to community, the ability to get volunteers from community to add value, pro-
bono stuff that government will always struggle to get, people to volunteer to support initiatives, to push back a little bit onto community their responsibility for particular, to share in the responsibility for an issue and not just expect government and funders to deal with it all. (Interview 12)

NGOs here are contrasted with public authorities: NGOs value is in being able to mobilise community resources and encourage communities to take responsibility for responding to social problems, rather than presuming that it is solely the domain of the state.

In summary, the justifications for the role of NGOs in drug policy processes centre around the ideas of community, independence and NGOs work as service providers. The potential contribution of NGOs to drug policy processes lies in their ability to: represent community and service users in policy processes; to provide a ‘counter-voice’ in policy processes and to trial and present innovative policy options; and to provide expert advice based on experiential knowledge. Most NGO representatives articulated a sense of responsibility, then, to ensure that the views of service providers, service users and people who use drugs are represented in policy processes. While the above outlines the potential and anticipated value of involving NGOs in drug policy processes, the practical experiences of NGOs representatives involved in policy work, and the opportunities for NGOs to contribute, are shaped by a wider range of forces, which I will now explore in the section that follows.

**Realities and Tensions of the Contemporary Drug Policy Environment**

In theory, based on their potential role outlined above, the non-government sector should be in a good position to justify greater involvement in drug policy processes. There are, however, a broad range of dynamics that are characteristic of the contemporary drug policy environment that act to shape the current position of NGOs in relation to the policy process. In this section, I will describe some of the conditions of the drugs field and the broader relations that frame NGOs ability to contribute to policy. In the first section, I consider the broader 'politics' of the drugs field, including the policy frameworks, key actors and drivers of policy change or otherwise in the field. Second, I explain how NGO representatives characterised their relationships with other actors in the field, including other NGOs,
government agencies and public authorities, and other stakeholders in the AOD sector. Finally, I consider how the nature of the role of NGOs and opportunities to contribute to drug policy processes is shaped by these broader politics and their relationships with government, as well as other stakeholders.

Politics and the Bureaucratic State

As in any domestic policy context, there are a number of drivers of drug policy in Australia, including but not limited to: international organisations, structures and developments; federal, state and territory governments; law enforcement, health, and other policy actors; as well as existing policy frameworks, ideologies and goals. There are a range of actors and drivers involved in domestic drug policy processes. Much like other areas linked with crime, policy-making in the drugs field is largely a bureaucratic process (Hughes, 2006), although at times particular issues have been capitalised on in electoral politics. Amongst participants, there was a sense that drug policy — while bureaucratically driven in the main, could also be quite political — particularly around certain issues. Participants (7) expressly stated that policy-making in the drugs field could often be ‘populist’ or reactionary, with participants citing the example of the ice inquiry in response to media reports about an ‘epidemic’ of methamphetamine use or the vetoing of the medically prescribed heroin feasibility study during the term of the Howard Government. For example, one participant described policy-making in the illicit drugs field in the following manner:

It’s very reactionary and sensationalist, and I mean you can see that when the Crime Commission busts a big seizure. (Interview 11)

At the national level, Australian drug policy making structures under the MCDS (now disbanded) and the IGCD have been criticised for being “overly bureaucratic, leading to a closed-shop approach to policy making and reducing the potential for policy input from outside the bureaucracy” (Hughes, 2006, p. 148). In terms of the national drug strategy, a number of participants noted that it is a Departmental document. One participated noted:

It’s never been, and I don’t think there’s much appetite for it to be a political mechanism, so it’s largely removed from the Ministerial input, it’s largely a Departmental document, the
departments of health come together and largely they’re all on board with harm minimisation. (Interview 15)

In talking about governments, participants distinguished between party political activity and bureaucratic activity, and politicians and bureaucracy:

I also think that there’s that real difference, actually, between the government with regards to politicians and their staff and then the bureaucracy over here. (Interview 9)

Several participants emphasised the importance of the bureaucratic system in formulating policy. One participant valued policy ideas from politicians, but considered bureaucratic processes important for policy formulation:

… you do need the bureaucrats in there because they’re experts for a reason. But in terms of policy I think yeah policy ideas from politicians is great. That’s what we all want isn’t it, in terms of our politicians, is clear policy ideas. But the actual formulation of policy should always be done through the processes of government I think. I think you’ve got a danger when you’ve got a politician who writes a piece of policy into legislation and it doesn’t go through the checks and balances… (Interview 11)

Another participant thought that the bureaucratic processes, and having strong people in the departmental sense, could temper some of the ‘whims’ of the political arena:

Well it’s interesting, because if you talk to people that have been around for a really long time, they talk about how when Howard came in people were really nervous about it. But at the end of his term, that actually drug and alcohol had done quite well. And that there was kind of two layers of things, there was the ‘tough on drugs’ on the surface, and then there was actually some quite sensible investments that happened underneath it. But what that required, from what I understand from them, was a strong consistent sector that could stay on message and keep pushing for it, and good bureaucrats and sensible people in the machine working together to kind of spit out sensible type of things while the kind of politics went off and did its thing. (Interview 2)

Garland (2001) describes how the predicament of crime control has different implications for political actors versus administrative actors (like the ‘politicians’ and ‘bureaucrats’ referred to here). Whilst political actors are concerned with gaining and maintaining political and popular support — sometimes
through reactionary and populist policy choices that lack credibility — the decisions of administrative actors, on the other hand, are “shaped by two agendas, one internal, the other imposed from the outside, and it is the administrators’ job to pursue their organizational tasks in ways that at least appear to accord with the concerns of their political masters” (p. 111). In this way, administrative/bureaucratic actors have a key role to play in striking a balance between some of the ‘reactionary’ politics of the electoral arena and maintaining an ongoing, stable policy approach in the drugs field.

**Drug Policy, Change and Political Risk**

The conservative policy-making environment around drugs — particularly in the national political arena — was a key theme that came across in a number of interviews. At the domestic level, as outlined in Chapter 1, governance of Australian drug policy is complicated by the federal system, where the Commonwealth and state and territory governments, and local governments all have roles to play. Interviewees felt that policy change was led by the states and territories, rather than at the national level. Participants cited examples of particular programs or innovations that were state led, such as the community opioid overdose programs involving the distribution of naloxone, the proposed ACT heroin prescribing feasibility study, and the supervised injecting facility in Sydney. One interviewee thought this relationship between federal and state/territory policy had positive outcomes, and used the example of the naloxone overdose prevention programs to illustrate this:

> So if we take the example of naloxone distribution programs. That had nothing to do with the feds except it suddenly got listed on the PBS. But that wasn’t a policy decision on their part or anything to do with what or how they wanted to see reducing opioid overdoses in Australia. But the practical work that happened through naloxone happened through the jurisdictions, and the jurisdictions kind of battled to compete against each other. So the jurisdictions kind of work in a way where if everyone is doing it and you’re not doing it you kind of stand out. So in some ways that can be a quite useful thing for them to kind of… but it also makes jurisdictions nervous to be the first one to do it. (Interview 2)

While innovation may be state led, the national government also has the power to control this through Commonwealth laws. The complexity of the relationship between national and state/territory policy is
also evidenced by the example of John Howard vetoing the ACT heroin prescribing feasibility study (discussed in Chapter 4), as one participant noted:

… the reason that it did not proceed was that the Federal government has the power over importing heroin or manufacturing heroin here in Australia.52 (Interview 4)

By implication, then, too much power concentrated at the national policy level could stifle policy change:

…what’s the relationship in drug policy between the federal government on the one hand and the states and territories on the other hand, and how do you get a better co-ordinated drug policy across the country. If that’s what you want. I by the way don’t think it is what you want in this area. I think as one state moves along, then the others then follow. And different states have taken leadership at different times on different issues. So that’s worth keeping in mind. (Interview 4)

In this way, this participant considered that a completely nationally co-ordinated and consistent approach to drug policy could have drawbacks in terms of suppressing state-led policy innovation.

Five participants explicitly mentioned that at the close of the 20th Century, Australia had been ‘leading the way’ in terms of drug policy through its harm reduction approach; several of these participants explicitly lamented that now, however, Australia was losing its international reputation in that space because of a conservative policy-making environment. For example, one NGO representative stated:

I think internationally we’ve always been seen as a leader in a whole lot of areas that was prepared to take some risks, and because of the size of our country we’re a bit more nimble to respond to changes. I think we’re losing that reputation, so I think work in the harm reduction space with NSPs and our response to blood-borne viruses was a really strong one, and I think we’ve had good responses to some treatment interventions, and ways around dual diagnosis and even working with families, we’ve been ahead of a lot of places. But we seem to be stuck in a very conservative environment, for a good ten years. So I think a lot of that has stalled, and there’s a conservativeness and a fear of people really stepping out and being bold and brave

52 This participant also noted that this decision was not made in isolation; at the time, a series of trials of pharmacotherapies (including buprenorphine, naltrexone and LAAM) were also underway, all of which continued.
and having leadership to challenge the conservative views of many of our politicians. (Interview 12)

There was a sense amongst some participants that political conservatism stifles the development of innovative and potentially effective but sometimes controversial responses.

The ‘politics’ of evidence was another idea that emerged from interviews. Interviewees generally felt that while ideally drug policy *should* be based on evidence, there are barriers to this happening in the drugs field. Although there is a strong political rhetoric of evidence, and it does direct funding criteria in relation to data collection requirements in contracts, the practical relationship of governments — particularly politicians — to the ‘evidence-base’ is ambivalent. Governing, of course, must also take into account community opinion. There was a sense that governments are risk averse, and that what works is not always what is popular, particularly with the community. This was noted by participants, particularly in relation to harm reduction and ‘evidence-based responses’:

> Often the solutions might be kind of the best of a bad… the options, harm reduction is hard to swallow if you’re a politician who wants everything to be rosy. And good outcomes in harm reduction don’t look good to the general community if you don’t understand the issue. (Interview 11)

> Particularly since in the harm reduction space is actually where we have some of the strongest evidence base in terms of interventions. So that’s something where we’ve got a kind of mismatch in terms of drug policy across the jurisdictions but also nationally in terms of the ‘what works’ isn’t very popular, and what’s popular kinda doesn’t work. (Interview 2)

Several participants noted that the drugs field was seen as a politically ‘risky’ topic offering little political gain:

> …There’s not really much to gain in terms of politics, we’re talking very crudely, obviously there’s a lot to gain in terms of public health and reducing suffering, but in terms of political outcomes, there’s not really a lot to gain. You’ve got an issue that’s very divisive, and people kind of continue on in the same vein. (Interview 11)

Another participant also noted that the controversial nature of drug policy makes it particularly risky
for minority governments:

…it’s true of minority governments in general, that they tend to keep quiet about controversial issues like drug policy. (Interview 19)

There was a sense amongst some interviewees that there is still a poor public understanding of harm reduction measures. According to Interviewee 19, this puts harm reduction organisations and drug user organisations in a vulnerable position:

The thing is that we’re always very mindful of our vulnerability, and that we’re never going to be the flavour of the month; in fact governments are often very uncomfortable about the fact that they fund us, and if the shit ever hit the fan, historically the government — state and federal — just run for cover and claim they know nothing about it, that they would never fund an organisation that wouldn’t try to get people off drugs. There’s such a poor understanding of harm reduction in the general community, and I think that includes politicians. (Interview 19)

In this sense, those providing harm reduction services felt vulnerable to funding cuts based on political whims.

According to participants, the controversial nature of policy options in the drugs field could present barriers to policy change because of a lack of community understanding:

I shouldn’t be so naïve to think that, I don’t want you to think that I’m naïve enough to believe that policy change in this sector, in this area is easy. It’s not, because there’s a whole range of considerations that impact on everybody, from the individual to the parents to loved ones, community, governments. How do you describe to a parent of a dying child who’s injecting themselves to death that harm reduction might be the best thing for them? Certainly it’s not an easy thing to consider but in effect it might be the thing that keeps them alive a little bit longer. (Interview 13)

This participant went on explain that this could present a disjuncture between the goals of governments and the goals of NGOs in the drugs field:

Well governments are often driven by their desire to stay in government. The AOD sector, by, maybe a desire to do something before them that impacts on the clients they see, and having an understanding of what would make a difference; and never would the twain meet, because if
governments are risk-averse and reflect that in the type of policy they implement, knowing full well that what works isn’t, what they implement is popular but what works isn’t, then that’s a problem. So you have that conundrum, should I do what I know will work, what the evidence says will work, or should I do what gets us off the front-page of the Herald Sun or some other rag. (Interview 13)

Because of these political risks, policy change in the drugs area is often slow or difficult, particularly at the national level. Garland (2001) notes that the major concerns for elected officials centre around ensuring ongoing political and popular support. Therefore in areas such as crime control, or drugs, policy options “that can most easily be represented as strong, smart, and either effective or expressive are most attractive” (Garland, 2001, p. 111). This can present a barrier to changing illicit drug policy, where the public may view ‘effective’ policy changes — particularly in the area of harm reduction — as out of step with community views, or as an admission of weakness or failure of the existing regime (Garland, 2001).

**Relationships**

On a practical level, a diverse range of relationships exist between NGOs and government in the drugs field. Partnerships formed between NGOs and governments in the Australian AOD field are derived from a whole range of state/territory and federal initiatives in diverse areas such as prevention, treatment, information and education, justice and diversion, and harm reduction. Participants discussed a range of partnerships with governmental and non-government agencies, and also discussed research partnerships. At the risk of identifying organisations, specific partnerships or projects will not be named here; however participants’ perspectives on these partnerships will be referred to in the analysis presented below.

Thinking back to the model of ‘good governance’ outlined in Chapter 2, part of the responsibility of government is to provide strategic plans (direction стратегического видения) for the sector, and provide funding and institutional structures that support the AOD sectors’ activities. The roles of governments in drug policy are largely defined in terms of providing overarching strategic direction, or a ‘shared vision’,
through policy, and providing resources to achieve policy goals. The degree to which participants felt that governments were fulfilling their role of providing strategic direction varied according to the jurisdiction being discussed. Some participants felt that in neglecting to release an up-to-date drug strategy since the last one expired in 2010 (NSW Department of Health, 2006), the NSW government had neglected to provide strategic direction for the drug and alcohol sector in that state. Several participants expressed the view that the Commonwealth government was not fulfilling its role. For example, one participant stated:

But the feds as a funder, and policy-setter, is one of the stakeholders in it but I think everyone else is behaving really well. I just don’t think they’re stepping up to the party and taking responsibility for their role. But the jurisdictions are really active, but yeah the feds just kind of go ‘ah well, y’know’. (Interview 2)

Reflecting further, this participant went on to note the changing views about the federal government as a funder:

…in some ways they [the federal government] kind of almost want to not be involved. So it makes it very difficult to try and even work in that kind of space. Personally I wouldn’t, we can barely get meetings with them let alone forge partnerships about joint planning or visions of where we want to go. (Interview 2)

Of course this was not the experience across the board. Participants reported positive relationships with some government agencies, with most explaining that this was about individual relationships. Some participants stated that they had better relationships with state departments and smaller funders, while one participant felt they had better relationships with people in the Commonwealth Government — specifically the health bureaucracy — because they were more active in their communication as funders for the sector, and regularly attended at treatment facilities receiving public funding. There was a sense that the place of NGOs in the policy process is fluid and changeable depending on the players in the government and the bureaucracy:

…I mean I think it changes a lot as to where NGOs fit and where community voice fits. I don’t think it’s a static thing, it moves — it changes on the government, who’s in, what they value, what they think is important. (Interview 9)
Most representatives, however, noted more regular communication with state and territory governmental agencies than Commonwealth Government agencies.

The majority of participants who cited regular communication with governmental actors and agencies stipulated that most of their communication was with departmentally based ‘bureaucrats’ rather than the Ministers’ office.

It’s very different dealing with the Minister’s office compared to dealing with the bureaucratic system. I know that even from working myself within other policy areas. (Interview 11)

Some participants also lamented that administrative actors did not always have a good sense of what NGOs do.

I think sometimes the government really don’t have a strong sense of what we do. The bureaucrats who put out the tenders every couple of years, they don’t really have a sense of what non-government organisations do, I’m not just talking about [NGO] or drug organisations, just non-government organisations in general. (Interview 18)

Participants expressed their appreciation of instances where funders and government agencies took the time to communicate, and at times even visited funded organisations, as they considered that this could facilitate a better understanding of the activities of the non-government AOD sector.

Participants discussed how the party orientations of governments could influence the nature of relationships between NGOs and governmental actors. Several participants (3) explicitly mentioned that Labor governments could be easier to work with than Liberal governments — although there were caveats to this assessment. Participants also noted the influence of particular think-tanks (for example the Institute of Public Affairs) and particular ideas (new public management, for example) on liberal governments at the political level. There was a suggestion that Liberal governments tended to be firstly, more conservative about drug policy; and secondly, more suspicious about services offered by NGOs. Participants described how Liberal governments had questioned the accountability of NGOs, and that Liberal/National Party Coalition governments had generally been more suspicious about services offered by NGOs:
I think there was, in terms of the [Liberal/National Party Coalition] government, there was a suspicion towards NGOs and there was a view — and it was a view that was offered to me and I heard it espoused — was that it’s a bit unregulated, not sure what’s going on, need to get control of it, need to get accountability; so there was this suggestion that there was a lack of accountability from the previous government. I think…it’s not without some truth but for me it’s not black and white, there’s a lot of grey, and I think there’s some truth in that. (Interview 18)

A number of participants highlighted an apparent paradox that although Liberal-National governments tended to be more conservative about drug policy, they also provided more funding.

…of all of the governments, it took a Howard government to fund a national drug user organisation if you can believe that. And the Howard Government has put the most money into needle and syringe programs. And so it’s really, it’s interesting. (Interview 8)

Indeed, a number of participants mentioned the Howard government’s funding for harm reduction organisations. One participant viewed extra funding for AOD from Liberal governments as a function of political conservatism:

The interesting thing that has happened to us is that it’s often the Liberal government that funds drug and alcohol services better. You could say, somewhat cynically probably, that it may be because ultimately the attitude is much stricter and less, not so much permissive but less open. And that actually has ended up putting money into the funding buckets. (Interview 5)

This shows the complex relationship between rationalities of neo-conservatism and the policies that are actually implemented.

A view was expressed by several participants interviewed for this study that relationships in the AOD sector, and between NGOs and government agencies, were more positive and productive in two particular jurisdictions: Western Australia (WA) and the Australian Capital Territory (ACT). Participants noted that the WA AOD system had recently had an increase in funding. Recent research by Berends et al. (2015) on the reform of WA’s AOD sector appears to support these positive assessments of the WA case, as the authors reported that the key stakeholders they talked to “reported a mutually supportive and constructive relationship and increased capacity, and they shared an agenda
for change” (p. 1). Indeed, WA was one of the few jurisdictions to have a statutory drug and alcohol office, although this has now been amalgamated with the Mental Health Commission (Government of Western Australia Mental Health Commission, 2015). Participants also speculated on the reasons for the constructive relationship between governments and NGOs in the ACT. In the ACT, participants theorised that the productive relationships could be due to the relatively small size of the bureaucracy in the ACT and the fact that stakeholders were ‘closer’ to each other. The ACT Drug Strategy steering group and the Alcohol, Tobacco and Other Drug Strategy Evaluation Group involves a range of stakeholders across government agencies and non-governmental agencies (ACT Health, 2010), and this was highlighted as a key strength by participants. One participant also noted that while the ACT AOD system had not had large investments, it had had stable investments.

In each jurisdiction, however, NGO representatives described some of the ways in which they had engaged in policy processes around drug issues. In Chapter 5, I outlined some of the different governance instruments in the drugs field; these governance arrangements in the drugs field structure the opportunities for NGOs to contribute to drug policy. In the section that follows, I describe some of the ways that participants discussed contributing to drug policy; in particular, I highlight how government/non-government partnerships have opened up a space for representatives of NGOs to be involved in more collaborative approaches to policy-making.

**Opportunities to Contribute**

The participants in this study described a range of ways that NGOs can contribute to policy-making processes. Participants described engaging in different activities around policy, including: sitting on committees and stakeholder reference groups; making submissions to public consultations on drug strategies and policies; making submissions to governmental inquiries and appearing at hearings; engaging in publicity campaigns; media releases; using social media; producing position papers; and providing information and input through their peak bodies. One participant noted the number of opportunities to contribute in terms of committees:
And there’s quite a number of those opportunities come up for those people who watch those committees and see well what committee is doing what at any given time. And sometimes you actually have to have a lateral look at them. (Interview 4)

Other mechanisms that were less formal included meeting directly with government, communicating with government agencies around services, and even lobbying government through petitions. Another participant discussed the opportunities that NGOs have had to contribute at the national level:

In terms of how important the NGOs views are, I’m hoping that it’s reflected in the recent federally funded projects that are around policy-setting and outcomes and future funding. There’s been an enormous number of opportunities for NGOs to contribute, but how much of that is taken into consideration I’m unclear at this stage. Usually though, and previous history would show, that there’s quite a significant amount of consideration of what NGOs have had to say, as a collective. (Interview 3)

Overall, there was a sense amongst participants that NGOs had been given the opportunity to participate in policy processes.

As the previous quotation suggests, a level of organisation and representation is required to allow the views of NGOs as a collective to be taken into consideration. Peak bodies that represent relevant NGOs as a collective voice facilitate participation and representation in policy processes (Hancock, 2006). At the state and territory level, the drug and alcohol peak bodies were considered by participants to be vital facilitators for NGOs in governance processes. As outlined above, a range of organisations discussed contributing to their jurisdictional peak body to provide information and comment on issues.

Through the peaks there is, we can influence policy through our peak bodies, and we certainly try to do that. But again too if whatever influence or change that the NGO sector is trying to engender through the peak bodies, if that is not picked up by the bureaucracy then, it probably won’t get picked up on. (Interview 6)

I think also because we had the peak body to represent us, there were more informal ways of talking to the peak. I mean we trust them and the submissions they make. (Interview 7)

The process of feeding information in to the peak bodies was considered vital:
And sometimes jurisdictional peaks - of which I’ve been part of, and I’ve been part of a national peak in fact I’ve worked for a national peak — don’t quite understand the nuances and the differences until they actually get direct service providers feeding into them. (Interview 3)

The relationship is reciprocal as well, as the peak bodies also feed that information back to their members and represent members in policy processes, with this being one of the key functions of peak bodies.

Participants in this study described a range of partnerships across the AOD sector, and between different types of organisations. Peak bodies were considered by participants to have a key role here in terms of encouraging partnership models in the sector through linking organisations in tendering processes and making suggestions for how organisations can work together. Participants described establishing and joining issues-based coalitions, and developing relationships with researchers to advance evidence-based practice. A number of participants described productive relationships within the sector:

I think we’ve got good partnerships within the sector itself, we’re seeing great partnerships across the peaks; we’re seeing great partnerships across research and treatment services; we’re seeing improved partnerships between consumers and treatment services. So we’re actually seeing a much more sophisticated way of the stakeholders of the sector working better together. So that’s really impressive. (Interview 2)

Most participants spoke of partnerships positively, and discussed particular examples of partnerships they worked in. The majority of participants acknowledged the emphasis on partnership working and discussed it in a positive sense at both the policy and service delivery levels:

Partnerships mean working really closely with key stakeholders, working really closely with other non-government organisations, working towards a common goal with government, with key communities, with you target group, that kind of stuff. That’s what partnerships is about, and there’s a huge focus on that kind of stuff, and there has been for a long time, about how services work together or how non-government organisations work with government and vice versa. You see examples of it every day, the work that I do every day, we work really closely with other services supporting a client who needs help or whether it’s something more broader, whether advocating for change, it goes on every day. I guess it’s about formalising those networks and working towards each other’s strengths. (Interview 14)
One participant, for example, noted the opportunities that consumer participation has presented for drug users to be involved in policy discussions:

… and because of the move towards consumer consultation and participation, and that’s certainly been enshrined in the recent reform… that consumer consultation concept is squarely there. That has helped us put our foot in the door, that we can represent the consumer voice and organisations, including in government, are keen to be able to tick that box. (Interview 19)

While DUOs have long had an accepted place in BBV policy, their role in drug policy — facilitated most visibly by the push for consumer participation in treatment — is perhaps more recent and not as well-established.

**Collaborative policy work**

The relations established through ‘partnerships’ have resulted in the emergence of new opportunities to contribute to policy-making. One participant noted that ‘partnerships’ could create different opportunities for how policy advocacy was done:

Yeah I think it changes the nature of how some advocacy can be done, more that it gives you more opportunities to advocate out of the public eye, behind closed doors in meetings and influence policy decisions and funding decisions, because you’ve got a greater access to people with open ears. On both sides, I think services to government and government, to be honest and open about their budgets and their challenges and what they’re trying to achieve. But it probably compromises or makes it a bit harder for services to go out in public and advocate in critical ways of government. Although services have straddled that well by, not criticising government, but highlighting the issues in the public and saying what they think needs to be done rather than just commenting or criticising the government for what they are or aren’t doing. So I think there’s ways around that. (Interview 12)

This illustrates the difference between collaborative policy work and critical policy work. Partnerships have provided more opportunities for collaborative policy work, such as through expert committees and other participatory mechanisms, as opposed to policy work that is actively critical of government policy (Cada & Ptácková, 2014).
Participants described the use of what can be termed ‘insider’ tactics (Almog-Bar & Schmid, 2013), as opposed to confrontational tactics, in their relations with public authorities. They highlighted the need to maintain productive and respectful relationships with government by avoiding advocacy strategies that were directly critical of the Government. Four participants directly mentioned avoiding publicly shaming the government and not using the media for public criticism of government, saying for example:

> We don’t do, we don’t do public shaming of the government because we want to maintain those partnerships. I don’t think you can really have a partnership if on one hand you’re having a conversation, and a productive relationship, and then on the next day you’re out in the Courier Mail saying ‘the government’s ridiculous’. Obviously we do media, and in the media we talk about the work that our services do and the different areas where we think that could be enhanced by changes in drug policy, but we don’t attack the government. (Interview 15)

> I think we have clear communication, we have trust, we’re not adversarial, we don’t use the newspaper to do things. We do sometimes but it’s pretty rare. We try and work with the bureaucracy as much as we can, and we help them with their consultation processes, we help them get access to researchers, we help them kind of find the people that would know about this stuff. And likewise they kind of come to us… (Interview 2)

Communicating and meeting with government stakeholders was considered an important method of establishing policy legitimacy and opening channels of communication

> It’s a main part of what I do, in my day-to-day, is meeting people. If they don’t know who you are, if they don’t know what you do, then you don’t get invited to that meeting. (Interview 1)

A number of representatives from NGOs mentioned the need for NGOs to recognise that partnership is a two-way street, meaning that NGOs should build relationships with government partners and emphasise the value that they can provide:

> So it’s about promoting what you do, who you are, how you can help them because obviously partnerships are meant to be a two-way relationship. That’s how we deal with the [Minister’s office], trying to build our relationship with [them] it’s not about being that weak partner ‘What about the NGO sector’, it’s around changing that and saying that we can be a vehicle to inform you, so you know what’s going on in the sector, so you know what trends are, you know what
services are being provided, where areas of need are happening, so we try to change that power imbalance too and make it a give and take relationship. (Interview 1)

In this way, the ideas of communication, trust and mutual respect were important. These ideas are consistent with suggestions in the literature that ‘insider tactics’, as opposed to confrontation, help to establish and maintain relationships of influence with government agencies and officials (Almog-Bar & Schmid, 2013). So, in this sense, partnerships have created greater opportunities for some representatives from NGOs to be involved in policy-making processes through collaborative policy-work and linkages. Although participants described a range of ways in which NGOs are able to contribute to policy-making processes, the nature of government/non-government relationships and the drug policy environment still presents some challenges.

**Challenges for the Non-Government Sector’s Role in Drug Policy**

In the previous section, I illustrated some of the ways that NGO representatives characterised the opportunities for NGOs to contribute to policy — in a sense, some of the ways that ‘partnerships’ discourse had been operationalised at the policy level. Participants, however, distinguished between the idea of government/non-government partnerships and the practical reality of working with government and others at the policy level. Some of the ‘ideals’ of partnerships in policy discussed by participants included co-designing services and policy, collaborating with governments and other stakeholders around common goals, and clear communication between stakeholders. There was the idea that partnerships could mean more comprehensive solutions for complex problems, and that they presented the opportunity to pool resources and present an inter-disciplinary, co-ordinated approach to drug-related problems. In short, partnerships could offer the possibility of an integrated approach and a greater range of services. Thus, meanings of partnership in the drug policy space are fluid and not fixed. The sector is reflexive about this — for example, NADA released a position paper on partnerships and acknowledged the range of ways they are understood and practiced (Network of Alcohol and other Drug Agencies (NADA), 2015). Although participants reported positive relations with government agencies, they also discussed particular dynamics that impact on the realisation of the ideals of partnership,
particularly at the policy level. In the section that follows, I discuss some of the key challenges impacting on the role of NGOs in drug policy including: government control of NGO activities, the problem of tokenistic inclusion in policy processes, power differentials and marginalisation, and changes to forums facilitating the representation of NGOs in national drug policy.

**Power Asymmetries and Government Control**

Although neoliberal political influences have meant that there are now a range of instruments and mechanisms through which NGOs can engage and be engaged in policy debates, the participants in this study outlined a range of practical tensions between partnership rhetoric and practices in the drugs field that presented challenges to their participation and representation in drug policy debates. The power differential in government/non-government relationships, where they are based on funding contracts, was noted. Speaking about the idea of ‘partnerships’, one participant stated:

> Look I think it’s good in theory but the reality is that there is an inequality in them; when one of the partners is the person or the organisation that holds the purse strings then there is that sense in which there’s an inequality in the partnership. And they’ve shifted from, although they’re talking partnership they’re also talking purchaser-provider. So we’re moving to this kind of commercial basis in the relationship. (Interview 6)

Comparable to this participant, other NGO representatives contrasted the funder-provider relationship with the idea of true partnership. For example, one described the power dynamics in these relationships in this way:

> Well the partnership is one of a funder and a provider really, and in that relationship there’s a power differential. And while there’s a lot of competition for those funds, the strength in that relationship lies with the funder… (Interview 18)

Because of this power differential in a funder-provider relationship, partnerships could stifle political advocacy and the ability of NGOs to comment on drug policy issues.

Mirroring some of the issues in the broader literature on government-NGO relations (discussed on pp. 28-36), some participants noted that government funding really shaped organisations’ activities.
Partnership models based on a funder-provider model were not considered true partnerships, because government agencies — administrative actors and political actors in some cases — could shape the agenda of these partnerships, and as a consequence shape NGO agendas and activities as well:

Sometimes really positive and other times just not. It often depends on the individual branch or area that you’re dealing with. It’s challenging I think for all the things that I’ve already mentioned I guess, what we want to do is restricted because of what the government might want to do and we have to do what our funding requires us to do. I think if those restrictions weren’t imposed we’d probably be a very different organisation. (Interview 18)

For these participants, government funding could present a threat to NGO independence, and raised the possibility of conflicting agendas. For example, one participant highlighted the potential for government contracting to compromise the independent policy role of NGOs:

Increasingly, it seems like that’s the way that governments are using NGOs, is sort of outsourcing in the belief that we’ll undercut ourselves with costs and run on the smell of an oily rag; cheaper than paying bureaucrats to do it. Which is good, but I see it as potentially threatening the role of not-for-profits and NGOs as being independent, you know, frank and fearless advice and criticism. (Interview 11)

Another participant commented on the reluctance of governments to take advice from the NGO sector and the lack of partnership at the policy level:

But I think that it’s been quite clear that for other [NGOs], peak bodies in particular, the government hasn’t really wanted to take that advice. So I think that those partnership models are not there at all. And even the ability for organisations to advocate. (Interview 5)

This control of NGOs ability to advocate, and act as independent from the government, through contracts, was a concern that recurred in several interviews.

*Advocacy is a dirty word?*

Echoing the concerns outlined in the literature review (pp. 28-36), Governments have often used contractual control to discourage organisations from speaking out publicly against the government or
using public funds for advocacy. The idea that ‘advocacy is a dirty word’ to be avoided came through in a number of the interviews (5).

…because even the word advocacy seems to be a dirty word. And it’s a risk, saying as an organisation that you do any sort of advocacy is risky; the government don’t want to fund advocacy. (Interview 14)

We’re not advocacy because of what happened with ADCA as well. So we framed ourselves as service support organisations, so we are supporting the non-government drug and alcohol sector through representation and through capacity-building. So we’re cautious of the a-word, the advocacy word because of the political environment. (Interview 1)

Participants discussed engaging in reframing of organisational activities to avoid the use of the term ‘advocacy’:

So that’s hard, you know you’re just not going to get funded if you do advocacy, you have to hide your advocacy projects in the depths of your organisation somewhere and actually say you’re doing something else: it’s advice, it’s not advocacy. (Interview 14)

In some jurisdictions, such as QLD, participants noted that under the Newman government public authorities had implemented gag-clauses on contracts to prevent organisations from speaking out against government policy. At the national level there is legislation (the Freedom to Advocate Act 2013) preventing gag-clauses on Commonwealth Government contracts, although news articles indicate that the Liberal-National Coalition Government had modified contracts so that Commonwealth funds cannot be used for advocacy purposes (Seccombe, 2014). This is an example of how government agencies practice power through regulation — imposing rules and regulations that shape the activities and behaviour of NGOs in ways that conform to those desired by the state. The control of NGO activities through contracts is an example of the expression of power through regulation and domination, where government agencies use NGOs to fulfil their own agendas. In terms of governmentality, this is illustrative of techniques that seek to align the activities of NGOs and other agencies with the government’s objectives (Burchell, 1991).
The reluctance of public authorities to provide core funding for policy development or advocacy undermines the potential for NGOs to contribute to policy processes:

I think there is a risk that, without core funding to do general advocacy, to do general policy development, that sometimes policy might become aligned with the government’s own priorities rather than an independent evidence-based, research-based contribution towards the policy. (Interview 3)

Several NGO representatives talked about the need for funded policy officer positions within organisations, for example:

…How that process could be improved, give us more money so we’ve got more capacity. We didn’t have a dedicated policy officer, we had a research officer and a workforce development officer and a community-based project officer but not a policy person. (Interview 7)

AOD NGOs are not currently resourced at a level that allows effective political participation, and there are few organisations that have funded policy officer positions.

**Tokenism**

For participants, partnerships at the policy level existed in form rather than function. A number of participants mentioned how NGOs were involved in policy-processes more as ‘lip-service’ rather than a genuine partnership. For example:

Well I’d say NGOs are there because if we weren’t there we’d be saying ‘we’re not there’. Do you know what I mean, we’re just actually part of the process because, ‘oh well, we better get the NGOs here’ y’know. We’re not necessarily I think, like a key player, although we probably like to think we are; but the reality is that most likely we are not a key player (laughs). (Interview 6)

This indicates some of the problems with requiring consultation processes as a matter of course rather than as a model of genuine partnership and mutual co-operation.
For relationships to more accurately resemble the ideals of ‘partnership’, a number of participants (7) identified the need for more regular dialogue and communication from public sector representatives. One interviewee noted the lack of communication at the national level:

Well I guess it’s in understanding the services that they fund, what they’re funding, being able to articulate what they want to provide and increasing communication. Because at the moment the communication is pretty poor. (Interview 1)

For some participants, the reasons for government decisions were not always clear, reflecting a need for greater communication and transparency:

But I think governments need to be a lot more transparent and there needs to be a lot more understanding about how policy is made, why or why it’s not implemented. (Interview 5)

Similarly, several participants criticised the tendency of public sector authorities to generally only consult with the non-government sector once policy response had been formulated, and documents had already been created. Timeliness was considered important, and being involved in discussions early in the process was highlighted as a key way to improve stakeholder processes.

Tokenistic inclusion in the policy process was a particular concern for representatives from drug user organisations. Within the AOD sector, drug user organisations face unique challenges in the policy process arising from the criminalised status of much drug use. While the rise of consumer representation in AOD treatment had created more opportunities for DUOs to participate, and participants expressed appreciation for the rise of consumer engagement models, there was a feeling that this could be tokenistic because of government processes requiring consumer engagement:

Yes, I think that we don’t often…it’s like we’re there so that they can tick a box or something. It’s a bit like service accreditation - they all say they do consumer participation, and we see no evidence of that; actually a survey once a year is not consumer participation. But they all tick the box, and the accreditors go in and go ‘yeah that’s fine, we’ll accredit you, we’ll give you accreditation’. (Interview 8)

Another participant noted that they wanted to encourage partnerships through consumer engagement, but also felt a sense of wariness:
I think we always want to encourage understanding and encourage consumer engagement and encourage those sorts of connections and those partnerships, but you also have to be a little bit protective about what you do and how much information you give away, and how you go about partnering with other organisations. (Interview 14)

The problem of tokenistic inclusion of drug user voices in policy-making processes has also been highlighted in the literature: Mold and Berridge (2008) explained how their interviewees often described consumer participation in treatment and policy as a ‘box-ticking exercise’ for administrative actors.

**Voice, Power and Exclusion**

When describing the potential of NGOs to impact on the form of policy, a number of participants (4) expressed the view that those with the ‘loudest voice’ were often the most influential in policy processes. The range of actors involved in drug policy processes vary, depending on the policy issue. The majority of representatives I spoke with were involved with organisations that commented on drug and alcohol policy, as well as other areas of health and social policy. The drivers in each of these areas are different. In the alcohol policy space, there was a sense that industry was a powerful player. Alcohol was also seen as a difficult area, because of the ‘drinking culture’ and industry interests:

> Alcohol being the drug that causes the most harm, not particularly keen to address from politicians. I’d be a little bit cynical and say there’s vested industry interests in that. Also just I think that people think that an attack on alcohol is an attack on this cultural way of life kind of thing, which is what we need to communicate better as NGOs and not-for-profits, that we are certainly not anti-alcohol, we’re about trying to reduce risky drinking. (Interview 11)

Another participant noted the influence of industry in trying to formulate policy in the areas of legal drugs:

> They [Governments] are influenced by various things, so they can sometimes be influenced by those that have the loudest voice. Unfortunately one would have to say that in the drug and alcohol space, that often is things like the tobacco or the alcohol industry. (Interview 5)
Another participant expressed frustration at the Governments hesitancy to regulate or put an ‘imposition’ on industries causing social harm, citing the problems caused by gambling and pharmaceuticals:

> So what we’re seeing is, in areas that are big social problems such as alcohol, gambling, pharmaceuticals, we have big pharma, big alcohol, and big gambling, running the show as they see fit and governments unable to do anything to really regulate those industries which are having a dramatic impact on our community. Put that in your thesis. (Interview 13)

Taking into account the contrasting regulatory approaches towards legal and illegal drugs, illicit drugs policy has different drivers, and stakeholders, compared to the alcohol, tobacco and pharmaceutical drugs policy. While stakeholders such as the media, the community and others are still important in illicit drugs policy, the role of industry is obviously different in this area. The key players and the dynamics of inclusion and exclusion are also different. Guided by the overarching policy approach of harm minimisation — which includes the three pillars of supply reduction, demand reduction and harm reduction — the partnership between health and law enforcement is key to the operation of Australian illicit drug policy.

For illicit drugs policy, the context of criminalisation profoundly shapes the thinkable and practicable policy actions in this area. Participants regularly highlighted the role of health and law enforcement bureaucracies in illicit drug policy processes. A number of participants (5) noted that law enforcement held a lot of power, and also received the most funding. For example:

> Well you know I think that basically what happens is the biggest say of all comes from the law enforcement sector… (Interview 6)

While there were a number of interviewees and organisations who mentioned support for prohibition and a preference against further decriminalisation or legalisation, others felt that the context of

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53 Although there is a role for industry in the form of programs to reduce the diversion of precursors (such as Project Stop) and pharmaceuticals such as amphetamine-type stimulants onto the black market.
prohibition and the subsequent focus on law enforcement created a policy environment that limited the thinkable and discussable policy directions:

Well I think we should be looking at new and dynamic ways of dealing with drugs. There’s always this kind of rhetoric that we can somehow stop people using drugs, or stop drugs coming into the country, which just means that we keep doing the same thing over and over again; money down the drain, and not enough money in the areas that does need it. So I think we don’t do enough looking at overseas experience… (Interview 17)

This participant went on to explain that the historical power of law enforcement in the illicit drugs domain often translated into a reluctance to step outside of law enforcement response:

And usually it’s, you know, for instance the response to the ice situation at the moment is to put more law enforcement in place, and there’s no kind of radical change in how we deal with these things. (Interview 17)

While drug policy is a partnership approach between multiple sectors, agencies and actors, at the national level, and in states and territories, health departments have overall leadership as drugs come under health portfolios. A significant number (8) of participants noted that they felt that drug policy was largely bureaucratically-driven, and that it was often the ‘same people’ commenting on drug policy:

…I think that existing bureaucracies have a say, like the health bureaucracy and treasury bureaucracy have a strong say in what happens. And they’re often, you know when you get a change of government you still in a sense they have the same bureaucracy in place and in a lot of ways things remain the same; there is some changes but in general things tend to remain the same. Which says to me that it’s more about being bureaucratically driven, political or in a sense government-driven. (Interview 6)

The idea that there are often the ‘same people’ involved in policy advice was mentioned by other participants. One interviewee noted the barriers to building an ‘evidence-base’ for particular types of services — here mentioned in terms of recovery-focused services — and that gaining an ‘evidence-base’ was easier for those already in the policy space:

Those who are already in the policy space, their budgets include ‘research’, their budgets include ‘policy development’, and of course they get re-funded to reinvent and reproduce the
data they want to resell to the policy-makers that are giving them the money. Well I say if you give us half a million dollars and let us do the empirical research, we’ll come back with our data. (Interview 10).

This participant considered that ‘evidence-based policy’ made it easier for those already in the policy space to gain funding for their own, generate further evidence for their policy positions and therefore perpetuate existing power dynamics.

As discussed in Chapter 2, medical professionals have long been central to definitions of addiction both historically and contemporarily (Berridge, 1979; Berridge & Edwards, 1981). Their centrality to drug policy processes and the framing of addiction in the opioid treatment field in particular is reflected in international research, particularly work coming out of the ALICE-RAP project, a major study of the ‘framing’ of addiction in European societies (Hellman et al., 2016; Hellman et al., 2015). One participant described how the traditional medical model of governmental policy overshadowed the incorporation of the community sector:

I think it’s also because drug and alcohol, the Government’s always (and like research) is a very medical model, it’s all about opioid treatment programs and those type of hospital-based services; yet we provide at least a third, if not more than a third, of services to people with drug and alcohol issues. But we often get lost, the community sector often gets lost. (Interview 1)

A perception of the sector as ‘unprofessional’ was considered a possible reason for the reluctance to include NGOs as legitimate partners in policy discussions. Two NGO representatives mentioned the effects of characterising the sector in this way:

…I think there’s still a poor perception that the NGO drug and alcohol sector is 12-step programs run by ex-addicts who are doing AA meetings and that’s pretty much all we do; that we’re unqualified; that we’re not professional; we’re not a professional sector. So for the past 10 years we have been doing our best to change that perception, especially through capacity building activities around improving the qualifications of the sector, making sure that they’re evidence-based and reflecting on the services. (Interview 1)

I think in the reality, NGOs suffer a little bit from the perception — and this is something that will change over time — that they’re sort of ma and pa type things, and they’re non-
professional, and the credibility and therefore the seriousness with what they have to say is not necessarily always considered valid. That’s a generalisation though. (Interview 18)

For these participants, the perception of the sector is still connected with its historical form (for example, AA and self-help groups) — they felt this impacted on the degree to which the sector is considered a ‘professional’ sector and the degree of legitimacy afforded them in policy processes. As Interviewee 1 above notes, however, extensive capacity building projects (as described in Chapter 5) have aimed at changing this perception.

Historical power relationships between medical professionals and drug user organisations also created particular imbalances in drug policy processes. One participant noted the relationship between drug users and clinicians in the drug and alcohol policy space, contrasting it with the affected community’s role in blood-borne virus policy in Australia:

I think when you look at the history of blood-borne viruses in Australia, that’s been a partnership approach that’s always included the community, so gay men, sex workers, drug users, sat around those tables and were part of the response. And in drug and alcohol, the people who have the biggest voice in that are doctors, and clinicians. And for them, people who inject drugs are their patients; and to give the patient that power, or empowerment, to be able to participate, I think is really threatening for them. (Interview 8)

In stark contrast to the rhetoric around consumer participation in treatment policy and planning, the criminalisation of drug use still represents a way for people who use drugs to be excluded from policy discussions. In terms of relationships with government in policy processes, there was a sense that people who use drugs are still marginalised. One participant felt marginalised by the state health bureaucracy:

And sometimes I think there’s a disconnect with that, and we’re certainly experiencing a disconnect with that particularly with the [Health Department] who just don’t seem to be interested in drug users’ voices at all. (Interview 8)

Like this participant, a number of other interviewees characterised DUOs policy involvement in terms of ‘fighting’ or ‘battling’ to be heard in policy processes:
…So I guess it really sometimes feels haphazard, it feels like a bit of an afterthought, a bit of a fight to just get some basic consultation happening. I don’t know if that’s explaining it well, but I guess it feels like it’s just a constant battle to get recognition to be involved in those policy discussions. (Interview 14)

There was a concern amongst participants that the representation of people who use drugs in policy processes was limited, compared with other voices in the policy process, such as in mental health, because of the stigma of criminalisation:

And then I think that it’s different depending on who you are representing. So mental health has a greater voice, a much greater voice that’s funded, that’s recognised, that’s respected, and drug users’ voices are just not very — they’re just not very interested in that at all. So that’s, yeah I think it’s a very fluid kind of process, and one we have to fight, we constantly have to fight to be heard and then find ways to market ourselves so that we are palatable enough to be heard. (Interview 8)

Criminalisation presented a barrier to drug user organisations’ inclusion in policy processes, when compared with other voices:

More generally I guess we often have to struggle to be at the table, as the consumer voice, and drawing a comparison between our representation and say, the gay lobby in the context of HIV, the differences are quite glaring in that I think the gay lobby has always been a lot more powerful; and I think that one of the things that contributes to our, or why it’s so difficult for us to have the sort of degree and level of representation that we desire, is the illegal nature of drug use — that’s the big stumbling block, and why it’s often very difficult for us to get, from our perspective and our argument, to have much traction. (Interview 19)

The illegal nature of drug use provided a kind of legitimacy for excluding people who use drugs from policy discussions. Some representatives suggested that the drug and alcohol field was also viewed as ‘less palatable’ and not as easily adopted as a cause compared with other areas, because of the stigma of criminalisation (see the discussion about fundraising for drug and alcohol issues on p. 136).

Some participants suggested that the lack of co-ordination and voice in the drug and alcohol field, compared to other areas, was an issue. One participant explained that there was not enough ‘voice’ in the drug and alcohol sector, and this made it difficult for other fields to engage with it:
It was actually through that work that I identified that there wasn’t enough connection and there wasn’t enough voice in the drug and alcohol space; that made it very difficult for other fields to kind of engage with it because it wasn’t as organised as it needed to be or as it could be. (Interview 2)

In particular, participants compared AOD to mental health several times, noting that mental health receives a much larger share of funding than the AOD sector. This is significant, considering the melding of AOD and mental health in health governance structures in a number of states and territories in recent years.\(^5\) There have been pushes for greater partnership working between AOD and mental health (as seen in comorbidity initiatives), and AOD sits with mental health in a number of jurisdictions. One participant contrasted the position of mental health and disability sectors with the position of drug and alcohol, explaining the differences through AOD’s failure to articulate a clear policy vision:

Whereas there’s been some other sectors, who are leaps and bounds ahead of us in terms of the disability sector and the mental health sector, in terms of advocacy. They’ve got a vision, sorry I keep harping about vision. They’re able to get carers, they’re able to get the voters on board because they have a clear vision that the community accepts. It’s taken them years of education, some of them, to get the community to accept their vision but gee they’re on a roll now. You look at the difference between the mental health budget and the drug and alcohol budget. Just as many people with mental health issues as there are with drug or alcohol issues, where’s the money going? Mental health. So I think there’s a lot of work to be done in the policy area. (Interview 3)

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\(^5\) In states and territories, health departments have responsibility for alcohol and other drug issues. There has also been a tendency for the melding of mental health and AOD. For example, in NSW, the Mental Health and Drug and Alcohol Office (MHDAO) in NSW Health have responsibility for drug and alcohol. In the ACT, THE Alcohol & Drug services under Mental Health, Justice Health and Alcohol & Drug Services (MHJHADS). In Victoria, drug and alcohol now falls under ‘Drugs, Community Mental Health & Primary Care’ in the Department of Health and Human Services (established in January 2015). In Queensland, the Mental Health Alcohol and Other Drugs Branch (MHAODB) of Queensland Health leads policy for AOD treatment. The Queensland Mental Health Commission and the Mental Health and Drug Advisory Council were set up under the Queensland Mental Health Act 2013. The commission and advisory council’s role is to drive ongoing reform, and as part of this they have the developed mental health and drug and alcohol strategic plan, as well as an alcohol and other drug action plan. Western Australia had a statutory drug and alcohol authority, known as the Drug and Alcohol Office, and even that has recently amalgamated with the Mental Health Commission.
This participant links the idea of a clear policy vision with the success of advocacy in the mental health field, and raises the concern that there is no clear vision in the drug and alcohol sector that the community can find resonance with.

**Conflicting views in the sector**

Harm minimisation, forming the national policy framework, is meant to act as a clear policy vision or framework for the AOD sector. Whilst the majority of participants expressed support for the policy of harm minimisation in some form or another, some tension was evidence in the different positions NGO representatives expressed in relation to the policy framework. Based on the commentary from participants detailed below, the message of harm reduction has remained a controversial one in the drugs field. Several participants (3) expressed hesitancy at the message of harm reduction. While they supported the harm minimisation framework overall, these participants considered that the balance of focus had shifted too much towards harm reduction. Several considered that the focus needed to be shifted towards prevention:

“I think probably maybe too much of a focus on harm minimisation, and not enough of a focus on the fact that there are ways of minimising harm that are not just about using more safely; and that maybe kind of, looking at the school drug and alcohol curriculum rather than accepting that kids will use drugs, maybe focusing on well how do we get kids not to use them, as well as doing the other stuff. (Interview 6)"

Two participants expressed concern about the message of harm minimisation:

“Every parent that I talk to other than drug users themselves, goes ‘that’s insane, that’s nuts’ intuitively because that’s crazy, why would you give that permission, why would you give that message? And I say well that’s the message that is being broadcast through a harm reduction only ideology. Harm reduction is important, no argument, it’s one of the three pillars of the National Drug Strategy. But when it becomes the only one, demand reduction is ignored and supply reduction is accused of being counter-productive. (Interview 10)"

One participant noted a preference for the term ‘harm prevention’:

“I think part of the problem though is that, we’re in favour of harm prevention by various means like increasing prices, restricting availability, and penalties for people that don’t obey those.”
But it’s become more, I think harm minimisation, harm prevention can involve harm minimisation and prevention — sort of aiming to prevent people starting on drugs in the first place. The way I see it the policy in Australia has tended to become more ‘well people are going to do it, we’ll focus on well how do we get them off it’, how do we minimise the harm with needle exchanges and methadone and this sort of stuff, rather than focusing on the prevention aspect. While you’re not going to prevent everyone starting on drugs, we realise that, but I think the focus should be on the prevention rather than the harm minimisation. (Interview 9)

This participant’s preference for the term harm prevention indicates the importance of framing in policy, and the ongoing conflict around the ‘message’ of harm minimisation (as highlighted in the discussion of the two public inquiries into substance use during the term of the Howard government in Chapter 4, pp. 106-108).

The majority of participants in this study, however, expressed support for harm minimisation and cited harm reduction strategies as a key strength of Australia’s drug policy approach. Several participants noted that harm minimisation provided a way for a range of services and perspectives to come together under one framework. One participant acknowledged the ‘conflict’ within the sector, but considered that harm minimisation provides a way for representing a range of interests:

…I mean we have a, we represent over [number removed] services who provide a diversity of services and so there is internal conflict hidden within our own sector. But our, [NGO], is supportive of the harm minimisation approach and within that, there is a continuum of approaches through from harm reduction through to abstinence-based service providers and there is a place for all of those under the harm minimisation policy framework. (Interview 1)

According to participants and for peak bodies in particular, making sure that the range of services and positions in the drugs field is represented in policy processes was considered important:

I think our membership is quite broad as well, we have religious based organisations, we have non-religious based organisations, we have different models of treatment, and our services have a lot of freedom to do innovative stuff, which government services don’t. So being able to bring that information into the policy process is probably helpful. (Interview 15)
In this way, the diversity of perspectives and services in the non-government AOD sector could be seen as a strength in contributing to innovative policy and service provision, and peak bodies could play an important role in mediating and representing these perspectives in policy processes.

**Forums for Representation**

Considering the range of views in the drug and alcohol sector, forums and institutions — such as peak bodies and advisory councils — that mediate and facilitate the representation of the diversity of these views are critical. The formal and institutional mechanisms for the representation of NGOs in drug policy-making processes at the national level have undergone important changes over the past three years. Specifically, three major changes have presented challenges to representation of NGO voices in the drug policy space at the national level: the defunding of the national drug and alcohol peak body ADCA; changes to the membership and status of national drug and alcohol advisory council ANCD; and the decommissioning of the National Indigenous Drug and Alcohol Council (Morgan, 2014). These changes will now be explored in turn.

Based on the commentary below, although work is underway to reconstitute a representative national peak body, the defunding of the national peak body, the Alcohol and other Drugs Council of Australia (ADCA) presents a significant challenge for the NGO AOD sectors and its ability to contribute to policy at the national level:

> The loss of that voice has been I think hugely detrimental to the sector. It, in theory, it does still exist, it just doesn’t have any capacity. So it’s extremely busy people volunteering their time with no paid secretariat. The board is doing the best that they can but the sector is not really getting the voice that it sufficiently needs, and I think we’re losing or we have a lack of cohesion in that. Also, we all don’t have confidence that we are being represented on committees, in the spaces where the sector needs to be represented. (Interview 2)

At the time, the government explained the defunding in terms of getting rid of a ‘duplication of services’:
The justification was that there was too many bodies the government was funding, and this was removing duplication, but they didn’t appreciate that ADCA was running the largest kind of library collection, online resources, managed resources, in the world. (Interview 12)

As the above participant notes, ADCA also performed a range of other functions, such as providing resources through a large library and information service — which apparently was not a consideration in the Abbott Coalition Government’s decision to defund the organisation.

Several participants suggested that there were rumours that the defunding had actually been more ideologically/politically driven rather than a simple financial decision. There were suggestions that ADCA’s defunding may have been because of the power of the alcohol industry and ADCA’s public commentary on alcohol policy in the media.

The stuff that came out in the papers was that the Senator’s Chief of Staff had direct connections with the alcohol industry, so it just looked like an absolute conflict of interest and they resigned etc. etc. But who knows what the real reasons were. The new chair of ADCA was an outspoken former politician that had spoken out against a whole lot of issues. (Interview 12)

This indicates the direct influence of politics and other stakeholders on forms of advocacy possible in the drugs field. This has already been highlighted in the discussions of power asymmetries and the influence of the alcohol industry in the alcohol policy field above (p. 197).

Based on the interview data, jurisdictional and state/territory peak bodies remain important mechanisms for representation of the Australian non-government AOD sector in policy-processes. Following the defunding of ADCA, the state and territory peak bodies have joined together to form a network called the AOD Peaks Network (QNADA Website, 2014). The object of this network is to facilitate continued and co-ordinated commentary on policy. The board of ADCA is also working to establish a new national peak body. An independent committee was established to provide advice on this and sector consultations and a survey went out to the sector and a report was submitted to the ADCA board in 2015 (“Report on the Requirements for the Establishment of a new National Peak Body for Alcohol and Other Drugs”, 2015).
The name of the Australian National Council on Drugs was changed to the Australian National Advisory Council on Alcohol and other Drugs (ANACAD) in late 2014. The membership constituency of the council was also changed, as well as its terms of reference that shape the council’s remit. The terms of reference no longer specifically mention representation of the AOD NGO sector or facilitating partnerships (Department of Health, 2016a). Some participants noted the role of the ANCD in providing a mechanism for NGOs to participate in the national policy space. At the time of most interviews, changes to the ANCD were generally rumours. Two participants interviewed after the changes were announced in December 2014 expressed concern that the membership of the advisory committee was not broadly representative:

We are a little concerned. Just purely on the makeup of it, it seems to have been diminished in importance from what it previously was, and concerningly has got a little bit more of a bent towards ‘the war on drugs’ type philosophy and abstinence and legal mechanisms to control drug usage, which is of concern for us. (Interview 15)

It just seems like, from what I know about the Advisory Committee is that it just seems to be more conservative people on the committee. People who sort of have the ideology like Drug Free Australia, and I can’t remember the names of the people who are on the committee right now, their names have escaped me, but yeah. (Interview 14)

This participant went on to voice their concern that the conservative ANACAD membership might encourage a further concentration on law enforcement measures and shift drug policy away from ‘what works’:

I’m just really worried that - it’s just crazy really that, like I said we have all this evidence, all this research that says what we need to do and what works, and it can absolutely just be refuted and ignored; and we can increase punishments and increase incarceration, increase funding to the ‘drug war’ to supply and control, controlling supply and that sort of stuff, and unfortunately that’s where the focus will probably be. (Interview 14)

Another challenge in terms of institutional structures was the removal of NIDAC, the National Indigenous Drug and Alcohol Council which was supported by the ANCD:
The other concern for us is the sidelining of NIDAC, the eradication of NIDAC, and that important voice that we saw was doing some good stuff there has been gotten rid of. (Interview 15)

This is significant as there is no national peak body representing the Aboriginal drug and alcohol sector (although NACCHO is important in this area). Even though Ted Wilkes, the previous chair of NIDAC, is now a member of ANACAD (Morgan, 2014), this has arguably represented a major downgrading of aboriginal drug and alcohol issues in the NDS policy governance framework.

**Conclusion**

This chapter has problematised the contemporary discourse of government/non-government ‘partnerships’ in drug policy, through a consideration of the experience of NGO representatives working with government and other agencies in the AOD policy domain. Participants interviewed for this study discussed the potential role and justification for NGO involvement in drug policy in a range of ways that paralleled discussions in the theoretical literature of the value of NGOs described in Chapter 2. NGOs were thought to act as an important voice of the community and of service users in policy processes, and to act as an independent counter voice to government. Because of their key role in service provision, and connection to communities and ‘experience on the ground’, NGOs were also thought to possess a special kind of expertise based on experiential knowledge; something that policy-makers were seen to lack. In this sense, NGOs could act as an important mediator between the state, the community, and ‘service users’ — serving both the state and the community, responsibilising and mobilising the community to act on drug issues (Garland, 2001).

In this chapter, I described some of the realities and tensions of the contemporary drug policy environment. I sketched out some of the ‘drug policy politics’ that shape the role of NGOs in the drugs field, where both the political, as well as the bureaucratic arrangements have consequences for policy-making and power relationships in the drugs field and for NGOs. Interviewees identified a range of opportunities for NGOs to participate in the drug policy space. The influence of ideas around governance and cross-sectoral partnerships has meant that NGOs are involved in governance
instruments such as stakeholder reference groups, steering committees; and public consultation processes are now more formalised and routine. Partnerships have presented opportunities for more collaborative policy work, rather than ‘radical’ or critical advocacy (Almog-Bar & Schmid, 2013). Whilst this could contribute to innovative policy-making, this practice could also be problematic in that it allows governments to further control the agenda, potentially excluding or silencing dissenting views except in contexts where NGOs are officially invited to policy discussions. Additionally, consumer engagement models have opened up a rhetorical space for the inclusion of people who use drugs at the drug policy ‘table’ so to speak. Participants highlighted the strong partnerships that have been formed across the sector in terms of collaborations between NGOs, researchers and other agents.

Despite these practices, the analysis in this chapter suggests that the idea that ‘partnerships’ in the policy process has remained more of a theory or goal than a reality of the current political environment. The criminalisation of drug use creates unequal power relations in this policy area, where drug user organisations, people who use drugs and ‘consumers’ feel stigmatised and are afforded a place in policy discussions only where they are recognised as playing a legitimate role. While drug user organisations have been involved as partners in blood-borne virus policy, they have faced particular challenges to their inclusion in AOD policy-processes, although the rise of consumer involvement in treatment planning has increased opportunities for their involvement in AOD policy to some degree. The exclusion of people who use drugs from policy discussions is also an issue in international jurisdictions, for example in Europe (Hellman et al., 2016; Hellman et al., 2015; Mold & Berridge, 2008). Hellman et al. (2016) note that “some stakeholders, such as user groups, have struggled to be represented in the public debates and policy processes” (p. 3). This raises questions about how models of good governance and partnership can legitimately function in a policy context that addresses criminalised behaviour and there are unequal relations of power.

Perhaps unsurprisingly, this study found a range of unequal power relations that work against the rhetoric of partnership. There are a number of challenges to the realisation of ‘partnership’ between governments and NGOs at the policy level in the drug field. First and foremost are problems with
underfunding, uncertainty and power differentials in funder-provider relationships. Non-government organisations are not currently resourced at a level that allows effective political participation, and there are few organisations that have funded policy officer positions. In some cases, governments have included ‘gag-clauses’ in service delivery contracts to actively prevent NGOs from criticising government policy. The analysis also showed that the state has had influence in terms of the form that advocacy or policy work can take, as well as organisations are able to survive and those disappear, indicating that the state engages a form of power through regulation. Recent government decisions, such as the defunding of ADCA, have reduced the capacity of NGOs to contribute to policy at the national level (although a new peak body is being formed). The changes to the advisory council, now known as ANACAD, raised concern because it lacks representatives from any peak bodies, harm reduction and drug user organisations or consumer representatives. The defunding in 2014 of the National Indigenous Drug and Alcohol Committee (NIDAC), which was supported by the ANCD, presents a problem for the representation of Aboriginal views in policy processes — although the chair of that committee is now a member of ANACAD. These decisions are examples of active expression of the political power of the state, where the state retains a central position in defining boundaries of inclusion and exclusion in drug policy processes (McKee, 2009).

Throughout this chapter, I have argued that the power relations behind ‘partnerships’ have an effect on NGOs policy work at various levels: by structuring the ways NGOs can engage with policy, creating both opportunities for them to contribute (for example, through collaborative policy-making rather than public advocacy) as well as undermining their political capacity through power differentials inherent in the funder-provider relationship. Partnerships can also shift power relations between stakeholders in the drugs field, as outlined here in the discussion of some of the relationships between NGOs, researchers, and people who use drugs. The analysis presented here suggests that although the rise of neoliberal strategies of government have encouraged the use of government rhetoric regarding partnerships with the community, and an increase in opportunities for NGOs to participate politically, the power dynamics characteristic of the AOD and broader policy and political sphere work to structure and constrain the capacity of NGOs to fully contribute to policy processes.
In summary, drug policy is characterised by complex power relations, and NGOs have been provided with particular opportunities to contribute to policy processes. The aim of the next chapter is to make some of the ways that NGOs can influence policy more visible through a focused analysis of ‘New Recovery’. Using policy transfer and translation as a framework to guide analysis, the chapter explores some of the factors that shape how NGOs actually engage with drug policy issues.

The last chapter problematised the notion of government/non-government ‘partnerships’ in the Australian drug policy field by highlighting some of the factors that shape and constrain how NGOs can work in this space. This chapter builds on the analysis presented in the last chapter by further unpacking the role of NGOs in drug policy, in this case by examining how NGOs actually engage with a particular drug policy issue. Whilst the policy language of ‘partnerships’ with the non-government sector tends to represent the sector as a collective entity, as the previous chapters have established there is considerable diversity in the functions and policy positions of NGOs (Butcher, 2015a), and this is true for the Australian AOD sector. This chapter uses the emergence of the idea of ‘new recovery’ in the Australian context as a vehicle for exploring how NGOs engage with and negotiate policy ideas and policy-making processes in the drugs field. ‘New recovery’ can be understood as both a social movement to advance the interests of people who identify as being in recovery from problematic drug and alcohol use, and a policy approach promoting recovery oriented systems of care (Humphreys & Lembke, 2014; White, 2011; White, 2007; White & Taylor, 2006). It is an international movement, and the idea of recovery has been taken up in policy particularly in the US and the UK — albeit in different ways. In 2012, the ideas behind ‘new recovery’ became a focus of debate in the Australian AOD field (Anex, 2012b; Australian Injecting and Illicit Drug Users League, 2012b; Australian National Council on Drugs, 2012; Queensland Network of Alcohol and other Drug Agencies, 2012; UnitingCare ReGen, 2012), and the idea of ‘recovery’ was taken up in policy in the Australian state of Victoria (State of Victoria Department of Health, 2013a). The aim of this chapter, then, is to explore some of the nuances of how Australian NGOs engage with policy through an analysis of ‘New Recovery’ using policy transfer and policy translation as a basis for the inquiry.

Policy transfer (Evans & Davies, 1999; Jones & Newburn, 2007) and policy translation (Balen & Leyton, 2015; Peck & Theodore, 2010; Stone, 2012) — broadly interpreted — offer an appropriate
framework for analysis because of the international influence — of trends in the US and the UK specifically — on ‘New Recovery’ in the Australian context. The analysis of policy transfer

…seeks to make sense of a process or set of processes in which knowledge about institutions, policies or delivery systems at one sector or level of governance is used in the development of institutions, policies or delivery systems at another sector or level of governance (Evans, 2009, pp. 243-244).

It provides a lens which differentiates between the multiple levels of the policy process, including the ‘macro’, ‘meso’ and ‘micro’ levels (Evans & Davies, 1999). The strength of policy transfer in this case is its multi-level descriptive approach. Dolowitz and Marsh (2000) outline a series of questions to ask in any analysis of policy transfer, including: why transfer policy, who is involved in transfer, what is transferred, from where, what are the degrees of transfer, and what restricts or facilitates the policy transfer process? In addition they suggest that analysis should take into account how the process of policy transfer is related to policy ‘success’ or policy ‘failure’. These questions will serve as a guide throughout the analysis presented in this chapter. Dolowitz and Marsh’s (2000) model, and the policy transfer literature more broadly, has been criticised for being too rationalistic, and not taking into account the ‘messiness’ of the processes that can be involved.

The approach to ‘policy transfer’, specifically ‘policy translation’, outlined in the critical policy studies literature allows for a more nuanced understanding of some of the issues involved in policy transfer, or how policy knowledges circulate and are negotiated (Balen & Leyton, 2015; Peck & Theodore, 2010). This directs attention to the role of ideas, contestation, and social agency in the process (Balen & Leyton, 2015). As Jones and Newburn (2007) note in their study of crime control policy, policy transfer should also investigate “the apparent transfer of policy ideas/symbols/rhetoric, policy content, and policy instruments, and second, the various processes by which such transfer comes about (or is constrained)” (p. 35). Thus attention to the transfer of symbols and rhetoric in policy is just as important as attention to the transfer of policy ‘instruments’ and technologies. Whilst the policy transfer literature is rationalistic, the policy translation literature focuses on the ‘politics’ of transfer, through “the ways in which policies (schemes, content, technologies and instruments) are constantly changing and
emphasizes the interactions, the complexity, and the liminality of encounters between actors, sites, scales, and contexts” (Balen & Leyton, 2015, p. 103). The meaning of policy, and the agency of social actors in interpreting and changing these ideas in policy, particularly through language and representation, is central to policy translation (Balen & Leyton, 2015). Whilst it is consistent with Foucauldian ideas, policy translation moves beyond the tendency in some governmentality literature to focus on state power and neglect non-state actors and agency (Herbert-Cheshire, 2003). It draws on ideas from Bruno Latour and Actor Network Theory, to focus on how social actors engage with policy and in so doing transform it (Herbert-Cheshire, 2003). Translation is viewed as an open-ended process “through which individuals transform the knowledge, truths and effects of power each time they encounter them” (Herbert-Cheshire, 2003, p. 456). The policy translation literature highlights the role of non-state ‘vehicles’ for transfer — including NGOs, independent policy institutes and social movements — as well as their role in the policy translation process, thus making it a useful framework for this analysis (Stone, 2001, 2012). Following Deborah Stone (1999, 2001, 2012), I investigate a series of questions drawn from the policy translation literature, including how policies are modified/adapted to their specific contexts; the role of feedback from stakeholders in policy transfer; and how NGOs have contributed to the contestation and negotiation of recovery policy in the Australian context. In doing so, this chapter responds to the final research question: How, and in what ways, have NGOs engaged with and attempted to shape drug policy?

To answer this question, the chapter draws on data from the qualitative interviews and document and policy analysis described in Chapter 3. The chapter begins by outlining the international story of ‘new recovery’, both as a social movement and as part of policy in the US, the UK and Victoria. It goes on to present a comparative analysis of how recovery has featured in policy in the UK, the US, and Victoria (Australia), in order to identify some of the key features of recovery policy in these jurisdictions. The chapter then turns to an analysis of the drivers of policy transfer in the Victorian context, including an analysis of how NGOs and non-state actors have been central to the movement of new recovery and the circulation of policy ideas, how they influenced the uptake of recovery in the Victorian drug policy context. Following on from this, I discuss the role of NGOs in responding to, facilitating and
constraining the development of ‘new recovery’ policy in the Australia context. I argue that Australian NGOs acted as translators, negotiators and at times, in resistance, to recovery policy. Overall, I propose that whilst there is evidence that policy transfer did occur, it was largely symbolic, and lacked the features of ‘recovery policy’ that have characterised this policy approach in international jurisdictions — most importantly, the government support (rhetorical and material) of community-based recovery-focused organisations.

**International ‘New Recovery’**

The rise of ‘new recovery’ in the Australian context is a complex example of policy transfer/learning, because the ‘lesson-drawing’ covers a range of jurisdictions, and areas of governance. The idea of ‘recovery’ has a (relatively) long history in drug and alcohol, and it is also a concept used in mental health (Berridge, 2012). As Virginia Berridge (2012) notes, the idea of ‘recovery’ in the AOD field can be traced back to the ideas of the temperance movement and the idea of ‘treatment’ for inebriety popularised during the late 19th Century. In this context, recovery is analogous to the ‘cure’; the goal of these early treatments for inebriety, and of the temperance movement, was abstinence. As noted in Chapter 2 (pp. 37) these early inebriety treatments fell into disuse, and the idea of ‘cure’ also waned in the early 20th Century. With the popularisation of twelve-step and mutual aid approaches to drug problems, the idea of recovery was wedded to abstinence in the US context (Berridge, 2012); although treatment practices in Britain at times also emphasised abstinence. In the UK context, the medical profession took a pragmatic approach to the treatment of addiction, with some medical professionals prescribing opiates to narcotics addicts — a practice that came to be known as the ‘British system’. Berridge (2012) observes the divergence between the UK and the US in drug treatment approaches from the early 20th Century: whilst the US approach emphasised abstinence from all drugs, as the 1914 Harrison Narcotics Act made it illegal for doctors to prescribe opiates to ‘addicts’, in the UK the Rolleston Report (1926) recommended the medical profession retain the power to prescribe maintenance doses of opiates to ‘addicts’. Although state legislation in Australia largely forbade it, similar practices also existed in the Australian context, where medical professionals still prescribed...
opiates as substitution therapy for narcotics addicts into the 1960s (Manderson, 1992). Overall however, the idea of ‘recovery’ came to be most closely associated with the disease-model of addiction; with twelve-step and other mutual aid groups, and other drug treatments such as TCs drawing on these approaches. The idea of ‘recovery’ was similarly popularised in the mental health field through the ‘consumer movement’ and mutual aid or self-help groups resulting from widespread deinstitutionalisation during the 1960s and 1970s (Ostrow & Adams, 2012).

In Australia and elsewhere, the balance between abstinence and harm reduction as governmental interventions shifted in the 1980s when the threat of HIV/AIDS sparked a reassessment of drug treatment priorities. Berridge (2012) notes that although the UK ‘drug voluntary sector’ practiced a kind of surreptitious harm reduction — ‘unspoken’ in the context of the ‘war on drugs’ of the 1980s — the threat of HIV/AIDS in the 1980s spurred a reassessment of drug treatment priorities, and harm reduction practices such as substitute prescribing and new methods such as needle exchanges were given legitimacy as tools in the fight against the spread of the epidemic. With the heavy influence of the disease model and its focus on abstinence, the US approach differed somewhat in this respect (Berridge, 2012); although methadone prescribing became an accepted practice, other harm reduction measures such as needle exchanges enjoyed less acceptance (Shaw, 2012). This tension between harm reduction approaches and abstinence-oriented recovery approaches has remained a central one in the drugs field. Furthermore, the meaning of recovery in the drug and alcohol field is contested, with no one accepted definition of the term (Lancaster et al., 2015; Neale, Nettleton, & Pickering, 2011). This tension is explored in greater detail later in this chapter.

Given the above, what is ‘new’ about ‘new recovery’ is not the idea of recovery, but the way it is framed. There are strong links between ‘new recovery’ as a social movement, and recovery in drug policy. In fact, the emergence of the ‘new recovery advocacy movement’ (NRAM) — as it has been called in the United States — can be traced back to a US government policy in the late 1990s, when the

US Federal government introduced a grants program56, the Recovering Community Support Program (RCSP) in 1998, to fund organisations led by people in recovery and their supporters (Humphreys & Lembke, 2014). Organisations oriented towards recovery (mutual aid and self-help groups for example) existed well before this, but the term ‘new recovery’ is used to “pay homage to earlier advocacy movements” of people in recovery, and also signpost the new direction taken by this movement (White, 2016a). William White (2007), a prominent recovery spokesperson in the US, explains that the new recovery movement, by virtue of its focus on solutions, is to be distinguished from earlier social movements:

…which sought to alter public perceptions of and public policies towards those with AOD problems by redefining the problem (‘alcoholism is a disease’), altering perceptions of those with the problem (‘the alcoholic is a sick person’) or promoting a particular intervention (‘treatment works’) (p. 700).57

Policy is a key target of the movement. The core values and ideas of the movement centre on personal recovery as a platform for advocacy, the importance of ‘authentic, grassroots representation’ in drugs policy, recovery leadership, and the value of cultural diversity (White, 2007). The strategies of the NRAM centre around: building strong local recovery advocacy organisations; advocating for meaningful representation in policy processes for people in recovery and their family members; educating the public, policy makers and service providers on recovery; creating recovery support centres that deliver non-clinical, peer-based recovery support services; and supporting research that illuminates effective strategies and the processes of long-term recovery (White, 2007, pp. 700-701).

In the US the government has been directly involved in supporting the ‘new recovery’ movement of people in recovery from alcohol and other drug use (Humphreys & Lembke, 2014). In the US, beginning with the introduction of the first recovery policy in 1998, the RCSP (noted above on p. 218), Governments encouraged the growth of the recovery movement by funding organisations with an

56 Administered through the Centre for Substance Abuse Treatment, part of the Substance Abuse and Mental Health Services Administration (SAMHSA), within the US Department of Health and Human Services (DHHS)
57 The New Recovery movement, however, is not actually unique in its ‘solution-focused’ approach. The harm reduction movement has also presented itself as solution-focused, in that it advocates practical solutions to the problems or harms stemming from drug use.
advocacy purpose (Humphreys & Lembke, 2014). Although these early grants supported this advocacy component, the US government has not always been entirely supportive of advocacy (Humphreys & Lembke, 2014). The Bush administration (2001-2009) elected in 2001 declined to continue funding the advocacy activities of recovery organisations, restricting RCSP grantees activities to providing peer-based services (Humphreys & Lembke, 2014). Humphreys and Lembke (2014) observe that US Congress has traditionally been wary of the use of public monies by executive branches — in this case the Substance Abuse and Mental Health Services Administration (SAMHSA) — to advance their own interests. In this respect the concern was that SAMHSA would further their own agenda by funding community groups that would then use these funds to lobby Congress to increase SAMHSA’s funding (Humphreys & Lembke, 2014). The federal government during the period of the Bush administration actively engaged with recovery policy through numerous activities, including introducing further grants programs and holding a national summit on recovery in 2005 to promote dialogue around the definition of recovery and its guiding principles (Humphreys & Lembke, 2014). The Obama administration, elected in 2009, took this further and incorporated recovery into the National Drug Control Strategy (Humphreys & Lembke, 2014). This will be explored in more detail later in the next section through the international comparison of recovery policy.

In the late 2000s, the ideas behind recovery-oriented policy spread to the United Kingdom. The focus on recovery in policy first emerged in the UK in Scotland in 2008, when the Scottish Government released their drug strategy entitled “The Road to Recovery: A New Approach to Tackling Scotland’s Drug Problem”, which outlined a clear focus on treatment approaches encouraging recovery from problematic drug use through abstinence (Duke, 2013; McKeganey, 2014). Following this, in 2010 the English Coalition Government introduced their drug strategy, Reducing Demand, Restricting Supply, Building Recovery: Supporting People to Live a Drug Free Life (Government, 2010). As Humphreys and Lembke (2014) note, there were a number of pre-conditions to the adoption of recovery policy in the UK, including a growing dissatisfaction with the existing orientation of drug service systems, as well as contact with recovery advocates from the US.
During 2012, ‘new recovery’ and recovery oriented systems of care became the subject of debate in the Australian AOD sector. The ANCD held a ‘1st Recovery Roundtable’, bringing together a range of stakeholders from the AOD field to discuss ‘new recovery’. A number of AOD NGOs released their own position papers on the topic (Anex, 2012a, 2012b; Australian Injecting and Illicit Drug Users League, 2012b; Queensland Network of Alcohol and other Drug Agencies, 2012; UnitingCare ReGen, 2012). In 2012, the ideas behind recovery-oriented policy influenced the restructuring of the AOD treatment system in Victoria. In 2012-2013, the Victorian Department of Health released a number of policy reform documents that incorporated recovery principles (State of Victoria Department of Health, 2012, 2013a; Victorian Department of Health, 2013). In what follows, I investigate the process and elements of policy transfer in the Victorian context. The next section compares and contrasts recovery policy in the US, the UK and Australia to consider the elements of policy transfer in the Australian context.

Recovery in Policy: What has been Transferred?

Comparing government policies around recovery across the US, the UK and the Victorian context, there are a number of similarities and differences in the way that the concept of recovery has ‘manifested’ in the policies of these countries (HM Government, 2010; Victorian Department of Health, 2013; White House Office of National Drug Control Policy, 2014). Table 6 below compares some of the relevant policy documents, agencies and government supported activities around recovery policy across the US, the UK, and Victoria, Australia. The definitions of recovery differ across the documents, and their positions on abstinence also differ. In the US, as noted, there has been a strong emphasis on abstinence (although pharmacotherapies have also been recognised as a legitimate means to achieve abstinence eventually) (Anex, 2012b). In the UK context, ‘new recovery’ has translated into a policy preference for funding abstinence and abstinence-oriented treatment programs over harm reduction programs, particularly methadone maintenance programs (Duke, Herring, Thickett, & Thom, 2013; McKeganey, 2012; McKeganey, 2014). The Scottish government adopted recovery as an organising principle or goal for their drug policy in 2008, and defined recovery as abstinence (McKeganey, 2014). In England, prior
to their election the Coalition government announced that their drug policy would encourage a return to an abstinence focus, and methadone was highlighted as a particular problem (Duke, 2013). As Duke (2013) notes, however, the Coalition strategy document allows for harm reduction techniques and methadone maintenance, concluding from her analysis of the strategy that “it would appear that the pragmatism that has characterized British drugs policy and treatment over history is likely to continue” (p. 51). Similarly, the Victorian policy framework incorporates recovery principles but sees them nestled still within the broader overarching harm minimisation framework (State of Victoria Department of Health, 2013a). In the Victorian context, recovery is not considered to be in conflict with the principles of harm minimisation:

Recovery-oriented approaches sit within the harm minimisation framework, acknowledging and building on people’s own resilience and resources. Recovery-oriented approaches recognise that people come to treatment through many different paths and that their goals and journey towards recovery and wellbeing are individual and unique. These approaches are reflected in the new principles and across system reforms (State of Victoria Department of Health, 2013b).

The recovery-oriented principles adopted in the Victorian alcohol and drug treatment principles note that interventions can include a range of approaches: “Treatment includes a variety of biopsychosocial approaches, interventions and modalities oriented towards people’s recovery” (p. 4-5). Across the Victorian documents, ‘recovery-oriented services’ are linked with the idea of continuity of care and integrated and responsive services. Similarly, continuity of care is emphasised in the US document Guiding Principles and Elements of Recovery-Oriented Systems of Care: What Do We Know From the Research? (Sheedy & Whitter, 2009). Person-centred recovery is echoed across all the policy documents, and the idea of integrated care is highlighted in the US documents and the Victorian documents.
### Table 6: Comparison of government policies around recovery in the United States, the United Kingdom and Victoria, Australia

<table>
<thead>
<tr>
<th>Relevant Policy Documents</th>
<th>US</th>
<th>UK</th>
<th>Victoria</th>
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<tr>
<td>Guiding Principles and Elements of Recovery-Oriented Systems of Care: What Do We Know From the Research?</td>
<td>Supporting people to live a drug free lifestyle</td>
<td>New directions for alcohol and drug treatment services: A framework for reform</td>
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<tr>
<td>Other documents available on the ONDCP website and the SAMHSA website</td>
<td>Putting Full Recovery First: A Roadmap to Recovery</td>
<td>Reducing the alcohol and drug toll Victoria’s plan 2013–20</td>
<td></td>
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<tr>
<td></td>
<td>Public Health England documents on mutual aid groups</td>
<td>Victorian alcohol and drug treatment principles</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Agencies</th>
<th>US Substance Abuse and Mental Health Services Administration (SAMHSA)</th>
<th>National Health Service, National Treatment Agency for Substance Misuse</th>
<th>Victoria — Department of Health and Human Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government supported activities and associated strategies</td>
<td>• Funding for recovery community organisations</td>
<td>• Treatment system restructuring</td>
<td>• Inclusion of recovery principles in policy documents</td>
</tr>
<tr>
<td></td>
<td>• Recovery Month — ONDCP participates in planning for National Recovery month in September (recoverymonth.gov)</td>
<td>• Payment by results</td>
<td>• Drug treatment system reform and ‘performance management’</td>
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<td></td>
<td>• Recovery Walk</td>
<td>• Greater Manchester West Mental Health NHS Foundation Trust’s Recovery Academy</td>
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<td></td>
<td>• President’s 2010 National Drug and Alcohol Recovery Month proclamation</td>
<td>• Public Health England guidance documents co-produced with mutual aid groups, commissioners and service managers</td>
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<td></td>
<td>• Outcome focused funding</td>
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At a macro-level, neoliberal economic ideas have been extremely influential across the US, the UK and Australia — in the area of health, this has manifested in the reshaping of health funding systems in the interests of increasing cost-efficiency (Beeson & Firth, 1998; Coburn, 2004). The synergy between ‘new recovery’ and neoliberal emphases on cost-efficiency and frugalism in public spending can be seen most clearly in two elements of recovery policy: ‘results-based’ or outcome-focused funding, and
the focus on ‘peer-based’, self-help recovery organisations. The recovery focus in the drug policy documents has translated into a focus on outcome monitoring in service systems, and funding processes designed to encourage a focus on recovery (Mason et al., 2015; Maynard, Street, & Hunter, 2011). How this has been expressed in each jurisdiction has varied. Payment by results was a key element of recovery policy in the UK context, and a particularly controversial one at that (Duke, 2013). In the Victorian context, the ‘reform’ of the drug and alcohol sector included recommissioning services to be in-line with the principles of the reform. “Person-centred, family and culturally inclusive, recovery-oriented treatment” is the first of these principles guiding reform of the Victorian AOD system, illustrating the influence of recovery on the reform (State of Victoria Department of Health, 2012). The Victorian policy documents released during 2012-2013 also discussed experimenting with payment by results, but the reform has ultimately resulted in ‘activity-based funding’ and outcome-monitoring rather than payment by results (Ritter & Berends, 2016; Savic & Fomiatti, 2016).

The idea of encouraging ‘voluntary’, ‘community-based’ and ‘self-help’ recovery organisations is also synergistic with neoliberal economic discourse. As Garland (2000) observes, “Market solutions, individual responsibility self-help have increasingly displaced welfare state collectivism and social policy to place more emphasis upon accounting and managerial expertise than upon professional social workers and clinicians” (p. 358). The focus on voluntary, self-help style recovery organisations is clear in the US and the UK context: a key part of recovery policy in these jurisdictions is government support for and encouraging of ‘recovery organisations’ (see Table 6 above), but this element of recovery policy appears to be missing in the Australian context. The US and the UK documents discuss the idea of peer recovery support services and in the case of the UK document, ‘recovery champions’, however these ideas are not addressed in the Victorian document. For example, the US Government is a sponsor of ‘Recovery Month’ and there are ‘Recovery Month’ materials on the SAMHSA website (Substance Abuse and Mental Health Services Adminstration, 2015). In 2014 and 2015 President Obama made presidential proclamations declaring September 2015 to be National Alcohol and Drug Addiction Recovery Month. The US government also established a new grants program called the Peer-to-Peer Targeted Capacity Expansion grant program, which provided funding to both established and emerging
‘recovery community organisations’ (RCOs) (Substance Abuse and Mental Health Services Administration, 2015). The Office for National Drug Control Policy (ONDCP) also provides policy leadership around recovery, establishing the Recovery-Oriented Systems of Care (ROSC) Learning Community. SAMHSA also provides policy leadership, conducting a range of activities related to supporting recovery organisations and organising an online policy academy for jurisdictions interested in implementing the ROSC framework (Humphreys & Lembke, 2014; Substance Abuse and Mental Health Services Administration, 2015). Like the US government, the UK government supports recovery organisations and activities — although Humphreys and Lembke (2014) note that they have not provided the significant material support for recovery organisations that they US government has. The UK Recovery Festival is co-organised by non-government and government sector (Humphreys & Lembke, 2014). In England, the National Treatment Agency for Substance Misuse under the National Health Service (now Public Health England) completed a body of work on mutual aid and recovery groups, and released a series of documents co-produced with mutual aid groups, commissioners and service managers (National Treatment Authority, 2016). I could locate no evidence that the Victorian government had engaged in similar types of activities in support of recovery focused organisations, although it appears to provide funding to organisations for ‘care and recovery co-ordination’. While there has been an inclusion of recovery principles in policy, at this stage there have been no funding programs and government-sponsored projects addressing or stimulating the growth of recovery organisations, and thus this key element of recovery policy is missing in the Victorian context.

The degree to which policy transfer occurred in the Australian context appears relatively limited. Recovery in the Australian context did not involve copying; it appears that the idea of recovery acted as an inspiration for policy change (State of Victoria Department of Health, 2012, 2013a; Victorian Department of Health, 2013). Although recovery-oriented systems of care feature heavily in the Victorian documents (State of Victoria Department of Health, 2012, 2013a; Victorian Department of Health, 2013), some of the key features of recovery policy in the US and the UK — in particular, the government support for recovery organisations — have largely been absent in the Victorian context. As opposed to being a direct copy of the US and UK approaches, recovery policy in the Australian is an
example of hybridisation — the most typical form of policy learning — because it combines aspects of programs in other settings to produce a policy that is still relevant to the local context in the recipient jurisdictions (Evans, 2009). As Stone (2012) notes, there are several dimensions of policy transfer, including the transfer of policy goals, institutions, regulatory, administrative or judicial tools, ideas and ideologies, and personnel. In the case of new recovery it appears that the transfer of goals, ideas and ideologies were important features in the process of policy transfer. Following Stone (2012), it is more useful to view it as a process of policy translation as much as transfer. She notes that various intermediaries modify policy ideas during this process, including non-state actors and organisations. She observes that these organisations often work in partnership with government and international organisations, resulting in “various forms of experimentalist governance” (p. 496). Working together in this manner, “their collective interactions constitute structures of policy translation” (Stone, 2012, p. 496). In the next section, I explore how NGOs and non-state actors were central to the movement of new recovery and the circulation of policy ideas that resulted in the uptake of recovery principles in Victorian drug policy.

The Role of NGOs in the ‘Policy Transfer’ Process

Agents of New Recovery

Non-government organisations and actors have been central to the ‘new recovery’ advocacy movement in the international context. The recovery movement and policy has seen strong support in the US and more recently the UK (Humphreys & Lembke, 2014). There are a number of ‘agents’ and organisations advancing the recovery movement across these jurisdictions. Strategies of the movement include public education and campaigning, policy advocacy, and recovery community support services and organising. Table 7 below outlines some of the key organisations, tactics, and policy entrepreneurs across the US, the UK and the Australian contexts.
Table 7: Civil society and recovery

<table>
<thead>
<tr>
<th>Example organisations</th>
<th>US</th>
<th>UK</th>
<th>Australia</th>
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<tbody>
<tr>
<td>Example organisations</td>
<td>Faces and Voices of Recovery</td>
<td>Faces and Voices of Recovery UK</td>
<td>Recovery Academy Australia</td>
</tr>
<tr>
<td>Example promotion strategies</td>
<td>Survey of people in recovery</td>
<td>Recovery Month</td>
<td>FAVOR Online survey of people in Recovery</td>
</tr>
<tr>
<td>Example Policy Enthusiasts/Recovery</td>
<td>William White</td>
<td>David Best</td>
<td>Life in Recovery Survey</td>
</tr>
<tr>
<td>Champions</td>
<td>Keith Humphreys</td>
<td>Neil McKeaganey (Scotland)</td>
<td>David Best</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(McKeaganey, 2014)</td>
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As noted in the table, in the US, there have been a number of prominent spokespersons for the recovery movement, including William White, Betty Ford, Keith Humphreys, along with a number of others (White, 2007; White & Taylor, 2006). Academics, in particular, have been key to the advancement of ‘new recovery’ (Gilman, 2011; White, 2016b). David Best (Best & Lubman, 2012) has been a spokesperson advancing recovery, in both the UK and Australia (Roth, 2011). He is the head of the ‘Recovery Academy’ in the UK, which is a group of clinicians and researchers working towards advancing recovery and recovery evidence. He also established the ‘Recovery Academy Australia’ (Recovery Academy Australia, 2016). There is significant international mobility, with recovery advocates travelling between different countries and presenting and holding recovery conferences (Roth, 2011).

Non-government and community recovery organisations have been central to the recovery movement (Best, 2012). In the United States, there is a great range of non-government organisations furthering the interests of people in recovery. Faces and Voices of Recovery (FAVOR) is one of these groups, and they are oriented towards political activity. The description from their website outlines an expressly political purpose, stating that they are
dedicated to organizing and mobilizing the over 23 million Americans in recovery from addiction to alcohol and other drugs, our families, friends and allies into recovery community organizations and networks, to promote the right and resources to recover through advocacy, education and demonstrating the power and proof of long-term recovery (Faces and Voices of Recovery, 2016b).

FAVOR engages in a number of activities to advance the interests of recovery organisations. The ‘Recovery Voices Count’ is a campaign that encourages the civic participation of people in recovery:

The goal is simple: to support recovery community organizations and their communities in developing and sustaining a constituency of consequence - an organized voice of people in recovery who are educated on key issues, vote on Election Day and hold elected officials accountable long after the polls close (Faces and Voices of Recovery, 2016a).

A similar organisation to FAVOR has emerged in the UK, called the Faces and Voices of Recovery UK (FAVOR UK) (Faces and Voices of Recovery UK, 2016). Like FAVOR in the US, FAVOR UK seeks to provide a voice for people in recovery, promote recovery activities (such as the Recovery Walk), and to work with other organisations to promote recovery (Faces and Voices of Recovery UK, 2016).

The level of organisation of the movement is highest in the United States and the UK; the movement appears to still be in its infancy in the Australian context. In the UK and the US, there are organisations that exist to organise and represent recovery community support organisations. In the US, there is the Association of Recovery Organisations. In the UK the ‘Recovery Federation’ is a Scottish organisation focused on supporting the development and linking up of Recovery Networks (UK Recovery Federation, 2015). There are the ‘Recovery Academies’ (noted in Table 7 above) which advance the recovery movement, but these organisations appear to be led mainly by academic, health and medical professionals in the drugs area. At this stage, there is no association or umbrella organisation of recovery organisations in Australia, and no organisation comparable to FAVOR. The most significant recovery organisation is the Recovery Academy Australia which was “founded as a voluntary association to promote and support activities that celebrate the reality of recovery from addiction — for individuals, their families, their communities and our wider society” (Recovery Academy Australia, 2016, p. 3). A
key part of the movement is the ‘recovery walks’, which have been organised across the US and the UK (Knopf, 2013; "Manchester welcomes UK Recovery Walk to the city," 2014), and also in Australia during ‘Recovery Month’ (September) (Best & Lubman, 2012; Stark, 2013). The Recovery Academy Australia has taken on responsibility for the ‘recovery walks’ in Victoria. Recovery walks are large organised walks to celebrate ‘recovery’.

Non-government organisations and actors have been central to advancing the recovery movement. The policy transfer and translation literature emphasises the role of social agency in determining the uptake of policy ideas from other jurisdictions: “Because ideas do not travel by themselves, policy actors, experts, states, and non-state actors, as well as organized and non-organized citizens, play an important role in translation” (Balen & Leyton, 2015, p. 103). In the case of the recovery movement, there is some evidence to support the work of particular non-state actors as being one of the key avenues driving policy change in the Victorian context.

**Drivers of Recovery in Victorian Policy**

The timely presence of recovery advocates in Australia contributed to the adoption of recovery principles by Victorian public authorities. According to the accounts of participants, and the analysis of documents, there were several factors that combined to provide the conditions that supported the adoption of recovery principles in Victorian AOD policy, including the presence of recovery advocates (David Best), the aligning of mental health and the drug and alcohol branches of the Victorian Health department, and the work that was underway to reform the drug treatment service sector in that state.

The interaction of recovery advocates and policy-makers appears to have been a key driver of policy transfer in the Australian context. In 2011, David Best, a prominent recovery proponent (as outlined above), travelled to Australia and began working at Turning Point in Victoria. Turning Point is an important organisation in the Victorian AOD field, providing treatment, research, policy advice and leadership in the field since it was established in 1994 (Turning Point, 2015). Through his position as
an Associate Professor in Addiction Studies at Turning Point and Monash University, Best acted as a policy advisor to the Victorian government. An ‘Australian Recovery Academy’ was also established, with Best as one of the advisors on this. A number of interviewees specifically cited David Best as a key driver of the adoption of recovery principles in Victoria. One participant explained the adoption of recovery in Victoria in this way:

> Recovery came to town a few years ago, it is a trend that’s occurred in America and the UK, and it sort of arrived with a vengeance in Victoria, largely due to a couple of individuals, one of whom was Dr — I mean I don’t think I’m breaching any confidentiality by naming names — but one of the key players in Victoria was Dr David Best, who was one of the very vocal exponents of recovery in the UK, and he took a position at Turning Point, and he gave enormous impetus to the recovery, the whole issue, and quality and recovery. A small group of people established the ‘Recovery Academy’, and again it was a couple of key individuals who were just tireless in pursuing the recovery agenda. (Interview 19)

This participant went on to explain how the presence of this key recovery advocate was influential in the incorporation of recovery ideas into the policy documents released at the time:

> What is interesting is that David Best has the ear of government, and that was largely how recovery found its way into the policies that were formulated during the reform period by the previous government. The language of recovery is scattered all throughout the documents that were issued throughout that reform process, and it is intriguing how that came about…I mean he’s now returned to the UK — Dr David Best has — so it was very much that coincidence of him being here at that particular juncture where policy was being reviewed and reformulated, and it is now part and parcel of the way treatment services have been, how they’ve been imagined and how they’ve been established, with recovery stuff. (Interview 19)

The desire to reform the AOD treatment sector in Victoria provided an important policy window for these policy actors to push recovery onto the reform agenda.

There have been several attempts at reform of the Victorian AOD sector since the 1990s (Ritter & Berends, 2016). As Ritter and Berends (2016) note that since 1994 there have been 5 documents outlining policy reforms of the AOD service system in Victoria. In their analysis of these documents, they state that the drivers of reform across these documents were generally consistent over time, and
included concerns around poor integration of services, disconnects between AOD and broader health and welfare services, poor service planning and concerns about quality of care (Ritter & Berends, 2016). The reform of the AOD treatment service sector was a major driver of ‘policy transfer’, as was the alignment of AOD and mental health bureaucracies, as this interviewee explains:

Yeah again it [new recovery] came out of predominantly the alignment between the drug and alcohol and mental health branches in the Department, and wanting to align some of the policy practices or elements that were going to — because the drug and alcohol and mental health services ended up being recommissioned and reformed at the same time, and there was a lot of work that was common that was going on in the department underlying that, and recovery in mental health had emerged as a real focus that was being driven by consumers, carers, and treatment providers. So it was raised and introduced with the sector. (Interview 12)

Although grassroots mobilisation is integral to ‘new recovery’, in the Australian context, the policy change behind the adoption of recovery has largely been led from the ‘top-down’; there has been less influence of organised grass roots recovery groups. David Best discussed this in an interview with William White, noting the resistance to recovery ideas amongst professionals in the Australian AOD field.

The embrace of the recovery concept has happened much, much faster by policymakers than by professionals involved in the treatment field. Many of the latter have been resistant to recovery ideas for a whole range of reasons. It’s been very interesting to watch this happen in Victoria… (White, 2012, p. 7)

The context in which the ‘transfer’ occurred in Victoria — the policy change being led by ‘policymakers’ rather than grassroots organisations, or professionals in the field — could partly explain the relative lack of rhetorical and material attention to supporting recovery organisations in the Victorian policy context (as highlighted in the comparison of recovery policy in the UK, the US and Victoria on p. ). In the next section, I explore how international and national NGOs have been central to the process of translating recovery policy in their respective jurisdictions, before turning to an analysis of how Australian NGOs modified and responded to policy ideas during the process of transfer.
Translating Recovery Policy in Domestic Contexts

In the US, the UK and the Australian contexts, non-government actors and agencies have been central not only to the ‘movement’ of new recovery, encouraging policy learning about recovery — as described in the ‘agents’ of new recovery and the recovery in policy section above — but also to the process of defining and debating the meaning of recovery, and thus translating recovery policy in their domestic contexts. In the US, the Betty Ford Consensus Panel has been influential in providing a definition of recovery for the US context, publishing an article on the topic in 2007 (The Betty Ford Institute Consensus Panel, 2007). In the UK, the United Kingdom Drug Policy Commission (UKDPC) has been actively producing documents and guidance regarding recovery in the UK context, and published a consensus document entitled ‘The UK Drug Policy Commission Recovery Consensus Group: A vision of recovery’ in 2008 (UK Drug Policy Commission, 2008). In Australia, in June 2012, the Australian National Council on Drugs (ANCD) convened the 1st Recovery Roundtable, which brought together a number of representatives from the non-government AOD sector to try and establish some consensus on recovery in the Australian AOD sector (Australian National Council on Drugs, 2012). Table 8 below compares the definitions of recovery contained in these consensus documents, as well as their positions on abstinence. There are considerable differences in the way that recovery is discussed across the documents.
## Table 8: Recovery consensus documents

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<th>Document</th>
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<tr>
<td><strong>Definition of recovery</strong></td>
<td>Betty Ford Institute Consensus Panel</td>
<td>United Kingdom Drug Policy Commission</td>
<td>ANCD 1st Recovery Roundtable</td>
</tr>
<tr>
<td>“A voluntarily maintained lifestyle composed characterized by sobriety, personal health, and citizenship” (The Betty Ford Institute Consensus Panel, 2007, p. 221)</td>
<td>“The process of recovery from problematic substance use is characterised by voluntarily-sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society” (UK Drug Policy Commission, 2008, p. 5)</td>
<td>None provided: “A key area of contention arose regarding the definition for recovery. Views ranged from existential to empirically-based opinions and information, including opposition to the use of the term at all and questioning its legitimacy if it could not be defined” (Australian National Council on Drugs, 2012, p. 1)</td>
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| **View of abstinence** | Central to definition: “Sobriety refers to abstinence from alcohol and all other non-prescribed drugs” (The Betty Ford Institute Consensus Panel, 2007, p. 222) | Control over substance use: “For many people this will require abstinence from the problem substance or all substances, but for others it may mean abstinence supported by prescribed medication or consistently moderate use of some substances (for example, the occasional alcoholic drink)” (UK Drug Policy Commission, 2008, p. 5). | That recovery does not mean that abstinence must be the goal for all people with alcohol and other drug problems (Australian National Council on Drugs, 2012, p. 1). |

That people seeking to either be abstinent, choosing to continue or unable to stop using drugs and alcohol all deserve effective assistance and support without facing unnecessary risks of harm to themselves or others (Australian National Council on Drugs, 2012, pp. 1-2).

Defining what exactly recovery is, and how it is achieved, appears to be a difficult task. As outlined in Table 8, a number of different definitions of recovery have been proposed. In the US, the idea of recovery was expressly linked with abstinence. The Betty Ford Institute (BFI) consensus document defines recovery as “a voluntarily maintained lifestyle composed characterized by sobriety, personal health, and citizenship” (The Betty Ford Institute Consensus Panel, 2007, p. 221), where sobriety is defined as “abstinence from alcohol and all other non-prescribed drugs” (Betty Ford Institute
The idea of recovery is also expressly linked with abstinence for US recovery organisations. For example, the FAVOR site explicitly discusses ‘abstinence-based recovery’. The UK document is more flexible about the idea of abstinence, characterising the process of recovery by “voluntarily-sustained control over substance use” (UK Drug Policy Commission, 2008, p. 5). The ANCD recovery roundtable notes that there was no agreed upon definition of recovery, and they did not come to one. The idea of abstinence was the subject of particular controversy. The roundtable report notes that there was agreement that recovery does not equate to abstinence: “recovery does not mean that abstinence must be the goal for all people with alcohol and other drug problems” (Australian National Council on Drugs, 2012, p. 1). All documents recognised individual variation in recovery ‘journeys’. The UK document emphasises that recovery is a continuum “towards which all services may contribute and the individual problem drug user is likely to require a range of different sources of help and support at different stages in their recovery” (UK Drug Policy Commission, 2008, p. 8). Similarly, the Australian document emphasises that people can take different pathways to ‘recovery’ and that recovery can take many forms, making continuity of care important. These differences in views on abstinence and approaches can be traced back to each particular countries’ drug policy systems and the way they have developed. As noted on pp. 209-212, historically in the US there has been a strong focus on abstinence in their drug policy, whilst the UK and Australia have embraced harm minimisation and harm reduction as guiding principles. The UK and Australian documents therefore make room for a range of services — including harm reduction services — along the ‘continuum’ of recovery.

The US and the UK consensus documents emphasise that treatment is not essential for someone to achieve recovery (The Betty Ford Institute Consensus Panel, 2007; UK Drug Policy Commission, 2008). The Australian document does not make a similar acknowledgement. In their comparison of the UKDPC document and the Australian Recovery Roundtable, Lancaster et al. (2015) argue that whereas in the UK document the drug using subject is painted as a responsible subject capable of managing their own drug use risks, in the Australian document the subject is ‘patientised’. There is a strong focus on

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58 An update in 2009 also reiterated that sobriety is abstinence.
drug treatment and services delivered by professionals for those deemed at risk, noting that the consensus in the ANCD Recovery Roundtable:

… illustrates that despite the apparent contestation between those advocating for recovery-oriented systems and those advocating for harm minimisation and the existing treatment system (including pharmacotherapy), both positions in their Australian context produce individual drug using subjects as being in need of curative intervention (Lancaster et al., 2015, p. 621).

While the place of recovery groups and mutual aid is acknowledged in the Australian document, there is little discussion or acknowledgement that people can ‘recover’ without treatment or services. The US document notes the role of mutual aid groups in recovery: “… there have been suggestions from the many individuals who attained recovery through mutual support groups or other informal methods that treatment is not necessary for recovery” (Betty Ford Institute Consensus, 2007, p. 226). The Australian document also recognises mutual aid groups: “That families and friends are very important in treatment and peer-support models are very effective, but are under-utilised and under-supported” (Australian National Council on Drugs, 2012, p. 2). The UK document notes that for services to become recovery-oriented requires a rethinking of the relationship between service users and professionals.

There is a key tension here between the role of experiential knowledge about recovery and professional knowledge. Zajdow (2001, 2004, 2005) has commented on the privileging of ‘scientific’ and expert knowledge in harm minimisation. She has produced several critiques of harm minimisation discourse, contrasting it with the discourse of twelve-step programs (Zajdow, 2001, 2004, 2005). She observes that although harm minimisation draws on a public health model, it opposes the disease model of addiction that underlies twelve-step programs. She argues that this presents a contradiction, in that harm minimisation actually increases drug users contact with health professionals: “harm minimisation is a remedicalisation of addiction with a more diffuse control over the individual; instead of the single general practitioner or psychiatrist, many other health professionals retain control” (Zajdow, 2004, p. 74). Twelve-step groups and recovery groups, on the other hand, act to undermine professional control, by privileging “group knowledge and individual experience over medical knowledge” (Zajdow, 2004, p. 74; Valverde, 1998; Valverde & White-Mair, 1999).
Negotiating and Resisting Recovery

NGOs area major provider of drug and alcohol services in Australia and particularly in the Victorian context; consequently, they are important stakeholders in drug policy. In the case of ‘new recovery’, there was considerable debate and discussion about recovery in Australia, amongst workers, and in the NGO sector. In Australia, the reaction of the AOD sector to ‘new recovery’, as apparent in the ANCD 1st Recovery roundtable, and other documents (Duke, 2013) (Anex, 2012a, 2012b; Australian Injecting and Illicit Drug Users League, 2012b; Queensland Network of Alcohol and other Drug Agencies, 2012; UnitingCare ReGen, 2012), as well as throughout my interviews with NGO representatives, was particularly reflexive about the politics behind ‘recovery’, both in terms of definitions and approaches, as well as its policy implications. Whilst organisations were receptive to the ideas of recovery, and noted that recovery already has an important place within Australia’s harm minimisation framework and its broad array of approaches (Australian Injecting and Illicit Drug Users League, 2012b; UnitingCare ReGen, 2012), the documents and interviewees highlighted some particular tensions and concerns in relation to ‘new recovery’.

A key concern in the negotiation and ‘translation’ of recovery policy in the Australian context was the very definition of recovery. Despite the apparent consensus in the ANCD 1st Recovery Roundtable Report that recovery does not have to equate to abstinence (as outlined above on p. 232), interviewees reflected back that this had been an ongoing point of concern. A number of interviewees indicated that for some, ‘New Recovery’ is still associated with abstinence and therefore has negative connotations. There are quite divergent views on the meaning of recovery. The understandings of recovery contained in the documents reviewed, and expressed by interviewees, can be broken into two broad categories: recovery means abstinence and recovery is a journey or continuum. The first, that recovery is abstinence position sees abstinence as the only legitimate goal of drug treatment. This view sees harm reduction programs and methadone maintenance as harmful, and as a continuation of addiction. Services should be oriented towards abstinence
To me, methadone is just keeping people on heroin, really isn’t it. It’s a heroin substitute but they’re still going to go out and get their heroin a lot of them. So they’re still drug addicted in a sense on the methadone. (Interview 9)

Similarly for another interviewee, while recovery could be a journey, the end goal should be abstinence:

So for me, New Recovery again, the term ‘New Recovery’ was a license for certain pro-drug advocates to redefine recovery. And recovery is about helping a person journey out of drug use as quickly, as effectively as possible, so ultimately they are drug free. Now it’s a journey, absolutely, so there might be drug use on the way. People fall, they may go back into drugs. They may use pharmacotherapy. But the intent, the endeavour, the absolute undeniable goal — like the Quit campaign — is cessation. That’s it. That’s recovery. (Interview 10)

The second perspective sees recovery as a continuum, where drug users may legitimately engage with a variety of different services, including harm minimisation services, along their own recovery journey. One participant, when asked about new recovery, noted the difficulty in defining recovery but that defining it as a journey allows a place for a range of services along that journey:

…if we say as they do that recovery is a journey then it’s got to start somewhere and people have to be safe while they’re starting the journey. So I would say in the early days for some people their recovery journey may involve in engaging with various harm minimisation strategies, and that’s for injecting drug users, using needle and syringe programs or maybe it would be the methadone program, it could be a controlled drinking program for people with alcohol dependence; so there’s a whole range of things. (Interview 6)

The struggle over the meaning of recovery is a significant one for policy, as indicated in the policy translation literature.

In some cases, NGOs engaged in active resistance against some of the more problematic elements of recovery policy. Interviewees, and the documents analysed, discussed the concerns around the payment-by-results framework that has been associated with recovery in the UK context. The ANCD Recovery Roundtable concludes that ‘recovery does not explicitly or implicitly support a ‘payment for results’ policy” (Australian National Council on Drugs, 2012). NGO representatives noted that Payment by
Results could impact services’ willingness to work with ‘difficult clients’, and thereby limit the services and options available to drug users:

I think what it means is, and what’s happened in the UK, is that services are less inclined to work with the most chaotic of drug users because they want to work with people who have the most chance at stopping using so again it feels like the more vulnerable people are left behind. It seems like that approach is having some influence here in Australia with the way our funding is going, and what we’re being required to do, and how we sort of have to disguise advocacy and disguise any real harm reduction in amongst everything else. So it definitely has a trickle-down effect, from those top-levels to the day-to-day, to the average person who uses drugs. These things affect their lives and their decisions. (Interview 14)

Several position papers produced by Australian AOD NGOs responded to the problems associated with ‘new recovery’ and funding for AOD services, making recommendations that pay by results be avoided (Australian Injecting and Illicit Drug Users League, 2012b; Queensland Network of Alcohol and other Drug Agencies, 2012). Whilst it is still early days, research from the UK indicates that the ‘pay for results’ schemes have had a negative effect on treatment retention and treatment completion (Mason et al., 2015).

In the Australian context, a range of other concerns were raised about ‘new recovery’, including its lack of evidence base, and the possibility that it was just a cover for a moralistic move towards abstinence-only services (Anex, 2012b; Australian Injecting and Illicit Drug Users League, 2012b). AIVL released a paper that questioned New Recovery’s conceptualisation of alcohol and other drug dependence as a ‘chronic’, ‘relapsing’ disease, and the harmful dichotomous categorisation of people ‘in recovery’ and those who are still actively using drugs (Australian Injecting and Illicit Drug Users League, 2012b). They also raised objections regarding the novelty of the ‘new recovery’ approach, noting the strong history of recovery organisations in Australia and the traditionally ‘pragmatic’ Australian approach arguing:

In this regard, the only genuinely ‘new’ element within the ‘new recovery’ agenda is that key new recovery advocates are seeking to replace our current pragmatic and evidence-based
philosophy and practice with a focus on a largely ideological and moralistic agenda (Australian Injecting and Illicit Drug Users League, 2012b, p. 5).

One interviewee noted their concern that ‘new recovery’ might lead to the preferential funding of abstinence-based services:

I find it very concerning. The word ‘recovery’ in drug and alcohol basically means abstinence-based rehabilitation leading to total abstinence, a disease-model twelve-step — not that there’s anything wrong with people going down those paths, but when it becomes public policy it’s putting all the eggs into a very small basket which really isn’t effective overall. If you take it to the degrees that someone like Bronwyn Bishop might do, it might mean that unless your service was actively getting people to be drug free, then you wouldn’t get funded. So perhaps services like ours would disappear. (Interview 17)

The economic discourses attached to ‘new recovery’ have been of particular concern for AOD NGOs.

In their commentary, AOD NGOs were reflexive about the political and economic implications of new recovery. Due to the funding environment in Australia, including cuts to public sector spending, the ANCD consensus document reflects economic concerns around the potential effect of recovery policy on resources in the AOD sector (Australian National Council on Drugs, 2012). The ANCD recovery roundtable report points out that the Australian AOD sector has been under-funded, and there was concern that recovery policy might lead to further under-funding as governments attempted to shift services on to mutual aid or self-help organisations that historically require less funding because they are staffed by volunteers (Australian National Council on Drugs, 2012). The move towards recovery-based organisations is synergistic with the push towards economic efficiency in neoliberal policy. An interviewee noted that mutual aid groups are a cheaper option than methadone maintenance programs or other treatment programs. When asked about ‘new recovery’, the interviewee explained:

Which is about the GFC and shifting stuff out of a government-financed sector to the self-help sector, isn’t it? Dressed up in the rhetoric of ‘the outcomes will be much better for the individual if they are better supported on exit from our treatment system by volunteers and mutual aid groups’, which do it for free generally. You want me to comment on that? The cynical part of me says it’s about getting stuff done on the cheap without the appropriate quality measure in
place, often by well-meaning people, because the system either can’t afford or has a different ideological bent to working with people with alcohol and drug issues. (Interview 13)

The discussion paper released by Anex also pointed to this tension in ‘new recovery’, noting that the lack of resources to support recovery policy in the UK should be a ‘lesson’ for Australia:

A lesson from the United Kingdom is that the new recovery philosophy is driving policy, but no additional resources required for systems-level transformation are forthcoming. If that was to be replicated in Australia it would most likely be highly disruptive and create harm that our public health approach seeks to prevent (Anex, 2012b, p. 1).

Economic issues have been highlighted by authors in the UK context. In her analysis of the shift to recovery policy in the UK, Duke (2013) notes the neat intersection between the recovery agenda’s emphasis on peer support and the government’s need to find efficiencies through public sector funding cuts. She observes that “it could be argued that drug policy has shifted its emphasis from harm reduction to crime reduction to resource reduction” (p. 49). As Duke (2013) notes, shifting some of the responsibility for support of people who use drugs onto voluntary and self-help groups is an attractive option for governments, because often these groups do not require public funding. Thus, instead of needing to provide increased funding to professional services to fulfil the emphasis on continuous care for drug treatment clients, ‘aftercare’ services can instead be provided cheaply by voluntary, self-help groups.

Overall, most NGO responses affirmed the appropriateness of harm minimisation as an overarching policy strategy in Australia, even where they were receptive to new recovery. The ANCD Recovery Roundtable Report notes that it would not be appropriate for recovery to guide overarching policy in Australia. It states that “recovery, regardless of definition, should not be the sole basis for a national drug strategy, particularly as it would tragically undermine the gains available from both harm and demand reduction” (Australian National Council on Drugs, 2012, p. 2). Similarly, other organisations emphasised the importance of retaining the ‘harm minimisation’ framework, and for ‘recovery policy’ to take account of the Australian context. The UnitingCare Regen document recommends dialogue
between recovery advocates, services, governments and stakeholders about how recovery fits with harm minimisation:

Australian providers of Harm Reduction-oriented services continue to engage with New Recovery advocates, Government and the wider community in frank and open discussion of the role of Recovery-oriented practice within Australia’s Harm Minimisation framework (p. 2).

QNADA’s Policy Position recommends that harm minimisation remain the overarching policy approach for treatment and prevention policy. The majority of these documents emphasise the important of Australia’s harm minimisation approach and the need for recovery policy to be implemented taking this into consideration. A number of participants in this study considered the recovery focus to be an obstacle to progressing future drug policy:

I understand harm reduction organisations are reluctant to talk about it because of what happened in the UK, where abstinence was seen as the end goal. We don’t ever want to see that here. I think what happened was that there was all this talk about ‘New Recovery’ but then it just kind of stopped, and I just think that this word now ‘recovery’ is a barrier to progressing drug policy. Even drug policy, people are afraid to use that word because of its connotations with abstinence-based services. And then you know the mental health sectors definition of recovery is different so it’s, yeah. (Interview 1)

On the whole, the AOD sector’s discussion of New Recovery in Australia was particularly mindful of the lessons of the policy experience in the UK, and the need to retain harm minimisation as an overarching strategy.

Recovery policy is still in its relative infancy in the Australian context. The most explicit example of ‘new recovery’ can be found in the Victorian adoption of recovery focused principles in its drug policy documents. Whether other jurisdictions in the Australian context will adopt ‘new recovery’ in policy remains to be seen. One informant expressed concern that recovery was already having an effect at the funding level, and that on a practical funding level ‘recovery’ and abstinence goals were already influencing contracts:

There’s real concerns there as well that that’s going to be the approach adopted nation-wide, and it seems to be quite apparent in Victoria where one of the sort of ‘new recovery’ advocates
is based at, it’s sort of already happening here to some extent whether it’s called ‘New Recovery’ or whatever the fuck it’s called. Because our funding is tied up with how many people we fuckin’ get to stop using or move towards counselling. (Interview 14)

This reflects more general moves of governments to implement outcome measures and linked funding requirements. These are relatively recent developments, and it is not yet certain how this will develop at the national level. The national drug strategies of the US and the UK feature recovery heavily. Although the most recent Australian National Drug Strategy (2010-2015) does mention recovery, it does so largely in passing and does not define or discuss the idea of recovery in any great depth; nor does it do so from a context explicitly connected with ‘new recovery’. The National Drug Strategy 2010-2015 includes the objective to “support people to recover from dependence and reconnect with the community” (Ministerial Council on Drug Strategy, 2011, p. 11). It acknowledges individual recovery pathways, and advocates centred-practice:

Treatment service providers can help individuals recover from drug dependence, help the individual access the internal resources they need (such as resilience, coping skills and physical health) and ensure referral and links to a range of external services and support (such as stable accommodation, education, vocational and employment support and social connections) (Ministerial Council on Drug Strategy, 2011, p. 11).

As Anex pointed out in their discussion paper, however, the term recovery is largely undefined in the NDS document (Anex, 2012b), and it is not yet clear whether recovery will feature in the new national drug strategy. As one participant reflected, new recovery is now part of the treatment landscape but how that is put into practice is another question:

So it is now part of our treatment landscape; it will be interesting to see how it actually plays out… how it looks once the new regime becomes more operational, but it’s certainly there in terms of concept in the way that the treatment landscape has been structured. (Interview 19)

This highlights the ongoing nature of the policy process, and the relevance of the policy translation literature in viewing ‘policy transfer’ not as a static thing but as a dynamic process where meanings shift and policy ideas are modified and adapted to their local context.
Lost in Translation? New Recovery in the Australian Context

Throughout this analysis, I have argued that the adoption of recovery policy in Victoria was largely symbolic. Consistent with the policy translation literature, non-government organisations and actors played important roles in both the circulation, transformation and negotiation of the meaning of recovery policy in the Australian context (Balen & Leyton, 2015; Stone, 2012). In particular, Australian NGOs highlighted some of the more problematic elements of recovery policy, and the importance of the local context and framework of harm minimisation already in place in Australian jurisdictions.

Dolowitz and Marsh (2000) note that there are three main factors in policy transfer that can have a significant effect on whether a policy succeeds or fails in the borrowing country: uninformed transfer, whether the borrowing country lacks sufficient information about the policy; incomplete transfer, where critical elements that facilitated the success of the policy in the transferring country are not transferred in the policy of the borrowing country; and inappropriate transfer, where “insufficient attention may be paid to the differences between the economic, social, political and ideological contexts in the transferring and the borrowing country” (Dolowitz & Marsh, 2000, p. 17). Drawing on this idea, then, it could be proposed that ‘New Recovery’ in the Australian context presents both a case of incomplete transfer and inappropriate transfer. It is incomplete, because some of the main elements that make up ‘recovery policy’ in the UK and the US have not been transferred — that is, government funding and support for recovery organisations and recovery activities. Arguably, it is also inappropriate because of the existing context and resilience of harm minimisation and harm reduction based organisations in Australia.

The chapter identified a number of factors relevant to the adoption and debate of recovery principles in the Australian context at the macro, meso and micro-levels. The macro in this context can be seen as the international context, of globalisation, shifts in the political economy of welfare and changing economic policies in reaction to ‘financial crises’, the influence of recovery policy in the US and the UK, and ideas and discourses around recovery, abstinence and harm reduction. Parallel developments can be seen in each jurisdiction in terms of attempts to reform approaches around public funding for
health and drug services. In each country there has been a concern to reform drug service systems to make them more efficient and focused on outcomes (Anex, 2012b; Duke, 2013; Mason et al., 2015). Recovery-oriented systems of care and related treatment system restructuring in the UK have been directly related to economic efficiencies, where the use of ‘payment for results’ have been a feature of these service systems (Duke, 2013). Further macro level changes include the influence of neoliberalism and the shift to responsibilising communities to address social problems as seen in the emphasis on the voluntary and self-help sector seen in recovery policy in the UK and the US (Garland, 2000). At an ideological level, the appropriate place of abstinence and harm reduction measures also featured in the recovery policy debates in each of these countries.

The meso level consists of the actual processes of policy transfer, the interactions between organisations and actors that facilitate the circulation of policy ideas: the relevant institutions and networks, including governmental agencies, ‘recovery champions’, bureaucrats and the new recovery ‘movement’ (social movement) (Mukhtarov, 2014). At the meso-level, networks of recovery advocates facilitated the uptake of recovery principles in the Australian context. The absence of a cohesive policy transfer network can be a significant obstacle to policy learning (Evans, 2009). As discussed on page 226, the recovery ‘movement’ in Australia is still relatively small at the ‘grass-roots’ level: there is no organisation that is similar to FAVOR in the Victoria or Australia, and no co-ordinating body for recovery organisations — there are few organised networks of recovery organisations in the Australian context compared with the US. The recovery academy that has been established in the Australian context was established by an AOD professional, and there is a lack of umbrella organisations or association or recovery organisations in the Australian context. Thus, the Australian ‘new recovery’ movement seems to be lacking leadership from organised groups of grass-roots recovery organisations. Second, in Australia there has been no clear government funding or support for recovery activities such as Recovery Month or Recovery Walks. Thus, ‘policy transfer’ has largely been symbolic because some of the main elements that make up ‘recovery policy’ in the UK and the US have not been transferred — that is, government funding and mobilised support for recovery organisations and recovery activities are absent.
At the micro level of analysis, the chapter explored how NGOs and the broad Australian AOD sector - those that are involved in implementing policy — negotiated elements of what is considered to make up recovery. Mukhtarov (2014) advocates that policy translation should focus on how policy actors engage with the movement of policy ideas across contexts and jurisdictions “by framing, re-framing and modifying the meaning of ideas that travel; engaging in constructing problems and solutions as pertinent to certain scales” (p. 76). NGOs promoted the learning of ‘negative lessons’ about recovery’, cautioning against some of the negative consequences of recovery policy in the UK. The concerns in the Australian context reflect both ideological and practical concerns around abstinence and harm reduction, as well as funding for drug services. There was concern that with the introduction of recovery policy, harm reduction services would no longer receive funding because they were not oriented towards getting clients ‘drug-free’.

The issue of abstinence versus harm reduction was a point of major contention in the Australian debate around New Recovery. Overall, the reaction of the Australian AOD NGO sector appeared to reaffirm the importance of harm minimisation as an overarching policy. Both the ANCD Roundtable and the ‘Recovery Academy Australia’ principles of recovery note that recovery does not require abstinence (Australian National Council on Drugs, 2012; Recovery Academy Australia, 2016). In the Australian context, what is considered important is continuity of treatment/services, having a range of approaches, and fighting against ‘siloing’ of services (Australian National Council on Drugs, 2012; Queensland Network of Alcohol and other Drug Agencies, 2012).

**Conclusion**

This chapter presented a multi-level analysis of new recovery as an example of policy transfer and policy translation. Although it could be argued that transfer did occur — features of recovery policy have been incorporated into Australian policy — the outcome was largely symbolic and lacks the substance that characterises recovery policy in the US and the UK. As opposed to being a direct copy
of the US and UK approaches, recovery policy in the Australian context is an example of hybridisation because it combines aspects of programs in other settings to produce a policy that is still relevant to the local context in the recipient jurisdiction (Evans, 2009). Recovery has been incorporated into the Victorian AOD treatment system, but is not seen to conflict with harm minimisation as the overarching policy framework. The response to ‘New Recovery’ in Australia illustrates the importance of historical, political and social contingencies in shaping the process of policy transfer, and the role of non-government actors in translating and negotiating policy ideas. The pre-conditions for recovery in the Australian context included dissatisfaction and repeated attempts at recommissioning of the drug treatment service systems in Victoria (Ritter & Berends, 2016). The strong history of harm minimisation — including harm reduction approaches — in the Australian context meant that recovery policy was not accepted uncritically, and the debate amongst NGOs (evidenced in the ANCD roundtable) largely ended in a reaffirming of the importance of harm minimisation as an overarching strategy. The more problematic aspects of recovery policy were highlighted by NGOs and actively negotiated in a national forum held by the ANCD, and through the release of policy positions by a number of NGOs. Abstinence was not seen as the only path to recovery, and recovery was seen as being able to fit under the framework of harm minimisation. The role of NGOs in the process was thus one of translation, negotiation and at times, active resistance.

The comparative dimension of this analysis has allowed for greater understanding of the influence of ideas in policy and of NGOs’ role in policy. The analysis presented here illustrates the complexity involved in NGO’s political participation, and the sometimes subtle and other times overt nature of advocacy, where organisations engage in acts of policy translation, negotiation and resistance. The following chapter explores these issues, and discusses how the findings in chapters 4, 5, 6, and 7 have broader implications for our understanding of the role of NGOs in drug policy.
Chapter 8: Discussion and Conclusion: Beyond Partnerships?

This study set out to consider the role of non-government organisations in drug policy, and more specifically, their relationships with governments and how this impacts on their policy work. Using extensive document analysis and interviews with 19 representatives from Australian NGOs, this thesis presented a critical analysis of some of the key issues facing NGOs in the drugs field. In this chapter, I draw on governmentality studies and other critical policy studies literature to explore the theoretical and policy implications of this study for understandings of government/non-government relations and the role of NGOs in the drugs field. The first part of the chapter summarises the major findings from the study in light of the research questions and discusses these findings in relation to the empirical and theoretical literature. Following this, the chapter outlines the broader implications and contributions of the research. The third section acknowledges the limitations of this research and makes suggestions for how this could be improved in future work. I conclude by offering some final thoughts on the relationship between NGOs, civil society and government in drug policy.

The research started from a problematisation of the idea of ‘partnerships’ between the government and the non-government sector in Australian drug policy. Throughout the analysis chapters, I have approached this idea in a number of different ways: through a genealogy of the idea of partnerships in policy, by analysing the conditions shaping the role of NGOs in the drug policy space, by analysing the positions of representatives from NGOs about their role in policy work, and through an analysis of new recovery policy in the Australia context. Each of these chapters built on each other to analyse different facets of government/non-government partnership rhetoric in the drugs field and the role of NGOs in drug policy. Below, I revisit the research questions framing this study and summarise the major points from my analysis before drawing these ideas together to discuss partnerships, inclusion and exclusion in the drug policy field in relation to the broader literature on drugs and criminal justice policy.
Review of the thesis

The objective of this thesis was document and analyse the role of non-government organisations in the Australian drug policy field and their relationships with government. To do this, several research questions were posed. Here, I will outline how each chapter responded to the research questions. Chapter 4 responded to the first research question, which asked ‘What are the key historical, social, and political conditions that have shaped government/non-government relations and the development of ‘partnerships’ in the drug policy field?’. The chapter analysed relationships between governments and NGOs in drug policy at the national level from the 1970s until the mid-2010s, with a particular focus on how the word ‘partnership’ came to figure into the national drug strategy. Overall, the chapter traced the ‘conditions of possibility’ for the current role of the non-government sector in contemporary drug policy through a genealogy of government-non-government partnerships in the drugs field. The chapter showed that several conditions contributed to the emergence of partnerships in the drug policy space.

One of the major ‘conditions of possibility’ for the current relationships between NGOs and governments can be traced to the emergence of drug and alcohol foundations from the 1960s, which allowed for the beginning of a professionalisation and creation of a drug and alcohol ‘sector’ that the government could engage with. This set the scene for the development of drug and alcohol peak bodies that we know today; peak bodies that now fulfil such important roles in the overall policy role of NGOs in the drugs field.

The broader relationships between governments and NGOs and changes in political strategy also contributed to the articulation of partnerships rhetoric and shaped the contemporary role of NGOs in drug policy. The influence of welfare ideas encouraged the growth of the community sector in the 1970s and 1980s, and the role of NGOs in AOD service provision was recognised and encouraged by state authorities during this period. The analysis presented in Chapter 4 highlighted how since the 1970s, the role of non-government organisations in drug policy has been expressed in relation to ‘community’; this is the site through which they are to operate, that they are to be identified with, to the extent of
responding, activating, working for/with and representing ‘the community’. But the image of community has shifted under neoliberalism.

The genealogy of ‘partnerships’ in national drug policy showed that whilst there is a long history of state-NGO relationships in this space, the actions of the Hawke government and the expansion of neoliberal policies since the 1980s laid the political foundations for the emergence of the rhetoric of government/non-government ‘partnerships’ in drug policy. More broadly, the neoliberal policies favoured by the Hawke-Keating governments led to a raft of political-economic changes and increasing contracting of the non-government sector for the delivery of services. With the introduction of the first national drug strategy — NCADA — during the term of the Hawke government in 1985, voluntary and community services were officially recognised in policy for their role in information, education, prevention and treatment activities. The chapter established, however, that evaluations of NCADA and its successors showed that NGOs did not feel they were properly involved in the planning, co-ordination or policy aspects of the strategies.

The combination of neo-conservative and neoliberal policies favoured by the Howard government allowed the ‘partnerships’ rhetoric to flourish in Australian drug policy. The idea of government/non-government partnerships was officially mobilised into the discursive landscape of national drug policy with the introduction of the National Drug Strategy ‘Building Partnerships’ in 1998 under the Howard federal government. ‘Building Partnerships’ formalised partnerships and introduced mechanisms to facilitate ‘partnerships’ with NGOs at the national level; in this context the Australian National Council on Drugs was introduced as a key mechanism to facilitate partnerships with the non-government sector. The Howard government was criticised, however, for favouring conservative, abstinence-oriented non-government organisations in political advisory structures (Mendes, 2001). At the same time however, funding for harm reduction services was increased under the Howard government; so the tendency towards conservative drug policy under the Howard government was by no means total. On a broader level, the Howard government was criticised for stifling the advocacy of non-government organisations through implementing gag-clauses on contracts, with commentators — including Julia Gillard —
describing NGOs as operating in a ‘climate of fear’ (Hamilton, 2004). The Rudd-Gillard Government also drew on a different kind of neoliberal discourse — a less authoritarian one — and implemented changes to try and repair relationships with the non-government sector with the National Compact between the federal government and the non-profit sector. This administration also initiated funding reforms of the health sector. Finally, the chapter highlighted how the federal government under Tony Abbott acted to undermine partnerships between the government and NGOs in the drug space through defunding the national peak drug and alcohol body, ADCA, and by restructuring the ANCD and changing its terms of reference to no longer include any mention of the non-government sector. The chapter highlighted how, at the same time, the Abbott-Turnbull government have drawn on neoliberal discourses in their commentary on drug policy. These issues illustrate the different ways that neo-conservative and social democratic political rationalities can influence the manifestation of neoliberal policy, a point also highlighted elsewhere by (O’Malley, 2002) in his comparative analysis of drug policy in Australia and the United States.

Chapter 5 built on the analysis in Chapter 4 by interrogating the different ways that neoliberalism has shaped the role of NGOs in the contemporary drug policy field. Chapter 5 addressed the second research question, which asked ‘What are the contemporary conditions shaping the role and work of NGOs in the Australian AOD field?’. The analysis traced four major discourses through which neoliberal political rationalities have problematised the drug policy field and impacted on the role of NGOs in drug policy: economic, scientific, instrumental and communicative. These represent distinct, but at times overlapping, ways of thinking and communicating about the government of drugs. The chapter showed that with the rise of neoliberal economic discourse, NGOs have been positioned as key deliverers of services. This economic discourse can also be located in the tendency towards an increased emphasis on efficiency, cost-effectiveness. NGOs were thought to have an edge in this context because they are considered more efficient at delivering services at lower funding levels. Tendering processes had benefits in terms of encouraging collaboration between services and drawbacks in terms of creating competition and mistrust; these issues have also been highlighted by (Spooner & Dadich, 2009, 2010) in their work on the Australian non-government AOD sector. The ongoing under-funding for the AOD
service system was highlighted as a major issue for the field, one that neoliberal economic discourses have certainly not helped. Broader government funding reforms across a number of jurisdictions (federal and state/territory) have been implemented recently with the aims of more efficient funding processes and accountability.

The chapter highlighted the trend towards neoliberal ideas in the AOD field, and the proliferation of techniques where governments are not generally seeking to shape individuals or organisations directly through state intervention, but indirectly by incentivising various forms of activity. We can see this is in the forms of funding provided, and the forms of activities encouraged by governments (workforce development, capacity building, and consumer involvement in treatment planning). Governments have provided incentive structures through funding requirements for NGOs to participate in their own ‘capacity building’. NGOs have also problematised their own capacity and that of the AOD workforce, instituting various professionalising and capacity building activities. These developments reflect the push to ‘professionalise’ the alcohol and other drug field that began with the formation of drug and alcohol foundations in the second half of the 20th Century.

Contemporary Australian drug policy draws on a clear instrumental discourse centred around the goals and practices of ‘harm minimisation’, where the non-government sector is positioned as playing an important role in terms of demand reduction and harm reduction. The overarching policy vision of ‘harm minimisation’ created particular relations in the policy field: although most participants expressed support from this overarching policy vision, the balance between pillars was a point of contention. Some participants felt that there had been too much of an emphasis on law enforcement, whilst others felt that the balance had shifted too much towards harm reduction, and would prefer more of a focus on prevention. A clear ‘scientific discourse’ was also evident in the policy documents with the push for ‘evidence-based services’ and ‘evidence-based policy’. This scientific discourse coalesces somewhat with the push for cost-effectiveness and efficiency, as well as instrumental ways of thinking in that ‘evidence-based services’ are equated with ‘effective’ services.
The final part of Chapter 5 established that there has been a strong tendency for contemporary drug policy documents to mobilise a communicative discourse that positions NGOs as important partners in governance in drug policy. The influence of ideas around governance and cross-sectoral partnerships has meant that NGOs are involved in governance instruments such as stakeholder reference groups, steering committees; public consultation processes are now more formalised and routine. Since the introduction of the *NDS Building Partnerships*, partnership rhetoric has become increasingly central to federal and state/territory drug policy discourse (Ministerial Council on Drug Strategy, 1998). NGOs have been explicitly recognised as partners in the strategy, and the state and territory documents also similarly state that NGOs are partners in the strategies (along with consumers).

All this is not to suggest that there has been a wholesale offloading of services onto NGOs, or a neat and clear direction of neoliberal ideas taking over the AOD sector. Indeed, the implementation of neoliberal ideas has been patchy at best. Chapter 6 explored this idea further by problematising the idea of ‘partnerships’ at the policy level. While I would argue that there has been a ‘normalisation’ of partnership rhetoric in drug policy and some associated techniques and themes, this normalisation means that it is also now somewhat of a ‘taken-for-granted’ idea. The degree to which structures and practices and power relations actually reflect the discourse of ‘partnerships’ is another matter. The chapter addressed the third research question, ‘What is the relationship between the rhetoric of government/non-government ‘partnerships’ and the experiences of NGO representatives in drug policy processes?’ Drawing primarily on the experiences and opinions of representatives from NGOs, the chapter discussed a number of dynamics impacting on the ‘partnership’ relation at the policy level. The rationale for NGOs involvement in drug policy was articulated in relation to their role in service provision, and their ability to represent clients and service users and ‘the community’. There was a sense that governments recognised that NGOs could play a role in policy processes thanks to heavy involvement in service provision and their position in relation to community. Participants also expressed a sense of responsibility as well, in terms of representing community, representing people who use drugs, and representing service users and clients. Through the analysis conducted in Chapter 6, I identified a number of dynamics creating practical opportunities and challenges for NGOs in the drug
policy space. Table 9 below summarises these opportunities and challenges, according to the broad themes of representation and participation, drug policy politics and relationships.

Table 9: Opportunities and challenges for NGOs in Australian drug policy

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Challenges</th>
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| **Representation and participation** | • NGOs perceived as a relatively minor player  
• Tokenistic inclusion?  
• Need for more systematic and formalised mechanisms for input into policy  
• Government actions to undermine drug policy mechanisms (e.g. changing ANCD to ANACAD and membership; defunding peak body ADCA etc.)  
• Drug user organisations still struggle to be part of policy discussions  
• Representation: lack of harm reduction peak body, lack of national Aboriginal drug and alcohol peak body (defunding of NIDAC)  
• Lack of ‘voice’ in the NGO/Community AOD sector (sometimes ‘forgotten about’); perception that other areas (e.g. mental health) have more voice  |
| • Important role as an ‘expert body’ because of service delivery activities, connection to community and independence from government  
• Greater opportunities to contribute to policy: sitting on committees and stakeholder reference groups  
• Consultation has become more formalised and routine  
• Consumer engagement models and opportunities for people who use drugs to be invited to policy discussions  |
| **Drug policy politics** | • Greater funding for supply reduction; prevention and harm reduction relatively under-funded  
• Drug policy as politically risky; slow policy change or ‘reactive’ or populist policy-making  
• Criminalisation and exclusion of voice of people who use drugs  |
| • Harm minimisation — NGOs important role in treatment, prevention and harm reduction  
• Evidence-based policy  
• Bureaucratic policy-making  
• State-led innovation in drug policy  |
| **Relationships** | • Restrictions on advocacy — explicitly through contracts or through implications of power differentials in funder-provider relationship  
• Reluctance to cite advocacy as part of work — preference for ‘representation’  
• ‘Hidden conflict’ in the sector  
• NGOs desire more transparency and communication from government  |
| • Strong partnerships described - collaboration across NGOs, with researchers, and with other fields (mental health, housing etc.)  
• Formation of issues-based coalitions  
• Consumer engagement models providing greater opportunities for people who use drugs to be part of policy discussions  
• Opportunities for different forms of policy work, collaborative policy work with government agencies |
The chapter highlighted some of the realities and tensions of the contemporary Australian drug policy environment. The discussion about ‘drug policy politics’ highlighted some of the politics of inclusion and exclusion in this policy space. In discussing the politics of evidence in the Australian drug policy arena, the chapter noted some of the tensions between evidence-based policy and political imperatives to secure popular support. The complexity of relationships in the drugs field shapes how NGOs might contribute to policy. Government/non-government sector partnerships have presented different opportunities for non-government organisations to participate governance instruments such as consultation processes and stakeholder reference groups and committees. This has seen a move towards more collaborative approaches to policy-making, as opposed to critical public advocacy (Cada & Ptácková, 2014).

As outlined in Table 9, there are a number of challenges for the non-government sector’s role in Australian drug policy. There are power differentials inherent in government/non-government partnerships where the relationship is that of funder and provider: this creates a situation where organisations are reluctant to criticise government policy as it can present a risk to their ongoing funding. Participants described avoiding the term ‘advocacy’, and instead preferred to use other terms such as ‘representation’ or ‘advice’. The problem of tokenistic inclusion was also mentioned by participants — this is a particular concern with public consultation processes. Changes to forums for NGOs to contribute to drug policy processes present another challenge. Recent bureaucratic changes have acted to undermine the representation of the non-government sector in national drug policy, for example through defunding the national peak body representing the alcohol and other drug sector, and by restructuring governance frameworks created to facilitate partnerships at the national policy level.

Chapter 7 addressed the fourth and final research question, ‘How have NGOs’ engaged with, and attempted to shape, drug policy?’ using a focused analysis of ‘new recovery’. The analysis brought together the historical and contemporary context to explore some of the different elements involved in NGO policy work in the drug field, and the influence of international developments in the field and the
way these are negotiated in policy processes. Using the framework of policy transfer, the chapter
identified a number of factors relevant to ‘new recovery’ in the Australian context at the macro, meso
and micro-levels. The macro in this context can be seen in shifts in the political economy of welfare
and changing economic policies in reaction to ‘financial crises’, the influence of recovery policy in the
US and the UK, and ideas and discourses around recovery, abstinence and harm reduction. The social,
cultural and political contexts in the US, the UK and in Australia, whilst quite different, do share some
parallels. In each of these countries there has been a concern to concern to reform drug service systems
to make them more efficient and focused on outcomes. The influence of neoliberalism and the shift to
responsibilising communities to address social problems can be seen in the emphasis on the voluntary
and self-help sector in recovery policy in the UK and the US. The rhetoric of ‘new recovery’ is
consistent with the neoliberal economic imperative to cut costs (recovery support organisations are
cheaper options to support than pharmacotherapy or more intensive treatment options).

‘New Recovery’ holds several attractions at this macro-political level. Recovery blends neoliberal
emphasis on responsibility with something that satisfies neo-conservative ideals and the prohibition
regime: a ‘recovering’ subjectivity (Walmsley, 2012). In this vein, if governments are seen to support
the ‘recovery movement’, they are not supporting the use of drugs but rather supporting citizens who
use drugs to conform to a more socially acceptable subjectivity of being ‘in recovery’ from drug use.

Recovery could be seen to carry less ‘political risk’ than perhaps harm reduction does because it is more
compatible with the current paradigm of criminalisation and the conservative element in politics, and it
does not seek to challenge this dominant paradigm. Implementing recovery focused policy is generally
compatible with international treaties and declarations, whilst pushing the boundaries of ‘harm
reduction’ policy is far more likely to draw unwanted attention and likely violate international treaties.

At the meso level, the chapter identified some of the relevant institutions, policies and networks making
up the new recovery social movement. At the meso-level, networks of recovery advocates facilitated
policy transfer in the UK (Walmsley) and then in the Australian context. Despite grassroots mobilisation
is a key aspect of ‘new recovery’, in the Australian context there has been less influence of organised
grass roots recovery groups. The recovery academy that has been established in the Australian context was established by a professional in the drug and alcohol field, so the Australian context lacks leadership from grass-roots recovery organisations. There are few organised networks of recovery organisations in the Australian context compared with the US. The absence of a cohesive policy transfer network can be a significant obstacle to policy learning (Evans, 2009). There has been a lack of material public support in the form of government funding or support for recovery activities in the Australian context when compared with the UK and the US. Thus, ‘policy transfer’ has largely been symbolic because some of the main elements that make up ‘recovery policy’ in the UK and the US have not been transferred — that is, government funding and support for recovery organisations and recovery activities are lacking.

At the micro level of analysis, the chapter explored how NGOs and the broad Australian AOD sector — those that are involved in implementing policy — negotiated elements of recovery. NGOs promoted the learning of ‘negative lessons’ about recovery’, cautioning against some of the negative consequences of recovery policy in the UK (for example, payment by results). The issue of abstinence versus harm reduction was a point of major contention in the Australian debate around New Recovery. There was concern that with the introduction of recovery policy, harm reduction and other services would no longer receive funding because they were not oriented towards getting clients ‘drug-free’. The chapter also illustrates some of the tensions between experiential knowledge and professional knowledge as well, and the struggle over authority — who is better placed to help ‘addicts’ to ‘recover’. NGOs in the Australian context appeared to negotiate some of the more problematic elements of recovery policy through the consensus process in the ANCD recovery roundtable, with the report stating that recovery does not equate to abstinence. Recovery was considered an inappropriate concept to guide any over-arching policy framework, but it was not seen as incompatible with the harm minimisation framework. The reaction of the Australian AOD NGO sector appeared to reaffirm the importance of harm minimisation as an overarching policy. The chapter highlighted how NGOs acted as negotiators, translators and at times, in resistance, to recovery policy. NGOs negotiated some of the more problematic aspects of the policy, translated the policy into the Australian context by affirming the
importance of the existing framework of harm minimisation, and at times, actively resisted recovery policy by denying its appropriateness in the Australian context.

**Partnerships, Inclusion and Exclusion in the Policy Process**

Overall the analysis presented in this thesis illustrates the complex ways that the contemporary Australian drug policy system has been both opened up and closed off to NGOs. The rise of neoliberal political rationalities have resulted in the proliferation of tactics and strategies that seek to ‘govern at a distance’, and stimulate the actions of a diverse range of stakeholders in projects of governing. Whilst NGOs have long had a role and relationship with government in the AOD space in Australia, the popularisation of partnerships rhetoric has increased the recognition of the role of NGOs in governance processes. Here, I agree with Colebatch (2009), who argues that “what is new is not the involvement of ‘non-government’ in the bureaucratic state; it is the official recognition of the governing being done by nongovernment and its incorporation in the organisation chart “ (Colebatch, 2009, p. 65). The language of partnerships provides a framework for understanding how the state and the non-government sector are to work together in the governance of drug use, implying a reconfiguration of the relationships between state, private and civil society from a hierarchical one to a horizontal one based on collective effort (Rose, 1999). This idea is reflected in international work on the related idea of ‘good governance’ in the drugs field — Singleton and Rubin (2014) noted that stakeholders considered the good governance framework to be idealistic although “difficult to disagree with” (p. 940), and the authors concluded that frameworks such as ‘good governance’ should not act as prescriptions, but rather as “heuristics that help provide insights and open-up thinking about potential solutions” (p. 940). Indeed, the very notion of partnerships problematises the relationships in the policy domain, suggesting that there is fragmentation and un-coordinated action, and that the solution to this is to work in partnership instead. Partnerships signify a pooling of resources, knowledge, and practices — collective action around shared goals. In terms of the policy process, partnerships discourse implies that NGOs will have the ability to input into policy and affect decision-making.
Evidently, based on the analysis presented in this thesis, there is still a gap between the policy goal of ‘partnership’ and what is actually implemented in the Australian drugs field. Participants in this study generally reflected the idea that ‘partnerships’ in the policy process remained more of a theory or goal than a reality of the current political environment. The inconsistency between partnership rhetoric and relationships in practice has been identified in other studies of partnerships in diverse areas (Crawford, 1999a). In their analysis of community policing discourses, O’Malley and Palmer (1996) write that “the partnership relation is often an illusion at the level of practice” (p. 145). This idea is also reflected in studies of partnership relations in the context of the drugs field. In his study of partnerships between the state and drug user organisations in Australia, Lucas (2011) concluded that partnerships operate at little more than the level of rhetoric. The analysis presented in this thesis adds to these assessments of partnerships in the drug policy space. The analysis demonstrated that whilst NGOs are being recognised and engaged in policy processes, the degree to which they feel legitimately ‘heard’ in the policy space differs.

The relationships between NGOs and governments and other stakeholders in the drugs field are of course considerably more complex than is presented by the ‘partnerships’ discourse. This research identified a number of dimensions of state/NGO relationships in the drug policy field that deviate from the ideals of partnership rhetoric. The first way that the partnerships ideal is not being met is in terms of representation and institutional mechanisms to facilitate NGO representation and participation in policy processes. This presents somewhat of a paradox in that there has been quite significant emphasis on partnerships and collaboration with NGOs in the drug policy space, yet the institutional mechanisms that had been created to facilitate this at the national level have been eroded (for example, through the defunding of ADCA or the changes to the ANCD). Second, the politics of the drugs field shape the degree to which NGOs are afforded a legitimate place in policy discussions. Third, relationships in the drugs field — partnerships/contractual relationships between governments and NGOs might have led to more collaborative working arrangements, but there is a power differential here. Government control of NGOs activities, in particular the active discouraging of ‘advocacy’, is a key concern. There are a number of possible consequences that stem from a purely state-driven agenda in the drugs field,
including the hampering of productive working relationships between NGOs and governments, the stifling of innovative policy responses from NGOs and the stagnation of drug policy frameworks. In short, the findings in this thesis show how the “situated politics” of the Australian drugs field could perpetuate the marginalisation of some voices in different drug policy debates (for example, people who use drugs, prevention-oriented organisations, Aboriginal drug and alcohol organisations), and how some of the actions taken by governments have acted to undermine the representation and participation of NGOs in drug policy.

The material presented here challenges the ‘network governance’ or ‘decentred governance’ narrative. As McKee (2009) notes, in contrast to governance, “a governmental analysis highlights that less direct government in society does not necessarily entail less governing” (p. 419). In many examples discussed in this thesis — the defunding of ADCA or the funding reforms, for example — the state has taken a more direct role than is suggested by the decentred governance thesis. As such, in these examples:

…the state retains its capacity to decide how and where to use different coordinating mechanisms, and regulates the interaction between different systems (for example, deciding when, and through what mechanisms, to replace a state-run service with one delivered through the market, or to implement its policy programme through partnership rather than through existing hierarchies). It decides how far and in what ways to provide material and symbolic support for proposals emerging from the complex pattern of policy networks (Newman, 2001, p. 19).

The analysis presented throughout this thesis showed the influence that the state in terms of the form that advocacy or policy work can take, as well as what organisations survive and which disappear. The respective roles of different NGOs and the roles afforded them by government is fluid according to time, situation, issue and location. Certain NGOs may be privileged in drug policy by different political administrations, at different points in time or in responding to particular kinds of drug issues.

Whilst it might appear that there are tensions in the decentralising and recentralising effects of these techniques, these are actually central to the operation of neoliberal government and policy (McKee, 2009). As Crawford (1995) notes trends towards partnerships and “appeals to community” are
characterised by tendencies towards both decentralisation and re-centralisation: “There exist conflicts between greater privatisation and voluntarisation of crime control through "community involvement" and the greater mobilisation of control at the centre” (Crawford, 1995, p. 119). As Rose and Miller (1992) note though:

…a ‘centre’ can only become such through its position within the complex of technologies, agents and agencies that make government possible. But, once established as a centre, a particular locale can ensure that certain resources only flow through and around those technologies and networks, reaching particular agents rather than others, by means of a passage through 'the centre' (p. 189).

Political authorities use a range of tactics to create the environmental conditions that conducive to achieving their objectives and to activate action on the part of non-state actors.

Centralised governments use economic controls to “set key dimensions of the environment in which private enterprises and other economic actors must calculate” (Rose & Miller, 1992, p. 189). This can be seen in the example of the relationship between contracts for service delivery and its impacts on policy advocacy. The state, at times, tried to discourage critical policy work through particular instruments such as conditions on contracts — this can be seen in the example of the implementation of ‘gag clauses’ on funding contracts to ‘stifle’ critical advocacy. At the same time, however, NGOs have also developed their own tactics and strategies to negotiate these limitations. Almog-Bar and Schmid (2013) note that recent years have seen an increase in the usage of “insider, institutional, and less aggressive tactics” by NGOs (p.11), tactics which Onyx et al. (2010) describe as “advocacy with gloves on” (p. 43). They discuss several factors that may have contributed to this situation, including the growing mutual dependency between NGOs and the state and increased collaboration on program design and implementation (Almog-Bar & Schmid, 2013). Additionally, ‘insider’ tactics, as opposed to confrontational tactics, may prove more conducive to establishing relationships of influence with government agencies and officials (Almog-Bar & Schmid, 2013). These kinds of trends were evident in this study. The representatives of NGOs in the drugs field I talked to described engaging in more collaborative policy work, and not engaging in ‘critical advocacy’, for example by not speaking out in
media. Consequently, both state and non-state actors engage in a kind of pragmatism to manage the relationships inherent under partnerships and to activate the desired kinds of activities of partners.

The partnerships rhetoric can be seen as a technique of neoliberal government through which NGOs are mobilised to act on drug use. It is through partnerships that NGOs act as mediators of the relationship between citizens — in this case, drug users — and political authorities, acting as a site through which the “community” can act upon drug use (Thomas et al., 2016). Accordingly, there is a synergy between what Rose (1999) calls ‘governing through community’ and the idea of governing drug use through partnerships. Rose (2000) notes, “increasingly, it is the language of community that is used to identify a territory between the authority of the state, the free and amoral exchange of the market, and the liberty of the autonomous, rights-bearing individual” (p. 1400). It is through the ‘community’ that social problems, and by extension the socially problematic, are to be addressed and managed (Rose, 1999). Rose (2000) highlights the moral authoritarian principles operating through this shift, where “the community” becomes “a means of moral reformation for lone parents, feckless idlers, drug addicts, and so forth” (p. 1409).

The political attraction of deference to ‘the community’ in policy rhetoric lies in its flexibility — it can be harnessed for a range of purposes — and its broad appeal to both neo-conservative and social democratic leanings. Cohen (1985) notes the political appeal of the word community to “both the left and right” (p. 117). Non-government organisations can be understood somewhat as the organised element of community. Their heavy identification with ‘the community’ can be a blessing as well as a curse, as it provides NGOs with a clear area of expertise and role in terms of representing ‘community’ in policy processes, but these appeals to community in policy can also justify greater denial of responsibility on the part of the state and the avoidance of broader, more difficult and politically-risky reform. In a sense, appeals to community and partnership can be used as a rhetorical device for making it look like the state is doing something, without actually doing much.
This positioning means that the community — individuals, organisations and other non-state agencies — must take on responsibility for social issues (Rose, 1999). Whilst Cohen (1985) views the assemblages of control that are administered in the name of community as an “essentially negative and constraining” (Rose, 1999, p. 176) formation of social control, Rose (1999) views these assemblages as a productive form of power; communities are activated and responsibilised to take responsibility for their own wellbeing. I tend to agree with Rose (1999), that this is not necessarily a negative, constraining form of power — although perhaps it has been exercised in this manner at times. We should, however, be wary of the shift towards community and individual responsibility for drug problems that the discourses of ‘partnership’ represent: whilst it may be that the community have an important role to play in addressing problems related to drugs, the danger lies in the increasing focus of the community as the only site through which these problems can be addressed.

In positioning the community as a policy solution and placing the responsibility for social problems on communities, governmental discourse is able to side-step those broader socio-economic and political factors beyond the control of communities that still influence and shape drug problems. These factors include poverty, homelessness, unemployment, deprivation and local issues that might have a basis in broader social policy (Rosewarne et al., 2007). In his critique of Garland’s (2001) ‘Culture of Control’, Young (2003) makes a strong argument about the dangers in over-relying on, and encouraging, these partnerships as forms of the administration of crime control and for placing the onus squarely on communities in solving issues of social order:

It assumes quite fancifully that the knowledge of how to deal with the massive problems of deprivation and resentment is actually present out there in the neighbourhood. Even if the knowledge were there — which it usually isn’t — the power to make any difference would be absent. I am not sure how the tackling of the gross inequalities which exist in our society can be dealt with on a local level nor how the massive problems of breakdown of work, family, community can be solved locally, although of all other these things must of necessity involve a local component. Once again this would seem to turn problems of the macro-level into problems of situation (p. 240).
Macgregor and Thickett (2011) too note the constraints on the ability of ‘communities’ and the limitations of localism in addressing the complex problems that are sometimes assigned to the realm of the local.

There are issues that ‘communities’ have little hope in changing, because they largely remain the domain of the state. There are a broad range of constraints on the ability of NGOs, and ‘communities’ to contribute to and shape drug policy. At the macro-level, of course, is the international drug control system and how it shapes domestic policy. International organisations, such as the UNODC remain influential players in maintaining the international drug control regime. They also have an, albeit less vocal or visible, role in national and other jurisdictional policies. Hellman et al. (2016, p. 3) note that “invisible external stakeholder communities”, such as international agencies, can exert influence on domestic policy. Discourses of community and partnerships tend to bypass these wider socio-political structures that also help determine and shape problems related to drugs: prohibition, criminal justice practices and policies, social exclusion related to criminalisation, lack of services, and other social policy. As such, these kinds of issues cannot be addressed by communities or individuals alone, but require governmental intervention from the state to change legislation and practice. For drug policy to become more ‘democratised’, as is promised by these discourses of partnership and stakeholder consultation, there needs to be a recognition of some of the limitations on the ability of NGOs and communities to actually tackle some of the ‘problems’ related to drug use, without governmental and wider structural reforms.

As many authors in the drugs and crime policy field have noted, there are limits to evidence-based policy-making; thus the representation of different experiences and values in the policy-process is important in the drugs field (Monaghan, 2010, 2011; Roberts, 2014). Roberts (2014) argues that “issues in drug policy are inherently contestable”, involving “normative and evaluative issues that are properly political” (p. 952). I agree when Roberts (2014) further argues that policy processes should be based on ‘evidence-informed pluralism’, where public consultation and engagement with multiple stakeholders can inform an ongoing, iterative process of policy development in the drugs field. As such, non-
government organisations can represent an important touch point and source of ‘counter-discourse’, “to challenge the governmentality of the state by creating a space for marginalised people to speak out and critique the state” (Carey, 2008, p. 19). But this can only happen where the state, and the non-government sector, both make space for the representation of difference in the policy process.

If we accept that part of the role of consultation processes and stakeholder engagement is the representation of different opinions in the policy process, including the representation of marginalised voices, then it is clear that some of the dynamics of government/non-government relationships in the drug policy space act to undermine this. Whilst trends towards collaborative policy can of course be viewed positively, there are also challenges associated with under-representation of difference in policy processes that are based on these ‘insider negotiations’. This includes the under-representation of marginalised voices, the over-representation of strategic interests according to who is allowed to participate and who has ‘the ear’ of government. For drug policy to become more ‘democratised’, as is promised by these discourses of partnership and stakeholder consultation, there needs to be a recognition and inclusion of ‘difference’ in policy consultation and stakeholder engagement, and a serious consideration of some of the limitations on the ability of NGOs and communities to actually tackle some of the ‘problems’ related to drug use, without governmental and wider structural reforms.

**Contribution and Implications**

This thesis contributes to the growing drug policy literature on governance and stakeholders in drug policy both on an empirical level, and a theoretical one, through a detailed qualitative study of the role of NGOs in drug policy. The empirical contribution lies in the qualitative documentation of both the historical and contemporary role of NGOs in drug policy, their relations with governments, and the presentation of new data relating to their role in policy. The thesis also makes an original contribution to knowledge by exploring the nuances of NGOs’ role in drug policy through a focused analysis of ‘New Recovery’ in the Australian context. It adds to understandings of how governments have positioned NGOs in this area, how NGOs have contributed to drug policy, and some of the tensions and
challenges for their role in drug policy. As highlighted in my discussion of the interview data for this project, those in the drug and alcohol sector are already reflexive about their practice and the field in which they work. Whilst some of this information contained in this thesis may be old news to practitioners in the field, in documenting and reframing some of these ideas the hope is that this work can provide a new perspective for reflection on the past and potential ways forward.

Whilst governments, NGOs and other stakeholders recognise the importance of governmental and non-governmental action in the drugs field, questions still remain as to how best to structure and co-ordinate that activity, and the best mechanisms to facilitate ‘partnerships’ in the drug policy environment. The weakening of representative bodies — such as the national peak body, ADCA, the ‘demotion’ of the ANCD, and the decommissioning of NIDAC — in the drugs field present significant problems, considering the importance of formal institutional mechanisms such as peak bodies for mediating the relationship between non-profit organisations and governments (Elson, 2011). The resistance to including consumer representatives, people who use drugs and drug user organisations in policy discussions remains a challenge that needs to be addressed. The concern, then, is the creation of mechanisms to allow the effective and broad representation of the whole range of positions that exist in the non-profit drug and alcohol sector. Overall, the best mix of mechanisms for representation and inclusion of NGOs in the policy process remains a question for the Australian AOD sector.

Limitations and Future Research

The methodological approach chosen is one of many that could be used to study the topics addressed by this thesis. Governmentality studies have a number of limitations. Research using governmentality has been criticised for refusing to make normative prescriptions, lacking any useful recommendations about what ought to be done, and for overly focusing on rhetoric at the cost of practice and experience. In this study I have tried to address these methodological limitations by adopting the approach of ‘realist governmentality’, and including a wide range of methods in the methodological repertoire of this research. There are, however, a number of areas that could be fruitfully addressed in future research, as outlined below.
First, future research could take a more applied approach to understanding the ingredients that make for productive NGO-government relationships in the drugs field. Although this thesis pointed to the fact that particular jurisdictions might enjoy ‘better’ relationships than others (for example WA and the ACT), it is not within the scope of this thesis to investigate exactly why this might be the case. Whilst this study has provided rich qualitative data on some of the dynamics of government/non-government relationships in the drug policy field, the methodological approach chosen directed my attention away from positivist questions of cause and effect — of exactly how government funding shapes advocacy activities and best practice models of government/NGO relationships in this policy space. Future work could fruitfully take a mixed method approach to these questions involving quantitative surveys of funding sources and advocacy activities supplemented with qualitative interviews of representatives from NGOs and governments to understand motivations behind funding and advocacy activities. To better understand policy advocacy and relationships in the drugs policy field, future research could use forms of social network analysis to investigate funding relationships, advocacy activities and policy networks in the Australian drugs policy community. Whilst good governance models a theoretical frame for understanding some of the ingredients of best practice, empirical research would assist in identifying the practical mechanisms and actions that facilitate good relationships in the drug policy space.

Second, a comparative mixed-methods case study design could be used to investigate and compare ratings of relationships between governments and NGOs and policy ‘conditions’ across jurisdictions. Shifts in the location of drug and alcohol policy in government departments (seen for example in the trend towards the melding of AOD and mental health) and changes in methods of funding impact on the power relations between stakeholders in the drugs field. The impact of the location of AOD policy in government departments is a question, as Ritter (2011) notes, that has largely been unaddressed in research to date. With the changes in funding regime at the national level, whereby organisations will be funded by local primary health networks (PHN’s), the question remains as to whether we may see a shift back to an emphasis on ‘medical’ ownership of drug problems and an emphasis on ‘addiction’ or dependence/disorders rather than harm reduction strategies. The growing reliance on contracting out of
the administration of health program funding (as in the Primary Health Networks at the federal level) will likely also have effects on NGOs in the drugs field. Similarly with the move to incorporate drug and alcohol with mental health even further in most jurisdictions, as well as the defunding of preventative health, it will be important to consider the implications of these moves for power relations and the potential exclusion or diminishing of importance of drug and alcohol, as well as harm reduction measures and prevention measures.

Third, future research could fruitfully include the perspectives of other stakeholders in the drug policy field. As with most research projects, the narrative presented in this thesis is only partial. The work presented in this thesis is based mainly on the voices of participants who are active in NGOs and is therefore limited largely to their perspective — it does not include the voices of government agencies, except in official form as contained in official documents, policy and reports, and it does not include the voices of the targets of these policies: people who use drugs themselves, except where they are represented by drug user organisations. Future work could address this by including voices from public administration and people who use drugs. As such, future work could focus on looking at the policy advisory systems of Australian drug policy more interactively/synergistically, considering the interaction of actors internal and external to government (Craft & Howlett, 2013).

Finally, further research could focus more specifically on the unique policy roles of particular types of organisations, including drug and alcohol peak bodies and aboriginal drug and alcohol organisations. Due to the broad scope of this thesis, it is not possible to comment on the activities or history of any particular organisations or types of organisations in great depth. The work presented here does not discuss the history and work of drug and alcohol peak bodies in-depth. This is an important area for future investigation, to illuminate how peak bodies represent and facilitate NGO participation in the drug policy space. My thesis also does not address the unique history and issues of drug policy in relation to Aboriginal and Torres Strait Islander and the work of non-government organisations in this area. This is a particularly important area for future research, considering the specificities of power.
relationships between Aboriginal and Torres Strait Islander peoples in the drug and alcohol space, and in the policy space more generally (Manderson, 1993, 1997).

Conclusion

This thesis set out to examine the idea of government/non-government partnerships in the drug policy field, and to understand its impact on the non-government sector’s participation in drug policy. Contemporary Australian drug policy draws heavily on a discourse of partnerships, under which a diverse range of stakeholders are positioned as important to fulfilling the goals of policy. As established throughout this thesis, however, questions still remain about how to move government/non-government partnerships beyond rhetoric and into practice, particularly at the policy level.

It is precisely because drug policy is such a contested area of state-centric policy-making that there is such room for non-state actors to engage with it, but also so many constraints on their ability to actually shape decision-making in the field (Roberts, 2014). Drug policy is an area that cuts across diverse fields that are not always within the scope of the state or its criminal justice agencies. It is an assumption of this thesis that NGOs can contribute meaningfully to policy, and that innovative policy and practice change often happens ‘from below’. These NGOs work with a highly excluded and criminalised population of ‘service users’, or as one participant put it, ‘clients at the arse end of the health system’ (Interview 13) In this sense, NGOs represent an important touch point to represent the experience on ‘the ground’, the ‘community’, and the interests of people who use drugs in the policy process, and to resist negative policy change. It is also important to recognise, however, that NGOs can also be involved in perpetuating dominant power relations.

In seeing partnerships as a technique of neoliberal government it should not be assumed that NGOs are increasingly being dominated by the state, that they are perpetuating or extending state power, or on the other hand that now under neoliberalism they have been ‘set free’ from these relations of power. The lines of distinction between “philanthropy and welfare”, “the state and civil society” have been “far more complex and mobile than people imagined” (Valverde, 2008, p. 164). As this thesis has shown,
the position of non-government sector organisations in relation to the state and (neoliberal) governmentality is complex; organisations “simultaneously resist, perpetuate and are regulated by the state” (Carey, 2008, p. 19). Some organisations work with the state in collaboration, some work for the state, and still others work outside of the state where they rely on funding sources from outside of government.

Like so many other fields, the lines between the state and civil society, government and non-government organisations, are not always clear-cut in the drug and alcohol field. Nevertheless, governmentality provides a lens to look past the sharp distinctions often delineated between the state and the non-government sector, to take account of the broad power relations running through voluntary action in the drug policy field. As Villadsen (2011) notes, “agents of civil society often play decisive roles in constructing domains of intervention that are later turned into objects of official governmental policy and planning. This is familiar ground for those who study governmentality” (p. 229). Part of the value of governmentality lies in this broad conception of politics, encouraging the study of a diverse array of practices of politics beyond the state. Governmentality thus provides a framework for viewing NGOs as important sites through which the microphysical processes of power work to shape modes of governance. In studying institutions through the concepts on which they are based, and the ideas, processes and activities that they engage in, provides possibility for recognising the interdependence of institutions, whereby “the transformation of one institutional field inexorably leads to questions about contiguous fields” (Garland, 2001, p. 6). Thus what I have tried to draw attention to here, is not just how the state mobilises the non-government sector in projects of governing, but also how the non-government sector mobilises the state and the kinds of ideas or discourses that structure power relations in this field. Non-government organisations in this sense need to be viewed as potential change agents, but we cannot lose sight of the fact that the politics of the drugs field matter for their ability to shape and influence the direction of policy.
Appendix A: Invitation to Participate in Research

Project Title: The politics of state-third sector partnership in the Australian drug and alcohol field

My name is Natalie Thomas and I am a PhD candidate in the School of Criminology and Criminal Justice at Griffith University. I would like to invite you to participate in my doctoral research entitled, *The politics of state-third sector partnership in the Australian drug and alcohol field*. The broad purpose of my study is to gain an understanding of the role of the third sector (also known as the non-government/not-for-profit sector) and its relations with government in the Australian drug policy field. In particular, the objectives of the study are to investigate understandings of 'partnerships' between the non-government/not-for-profit sector and governments in the Australian drug policy field, and the implications of these partnerships for non-government sector policy advocacy around drug and alcohol issues.

With this in mind, I am interested in talking to staff from non-government organisations who work in a policy, advocacy or research role, or whose role includes performing policy advocacy work. I would also be interested in talking to staff that have previously performed these duties. For the purposes of this research, policy or advocacy work includes a range of policy-relevant activities, including commenting on government policy, preparing submissions for public reviews or inquiries, liaising with government stakeholders, participating in consultation processes, or preparing policy positions and statements. I ask that you take the time to distribute the attached letter to anyone in your organization who is involved in these roles.

Participation in the project will involve a face-to-face interview at a time convenient for you. Interviews should last no more than one hour. Participation is completely voluntary, and interview data will be de-identified.

If you are interested in participating in this research study or know an appropriate staff member who may be interested, please contact me either by telephone on 0430 374 276 or email (Natalie.Thomas@griffithuni.edu.au). You are not obliged to participate by contacting me. All emails are private.

The study has been granted ethical approval by the Griffith University Office for Research (Protocol Number: CCJ/43/13/HREC). If you have any questions or concerns about this project you can contact myself or my supervisor, Dr. Melissa Bull by telephone on (07) 3735 3328, or by email (m.bull@griffith.edu.au).

Also, please feel free to forward this email to anyone you think may be interested in participating in this project.

Sincerely,

Natalie Thomas
Appendix B: Interview Guide

Individual/Organisational Background

1. Can you tell me a bit about your experience in the drug and alcohol sector, and how you have come to work in this role? Time in organisation/role?

Policy process

2. Can you tell me how you think the drug policy process actually works in Australia — how does it happen and who has a say? At the federal level? At the state and local level?
3. What mechanisms are in place for NGOs to contribute to drug policy in Australia? In your state/territory?
4. What involvement does your organisation have with the drug policy process in Australia? For example, what kind of policy work does your organisation participate in? Are there any formal mechanisms in place for your organisation to contribute to policy? Informal?
5. How would you characterise the role of NGOs in the drug policy process in Australia? What purpose do NGOs serve in the policy process?
   a. What does/would “success” look like to you? How do you know that you are making progress?
6. (If relevant) Can you tell me about the relationship between your organisations service delivery and policy advocacy?

Relations with Government and Partnerships

7. In general, how would you characterise relations between the government and the non-government sector the drug field over the time of your experience? Currently?
8. Can you tell me what the concept of partnerships between the government and the non-profit sector means to you? In the drug field?
9. Can you tell me about government-non-government sector ‘partnerships’ in terms of service delivery? In terms of the policy process?
10. Do you think the idea of ‘partnerships’ in the drug field affects NGO advocacy and policy work, and if so, how? Your organisation’s work specifically?
11. Tell me what you think the Abbott government means for drug policy
12. Tell me about what you think the change in state government means for voluntary sector participation in the drug policy process

Drug Policy
13. What are some of the strengths, and some of the problems, of Australian drug policy?
15. Can you tell me what you think about harm minimisation?
16. What are your organisation’s priorities in terms of commenting on drug policy?
17. What do you think should be the priority issues of Australian drug policy and how does this differ from current policy?
18. What is ‘evidence-based treatment’ in the drug and alcohol field and what does it mean to you?
19. Can you tell me your thoughts on the provision of drug treatment and interventions services in a criminal justice context?
20. Can you tell me your thoughts on the ‘new recovery’ movement’?

Thank you for your participation.
Appendix C: Information Sheet

Participant Information Sheet

Project Title: The politics of state-voluntary sector partnership in the Australian drug and alcohol field

Dear Participant,

You are asked to participate in a research study conducted by Natalie Thomas from the School of Criminology and Criminal Justice at Griffith University for the purposes of a PhD thesis, supervised by Dr Melissa Bull, Dr Catrin Smith and Dr Rachel Dioso-Villa. Your participation in this study is entirely voluntary. Please read the information below and ask questions about anything you do not understand, before deciding whether or not to participate.

Purpose of the Study

The broad purpose of my study is to gain an understanding of the role of the voluntary sector and its relations with the state in the Australian drug policy field. In particular, the objectives of the study are to investigate understandings of ‘partnerships’ between the voluntary sector and the state in the Australian drug policy field, and the implications of these partnerships for voluntary sector policy advocacy around drug and alcohol issues. You have been invited to participate in this project because you are a staff member who is (or has been) involved in a policy, advocacy or research role in a voluntary sector organisation.

Procedures

If you volunteer to participate in this study, you will be asked to do the following:

1. Participate in a tape-recorded interview, anticipated to be approximately 30 to 60 minutes long, in which I will invite you to talk about your views of state-voluntary sector partnerships, drug treatment, and policy, recollect examples, or discuss other related issues of concern to you relating to drug policy. Following the interview, I will transcribe the recorded conversation.

2. This interview transcript will be shared between the research team, although names will be kept confidential. Interview transcripts will be de-identified.

Confidentiality

Interviews will be recorded and fully transcribed. Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission. Confidentiality will be maintained by using a pseudonym instead of your name when transcribing the interview. Thus data will not be reported in any way that will allow the identification of individual respondents. The information you provide, as well as any direct quotes you might provide, will be de-identified during the transcription process and the reporting process. Data will not be reported in any way that will allow the identification of individual respondents. No identifying information will be kept on file at the completion of the research.

Data Storage

Interviews will be recorded and fully transcribed. Any physical materials (written notes, consent forms, etc.) will be stored in a locked filing cabinet in a secure location, and only the researcher and her two supervisors will have access. Any electronic materials (transcribed notes, and audio files) will be de-identified and password protected.

Potential Benefits and Risks

This study will not bring you specific benefits outside of providing an opportunity to share your views about the voluntary sector, state-voluntary sector partnerships and drug policy.

The research team does not believe there are any risks beyond normal day-to-day living associated with your participation in this research.
Participation and Withdrawal

If at any time you feel uncomfortable responding to a question, feel free to decline responding to the item(s). You may also withdraw from the study at any time without any adverse consequence.

Contacts

If you have any queries about the study itself, please do not hesitate to call myself on (07) 3735 5858, or my supervisor, Melissa Bull on (07) 3735 3328.

Griffith University conducts research in accordance with the National Statement on Ethical Conduct in Human Research. If you have any concerns or complaints about the ethical conduct of the research project you can contact the Manager of Research Ethics at Griffith University on (07) 3735 5585. Alternately, you can contact them at the following email address: research-ethics@griffith.edu.au.

Legal Privacy Statement

The conduct of this research involves the collection, access and / or use of your identified personal information. The information collected is confidential and will not be disclosed to third parties without your consent, except to meet government, legal or other regulatory authority requirements. A de-identified copy of this data may be used for other research purposes. However, your anonymity will at all times be safeguarded. For further information consult the University’s Privacy Plan at http://www.griffith.edu.au/about-griffith/plans-publications/griffith-university-privacy-plan or telephone (07) 3735 5585.

If you are happy to continue, please read and understand the following points on the consent form before signing and dating the consent form in the space provided.

Yours Sincerely,

Natalie Thomas
Appendix D: Consent Form

Consent to Participate in Research

Project Title: The politics of state-voluntary sector partnership in the Australian drug and alcohol field

Research Team: Natalie Thomas, Dr Melissa Bull, Dr Catrin Smith, Dr Rachel Dioso-Villa

I have been given information about the above named project and discussed the research project with Natalie Thomas who is conducting this research as part of a PhD thesis supervised by Dr Melissa Bull, Dr Catrin Smith and Dr Rachel Dioso-Villa in the School of Criminology and Criminal Justice at Griffith University.

By signing below, I confirm that I have read and understood the information package and acknowledge that:

- I understand that my involvement in this research will include a semi-structured interview;
- I have had any questions answered to my satisfaction;
- I understand the risks involved;
- I understand that there will be no direct benefit to me from my participation in this research;
- I understand that my participation in this research is voluntary;
- I understand that if I have any additional questions I can contact the research team;
- I understand that I am free to withdraw at any time, without comment or penalty;
- I understand that I can contact the Manager, Research Ethics, at Griffith University Human Research Ethics Committee on 3735 5585 (or research-ethics@griffithuni.edu.au) if I have any concerns about the ethical conduct of the project; and
- I understand that my interview will be audio-taped;
- I understand that only the research team will have access to this tape;
- I understand that the audio-tape will be erased following transcription;

By signing this document I agree to participate in this project.

Name of Participant:kinsm---------------------------

Signature & Date: ---------------------------------------------------------------

You may request a summary of the major findings of the project, and you are free to review or amend your deidentified comments contained therein by contacting Natalie Thomas (Email: natalie.thomas@griffithuni.edu.au; Telephone: 07 3375 6858).

Please indicate if you wish to receive a summary of the major findings upon completion of this study: YES / NO

Preferred contact address for receiving summary of findings:

-------------------------------------------------------------------------------

Thank you for your participation.
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